A DESCRIPTIVE STUDY: PROFESSIONAL AND SOCIO-CULTURAL PROFILES OF MENTAL HEALTH WORKERS IN TURKEY

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A Descriptive Study: Professional and Socio-cultural Profiles of Mental Health Workers in Turkey

Betimleyici Çalışma: Türkiye'deki Ruh Sağlığı Çalışanlarının Profesyonel ve Sosyo-kültürel Profilleri

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Thesis Abstract

A Descriptive Study: PROFESSIONAL AND SOCIO-CULTURAL PROFILES OF MENTAL HEALTH WORKERS IN TURKEY

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The main purpose of the study was to describe the mental health workers in Turkey in terms of four aspects, which were socio-demographic characteristics, educational background, professional information, and political and religious related social identities. A sample of 245 mental health professionals, consisting of psychologists, psychiatrists, psychological counselors, clinical psychologists and clinical psychology MA students filled out the questionnaire. Two methods were utilized. The public link of the questionnaire was sent to the major email groups in which mental health workers were the members. Via the link, the purpose and the content of the study were stated. In addition, the questionnaire was converted into a hard copy, and then distributed to major hospitals, psychological counseling centers, and private psychotherapy clinics in Istanbul. The findings displayed detailed information about the mental health workers in terms of five groups. These were socio-demographic characteristics, educational and training background, experience related

characteristics, client related characteristic and proposed interventions. The study further investigated factors that predict healing in clients, drop-out rates and reasons, proposed primary interventions, and difficulties experienced by professionals with different cases. Lastly, limitations and implications for further studies were discussed.

Tez Özeti

Betimleyici Çalışma: TÜRKİYE'DEKİ RUH SAĞLIĞI ÇALIŞANLARININ PROFESYONEL VE SOSYO-KÜLTÜREL PROFİLLERİ

Sevilay Sitrava-Günenç

Bu çalışmanın temel amacı, Türkiye'deki ruh sağlığı çalışanlarının, sosyo-demografik özellikler, eğitim geçmişi, profesyonel bilgiler ve politika ve dinle ilişkili sosyal kimlikler olmak üzere dört açıdan betimlemektir. Araştırma anketini, psikolog, psikiyatrist, psikolojik danışman, klinik psikolog ve klinik psikoloji yüksek lisans öğrencilerinden oluşan toplam 245 kişi doldurdu. İki yöntem kullanıldı. Anketin linki, ruh sağlığı çalışanlarının üye olduğu e-posta gruplarına gönderildi. Bu linkte, ayrıca çalışmanın içeriği ve amacı belirtildi. Buna ek olarak, anketin basılı kopyası hazırlanarak, İstanbul'daki belli başlı hastanelere, psikolojik danışmanlık ve psikoterapi merkezlerine gönderildi. Araştırmanın sonuçları, ruh sağlığı çalışanlarının beş ayrı gruptaki detaylı bilgilerini göstermektedir. Bunlar, sosyo-demografik özellikler, eğitim geçmişi, deneyimle ilişkili özellikler, danışanlarla ilişkili özellikler ve önerilen müdahalelerdir. Ayrıca, bu çalışma danışanlardaki iyileşme oranını, klinik tedaviyi yarıda bırakma oranı ve sebeplerini, önerilen birincil müdahaleleri, farklı vakalarla

çalışırken profesyonellerin yaşadığı özorluk derecelerini yordayan faktörler incelenmiştir. Son olarak, çalışmanın kısıtlılıkları ve gelecek araştırmalara dair öneriler tartışılmıştır.

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CHAPTER I. INTRODUCTION

The field of mental health has been given more importance in the last two decades by health sector professionals, such as medicine doctors, nurses and dieticians, and lay people in Turkey. The mental health is considered with the body health together. It is almost impossible to detach the body and mind pair. This couple is implied that humanôs health is formed by being both ñmentally hygieneò (Kraft, 2009), and also bodily.

Mental health is conceived of as a complete state in which individuals are free of psychopathology and *flourishing* (Keyes, 2002) with high levels of emotional, psychological, and social well-being. The rising importance of mental health field brings the inquiry about the field in details. By whom this field is comprised of in Turkey, the specialties of these professionals will be the first step of defining the mental health field in Turkey.

Hence, in this study, the mental health workers will be described in terms of many characteristics, such as demographic information, professional profiles, and socio-cultural profiles. By defining the descriptive features of mental health workers, the current picture of the field will be

seen. This will enable to learn who works as a mental health worker, in which setting one works, of which academic and professional educations one has, and etc.

In this research, mental health professional and socio cultural profiles of mental health workers in Turkey will be described. Who the mental health workers are, what kind of identifying variables they have, political, socio cultural views of professionals, which field of study they graduate, which educational programs they undergo, personal therapy for professionals, which theoretical orientation they are capable of and prefer to use are the main points of the study.

In addition to the description of the mental health sector in Turkey, this study presents the explorative statements about the mental health field in Turkey and the characteristics of the professionals. Therefore, the effective variables of the mental health field will be explored.

1.1. Literature Review

1.1.1. What is Health?

Health is the most crucial condition for every living thing, in order to exist and survive. For human beingsô health brings some other needs with itself. Physical needs are the formerly ones, which make human beingsô life more livable. Being sheltered, nourished with both food and water, having air are the indicators of the fact that human beings are provided physical needs to survive. Then, as Maslow (1987) mentions in the theory of needs of hierarchy feeling safe and secure is the second step to be provided, in

addition to physical needs. These needs are the first ones that form body health. Besides body fitness, health has one more important component enabling human beings live, which is mental health.

World Health Organization (WHO, 2006) defined health as being ña state of complete physical, mental, and social well-being and not merely the absence of disease or infirmityò (p. 1). Thus, oneôs health cannot be considered as only one part, like physically, but also mental health and social well being are the other complementary parts of health.

1.1.2. What is Mental Health?

One important component of health is mental health, which is a term used to describe either a level of emotional well being or an absence of a mental disorder as a psychopathology (Keyes, 2005). World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her communityò (WHO, 2005, p. 1). Mental health includes perception, cognitive schemas, coping mechanisms, socially wellness, and emotions. These form all human beings mentally. As Keyes (2002) defines mental health which is a positive functioning constituted by the subjective wellness, including oneôs perceptions, and oneôs evaluations of life in terms of quality and the effectiveness. Thus, mental health has a role to determine oneôs behaviors, cognition, social interactions, and etc.

As mentioned above, health can be considered neither without mental health nor without physical or psychosocially health. From a holistic perspective, they all interact with one another, and contribute to oneôs daily life. If a human being feels disturbance in oneôs body, one may immediately want to get help from a medicine doctor. In addition, if one becomes to have a problem with an acquaintance, one generally may get in contact with the other party to solve their problem. Yet, when a human being feels a problem, one may not know how to overcome the problem, or get help from a professional being from a mental health service.

1.2. Mental Health Services in General

1.2.1. History of Mental Health Services in General

Mental health field stands for a variety of services. In general all around the world, this sector includes psychopharmacological treatment, psychotherapy, psychological counseling, pedagogical support, rehabilitation works and etc. These all deal with the human beingsô psychological wellness, behaviors, hormone levels, and/or perceptions etc.

In Europe, during the Middle Age period, mental health was concerned with insanity, as a mental disorder, instead of oneôs health as a whole. In England, a public hospital being the largest one in those years was built in 1744, in order to deal out with insanity (Jones, 1972). The hospital, named Bethlem, became the one of the most crucial parts of National Health Service in the year of 1948 (Jones, 1972). During those times, only the people with ñimpotent poorò (p. 18) condition, being not able to work and

provide oneôs own physical needs, were treated, any other kinds of mental illness were not even taken into consideration.

In many other societies, spiritual or religious explanations dominated the methods within which people with mental disorders had been treated for decades. Then in the seventeenth century, the illness of madness was explained as a physical state (Funk, Saraceno, & Pathare, 2003). A huge amount of ñimpotent poorò (Jones, 1972, p. 18) people had been confined in poorhouses, public prisons, workhouses or general hospitals in Europe and in the North America during 1600ôs and 1700ôs (Goodwin, 1997). These people were named as ñsubhumanò (Funk, Saraceno, & Pathare, 2003, p. 17) who were believed as incurable patients, and physically restrained in terms of confinement. During the eighteenth century, people being mentally disturbed were being used to check the living conditions whether they were poor or not.

With the improvement of humanitarian attitude, during the eighteenth century, some reforms were needed to cure mentally disturbed people. In order to serve to this aim, many institutions developed more different treatment programs, being more moral (Breakey, 1996). This perspective of moral treatment programs led to the constructions of many other shelters both in the United States and European countries. Yet, there became also some other problematic in this model of treatment in the huge, public institutions. These were financial restrictions, and huge amount of people who applied to those institutions. Eventually, these public

institutions became the institutions providing only protection and care to mentally restricted human beings (Funk, Saraceno, & Pathare, 2003).

During the twentieth century, there became a change in custodial programs, emphasizing only protection and care services. More emphasis occurred in treatment of people being mentally restricted, which was a more humane perspective (Funk, Saraceno, & Pathare, 2003). By the end of World War II, human rights had been more evolved and these prospering movements focused more on the defeat oneôs human rights. It was adduced that in the asylums, there were poor living conditions, caring and treatment programs were not enough and humanistic. Thus, human rights were violated in these institutions which were for the human beings, who were mentally restricted. In order to overcome this problem, the movement of deinstitutionalization had emerged (Anthony, 1993).

Deinstitutionalization stood for the processes of decreasing the number of chronically mentally restricted patients, who stayed in the state mental hospitals, minimizing and shutting down some amount of hospitals. Instead of these institutions, some other mental health services had been developed (Anthony, 1993). Since mental disorders might have some kinds of needs and demands, in terms of vocation, residency, education, and social interactions, alternative community- based settings had been developed. Towards the mid 1970ôs, in the States, the National Institute of Mental Health had promoted an idea of a system which was community supportive one (Turner & TenHoor, 1978). This community supportive system represented for the exclusion of isolation of the people, being mentally

restricted. In other words, these mentally ill people were assisted to meet their needs and enhance the potentialities without excluding from the community (Anthony, 1993).

In the European countries, such as in Italy, mental hospitals were also closed and instead of those, community-based services which were providing psychosocial rehabilitation, medical care and treatment for emergency circumstances (Funk, Saraceno, & Pathare, 2003). Moreover, these community-based services became more common in other countries and cities around the world such as Melbourne in Australia, Santos in Brazil, Lile in France, Madrid in Spain, and London in the United Kingdom (Funk, Saraceno, & Pathare, 2003).

Yet, then deinstitutionalization had been found inadequate, because this process was a complex one including implementations of the alternative supportive programs out of the mental hospitals (Funk, Saraceno, & Pathare, 2003). These alternative programs for the community health were believed cost effective, especially for the chronic patients who needed to stay in the hospitals. Then, it was realized that with the adequate budget and human resources service, community-based services might be established, without accompanying deinstitutionalization (Funk, Saraceno, & Pathare, 2003). In some developing countries, psychiatric hospital services which were the basic ones were improved and also some other psychiatric units were being established (Kilonzo & Simmons, 1998). In addition, there were some other hospitals which integrated the basic mental health services with the general

health services with the help of training the professionals to give the primary care in mental health (Kilonzo & Simmons, 1998).

With the coming of the 21st century, more significant improvements for the treatment of people who had mental disorders have been occurred. With the progress in social sciences, in treating the mental health, psychological and psychosocial aspects have been taken into consideration (Funk, Saraceno, & Pathare, 2003). Eventually, mental health workers have the chance to reach more effective treatment programs for the people with mental disorders.

1.2.2. The Diversity of Mental Health Service in General

In 1980ôs classification of the results of illnesses, World Health Organization has defined the services of mental health field such as treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support and self-help (Anthony, 1993). These are the service categories that help the people suffering from mental disorders.

Treatment was effective to reducing the intensity of symptoms in order to relieve from the symptoms which might make the human beings distressed. Crisis intervention was used for controlling and solving oneôs problems which might be dangerous and/or critical. With this kind of help, people with mental health illness were intended to provide personal safety. The other type of mental health service was named as case management. It was the service that planned to obtain the important and necessary services for the people with mental illness, which were their needs and desires. The

outcome of this service was to access the care giving of the service (Anthony, 1993).

Rehabilitation was the other service category. The aim of this service was to develop skills of mentally restricted people and support them to achieve their goals in life. This eventually was expected to improve role functioning for those people. In order to provide self-development for the people suffering from mental illnesses, there was the service called as enrichment. It was planned to engage the patients in the activities which are suitable and satisfying for them. The other type of services was that rights protection. It was aimed to provide equal opportunity for the people being mentally restricted. Thus, the aim of this service was to advocate and upgrade oneôs rights in this field.

In addition, there was the other basic support service type. This was planned to assure personal survival, by providing human beings places, and needs which are required for survival, such as shelter, food, and health care. The last type of mental health services was named as self-help. This kind aimed to provide empowerment for the people themselves. This occurred with exercising a voice and choosing an alternative in oneôs own life (Anthony, 1993).

In those years, 1980ôs, mental health services for the people who needed special treatment program being suitable for one emphasized on not only mental impairments or relieving symptoms, but also functional limitations which are significant in oneôs life, disabilities, and handicaps for the one (Anthony, 1982). Thus, the treatment became effective in oneôs

whole life, in terms of such as employment, social interactions, and self-determination.

In recent times, mental health field has been more dealing with the human beings as a whole as mentioned above. People who have some kinds of problems either about mentally or socially or emotionally, in whatever settings, they are helped by the professionals. The professional help may differ according to the needs and purposes of an individual, having a problem. Both the kind of service category and the settings may depend on the individuals and/or problems. The mental health services may be given by a psychiatrist, psychologist, counselor, consultant, doctor, school counselor, and/or a member of a family. The settings may also be a hospital, school, and/or home.

1.2.3. The Importance and Functions of Mental Health Services in General

According to the number of publications in each year, it has been obvious that mental health services have become more common in the last two decades (Safran, Mays, Huang, McCuan, Pham, Fisher, McDuffie, & Trachtenberg, 2009). Around the world, mental health care systems have spread out largely. Since there have been different types of mental health services, the prevalence of utilization of service categories may differ according to the countries, or needs, wants of the people looking for a mental health service.

In the United States, mental health services have mostly taken place in terms of social variables, such as employment, housing, and income

(Safran et al., 2009). These kinds of circumstances for oneôs life may be significant enough to define mental health. Eventually, in the field of mental health, human beings are aimed to provide the mental health service in terms of improving and/or exploring oneôs social traits. Moreover, the mental health services may also be utilized in terms of psychometric assessments. Yet, it has been found out (Safran et al., 2009) that psychometric values may depend on the racial and/or cultural differences. Thus, the values may be different in culture to culture, and this may not be valid for all the populations.

In the Far East, such in China, mental health issues have been seen within the family dynamics (Lim, Lim, Michael, Cai, & Schock, 2010). Since in China, collectivism has been the significant characteristic for the society, even the problems for one person has been dealing in a matter of collectivism. Eventually, resolving a problem or a situation for an individual has been seen with the family as a whole (Lim et al., 2010). In addition, individual psychotherapy is currently available, even though being limited. Individual psychotherapy from specialized professional is also very limited, being available in mostly the urban settings.

For those of the reasons, the professionals suggest to study in a different way, by both including the community as a whole and improving techniques for personal therapies. As soon as the works for the community would provide immediate resolving types in a society, and/or the ability to anticipate the possible problems, and behave in accordance with that. For these reasons, prevention studies are planned to study in the near future in

China (Lim et al., 2010). Moreover, in order to develop the effectiveness of personal psychotherapy, more sufficient and theoretical intervention techniques are planned to involve in the mental health services (Lim et al., 2010).

In Europe, such in the United Kingdom, primary care in terms of mental health is conceived at schools. Since there has been a rise in the rate of school leaving in UK, especially in Wales for a few years, emotional health care has been the uprising point of view in schools (Terry, 2006). Leaving a school may point or stand for an intensive feeling, as a result of an experience that the student has lived at home, or school, or etc. Yet, the contribution place of those feelings has become the schools. The reasons for this may be being illiterate in terms of emotions, or having a limited emotional repertoire to express oneself. Eventually, mental health services are believed to become widespread especially in schools, where is the best community place to reach large amounts of people, at school ages (Terry, 2006).

In Canada, mental health services have been mostly given by the psychiatrists. They have been giving people, who needed mental health service, mostly medical treatment, by utilizing psychiatric medication (Kolodny, 2007). In addition to higher prevalence of medication by the psychiatrists in Canada than the other mental health care systems, psychiatrists have also played an administrator role for the well being of the society, as a whole. They are given both the role of a doctor, and also the

role of the administrator, who organizes and/or modifies mental health policies, and supplies indirect commune services (Kolodny, 2007).

1.3. Mental Health Service in Turkey

1.3.1. History of Evolution of Mental Health in Turkey

The mental health has been given importance since the Seljuk and Ottoman periods (Gökalp & Aküzüm, 2007). In the East part, psychotic people were thought to be sinless, and assumed to be closer to God. With that reason, for those individuals with psychosis were given much more respect. By the era of healing, new buildings had also constructed in case the individuals diagnosed with mental illness were able to be cured, in the teaching hospitals (Gökalp & Aküzüm, 2007). Then, asylums were built for those mentally ill people to treat them with music and flower-scented baths (Bayülkem, 2002).

The financial support for these developments had been taken by agricultural, artisan, craftsman works till the Ottoman Empire (Gökalp & Aküzüm, 2007). These artisansô works had played important roles in terms of social security organizations, so that the members of the organizations could have given financial support. With these support, asylums were built in the country for the individuals diagnosed with any kind of mental health problem.

In 1935, legislation period had started preparing. After a decade, in 1945, the Social Security Institution was constituted in order to provide health needs of working class, being included in the social security system

(Dilik, 1971). Then, with the period of socialization and decentralization of health care in 1960s, preventive mental health implementations had been increased, especially in rural areas. This service had also been free of charge for the large populations in those areas (Gökalp & Aküzüm, 2007).

There had been also reforms in the mental health houses, and/or asylums in years. In the beginning of the twentieth century, asylums were reformed firstly, where were the favorite place in order mental illness to be cured. Then the first mental health hospital was founded in Elazig in the east part, and in Manisa in the west part of Turkey (Gökalp & Aküzüm, 2007). In psychiatry and neurology the first teaching hospital was founded in Bakirkoy, Istanbul in 1927.

During 1940s, individuals diagnosed with a mental illness had stayed in the hospital and were employed in the hospital in cooking, laundry, agricultural works, gardening and some other different jobs with a few salaries. Yet, because of the financial problems and limited resources, the system could not have continued (Gökalp & Aküzüm, 2007). By the support of psychiatry departments in Ankara and Kocaeli universities, new mental health hospitals were founded. New rehabilitation centers have also been constituted for a few years, within which both inpatients and outpatients have been given treatment. The families of the patients have also been given psychological support (Gökalp & Aküzüm, 2007).

1.3.2. Demographic Information of Mental Health Workers

Mental health workers have mostly meant psychiatrists in the past years, especially because of the mental health hospitals. Yet, in the last decades, mental health services in all countries, including Turkey have been expanded in range. In Turkey, mental health professionals have been working in different jobs in the mental health sector, including psychiatrists, clinical psychologists, psychologist with any other specialization field of psychology, neuro-psychiatrists, psychological counselors, social workers and/or psychotherapists.

With a start of definition of ñpsychotherapistò, Hill, Nutt, & Jackson (1994, p. 365) defined it as ñone who has been specifically trained as a professional therapist (e.g. counseling or clinical psychologists, psychiatrists, counselors, or social workers) or one who has been in training (e.g. prepracticum student, practicum student, and intern)ò. Thus, psychotherapist might be the adjective which defines the implementation of any kind of mental health worker. All the mental health workers have a possibility to be a psychotherapist, until they reach the requirements for that profession.

Psychotherapists may come from various areas of mental health sector. Guinee (2000) mentioned a brief report of the therapist sample. In his research, he had searched for the articles that were published in the Journal of Counseling Psychology between the years of 1988-1997. He questioned the characteristics of the therapists, and how consistently they reflected their traits on the researches. He mentioned about the

characteristics such as number of the sample, age, gender, race/ethnicity, professional status, setting, academic training, level of experience, theoretical orientation.

According to the results of Guineeôs study (2000), the number of the therapist sample is ranged from 1 to 320, with a mean of 30.4 (SD=49.23). Age range is from 22.5 to 51.5 with a mean of 36.2 (SD=7.5). 59% of the participants are female, 42% are male. The race/ethnicity of European Americans constitutes 86% of the samples. In terms of professional status, 52% of them are graduate students, 48% of them are professional therapists. In the present study, it is aimed to describe these variables mentioned above in Guineeôs study (2000), in the Turkish population among people who are dealing with the mental and psychological health sector. The gender distribution, age interval, professional statuses are intended to be described as the demographic information of the sample. In addition, working settings of the mental health workers are planned to be defined, mostly where the mental health professionals do work in Turkey. These work settings may be in a range, including private or state hospitals, private clinics, private or state schools, private or state universities, and etc.

1.3.3. Occupational Features of Mental Health Workers

1.3.3.1. Work Settings

In addition, work setting plays an important role for the implementation of the treatment program. In the study (Guinee, 2000) it is found out that 25% of the therapist sample work in the university counseling

centers, 9% of them work in both counseling center and hospital clinic, 8% of them work in academic departments, and 4% of them work in the mental health centers. 23% of the samples have the clinical psychology or counseling psychology training.

1.3.3.2. Experience years

There are various occupational features of mental health field, especially in terms of the professional characteristics. One of them which may play an important role for the treatment programs is experience year. It might be believed that the more experienced of a mental health worker, the better results may be taken from treatment. Yet in Guineeôs study (2000) experience years are argued whether the number of the experience year is valid for better solutions of treatment, or the number of the experience year with supervision is more valid. In his study (Guinee, 2000) the level of the experience of the therapist classified in three groups, novice (less than 2 semesters supervised practicum), experienced (2 or more completed semesters supervised practicum), experienced (postdoctoral psychologist).

1.3.3.3. Theoretical orientation

In addition to experience years, theoretical orientation of a mental health professional is the other important factor that may lead to various effects. Orientation of a mental health worker may influence the psychological process of a patient in terms of time, money, point of view, and etc. Since there are a variety of orientations, the chosen and

implemented ones may be effective for both the professionalôs opportunities and personal characteristics and the patientôs daily life.

In order to determine the theoretical orientation of the professionals, in Guineeôstudy (1994), participants are asked to list the most useful orientation they feel for themselves. In addition, Vasco and Dryden (1994) mentioned that while the therapists are selecting their theoretical orientation, they attend to different kinds of issues. The theoretical orientations are classified as humanistic and psychodynamic, systemic, cognitive, behavior, and eclectic. Thus, the points, that the therapists value, are different from each other.

A therapist who chooses to work with a humanistic or psychodynamic approach, he emphasized that orientation of his own therapist influenced his selection of his own orientation as a therapist. A systemic therapist is influenced by family experiences and type of patients they work with. These two groups of people are not influenced by the research results.

On the other hand, cognitive psychotherapists are seemed to be influenced by the research results, but not the orientation of own therapist. Behaviorstic psychotherapists are influenced by the research results, but without the effect of personal philosophy and values, and ability to help one understand oneself. Finally, therapists who choose eclectic approach, are also influenced by research results, and thinking of the ability to help one understand oneself, but without emphasizing the personal philosophy and values, and accidental circumstances (Vasco & Dryden, 1994).

The preference of the theoretical orientation is also found related with the values of the psychotherapists (Rubinstein, 1994). It is mentioned that the therapistsô values are significant for choosing the theoretical orientation, and in addition the attitudes toward the patients are associated with the values of the therapists. In another study (Norcross & Wogan, 1987), it is emphasized that 89% of the sample agree on personal values of psychotherapists have direct influence on the psychotherapy outcome. In addition, 43% of the sample agrees that therapy should be influenced by the therapistsô values, and 37% of the sample disagree on this. Moreover, therapists prefer behaviorist and humanistic approaches seem to agree more on the influence of the values, rather than the professionals of psychoanalytic approach.

In some other studies (Garfield & Kurtz, 1976; Vasco & Dryden, 1994) many other issues have been suggested in choosing the proper theoretical orientation for the professional.

In one of these studies (Garfield & Kurtz, 1976), it is found that most of the (55%) clinical psychologists prefer to work with eclectic approach in their practical field of profession. The second preferred theoretical orientation among the sample is psychoanalytic approach (11%).

In the other research (Vasco & Dryden, 1994), it is also discussed about the changes in the initial theoretical orientation. It is believed that the clinical experience of the therapist is the most fundamental factor that influences the changing the first orientation of the therapists. Yet, of course this change may not be occurred, unless the therapists are flexible enough.

In the present research, one of the important points is to see the prevalence of these theories in terms of being used by the psychotherapists, clinicians, psychiatrists, social workers, school counselors and etc in Turkey. Moreover, whether the theory they use are related with their previous experiences in their self-psychotherapy period. Hence, this study also tries to investigate whether the people working in psychological health field take psychotherapy for themselves, before or during their profession, or not.

1.3.3.4. The professional and academic profiles of mental health workers

In the study (Garfield & Kurtz, 1976), the professional and academic profiles of the clinical psychologists in the United States in the 1970s have been identified. The majority of sample of the study have a doctoral degree, with the percentage of 95. The level experience of the clinicians is different. It is less than one third of the sample, that their experience is less than 10 years. Besides, less than one third of the sample has the experience level of 20 or more years. The majority of the sample (%59) indicates that they view themselves as clinical practitioners, and secondly they view themselves as academicians with 20% (Garfield & Kurtz, 1976).

In another study (Affleck & Garfield, 1960), it is mentioned that experience is related with the congruent views of the patients about the psychotherapy process. This stands for the fact that the more the therapist is experienced, the more congruent idea he/she has about what the patient is

thinking about his/her own psychotherapy period. On the other hand, social workers of the study (Affleck & Garfield, 1960), show high reliability in the ratings of intelligence. Yet it is also mentioned that they show less agreement than experienced clinical psychologists about the psychotherapeutic outcomes or aspects.

1.3.3.5. Personal psychotherapy for the Mental Health Workers

Years of experience, working as a clinical psychologist, or psychiatrist, or social worker or school counselor, having personal therapy for the psychotherapists are also found indicative for the outcomes of the psychotherapy process of a patient. Thus, for a clinician working with different kinds of patients having personal therapy is very indicative (Garfield & Kurtz, 1976) in terms of being effective as a professional in that period. In this study, the sample contains 855 professionals, and 63% of the sample size has been taken their personal therapies. It is mentioned most of the professionals being undergone psychotherapeutic support are female. Moreover, one of the questions asked in the questionnaire of the study is whether every clinical psychologist must experience personal therapy process, or not. The answers are mostly ñyesò (45%) and ñnoò answers are not so few (38%). 17% of the sample is undecided for this question.

Another question being asked in the study (Garfield & Kurtz, 1976) is in what degree personal therapy for the psychotherapists is prerequisite in terms of being effective in the clinical performance of therapists. 36% of the sample mentioned that personal therapy is very important. 26% of the

sample agreed that personal therapy is moderately important. 22% of the sample is undecided about the importance of personal therapy. 15.5% of the sample mentions that it is unimportant.

In the present study, one of the aims is to find out whether professions dealing with psychological health issues spend much importance to take personal therapy, during or before they start performing in the field. Moreover, this study tries to mention whether there is an association between the theoretical orientation of personal therapy and the contents of the theoretical education of the psychotherapists, with explaining what kinds of educational programs psychotherapists undergo.

1.3.3.6. Political and Religious Views of the Mental Health Workers

Political views and religion are also important in terms of identifying professionals of psychological health field (Rubinstein, 1994). In this study, political views and the religious beliefs of the therapists in Israel are investigated. The sample size of the study is 624, and most of the practitioner participants (46.7%) define themselves from the left wing. This does not stand for Socialist view, yet traditional distinction between right and left wings in terms of socioeconomic system. Moreover, majority of the practitioner sample (76.5%) of the study (Rubinstein, 1994) defined themselves as secular in the scale of secular, traditional, orthodox, and ultraorthodox. 13.1% of the other practitioner sample defined themselves as traditional, 9.7% as orthodox, and lower than 1 % as ultraorthodox.

1.4. Research Questions and Explorations

1.4.1. Research Questions

The current study presented the variables that identified the mental health workers in Turkey in four different aspects. The first of them was socio-demographic characteristics. Secondly, educational backgrounds of the mental health workers were described. Thirdly, the professional details of the professionals in the mental health field were investigated. And lastly, political and religious related social identities of the mental health professionals in Turkey were described. In terms of these different four aspects, how the mental health workers were distributed in the field was the topic mentioned in the study.

1.4.2. Explorations

For the explorative analyses of the study, possible predictors of following dependent variables were explored: 1) Mental health workersô perceived level of healing in their clients. 2) The percentage of clients who completed the clinical service that was suggested by the professionals in appropriate time. 3) The drop out reason that difficulties were experienced in the clinical relationship, mostly due to the clinician. 4) The drop out reason that difficulties that were experienced in terms of theoretical orientation. That is, the theoretical orientation that the professional endorsed did not match with the clientôs needs or problems. 5) The primary intervention which was getting help from a mental health professional for

the people who experienced psychological difficulties in Turkey. 6) Psychotherapy as the proposed type of primary clinical intervention by the mental health workers for the people who experienced psychological difficulties in Turkey. 7) Total degrees of difficulty that the mental health workers experienced with different cases.

CHAPTER II. METHOD

2.1. Participants

The sample of the study was the professionals who work in the mental health service actively. The professionals who did not work with the clients actively excluded from the sample. The participants, the details of which could be seen in Table 1 named as socio-demographic characteristics, were described in terms of gender, age, marital status, birth place and city of residence.

Distribution of the socio-demographic characteristics was presented in Table 1 according to frequency and percentage distributions. As can be seen from the table, the sample consisted of 245 individuals. There were 195 females (79.6%), and 50 males (20.4%) in the sample.

Age of the participants had a mean of 32 (n= 244; SD= 8.1). The most prevalent age group was found to be 26 to 30 with 34.8%, followed by the age group of 22 to 25 with 21.7%.

In terms of marital status, the participants of the study were divided into two groups. The first group was the singles (58.4%), and the second

Table 1. Socio-demographic characteristics

Characteristics	*N*	*%*
Gender		
Female	195	79.6
Male	50	20.4
Age groups		
22-25	53	21.7
26-30	85	34.8
31-35	46	18.9
36-40	25	10.2
40+	35	14.3
Marital Status		
Single	143	58.4
Married/ Living Together	102	41.6
Birth Place		
Village/ District	18	7.3
Town	31	12.7
City	64	26.1
Metropolis	132	53.9
City of Residence		
İstanbul	177	72.2
Ankara	22	9.0
İzmir	12	4.9
Bursa	6	2.4
Others	28	11.4

Note: n= 244 for Age groups and *n*= 245 for the others.

group was formed by the people who were married or living together with a partner (41.6%).

With regard to the birth places of the participants, the majority (53.9%) was born in metropolitan cities, followed by cities (26.1%), towns ((12.7%), and villages or districts (7.3%).

The current cities of residence of the participants were also described in Table 1. Since there are eighty one cities in Turkey, the most common ones were presented, and the other ones with the lower frequencies were named as others. The highest percentage of the sample resided in İstanbul

(72.2%), followed by Ankara (9%), Ýzmir (4.9%), and Bursa (2.4%). 11.4% of the sample resided in the other cities of Turkey.

Table 2 contained the self reports of university degrees, and/or master, and/or doctorate, and/or post-doc degrees, self- description of occupation, and work setting.

The sample has a variety of occupation in the mental health field. The distribution of the occupations was presented in Table 2. The participants named their occupations by self report. They might define their occupations not only in one profession, but also more than one. The most percentage of the sample was formed by the individuals who work as a ñpsychologistò, with the highest percentage of 42.4.

The second popular occupation in the sample was ñclinical psychologistò group (18.8%). With the percentage of 20, the other group was the ñpsychotherapistò group. The fourth occupation group was ñpsychological counselorsò (10.2%). The following self reported occupation group was ñadult psychiatristò (7.4%).

The other occupation group identified by the participants was the ñpsychological counselor MAò group (7.3%). The following group was constituted by the ñadult psychiatrist internò group (5.3%). The other one was the ñpsychoanalyst candidateò group (3.2%). The following group of occupation was ñchild and adolescent psychiatristò group (1.2%).

Table 2. Characteristics of occupation, educational level, and work setting *(n= 245)*

	n	*%*
Occupation		
Psychologist	103	42.4
Clinical psychologist	48	18.8
Psychotherapist	48	20.0
Psychological counselor	25	10.2
Adult psychiatrist	19	7.4
Psychological Counselor, MA	18	7.3
Adult psychiatrist intern	14	5.3
Psychoanalyst candidate	8	3.2
Child & Adolescent psychiatrist	7	1.2
Psychoanalyst	5	2.0
Psychiatry nurse	5	2.4
Others	33	12.9
Education level		
Undergraduate degree	148	60.4
Master degree	73	29.8
Doctorate degree	22	9.0
Work setting		
Private psychological counseling center	41	16.7
Private psychotherapy center	35	14.2
State hospital	23	9.4
State psychiatry hospital	23	9.4
Rehabilitation center	18	7.4
Private university	18	7.4
Private office	17	6.9
State mental health hospital	16	6.5
Private hospital	15	6.1
NGO	15	6.1
Others	101	40.8

Note: n= 243 for Education level and *n*= 245 for the others.

The following two groups were identified by ñpsychoanalystò (2%) and ñpsychiatry nurseò (2.4%). The last group of occupation was defined as ñothersò which stood for the other types of occupations defined by the participants except the ones defined above (12.9%).

The individuals in the sample are reported their university degrees, in terms of undergraduate, graduate, doctorate levels. In table 2, the distribution of the university degrees was also presented. There were only two people who did not mention their degrees. Thus, there are only two missings in the sample. The highest percentage of the degrees was held by the participants (60.4%), who had only undergraduate level in their own field. The second group was formed by the individuals, who held only masterôs degree (29.8%), after their undergraduate level. In the last group, there were the participants who reported that they had doctorate level (9%), after their undergraduate and masterôs degrees.

The participants were also reported their work settings. The distribution of the settings was presented in table 2. The most common work setting of the sample was private psychological counseling center (16.7%). The following working setting of the sample was private psychotherapy centers (14.2%). The third common work place of the individuals in the study was state hospitals (9.4%). With the same percentage, the other work setting being reported by the sample was state psychiatry hospitals. The following two places at which the professionals work were the rehabilitation center and private universities (7.4% each). The next common working setting mentioned by the sample was the private offices of the mental health

workers (6.9%). The other place was the state mental health hospitals (6.5%). The next two working setting were private hospitals and non-governmental organizations (6.1% each). And the last group of work setting was named as ñothersò (40.8%) which included the other mental health working settings reported by the participants. It included the ones who did not work in the settings mentioned above, but in different ones. 40.8% of the sample was formed by this group.

2.2. Instruments

2.2.1. Questionnaire for the mental health workers

This study was a part of a larger study. The questionnaire of the larger study was developed by the research team (Murat Paker, Sevilay Sitrava-Günenç, and Ezgi Soncu) and was consisted of five modules. The modules were: 1) socio-demographic information, 2) educational background, 3) professional information, 4) self-definitions in terms of political and religious views, 5) clinical scales. The current study was based on only the first four modules of this larger study. These four modules of the questionnaire can be seen in Appendix 1.

In the first module, as demographic variables age, gender, marital status, hometown, and current town of the participants were asked.

The second module was named as education. In this module, the educational degrees were mentioned, whether the professionals had a bachelorôs, masterôs, doctoral and post-doctoral degrees, or not. If there was, it was expected to see from which field of study specifically the participants

had a bachelorôs degree, and masters, and doctoral degree. These were asked in a ñYes/Noò question format, if the answer was ñYesò then the participants were expected to write down whether it was abroad, or not, with the graduation year.

In the third module, professional profiles of the participants were expected to figure out. In this part, how the participants named themselves as a person performing clinical practice actively in the field was mentioned. In which settings, the professionals were working in terms of clinics, whether the participants were also working as an academician or not, whether the professionals provided clinical supervision to colleagues or not, the experience years of the participants were all asked in this module. This information was considered to report by the participants, by choosing multiple choices which best fit for themselves.

In addition, theoretical orientation of the clinical professionals, their theoretical education, and personal therapy for the clinicians and personal clinical supervision for the professionals were the important parts of the module.

Moreover, foreign languages the participants were capable of reading, and/or writing, and/or speaking, and/or being able to use them during the clinical practice was also asked in this module. The profiles of the patients/counselees applying for any kind of psychological help were intended to figure out. The progresses of these patients/counselees during any kind of psychological support, what the first and the second interventions for these people should be for their benefits were also

considered to define. Among these patients/counselees, with what kind of problems the professionals might be coerced was the other part of the module.

In the last module, the political, religious, and ethnic profiles of the participants were asked. The listed adjectives were asked in a likert scale format. The participants were expected to give answers in the five point scale, in which ñ0ò stood for ñnever define oneselfò, and ñ4ò stood for ñcompletely define oneselfò.

2.3. Procedure

The data of the current study was first collected through a web-based survey program called Webropol. The questionnaire of the study designed by the research team was set on the web site; and the link of the questionnaire was sent to the email groups of the professionals, in which psychologists, psychiatrists, psychological counselors, social workers, and other mental health workers were the members. With emails, e-invitations of the study were sent to people in the field. The ones, who accepted the e-invitation, could participate in the study. It was possible for the participants to go back to the questionnaire whenever they preferred to continue. It took approximately 30-40 minutes to fill in the questionnaire.

Via web link, between August 2009 and December 2009, there were 204 people being reached through Internet. Yet, it was thought limited for the purposes of the study, and then another process was added into the procedure. Then, in January 2010, hard copy of the questionnaire was

prepared and distributed to the mental health work settings by the research team. Those places were the ones which were the prominent psychiatry departments, mental health hospitals, psychotherapy centers, psychological counseling centers located in Istanbul. 264 questionnaires were sent to the mental health centers. 41 of them had returned. The return rate of the questionnaires was 15.5%. This sampling lasted three more months, beginning in January 2010 and lasting in April 2010.

In the sample, there were totally 245 participants. 204 (83.3%) were participated via e-invitations and 41 (16.7%) through hard copy invitations.

2.4. Data Analysis

In this study, identifying information of mental health workers working in the field of psychological health in different cities of Turkey was considered to figure out. The socio-demographic information, educational and professional characteristics were intended to describe. These variables were computed with the frequencies and percentage levels among the Turkish population of professionals working in mental health sector.

These professionals were divided into six different groups, according to the professions. The first group was the psychologists with BA degree and/or with a MA degree rather than clinical psychology (n=92). The second was formed by the psychiatrists, both the interns and the residents (n=31). The third group was defined by the psychological counselors who have a bachelorôs degree in the field of guidance and psychological counseling (n=29). In the fourth group, clinical psychologists who have a

masterôs degree in the field of clinical psychology were included (n=51). The fifth group was formed by the clinical psychology MA students (n=29), and the last group was named as ñothersò who did not match the previous groups, but others, such as social workers, psychiatry nurses and etc (n=13).

The relationships of the categorical variables among the six groups above were computed by Chi-Square. In addition, the relationships of the continuous variables among the six groups were computed by One-Way Analysis of Variance (ANOVA). The relationships among the groups were analyzed by Post hoc Scheffe results. Moreover, multiple regression analyses were performed for the explorative statements of the study.

CHAPTER III. RESULTS

3.1. Descriptive Analyses of the Study

In order to describe the characteristics of the mental health professionals, the results were classified into five groups, according to their contents. These are; socio-demographic information, education and training, experience related factors, client-related factors, and proposed interventions.

3.1.1. Socio-demographic Characteristics of the Sample

There were a total of 245 participants who completed the questionnaire of the study and included in the analyses. The mean age of the overall sample was 32. The sample of the study was mostly between the ages of 26 and 30, this age interval constituted 34.8% of the sample. Minimum age of the sample was 21, maximum was 61. The psychologists (M= 29.5) and the clinical psychology MA students (M= 27.3) were significantly younger than the other four groups.

Table 3 shows the socio-demographic characteristics of the whole sample and each professional group. The results showed that the mental health professionals were mostly female (79.6%). One fifth of the sample

was male. Psychiatrists were the only group in the sample with a majority of males (61.3%). More than half of the sample was single (58.4%). Almost half of the sample (44.5%) got divorced once. The highest percentages of getting divorced once belonged to psychologists and clinical psychology MA students, unexpectedly.

In terms of birth place, psychologists, psychological counselors, clinical psychologists and clinical psychology MA students were mostly born in metropolises. Yet, psychiatrists were mostly born in cities, and other professional group was mostly born in towns. Currently, majority of the professionals (72.2%) resides in Istanbul as a metropolis.

Table 3. Socio-demographic Characteristics

Socio-demographic Characteristics	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych. (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Mean Age (SD)	32.0 (8.1)	29.5 (6.9)	37.0 (8.6)	34.2 (7.3)	33.6 (8.5)	27.3 (5.1)	37.8 (9.3)	.000 1=5<2=3=4=6
Age Groups %								.000
22-25	21.7	37.0	---	6.9	---	55.2	8.3	
26-30	34.8	31.5	35.5	27.6	52.9	27.6	16.7	
31-35	18.9	16.3	16.1	37.9	19.6	10.3	16.7	
36-40	10.2	7.6	12.9	13.8	9.8	3.4	33.3	
40+	14.3	7.6	35.5	13.8	17.6	3.4	25.0	
Gender %								.000
Female	79.6	85.9	38.7	79.3	88.2	82.8	92.3	
Male	20.4	14.1	61.3	20.7	11.8	17.2	7.7	
Marital Status %								.027
Married & Living Together	41.6	34.8	54.8	55.2	49.0	20.7	53.8	
Single	58.4	65.2	45.2	44.8	51.0	79.3	46.2	
Number of Children %								NS
0	42.4	40.2	38.7	34.5	54.9	44.8	30.8	
1	44.1	47.8	35.5	55.2	33.3	51.8	38.5	
2	10.2	8.7	19.4	10.3	7.8	3.4	23.1	
3	3.3	3.3	6.5	---	3.9	---	7.7	
Number of Divorce %								NS
0	52.7	45.7	54.8	65.5	53.8	48.3	61.5	
1	44.5	54.3	35.5	31.0	42.5	51.7	38.5	
2	2.9	---	9.7	3.4	3.8	---	---	

Table 3. Socio-demographic Characteristics (contôd)

Socio-demographic Characteristics	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Birth Place %								.000
Metropolis	53.9	55.4	32.3	55.2	68.6	65.5	7.7	
City	26.1	22.8	48.4	20.7	21.6	27.6	23.1	
Town	12.7	14.1	9.7	17.2	5.9	6.9	38.5	
Village or District	7.3	7.6	9.7	6.9	3.9	---	30.8	
City of Residence %								.009
Istanbul	72.2	59.8	80.6	82.8	74.5	89.7	69.2	
Ankara	9.0	10.9	16.1	6.9	5.9	3.4	7.7	
Izmir	4.9	4.3	---	3.4	9.8	---	15.4	
Bursa	2.4	2.2	---	---	5.9	3.4	---	
Other	11.4	22.8	3.2	6.8	3.9	3.4	7.7	

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in guidance and psychological counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students
6: Other professionals (eg. Social workers, nurses etc.)

Participants rated some characteristics in terms of the degree to which they define their social identity as presented in Table 4 (for detailed table see Appendix 2). The participants rated the social identities in a likert scale from 0: no identification to 4: totally identified. These characteristics were classified into five different groups, according to the concept that they are based on as geography-based, national/ethnic, religious, political and sexual identities.

In terms of geography based identities, mental health professionals believed that mostly being an Earth citizen (3.1) and being from Turkey (2.7) identified them; whereas geographical-region based definitions identified them least (e.g. Tharcian: 0.4).

Comparing the six groups regarding geography-based identities, there were significant differences. It was found that: 1) Being Anatolian identified psychiatrists (1.6) more significantly than and clinical psychology MA students (0.4).

2) Psychiatrists (1.4) were the most identified group significantly with being Middle Eastern; whereas clinical psychology MA students (0.6), psychological counselors (0.5), and others (0.3) identified themselves significantly least.

In terms of national/ethnic identities, the mental health professionals mostly believed that being Turkish (2.2) identified them mostly, in spite of at somewhat level. They believed that the other national/ethnic identities did not identify them.

Regarding religious identities, the mental health professionals believed that being Muslim (1.5) and Sunni (1.0) defined them, despite to a low degree. Clinical psychologists believed that religious identities defined them the least, whereas the other professionals defined themselves the most with religion.

Comparing the six groups, there were significant differences regarding religious identities. It was found that: 1) Other professionals (2.5) identified themselves with being Muslim mostly (2.5); whereas psychiatrists (1.2) and clinical psychologists (1.0) defined themselves as Muslim the least.

2) Regarding being Sunni, others (1.8) defined themselves mostly, clinical psychology MA students (0.7), and clinical psychologists (0.5) were identified with being Sunni the least.

3) Other professionals defined themselves being Shiite the most, whereas psychiatrists (0.03) identified themselves with being Shiite the least.

The mental health professionals believed to be left-winger (1.4) mostly in terms of political identities. Among the groups, there were no significant results. In addition, regarding sexual identities, participants mostly defined them as heterosexual (2.5).

Table 4. Social Identities of Mental Health Professionals Groups

Social identities- Mean (SD) [0= no identificationé 4= high identification]	Total (n=244)	1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Geography-based identities								
Earth citizen	3.1 (1.1)	3.3 (1.0)	3.0 (1.0)	3.1 (1.2)	2.9 (1.3)	3.5 (0.8)	2.7 (1.4)	NS
Asian	1.2 (1.2)	1.4 (1.3)	1.3 (1.1)	1.3 (1.3)	1.1 (1.1)	1.0 (1.2)	1.1 (1.7)	NS
European	1.7 (1.3)	1.7 (1.2)	1.9 (1.2)	1.8 (1.4)	1.9 (1.3)	1.7 (1.4)	1.3 (1.5)	NS
Middle Eastern	0.9 (1.2)	0.9 (1.2)	1.4 (1.2)	0.5 (1.0)	1.1 (1.3)	0.6 (1.0)	0.3 (0.8)	.010 1=2=3=4=5=6
From Turkey (Türkiyeli)	2.7 (1.3)	2.8 (1.3)	3.0 (1.0)	2.4 (1.5)	2.7 (1.3)	2.7 (1.4)	3.0 (1.0)	NS
Anatolian	1.1 (1.3)	1.3 (1.4)	1.6 (1.3)	1.0 (1.2)	0.8 (1.2)	0.4 (0.9)	1.3 (1.4)	.005 5<2
Thracian	0.4 (0.9)	0.4 (1.0)	0.3 (0.7)	0.3 (0.8)	0.3 (0.9)	0.4 (0.9)	0.7 (1.1)	NS
National/Ethnic Identities								
Turkish	2.2 (1.5)	2.3 (1.6)	2.0 (1.4)	2.3 (1.6)	2.0 (1.5)	1.8 (1.5)	3.2 (1.2)	NS
Kurdish	0.3 (0.8)	0.3 (0.8)	0.7 (1.2)	0.2 (0.6)	0.2 (0.8)	0.2 (0.8)	0.2 (0.6)	NS
Arabian	0.1 (0.6)	0.2 (0.8)	0.03 (0.2)	0.2 (0.6)	0.02 (0.1)	0.03 (0.2)	---	NS
Circassian	0.1 (0.5)	0.1 (0.5)	0.1 (0.6)	0.2 (0.5)	0.1 (0.4)	0.1 (0.4)	0.2 (0.6)	NS
Bosnian	0.1 (0.5)	0.1 (0.3)	0.1 (0.3)	0.2 (0.5)	0.1 (0.4)	0.5 (1.1)	---	.005 1=4<5
Jewish	0.1 (0.5)	0.1 (0.3)	---	0.2 (0.8)	0.1 (0.7)	0.2 (0.9)	0.1 (0.3)	NS
Greek	0.1 (0.3)	0.1 (0.3)	0.03 (0.2)	0.2 (0.6)	0.04 (0.3)	---	0.1 (0.3)	NS
Religious Identities								
Muslim	1.5 (1.5)	1.7 (1.6)	1.2 (1.4)	1.7 (1.5)	1.0 (1.3)	1.4 (1.5)	2.5 (1.5)	.015 1=2=3=4=5=6
Sunni	1.0 (1.4)	1.2 (1.6)	0.9 (1.3)	1.1 (1.5)	0.5 (1.1)	0.7 (1.1)	1.8 (1.8)	.016 1=2=3=4=5=6

Table 4. Social Identities of Mental Health Professionals (contôd)

Social identities- Mean (SD) [0= no identificationé 4= high identification]	Total (n=244)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Alawite	0.2 (0.8)	0.3 (0.8)	0.1 (0.3)	0.3 (0.6)	0.3 (0.9)	0.2 (0.7)	1.7 (0.6)	NS
Shiite	0.1 (0.4)	0.1 (0.5)	0.03 (0.2)	0.1 (0.3)	---	---	0.5 (1.0)	.008 4=5<6
Political Identities								
Right-winger	0.2 (0.6)	0.2 (0.7)	0.1 (0.4)	0.2 (0.8)	0.1 (0.5)	---	0.2 (0.4)	NS
Left-winger	1.4 (1.5)	1.3 (1.5)	1.7 (1.4)	1.4 (1.5)	1.6 (1.4)	1.4 (1.5)	1.2 (1.5)	NS
Centralist (Merkezci)	0.3 (0.7)	0.4 (0.9)	0.3 (0.6)	0.4 (0.9)	0.2 (0.6)	0.1 (0.3)	0.3 (0.6)	NS
Nationalist	0.6 (1.1)	0.7 (1.1)	0.5 (1.0)	1.1 (1.4)	0.5 (1.1)	0.4 (0.9)	0.8 (1.1)	NS
Sexual Identities								
Heterosexual	2.5 (1.6)	2.5 (1.8)	2.4 (1.5)	2.6 (1.6)	2.5 (1.5)	2.5 (1.7)	2.3 (1.8)	NS
Homosexual	0.1 (0.4)	0.04 (0.4)	0.1 (0.5)	0.1 (0.3)	---	0.1 (0.7)	---	NS
Bisexual	0.1 (0.4)	0.1 (0.4)	0.1 (0.4)	0.2 (0.8)	0.02 (0.2)	0.04 (0.2)	0.1 (0.3)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

0= This social identity **NEVER** defines me. **1=** This social identity defines me **A LITTLE**. **2=** This social identity defines me **SOMEWHAT**. **3=** This social identity defines me **QUITE WELL**. **4=** This social identity defines me **TOTALLY**

3.1.2. Educational and Training Background

Table 5 shows that in terms of educational background, all participants had at least a bachelorôs degree. 39.5 % of the sample had a masterôs degree in different fields of study, and 9.3 % of the sample had a doctoral degree. In the group of psychologists, most of the participants (98.9 %) had a bachelorôs degree in psychology, and there were very few people who had a BA degree in psychological counseling and other BA degrees (1.1 % for each). In psychologists group, none of the participants in this group had clinical psychology masterôs degree, but 21.8% of the group had MA degrees in the other fields as presented in Table 5.

In the second group consisting of psychiatrists, 100% had an MD degree. Almost half of the psychiatry group (41.9 %) had a specialization in adult psychiatry, and 6.5 % of the group had a specialization in child and adolescent psychiatry. Thus, 51.6% of this group consisted of psychiatry interns.

In the third group consisting of psychological counselors, 79.3% of participants have completed BA. 41.4% of them had a MA degree in the field of guidance and psychological counseling. Besides, the participants in this group finished psychology, pedagogy, and others (13.8, 10.3, and 3.4%, respectively). The others had the MA degrees in the fields of neuropsychology (3.4%), other psychology (10.3%), and others (6.9%). 3.4% of the third group had a doctoral degree in other PhD field.

All participants in the fourth group consisting of clinical psychologists completed an MA degree in clinical psychology. Majority of

them had a BA in psychology (90.2%), followed by psychological counseling (3.9%), medicine and other BA degrees (2.0% each). 2.0% of the clinical psychologists completed an additional MA degree in other fields. 7.8% of the clinical psychologists having MA degrees in clinical psychology also had doctoral degrees in clinical psychology, and 2% of the clinicians had a doctoral degree in other psychology fields.

In the fifth group, 82.8% of the clinical psychology MA students completed BA degree in psychology, and 17.2% in psychological counseling and 6.9% in other fields.

In the last group, most of the other professionals (76.9%) had BA degrees in other study fields (e.g. nursing), 15.4% of the group had social service BA degree, 7.7% had a pedagogy BA degree. 46.2% of the group had a MA degree in other fields, and 15.4% had a PhD degree in other study fields, such as social work and psychiatric nursing.

Because of the low numbers in the cells, data analysis could not be conducted. Eventually, the percentage distribution was analyzed.

Table 5. Educational Background

Degrees (%)	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3* Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)
Any university degree	100.0	100.0	100.0	100.0	100.0	100.0	100.0
BA degrees							
Psychology BA	67.3	98.9	---	13.8	90.2	82.8	---
MD	13.1	---	100.0	---	2.0	---	---
Psychological Counseling BA	12.7	1.1	---	79.3	3.9	17.2	---
Pedagogy BA	1.6	---	---	10.3	---	---	7.7
Social Service BA	0.8	---	---	---	---	---	15.4
Other BA	6.5	1.1	3.2	3.4	2.0	6.9	76.9
MA degrees							
Clinical Psychology MA	20.8	---	---	---	100.0	---	---
Neuropsychology MA	0.8	1.1	---	3.4	---	---	---
Health psychology MA	0.8	2.2	---	---	---	---	---
Other psychology MA	3.3	5.4	---	10.3	---	---	---
Psychological Counseling MA	5.3	1.1	---	41.4	---	---	---
Forensic Science MA	1.6	4.3	---	---	---	---	---
Pedagogy MA	0.4	1.1	---	---	---	---	---
Other MA	6.5	7.6	---	6.9	2.0	---	46.2

Table 5. Educational Background (contôd)

Degrees (%)	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3* Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)
PhD degrees							
Adult Psychiatry MD	5.3	---	41.9	---	---	---	---
Child Adoles. Psychiatry MD	0.8	---	6.5	---	---	---	---
Clinical Psychology PhD	1.6	---	---	---	7.8	---	---
Other Psychology PhD	0.4	---	---	---	2.0	---	---
Other PhD	1.2	---	---	3.4	---	---	15.4

Those that have completed BA degree in Guidance and Psychological Counseling might have double major degrees in other fields.

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in guidance and psychological counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The total numbers of hours of theoretical training based on clinical subfields were in a wide range as presented in Table 6. The mean number of total theoretical training hours that the participants took was 704.3. Mental health professionals mostly got training in psychoanalytic/psychodynamic psychotherapy (103.7), and techniques of clinical interview (103.3), followed by diagnostic evaluation (82.5%), cognitive behavioral psychotherapy (68.7), and psychological assessment (45.6).

Table 6 demonstrated the mean numbers of hours of clinical subfields that the six professional groups got training in detail. Based on ANOVA results, there were significant differences among groups in terms of getting training in different types of clinical subfields. It resulted that:

1) Although psychologists were the least trained group totally (491.3), they were the most heterogeneous group in terms of getting training in different types of clinical subfields. They mostly got training in techniques of clinical interview (74.9), cognitive behavioral psychotherapy (55.4), followed by psychoanalytic/psychodynamic psychotherapy (54.4), and psychological assessment (42.7).

2) Psychiatrists, taking training in most hours (1359.6) among the six groups, took training mostly in the subfields of psychoanalytic/psychodynamic psychotherapy (239.3), diagnostic evaluation (233.1), psychopharmacology (225.7), techniques of clinical interview (215.8), and biological psychiatry (191.0).

3) Psychological counselors, being the third most trained group (611.7) among the six groups, mostly took the trainings in the subfields of

psychoanalytic/psychodynamic psychotherapy (76.6), followed by cognitive behavioral psychotherapy (72.3), techniques of clinical interview (67.9), and systemic psychotherapy (55.8).

4) Clinical psychologists, who were the second most training-taken group (921.5), had the most hours in psychoanalytic/psychodynamic psychotherapy field (153.5), followed by techniques of clinical interview (132.7), cognitive behavioral psychotherapy (97.4), and diagnostic evaluation (97.0).

5) Clinical psychology MA students, who were ranked fifth in terms of training hours (516.0), mostly took trainings in the subfields of psychoanalytic/psychodynamic psychotherapy (140.3), techniques of clinical interview (79.7), and diagnostic evaluation (58.0).

6) The ñotherò professional group got training mostly in the subfields of techniques of clinical interview (70.0), cognitive behavioral psychotherapy (64.8), and psychological assessment (55.8). The ñotherò professionals took the most number of hours (17.1) in the field of transactional analysis among the six groups.

Table 6. Total Number of Hours in Theoretical Training Based on Clinical Subfields Groups

Theoretical Training Mean # of hrs. (SD)	Total (n=221)	1 Psychologists (n=88)	2 Psychiatrists (n=28)	3 Psych. Counselors (n=26)	4 Clinical Psych (n=42)	5 Cli.Psy. M.A. St. (n=28)	6 Others (n=9)	p (NS, if p>.05)
Techniques of Clinical Interview	103.3 (175.9)	74.9 (85.7)	215.8 (422.5)	67.9 (72.8)	132.7 (111.8)	79.7 (65.6)	70.0 (94.3)	.004 1<2
Psychopharmacology	44.9 (146.1)	12.9 (32.8)	225.7 (355.5)	9.0 (21.5)	29.1 (33.0)	25.1 (45.5)	32.7 (46.9)	.000 1=3=4=5=6<2
Biological Psychiatry	39.3 (139.2)	19.4 (61.9)	191.0 (331.8)	6.3 (20.4)	22.4 (61.9)	7.0 (19.9)	35.8 (63.5)	.000 1=3=4=5<2
Diagnostic Evaluation	82.5 (170.1)	54.4 (78.8)	233.1 (383.0)	30.3 (49.1)	97.0 (139.6)	58.0 (62.4)	48.9 (98.1)	.000 1=3=4=5<2
Psychoanalytic/Psychodynamic Psychotherapy	103.7 (186.2)	39.5 (61.9)	239.3 (283.9)	76.6 (175.8)	153.5 (230.7)	140.3 (197.5)	41.1 (65.1)	.000 1=3<2=4
Humanistic PT	18.8 (61.0)	14.8 (56.8)	14.3 (75.6)	42.2 (107.5)	20.6 (36.7)	12.4 (24.0)	15.0 (29.4)	NS
Behavioral PT	34.9 (70.7)	38.6 (77.9)	27.5 (35.1)	49.6 (110.3)	41.1 (66.3)	13.5 (27.7)	16.0 (28.9)	NS
Cognitive PT	33.8 (59.8)	26.5 (38.7)	49.1 (99.6)	40.3 (71.7)	46.6 (63.0)	16.9 (42.1)	33.2 (54.9)	NS
Cognitive Behavioral PT	68.7 (90.0)	55.4 (72.5)	92.1 (121.9)	72.3 (119.4)	97.4 (85.4)	43.1 (45.5)	64.8 (127.0)	NS
Systemic PT	17.9 (65.1)	5.8 (16.8)	15.7 (58.9)	55.8 (125.5)	21.5 (63.6)	6.5 (20.9)	51.6 (149.5)	.008 1<3
Art Therapy	21.0 (89.3)	16.1 (56.2)	9.1 (29.7)	19.3 (39.2)	49.0 (183.9)	12.6 (24.2)	10.6 (12.9)	NS
Somatic Therapy	5.6 (19.4)	3.7 (15.5)	1.9 (9.5)	6.2 (11.9)	11.3 (31.3)	3.8 (13.1)	13.3 (33.2)	NS
Transactional Analysis	4.9 (12.2)	4.0 (8.0)	0.04 (0.2)	7.5 (12.9)	6.5 (14.6)	4.2 (10.8)	17.1 (32.9)	.006 2<6
Integrative Therapy	6.9 (27.3)	5.4 (19.9)	0.4 (1.9)	16.5 (61.2)	7.7 (19.9)	8.1 (21.8)	5.6 (16.7)	NS
Psychological Assessment	45.6 (123.9)	42.7 (164.3)	3.8 (10.0)	38.5 (64.4)	85.5 (110.0)	41.3 (56.7)	55.8 (166.6)	NS

Table 6. Total Number of Hours in Theoretical Training Based on Clinical Subfields (contôd)

	Groups							
Theoretical Training Mean # of hrs. (SD)	**Total (n=221)**	**1 Psychologists (n=88)**	**2 Psychiatrists (n=28)**	**3 Psych. Counselors (n=26)**	**4 Clinical Psych (n=42)**	**5 Cli.Psy. M.A. St. (n=28)**	**6 Others (n=9)**	**p** (NS, if p>.05)
EMDR	38.0 (61.8)	41.2 (60.1)	6.8 (14.3)	29.3 (61.5)	62.2 (85.0)	34.5 (42.0)	27.8 (56.5)	.011 2<4
Others	35.6 (129.9)	35.8 (145.0)	33.9 (169.9)	44.0 (89.5)	45.7 (135.3)	9.0 (21.5)	48.9 (119.6)	NS
Total	704.3 (865.4)	491.3 (498.0)	1359.6 (1688.4)	611.7 (706.2)	921.5 (772.9)	516.0 (409.3)	588.0 (822.2)	.000 1=5<2

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

In terms of personal therapy, some characteristics were presented in Table 7 (for more detailed table, see Appendix 3). More than half of the sample (58.8%) completed or have been continuing their personal individual psychotherapy process. Thus, 41.1% did not receive any personal psychotherapy session. Majority of the psychiatrists (58%) and others (61.5%) did not have any psychotherapy experience. The five groups, except psychological counselors received psychotherapy from approximately two different therapists. The mean number of different psychotherapists was 3 for psychological counselors.

Although psychiatrists were one of the groups received psychotherapy the least among the six groups, the longest personal psychotherapy sessions in number of total sessions (331.6), in number of months (35.1) and sessions per month (6.5) were the highest in the group.

In terms of theoretical orientation, the sample mostly had psychodynamic psychotherapy (25.7), and secondly cognitive behavioral psychotherapy (16.7). The first and the second used types of theoretical orientations were the same for psychologists, psychological counselors, clinical psychology MA students, and the ñothersò professional group. Yet, this distribution rates were different for psychiatrists and the clinical psychologists. These two groups mostly took psychoanalysis and psychodynamic psychotherapy. Psychiatrists mostly have undergone psychoanalysis and psychodynamic psychotherapy (25.8% and 16.1%, respectively), and clinical psychologists mostly took psychodynamic psychotherapy and psychoanalysis (31.4% and 27.5%, respectively).

Table 7. Personal Therapy Groups

Characteristics of Personal Therapy	Total	1 Psychologists	2 Psychiatrists	3 Psych. Counselors	4 Clinical Psych	5 Cli.Psy. M.A. St.	6 Others	p (NS, if p>.05)
Received personal therapy %	**n= 244**	**n= 92**	**n=31**	**n=29**	**n=51**	**n=29**	**n=13**	.006
Yes	58.8	52.4	42.0	68.9	72.5	72.4	38.5	
Completed	35.1	37.0	22.6	44.8	43.1	24.1	23.1	
Continuing	23.7	15.4	19.4	24.1	29.4	48.3	15.4	
No	41.2	47.6	58.0	31.1	27.5	27.6	61.5	
Number of Therapists- M (SD)	**n= 150**	**n= 53**	**n= 14**	**n= 20**	**n= 37**	**n= 21**	**n= 5**	
# of different therapists	1.9 (1.3)	1.9 (1.5)	1.6 (0.9)	2.7 (2.1)	1.8 (0.8)	1.7 (0.8)	2.0 (0.7)	.040 1=2=3=4=5=6
Longest personal therapy	**n= 145**	**n= 51**	**n= 14**	**n= 19**	**n= 36**	**n= 20**	**n= 5**	
Mean # of sessions (SD)	137.8 (203.3)	62.3 (122.2)	331.6 (311.7)	87.2 (122.5)	204.2 (217.0)	138.2 (219.9)	78.8 (123.8)	.001 1<4
Mean # of months (SD)	22.7 (22.0)	16.4 (20.0)	35.1 (29.5)	14.8 (11.3)	33.7 (23.8)	18.7 (17.8)	21.2 (12.1)	.001 1<4
Mean # of sess./mo. (SD)	4.6 (3.6)	3.4 (3.2)	6.5 (3.6)	4.5 (3.6)	5.5 (3.9)	5.7 (3.5)	2.0 (0.7)	.001 1=2=3=4=5=6
Theoretical Orientation of the longest personal therapy %	**n= 245**	**n= 92**	**n=31**	**n=29**	**n=51**	**n=29**	**n=13**	
Psychoanalysis	14.3	7.6	25.8	10.3	27.5	10.3	---	.005
Psychodynamic PT	25.7	20.7	16.1	27.6	31.4	44.8	15.4	NS
Humanistic PT	6.9	8.7	---	10.3	7.8	6.9	---	NS
Behavioral PT	4.1	8.7	3.2	---	2.0	---	---	NS
Cognitive PT	6.5	12.0	6.5	3.4	2.0	3.4	---	NS
Cognitive-Behavioral PT	16.7	29.3	3.2	17.2	7.8	10.3	7.7	.002

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology 2: Psychiatry interns and residents 3: Those who have a B.A. degree in Guidance and psychological Counseling 4: Those who have clinical psychology M.A. degree 5: Clinical psychology M.A. students. 6: Other professionals (eg. Social workers, nurses etc.)

The type of field-related materials read by professionals is presented in Table 8. In terms of reading materials of the professionals of the study, number of article (7.5) and book (1.8) read in a month. The minimum and maximum numbers of the articles are 0 and 100, for books 0 and 10, respectively.

Psychiatrists have read articles mostly (M= 10.9, SD= 17.5), whereas the others have been reading less (M= 4.8, SD= 6.7). Although the number of articles varied widely, the mean number of books did not vary much across groups, all being around 2. Since there is a wide range in the numbers of articles, it may cause very high standard deviation.

Table 8. Type of Materials Read by the Professionals

Type of Materials Read by the Professionals- M (SD)	Total (n=242)	Groups 1 Psychologists (n=91)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=28)	4 Clinical Psych (n=50)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
# of article read per month- Mean (SD)	7.5 (10.6)	7.1 (12.1)	10.9 (17.5)	5.3 (3.9)	7.6 (6.9)	7.8 (5.3)	4.8 (6.7)	NS
# of book read per month- Mean (SD)	1.8 (1.7)	1.8 (1.7)	1.9 (2.4)	1.9 (1.3)	1.7 (1.2)	1.8 (1.2)	1.7 (2.6)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Table 9 presented the second languages other than Turkish that the mental health professionals could use in terms of reading, writing, speaking, and ability to use in clinical practice (for detailed table, see appendix 4).

English was the most used language in all four abilities, as reading (87.3%), writing (79.2%), speaking (73.9%), and ability to use in clinical practice (44.5%). French was the second most language being used, in these four abilities (10.6%, 8.2%, 7.8%, and 5.3%, respectively). German was the third most language that the mental health professionals in the study could use in these four abilities (11.0%, 8.6%, 7.8%, and 1.2%, respectively).

Comparing six groups, there were significant differences in terms of using languages. It was found that: 1) In terms of reading English, clinical psychology MA students (96.6%), clinical psychologists (96.1%), psychiatrists (87.1%), psychological counselors (87.1%), psychologists (84.8%), and others (69.2%) used English mostly.

2) In terms of writing English, clinical psychology MA students (93.1%), clinical psychologists (90.2%), psychiatrists (74.2%), psychologists (73.9%), psychological counselors (72.4%), and others (69.2%) could use mostly.

3) In terms of speaking English, clinical psychology MA students (89.7%), clinical psychologists (86.3%), psychological counselors (75.9%), psychologists (68.5%), psychiatrists (71%), and others (30.8%) could use mostly.

4) In terms of ability to use English in clinical practice, clinical psychology MA students (69%) and psychiatrists (64.5%) were the two

groups mostly could use English. The other four groups which were clinical psychologists (56.9%), psychological counselors (37.9%), psychologists (30.4%), and others (7.7%) could use English in clinical practice.

5) In terms of ability to use French in clinical practice, clinical psychology MA students (13.8%) and psychiatrists (9.7%) again had the most ability.

Table 9. Knowledge of Second Language Other than Turkish

Languages (%)	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	P (NS, if p>.05)
English								
Reading	87.3	84.8	87.1	79.3	96.1	96.6	69.2	.037
Writing	79.2	73.9	74.2	72.4	90.2	93.1	69.2	NS
Speaking	73.9	68.5	71.0	75.9	86.3	89.7	30.8	.001
Able to use in clinical pract.	44.5	30.4	64.5	37.9	56.9	69.0	7.7	.000
French								
Reading	10.6	4.3	12.9	6.9	17.6	24.1	---	.015
Writing	8.2	4.3	6.5	3.4	15.7	17.2	---	NS
Speaking	7.8	4.3	9.7	3.4	13.7	13.8	---	NS
Able to use in clinical pract.	5.3	4.3	9.7	3.4	7.8	13.8	---	NS
German								
Reading	11.0	10.9	9.7	13.8	11.8	13.8	---	NS
Writing	8.6	7.7	9.7	13.8	7.8	10.3	---	NS
Speaking	7.8	6.5	12.9	6.9	9.8	6.9	---	NS
Able to use in clinical pract.	1.2	1.1	3.2	---	---	3.4	---	NS
Kurdish								
Reading	3.3	1.1	9.7	---	3.9	3.4	7.7	NS
Writing	2.4	1.1	6.5	---	2.0	3.4	7.7	NS
Speaking	4.5	3.3	12.9	---	3.9	3.4	7.7	NS
Able to use in clinical pract.	1.6	1.1	6.5	---	---	3.4	---	NS
Spanish								
Reading	2.9	3.3	---	---	---	13.8	---	.006
Writing	2.9	2.2	---	---	2.0	13.8	---	.011
Speaking	2.9	1.1	---	---	2.0	17.2	---	.000
Able to use in clinical pract.	0.8	---	---	---	2.0	3.4	---	NS

Table 9. Knowledge of Second Language Other than Turkish (contôd)

Languages	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Azerbaijani								
Reading	1.2	2.2	3.2	---	---	---	---	NS
Writing	1.2	2.2	3.2	---	---	---	---	NS
Speaking	1.6	3.3	3.2	---	---	---	---	NS
Able to use in clinical pract.	0.8	1.1	3.2	---	---	---	---	NS
Arabic								
Reading	1.2	2.2	3.2	---	---	---	---	NS
Writing	0.4	1.1	---	---	---	---	---	NS
Speaking	0.4	1.1	---	---	---	---	---	NS
Able to use in clinical pract.	0.8	---	---	---	2.0	3.4	---	NS
Hebrew								
Reading	0.8	1.1	---	---	---	3.4	---	NS
Writing	0.8	1.1	---	---	---	3.4	---	NS
Speaking	0.8	1.1	---	---	---	3.4	---	NS
Able to use in clinical pract.	0.4	1.1	---	---	---	---	---	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

3.1.3. Experience-related Characteristics

In terms of active clinical practice, the participants defined themselves as ñpsychologistsò (42.4%) as presented in Table 10. The 20% sample defined themselves as ñpsychotherapistsò, 18.8% as ñclinical psychologistsò, and 10.2% as ñpsychological counselorsò. The definitions of the professions determined the specific characteristics of their duties in the field, except ñpsychotherapistò. Thus, it was important to see who defined themselves as ñpsychotherapistò in the field. The participants who defined themselves as ñpsychotherapistò were mostly clinical psychologists (41.2%) and clinical psychology MA students (34.5%).

Since participants were able to define themselves with more than one item, the percentages might exceed 100%. The psychologist group of the sample defined themselves mostly (82.6%) as psychologists, and in addition as psychotherapists and others (12% for each). The psychiatrist group mostly defined themselves as adult psychiatrists (58.1%), and adult psychiatry interns (41.9%), and psychotherapists (12.9%). The psychological counselors defined themselves mostly as psychological counselors (51.7%), and psychological counselor specialists (44.8%).

The fourth group consisted of the participants having MA degrees in the field of clinical psychology and defined themselves mostly as clinical psychologists (86.3%), and psychotherapists (41.2%). The fifth group that included clinical psychology MA students defined themselves mostly as psychologists (75.9%), psychotherapists (34.5%) and psychological counselors (17.2%). The possible reason for defining themselves as

psychological counselors might be due to their BA degree in that field. The last group, named as ñother professionals,ò defined themselves mostly as psychiatry nurses (46.2 %), social workers and psychotherapists (15.4 % for each). Table 10 demonstrated the details and frequency of the self-definitions for the whole sample and the six professional groups.

Because of the low numbers in the cells, the statistical analyses were disregarded after the sixth variable, which was ñotherò.

Table 10. Active Clinical Practice Groups

Active Clinical Practice (%)	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Psychologist	42.4	82.6	---	3.4	9.8	75.9	---	.000
Psychotherapist	20.0	12.0	12.9	3.5	41.2	34.5	15.4	.000
Clinical Psychologist	18.8	---	---	---	86.3	6.9	---	.000
Psychological Counselor	10.2	2.2	---	51.7	3.9	17.2	7.7	.000
Other	8.9	12.0	---	6.9	5.9	6.9	38.5	
Adult psychiatrist	7.4	---	58.1	---	---	---	---	
Psych. Counselor MA	7.3	3.3	---	44.8	3.9	---	---	
Adult Psychiatry Intern	5.3	---	41.9	---	---	---	---	
Psychoanalyst Candidate	3.2	2.2	9.7	---	2.0	6.9	---	
Psychiatry Nurse	2.4	---	---	---	---	---	46.2	
Psychoanalyst	2.0	---	9.7	---	3.9	---	---	
Child Psychiatrist	1.2	---	9.7	---	---	---	---	
Health Psychologist	1.2	3.3	---	---	---	---	---	
Pedagogue	0.8	---	---	3.5	---	---	7.7	
Social Worker	0.8	---	---	---	---	---	15.4	
Neuropsychologist	0.4	---	---	---	2.0	---	---	
Pedagogue MA	0.4	---	---	3.5	---	---	---	
Child psychiatry intern	0.4	---	3.2	---	---	---	---	

Groups: 1: Those who have a B.A. or M.A. degree in psychology other than clinical psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in guidance and psychological counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc)

Participants of this study worked at a wide range of different clinical settings at full time or part time status. Those working full time were mostly employed in state hospitals (8.6 %), psychiatry departments in state hospitals (7.8 %), and state mental health hospitals (6.1 %). On the other hand, part time workers in the mental health field were employed by the private psychological counseling centers and private psychotherapy centers (12.2 % for each). Table 11 demonstrated the frequency of the clinical work settings of the sample and the six professional groups in detail. Because of the low numbers in the cells, no data analysis could be conducted. Thus, the percentage distributions were mentioned. According to these findings, they were as in the following:

1) Psychologists were the most heterogeneous group in terms of work settings. They have been working in all relevant mental health related settings. 2) Psychiatrists, as expected, mostly have been working at the hospitals as compared to the other groups. 3) Psychological counselors mostly have been working at the private psychological counseling centers, guidance research centers, and elementary schools. 4) Clinical psychologists mostly have been working at private psychotherapy and counseling centers and private universities. 5) Clinical psychology MA students mostly have been working at private psychotherapy and counseling centers, education and rehabilitation centers, and NGOs. 6) ñOtherò group (psychiatric nurses and social workers) mostly have been working at state hospitals and NGOs.

Table 11. Clinical Work Settings

Settings (%)	Total (n=245)		1 Psychologist (n=92)		2 Psychiatrist (n=31)		3 Psych. Counselors (n=29)		4 Clinical Psych (n=51)		5 Cli.Psy. MA St. (n=29)		6 Others (n=13)	
	FT	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**
State Hospital	8.6	0.8	8.7	---	19.4	6.5	---	---	5.9	---	3.4	---	23.1	---
State Hospital, Psychiatry Department	7.8	1.6	5.4	2.2	22.6	3.2	---	---	9.8	2.0	3.4	---	7.7	---
State Mental Health Hospital	6.1	0.4	5.4	---	19.4	---	---	---	3.9	---	3.4	3.4	7.7	---
Other State Institutions	5.3	0.4	9.8	1.1	---	---	---	---	2.0	---	6.9	---	7.7	---
Private Psychological Counseling Center	4.5	12.2	3.3	10.9	---	---	20.7	17.2	2.0	17.6	---	20.7	7.7	---
Private University	4.1	3.3	---	---	---	---	3.4	6.9	15.7	5.9	---	10.3	7.7	---
Municipal Health Center	3.7	0.8	9.8	1.1	---	---	---	---	---	---	---	3.4	---	---
Private Ed&Rehabil.Center	3.3	4.1	6.5	4.3	---	---	3.4	6.9	2.0	---	---	13.8	---	---
Guidance Research Center	2.9	0.4	3.3	---	---	---	10.3	3.4	---	---	3.4	---	---	---
State University	2.4	1.6	1.1	---	---	---	3.4	3.4	3.9	3.9	3.4	---	7.7	7.7
Private Psychotherapy Cent.	2.0	12.2	2.2	5.4	3.2	3.2	3.4	6.9	2.0	33.3	---	17.2	---	---
Courtroom	2.0	---	5.4	---	---	---	---	---	---	---	---	---	---	---
Private Clinic	2.0	4.9	---	---	---	---	3.4	6.9	2.0	7.8	3.4	10.3	---	---
Private Mental Health Hosp.	1.6	---	1.1	---	3.2	---	---	---	2.0	---	3.4	---	---	---
Private Hospital	1.6	4.5	1.1	5.4	3.2	6.5	---	---	2.0	5.9	3.4	3.4	---	---

Table 11. Clinical Working Settings (contôd)

Settings (%)	Total (n=245)		Groups 1 Psychologists (n=92)		2 Psychiatrist (n=31)		3 Psych. Counselors (n=29)		4 Clinical Psych (n=51)		5 Cli.Psy. M.A. st. (n=29)		6 Others (n=13)	
	FT	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**
State Elementary School	1.6	0.4	1.1	---	---	---	10.3	3.4	---	---	---	---	---	---
Private Elemen. School	1.6	0.4	1.1	---	---	---	10.3	3.4	---	---	---	---	---	---
Other Private Institutions	1.6	0.4	3.3	---	---	---	---	---	---	2.0	3.4	---	---	---
State Hospital, Non-Psychiatry Department	1.2	---	2.2	---	---	---	---	---	---	---	---	---	7.7	---
Private Medicine Hospital, Psychiatry Dep.	1.2	---	---	---	6.5	---	---	---	2.0	---	---	---	---	---
NGOôs	1.2	4.9	2.2	3.3	---	---	---	3.4	---	5.9	---	10.3	7.7	15.4
Private Outpatient Clinic	0.8	1.2	1.1	1.1	---	---	---	---	2.0	---	---	6.9	---	---
State High School	0.8	0.8	2.2	1.1	---	---	---	3.4	---	---	---	---	---	---
Private Kindergarten	0.8	2.9	---	3.3	---	---	3.4	3.4	2.0	2.0	---	6.9	---	---
Private High School	0.8	---	1.1	---	---	---	3.4	---	---	---	---	---	---	---
Nursing Home	0.8	0.4	1.1	1.1	---	---	---	---	2.0	---	---	---	---	---
Family Health Center	0.4	---	---	---	---	---	---	---	---	---	---	3.4	---	---
Prison	0.4	0.4	---	1.1	---	---	---	---	---	---	3.4	---	---	---
Private Teaching Inst.	---	0.4	---	1.1	---	---	---	---	---	---	---	---	---	---
Womenôs Shelter	---	0.4	---	---	---	---	---	---	---	---	---	3.4	---	---

Note: Some participants marked more than one clinical setting.

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology.2: Psychiatry interns and residents.3: Those who have a B.A. degree in Guidance and psychological Counseling. 4: Those who have clinical psychology M.A. degree. 5: Clinical psychology M.A. students. 6: Other professionals (eg. Social workers, nurses etc.)

In terms of clinical experience and expertise, the 9.8% of the sample have been working in a faculty at a university at either full time or part time status. 12.2% of them worked in the state universities, and 8.2% worked in the private universities. 18.4% of the participants were trainers out of the university and offered non-academic training (see table 12).

Regarding the mean number of clinical experience years, there was a significant difference among groups, and the groups were ranked as follows: others (10.1), psychiatrists (10.0), psychological counselors (8.9), clinical psychologists (8.6), psychologists (5.0), and clinical psychology MA students (2.2).

The sample took individual, group and peer clinical supervisions. 26.9% of the participants currently receive individual supervision, 23.3% group supervision, and 7.8% peer supervision.

44.9% of the sample has been receiving clinical supervision and 9.8% of the sample has been giving clinical supervision. Comparison of the six groups regarding supervision yielded the following observations: 1) Psychiatrists (25.8%) and clinical psychologists (17.6%) were the groups mostly with supervisors, whereas psychologists (2.2%), clinical psychology MA students (3.4%) and others (7.7%) were groups with the least supervisors. 2) Regarding being a supervisee, there was a very significant difference among the six professional groups and the groups were ranked as follows: clinical psychology MA students (72.4%), clinical psychologists (68.6%), psychological counselors (48.3%), psychiatrists (41.9%), psychologists (26.1%), and others (23.1%). 3) Regarding the mean number

of regular supervisors whom professionals worked with so far, there was a significant difference among groups, and the groups were ranked as follows: clinical psychologists (4.5), psychiatrists (3.2), clinical psychology MA students (2.6), psychological counselors (2.3), psychologists (1.4), and others (1.3).

4) Regarding the mean number of total received supervision hours so far, there was a significant difference among groups, and the groups were ranked as follows: psychiatrists (367.3), clinical psychologists (353.4), psychological counselors (205.0), psychologists (90.6), clinical psychology MA students (87.2), and others (68.0).

Table 12. Clinical and Academic Experience and Expertise Groups

Experience and Expertise	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Faculty at a University %								.022
Part time	6.1	---	9.7	10.3	7.8	6.9	23.1	
Full time	3.7	1.1	6.5	6.9	5.9	---	7.7	
Type of University %								.003
State University	12.2	9.8	22.6	10.3	11.8	3.4	30.8	
Private University	8.2	---	9.7	13.8	17.6	10.3	7.7	
Trainer out of the university %	18.4	13.0	22.6	31.0	25.5	---	30.8	.012
Giving Clinical SV %	9.8	2.2	25.8	10.3	17.6	3.4	7.7	.001
Receiving Clinical SV %	44.9	26.1	41.9	48.3	68.6	72.4	23.1	.000
Individual SV %	26.9	12.0	29.1	27.6	43.1	51.7	7.7	NS
Mean # of hrs/mo. (SD)	1.2 (2.4)	0.6 (2.3)	2.6 (5.6)	0.7 (1.2)	1.6 (2.4)	1.8 (3.0)	0.2 (0.6)	.010 1=2=3=4=5=6
Group SV %	23.3	14.1	12.9	34.5	31.4	41.4	15.4	NS
Mean # of hrs/mo. (SD)	1.4 (3.7)	0.7 (2.0)	2.1 (7.2)	1.3 (2.3)	1.7 (3.6)	2.4 (3.8)	0.8 (2.3)	NS
Peer SV %	7.8	1.1	6.5	6.9	19.6	13.8	---	NS
Mean # of hrs/mo. (SD)	0.3 (1.1)	0.04 (0.4)	0.4 (1.6)	0.3 (1.0)	0.6 (1.4)	0.5 (1.3)	---	.028 1=2=3=4=5=6
Mean # of regular supervisors so far (SD)	2.5 (2.9)	1.4 (2.6)	3.2 (2.7)	2.3 (1.8)	4.5 (3.3)	2.6 (2.4)	1.3 (1.4)	.000 1=3=6<4
Mean # of total received SV (SD)	189.9 (370.3)	90.6 (168.9)	367.3 (569.1)	205.0 (422.5)	353.4 (505.6)	87.2 (90.4)	68.0 (97.3)	.000 1<2=4
Clinical experience- Mean # of yrs (SD)	6.8 (6.9)	5.0 (5.0)	10.0 (7.8)	8.9 (8.2)	8.6 (7.3)	2.2 (1.6)	10.1 (11.0)	.000 5<1<3=4<2=6

Table 12. Clinical and Academic Experience and Expertise (contôd)

Experience and Expertise	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)
Academic title %							
Professor	1.6	---	3.2	3.4	2.0	---	7.7
Assc. Prof.	0.8	---	6.5	---	---	---	---
Asst. Prof.	1.6	---	3.2	---	3.9	---	7.7
Dr.	9.0	---	61.3	3.4	2.0	---	7.7
Lecturer	1.6	---	---	6.9	2.0	---	7.7

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Table 13 presented the distribution of the types of clinical practice of the professional groups. Participants were asked their types of active clinical practice, as total clinical practice in 100%. The subjects whose total distribution was between 20 and 120% were included in the analysis, in order not to lose data. Those who distributed totally less than 20% and more than 120% excluded in the analyses (N= 231).

The professionals of the study reported psychotherapy (41.5%) as the most employed type of clinical practice. Psychological counseling was the second most utilized type of clinical practice (25.3%), followed by psycho-education (11.3%).

Comparing the six groups regarding type of clinical practice, it was found that 1) Psychologists were the most heterogeneous group in terms of clinical practice types. They utilized all types of practice, psychotherapy (32.4%), psychological counseling (31.6%), and psycho-education (13.6%). 2) Psychiatrists, as expected, mostly used drug treatment (49.5%). In addition, more than one third of the psychiatrists used psychotherapy (38.4%) for their clients. 3) Psychological counselors used psychological counseling (57.1%), followed by psychotherapy (14.1%), and psycho-education (10.4%). 4) Clinical psychologists, as expected, mostly used psychotherapy (71.6%), and psychological counseling (14.5%) for their clients. 5) Clinical psychology MA students also used mostly psychotherapy (56.7%), psychological counseling (20.3%), and psycho-education (10.0%). 6) The ñothersò professional group used mostly psycho-education (55.6%),

psychological counseling (18.9%), and other types of clinical practice (17.2%).

Table 13. Distribution of the type of clinical practice

Type of Clinical Practice- Mean % (SD)	Total (n=231)	Groups 1 Psychologists (n=85)	2 Psychiatrists (n=30)	3 Psych. Counselors (n=28)	4 Clinical Psych (n=50)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=9)	p (NS, if p>.05)
Drug treatment	6.9 (19.0)	1.2 (7.6)	49.5 (23.4)	---	---	0.5 (2.0)	---	.000 1=3=4=5=6<2
Other biological treatment	0.7 (3.2)	0.1 (0.5)	5.2 (7.3)	---	---	0.2 (0.9)	---	.000 1=3=4=5=6<2
Psychotherapy	41.5 (35.1)	32.4 (31.4)	38.4 (26.1)	14.1 (26.2)	71.6 (25.4)	56.7 (36.8)	6.1 (13.6)	.000 1=2=3=6<4=5
Psychological counseling	25.3 (30.0)	31.6 (29.9)	2.3 (5.2)	57.1 (33.2)	14.5 (16.6)	20.3 (31.0)	18.9 (26.7)	.000 2=4<1=5=6<3
Special education	6.1 (18.4)	9.6 (32.5)	---	11.3 (21.7)	3.0 (15.2)	4.1 (10.8)	2.2 (6.7)	NS
Psycho-education	11.3 (18.2)	13.6 (19.0)	3.5 (6.6)	10.4 (11.0)	5.3 (8.0)	10.0 (12.7)	55.6 (38.4)	.000 1=2=3=4=5<6
Other	7.4 (19.8)	10.5 (24.9)	1.3 (7.3)	3.9 (12.3)	5.5 (14.7)	7.8 (18.6)	17.2 (33.2)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Table 14 presented the distribution of theoretical orientation of the mental health professionals. The sample distributed 100% into the categories which were suitable for their theoretical orientation type. The ones who rated totally less than 50% and more than 130% were excluded in the analysis (N= 222).

The 28-item list of theoretical orientations was classified into five groups as: psychoanalytic approaches (41.6%), cognitive-behavioral approaches (22.5%), humanistic approaches (14.9%), biological psychiatry (5.9%), and other approaches (15.5%). Comparing the six groups, there were significant differences among the groups.

Table 14 presented that more than one third of psychiatrists employed biological psychiatry (35.7%) and psychoanalytic approaches (39.9%). In addition, almost half of the clinical psychologists (53.6%) and one third of the psychological counselors (32.8%) preferred to utilize psychoanalytic approaches. Clinical psychology MA students were the other group who mostly employed psychoanalytic approaches (63.1%). On the other hand, humanistic approaches were least employed by psychiatrists (3.3%) and clinical psychologists (9.2%).

In terms of the six professional groups, there were significant differences regarding theoretical orientations. It was found that: 1) Psychologists mostly used cognitive-behavioral therapy (20.1%), Freudian psychoanalysis (8.5%), client centered psychotherapy (7.9%) and existential psychotherapy (6.6%), and attachment theory (6.5%). 2) Psychiatrists mostly used Freudian psychoanalysis (11.5%), cognitive behavioral therapy

(8.9%), Kleinian object relations theory (5.5%), and they minimum utilized client-centered psychotherapy (0.3%).

3) Psychological counselors mostly used cognitive behavioral therapy (12.2%), gestalt psychotherapy (10.8%), Freudian psychoanalysis (10.0%), and client centered psychotherapy (7.9%). 4) Clinical psychologists mostly used cognitive behavioral therapy (12.2%), Freudian psychoanalysis (11.3%), Kleinian object relations (8.0%), existential and gestalt psychotherapy (3.6% for each).

5) Clinical psychology MA students mostly used Freudian psychoanalysis (11.1%), and Kleinian object relations (9.3%), cognitive behavioral therapy (6.1%), existential psychotherapy (5.4%), and client centered psychotherapy (4.3%). 6) ñOtherò professionals mostly used existential psychotherapy (12.1%), Kleinian object relations (11.4%), client centered psychotherapy (10.0%), cognitive therapy (9.3%), and cognitive behavioral therapy (7.1%).

Table 14. Distribution of Theoretical Orientation of the Professionals Groups

Theoretical Orientation of the Professionals- Mean % (SD)	**Total (n= 222)**	**1 Psychologists (n= 85)**	**2 Psychiatrists (n= 30)**	**3 Psych. Counselors (n= 23)**	**4 Clinical Psych (n= 49)**	**5 Cli.Psy. M.A. St. (n= 28)**	**6 Others (n= 7)**	**p** (NS, if p>.05)
Biological Psychiatry	*5.9 (15.5)*	*1.5 (5.9)*	*35.7 (25.2)*	*0.5 (1.5)*	*0.9 (2.6)*	*1.8 (4.3)*	---	*.000 1=3=4=5=6<2*
Any Psychoanalytic Approach	*41.6 (34.8)*	*32.0 (29.1)*	*39.9 (29.3)*	*32.8 (32.3)*	*53.6 (40.0)*	*61.3 (36.5)*	*31.4 (35.7)*	*.000 1<4=5*
Freudian Psychoanalysis	9.9 (16.4)	8.5 (15.1)	11.5 (16.0)	10.1 (14.7)	11.3 (20.3)	11.1 (16.8)	6.4 (9.4)	NS
Object Relations (M. Klein)	5.5 (9.4)	2.5 (5.3)	5.5 (7.8)	4.7 (6.3)	8.0 (12.0)	9.3 (8.4)	11.4 (26.1)	.001 1<5
Independent Object Relations (Fairbairn, Winnicott, etc.)	5.0 (8.7)	3.4 (8.2)	4.0 (6.4)	4.9 (8.3)	7.6 (11.0)	6.6 (7.6)	2.9 (7.6)	NS
Ego psychology (Anna Freud, Hartmann, etc.)	2.4 (4.5)	2.4 (4.9)	2.4 (5.3)	1.1 (2.6)	2.6 (4.0)	3.0 (4.6)	2.9 (4.9)	NS
Interpersonal Psychoanalysis (Sullivan)	2.1 (4.9)	2.3 (4.8)	1.0 (2.3)	2.1 (5.8)	0.9 (2.4)	5.2 (7.9)	0.7 (1.9)	.005 2=4<5
Contemporary French psychoanalysis	2.0 (8.2)	2.0 (7.9)	2.0 (7.6)	0.5 (2.1)	3.3 (11.6)	1.8 (6.8)	---	NS
Lacanian Psychoanalysis	0.9 (4.8)	0.2 (0.9)	0.6 (2.0)	0.9 (2.4)	1.2 (3.2)	2.7 (12.3)	---	NS
Self-psychology (Kohut)	3.9 (7.2)	2.2 (5.1)	6.0 (8.2)	2.2 (3.9)	5.1 (8.4)	6.8 (9.8)	1.4 (3.8)	.008 1=2=3=4=5=6
Intersubjective Psychoanalysis (Stolorow, etc.)	1.1 (4.2)	0.3 (1.9)	0.5 (2.0)	0.3 (1.2)	3.0 (7.7)	1.6 (3.9)	---	.011 1<4
Attachment Theory	5.5 (7.7)	6.5 (8.8)	3.2 (7.7)	4.4 (6.2)	5.1 (6.2)	6.3 (7.0)	5.7 (9.8)	NS
Relational Psychoanalysis (Mitchell, Aron, etc.)	2.9 (9.5)	1.2 (4.0)	0.8 (2.7)	1.6 (4.6)	5.6 (14.0)	7.0 (16.4)	---	.013 1=2=3=4=5=6
Other Psychoanalytic Theor.	0.5 (4.3)	0.5 (2.0)	2.3 (11.0)	---	---	---	---	NS

Table 14. Distribution of Theoretical Orientation of the Professionals (contôd)

Theoretical Orientation of the Professionals- Mean % (SD)	Total (n= 222)	Groups 1 Psychologists (n= 85)	2 Psychiatrists (n= 30)	3 Psych. Counselors (n= 23)	4 Clinical Psych (n= 49)	5 Cli.Psy. M.A. St. (n= 28)	6 Others (n= 7)	p (NS, if p>.05)
Any Humanistic Approach	*14.9 (18.6)*	*19.2 (20.6)*	*3.3 (8.3)*	*25.4 (21.5)*	*9.2 (13.9)*	*11.9 (14.9)*	*28.6 (19.7)*	*.000 2=4<1=3=6*
Existential Psychotherapy (Rollo May, etc.)	5.3 (9.6)	6.6 (11.4)	1.5 (4.1)	6.7 (13.3)	3.6 (6.7)	5.4 (6.5)	12.1 (10.7)	.035 1=2=3=4=5=6
Gestalt Psychotherapy (Perls, etc.)	3.8 (8.7)	3.8 (6.7)	0.5 (2.7)	10.8 (18.1)	3.6 (6.7)	1.7 (3.6)	5.7 (15.1)	.001 1=2=4=5<3
Client-Centered Psychotherapy (Rogers, etc.)	5.2 (9.7)	7.9 (12.3)	0.3 (1.1)	7.9 (8.7)	1.9 (4.9)	4.3 (8.8)	10.0 (14.1)	.000 2=4<1
Other Humanistic Theories	0.6 (2.8)	0.9 (3.0)	1.0 (5.4)	0.04 (0.2)	---	0.4 (1.9)	0.7 (1.9)	NS
Any Cognitive Behavioral Approach	*22.5 (25.7)*	*28.3 (26.0)*	*17.1 (21.8)*	*22.2 (28.7)*	*23.0 (28.8)*	*11.2 (16.8)*	*17.9 (19.5)*	*.044 1=2=3=4=5=6*
Behavioral Therapy (Skinner, Solomon, etc.)	2.8 (5.4)	3.3 (6.2)	3.8 (5.4)	3.7 (5.3)	2.4 (5.1)	0.8 (2.6)	1.4 (3.8)	NS
Cognitive Therapy (Beck, etc.)	5.7 (10.6)	4.8 (8.5)	4.3 (11.2)	6.3 (9.3)	8.0 (13..8)	4.3 (9.5)	9.3 (12.4)	NS
Cognitive-Behavioral Therapy (Clark, Barlow, etc.)	14.0 (18.4)	20.1 (20.9)	8.9 (13.3)	12.2 (20.4)	12.7 (16.3)	6.1 (12.2)	7.1 (9.5)	.002 5<1
Any Other Approach	*15.5 (21.2)*	*18.8 (21.5)*	*4.9 (11.8)*	*18.0 (17.9)*	*13.5 (2.0)*	*17.3 (28.8)*	*18.6 (19.3)*	*NS*
Systemic Therapy	2.1 (6.8)	1.5 (3.9)	0.5 (2.0)	4.8 (8.3)	2.3 (8.8)	1.4 (5.9)	7.1 (18.9)	NS
Art Therapy	2.1 (6.5)	2.6 (7.2)	0.1 (0.4)	3.7 (7.1)	1.1 (3.8)	2.7 (7.6)	5.7 (15.1)	NS
Somatic Therapy	0.8 (2.5)	1.1 (3.0)	---	0.9 (2.5)	0.7 (2.7)	0.5 (1.6)	1.4 (2.4)	NS
Transactional Analysis	0.6 (2.6)	0.9 (3.2)	0.03 (0.2)	0.4 (1.2)	0.7 (3.2)	0.2 (1.0)	2.1 (3.9)	NS

Table 14. Distribution of Theoretical Orientation of the Professionals (contôd)

Theoretical Orientation of the Professionals- Mean % (SD)	Total (n= 222)	Groups 1 Psychologists (n= 85)	2 Psychiatrists (n= 30)	3 Psych. Counselors (n= 23)	4 Clinical Psych (n= 49)	5 Cli.Psy. M.A. St. (n= 28)	6 Others (n= 7)	p (NS, if p>.05)
EMDR	2.3 (7.5)	2.9 (8.6)	0.3 (1.0)	1.0 (2.9)	3.2 (9.0)	2.5 (8.4)	---	NS
Eclectic Therapy	3.2 (8.4)	4.3 (10.2)	2.9 (9.8)	4.1 (7.8)	1.7 (5.5)	2.5 (6.4)	0.7 (1.9)	NS
Integrative Therapy	2.7 (10.8)	2.9 (12.6)	0.9 (2.7)	2.3 (6.5)	1.8 (4.4)	6.3 (18.9)	---	NS
Other	1.7 (8.3)	2.6 (9.5)	0.2 (0.9)	0.9 (4.2)	1.9 (11.5)	1.1 (4.2)	1.4 (3.8)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The mental health professionals in the sample evaluated the level of difficulty for client groups as presented in Table 15. The participants rated their subjective level of difficulty on a likert scale from 1: no difficulty to 5: so difficult that s/he cannot work.

The sample had the most difficulty while working with sexual abusers/rapists (3.8), anti-social personality (3.3), and schizophrenic patients (3.2); whereas they had the least difficulty while working with people with different ethnic identity (1.2), religious beliefs (1.3) than the professional, and people in poverty (1.3).

The comparison of the six groups regarding degrees of difficulty experienced with different cases demonstrated significant differences among the groups. It appears that: 1) regarding working with schizophrenic patients, there was a significant difference among the six groups. Psychiatrists (1.4) and others (1.8) had a significantly lower difficulty than psychological counselors (4.1), psychologists (3.6), clinical psychologists (3.3), and clinical psychology MA students (3.2)

2) Regarding working with alcohol/substance abuse, there was a significant difference among the six groups. Psychiatrists (2.6) and others (2.3) were more comfortable with alcohol/substance abusers, whereas clinical psychologists (3.6) had the most difficulty.

3) Regarding working with cancer patients with bad prognosis, there was a significant difference among the six groups. Psychiatrists (2.3) and others (2.2) were more comfortable with cancer patients, whereas clinical

psychology MA students (3.7) and psychological counselors (3.5) had the most difficulty.

4) Regarding working with serious risk for suicidality, there was a significant difference among the six groups. Psychiatrists (2.3) had the least difficulty with clients at risk for suicidality; whereas psychological counselors (3.4) had the most difficulty.

5) Regarding working with borderline personality, there was a significant difference among the six groups. Clinical psychologists (2.4) and psychiatrists (2.3) were more comfortable with borderline personality, whereas psychological counselors (3.2) had more difficulty.

6) Regarding working with elderly, there was a significant difference among the six groups. Clinical psychology MA students (3.1) had the most difficulty with elderly, whereas psychiatrists (2.0) and others (1.7) had the least difficulty.

7) Regarding working with narcissistic personality, there was a significant difference among the six groups. Clinical psychologists (2.2) and others (2.1) were more comfortable with narcissistic personality, whereas psychologists (2.8) and psychological counselors (2.7) had more difficulty.

8) Regarding working with homosexuals, there was a significant difference among the six groups. While psychologists (1.8), others (1.6) were less comfortable with homosexuals, clinical psychology MA students (1.3) were more comfortable.

The means of the difficulty level as rated for all patient groups were computed for each participant, pointing an overall level of difficulty.

Regarding total difficulty mental health professionals experienced with different cases, there was a significant difference among the six groups. Psychologists, psychological counselors and clinical psychology MA students (2.5 for each) had a slightly higher difficulty than psychiatrists (2.2), and others (2.0).

Table 15. Degrees of Difficulty with Different Cases Groups

Degrees of Difficulty with Different Cases- Mean (SD) [1= no difficultyé 5= extreme difficulty]	Total (n=244)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=28)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Sexual abusers/Rapists	3.8 (1.2)	3.9 (1.2)	3.4 (1.1)	3.9 (1.4)	3.8 (1.1)	4.1 (1.1)	3.3 (1.3)	NS
Anti-social personality	3.3 (1.1)	3.3 (1.2)	3.2 (0.9)	3.3 (1.0)	3.4 (1.0)	3.2 (1.1)	2.9 (1.1)	NS
Schizophrenic patients	3.2 (1.5)	3.6 (1.2)	1.4 (0.7)	4.1 (1.4)	3.3 (1.3)	3.2 (1.4)	1.8 (1.1)	.000 2=6<1=3=4=5
Alcohol/Substance Abuse	3.1 (1.3)	3.1 (1.3)	2.6 (1.0)	3.6 (1.3)	3.6 (1.2)	3.1 (1.3)	2.3 (1.3)	.001 2=6<4
Cancer patients with bad prognosis	3.0 (1.3)	3.0 (1.3)	2.3 (0.7)	3.5 (1.3)	2.7 (1.3)	3.7 (1.4)	2.2 (1.3)	.000 2=6<3=5
Serious risk for suicidality	3.0 (1.2)	3.1 (1.3)	2.3 (0.9)	3.4 (1.2)	3.0 (1.1)	3.2 (1.3)	2.7 (1.4)	.008 2<3
Sexually abused Children	2.7 (1.3)	2.6 (1.3)	2.9 (1.2)	2.9 (1.5)	2.7 (1.2)	2.5 (1.2)	2.7 (1.4)	NS
Borderline personality	2.7 (1.2)	2.9 (1.2)	2.3 (1.0)	3.2 (1.3)	2.4 (1.2)	2.6 (0.9)	2.5 (1.4)	.009 1=2=3=4=5=6
Physical and psychological Abusers	2.7 (1.1)	2.6 (1.2)	2.7 (1.0)	2.5 (1.2)	3.0 (1.0)	3.0 (1.1)	2.6 (1.2)	NS
Elderly	2.6 (1.2)	2.7 (1.2)	2.0 (1.0)	2.5 (1.2)	2.6 (1.4)	3.1 (1.2)	1.7 (1.0)	.000 2=6<5
Narcissistic personality	2.5 (1.1)	2.8 (1.1)	2.3 (1.0)	2.7 (1.2)	2.2 (1.0)	2.3 (1.1)	2.1 (1.1)	.008 1=2=3=4=5=6
Survivors of political violence/torture	2.3 (1.2)	2.4 (1.3)	2.1 (0.9)	2.4 (1.3)	2.4 (1.1)	2.3 (1.2)	1.8 (1.1)	NS
Sexually abused Women	2.3 (1.1)	2.3 (1.2)	2.4 (1.0)	2.4 (1.1)	2.0 (0.9)	2.3 (1.1)	2.3 (1.2)	NS
Physically and psychologically abused Children	2.1 (1.2)	1.9 (1.1)	2.4 (1.2)	1.8 (1.2)	2.3 (1.3)	2.2 (1.0)	2.2 (1.4)	NS

Table 15. Degrees of Difficulty with Different Cases (contôd)

Degrees of Difficulty with Different Cases- Mean (SD) [1= no difficultyé 5= extreme difficulty]	Total (n=244)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=28)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Physically and psychologically abused Adults	1.8 (0.9)	1.8 (0.9)	2.1 (1.1)	1.6 (0.8)	1.7 (0.9)	2.0 (0.8)	1.5 (0.9)	NS
Homosexuals	1.6 (0.9)	1.8 (1.2)	1.4 (0.7)	1.5 (0.6)	1.4 (0.8)	1.3 (0.7)	1.6 (0.8)	.024 1=2=3=4=5=6
People with no/low education	1.6 (0.9)	1.8 (0.9)	1.4 (0.5)	1.6 (0.8)	1.6 (1.0)	1.7 (0.8)	1.6 (1.0)	NS
People in poverty	1.3 (0.7)	1.3 (0.6)	1.2 (0.6)	1.4 (0.9)	1.3 (0.8)	1.4 (0.7)	1.2 (0.6)	NS
People with different religious beliefs than the professional	1.3 (0.7)	1.3 (0.8)	1.1 (0.4)	1.3 (0.8)	1.2 (0.7)	1.1 (0.4)	1.5 (0.9)	NS
People with different ethnic identity than the professional	1.2 (0.6)	1.2 (0.5)	1.1 (0.6)	1.2 (0.6)	1.2 (0.7)	1.0 (0.2)	1.3 (0.6)	NS
Total Difficulty [1= no difficultyé 5=extreme difficulty]	2.4 (0.6)	2.5 (0.6)	2.2 (0.4)	2.5 (0.5)	2.4 (0.5)	2.5 (0.5)	2.0 (0.6)	.005 1=2=3=4=5=6

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Degrees of difficulty:
1= Being able to work without any difficulty
2= Being able to work with a little difficulty
3= Being able to work despite difficulty
4= Due to much difficulty, Iôd prefer not to work 5= I cannot work

Participants in this study evaluated their degrees of satisfaction, regarding different dimensions of mental health profession as illustrated in Table 16. The participants rated each dimension on a likert scale, from 1: not pleased to 4: very pleased.

The mental health professionals have mostly been pleased with professional satisfaction (2.9), social status (2.8), and work environment (2.7).

Comparing the six professional groups, there were significant differences among the groups. It resulted that: 1) Regarding social status, there was a significant difference among the six professional groups. Clinical psychologists, clinical psychology MA students were mostly satisfied with social status, whereas psychiatrists and psychological counselors, psychologists, and others were less pleased.

2) Regarding professional organization, there was a significant difference among the six professional groups. Psychiatrists were pleased most with professional organization, whereas psychologists were less pleased.

3) Regarding total degrees of satisfaction in the entire dimensions, there was a significant difference among the six professional groups. Clinical psychologists and psychiatrists were more pleased overall with the dimensions than psychologists, psychological counselors, clinical psychology MA students, and others.

Table 16. Degrees of Satisfaction in Different Professional Dimensions Groups

Professional Dimensions-Mean (SD) [1= not pleasedé 4= very pleased]	Total (n= 233)	1 Psychologists (n= 92)	2 Psychiatrists (n= 31)	3 Psych. Counselors (n= 29)	4 Clinical Psych (n= 44)	5 Cli.Psy. MA St. (n= 24)	6 Others (n= 13)	p (NS, if p>.05)
Professional Satisfaction	2.9 (0.9)	2.8 (0.9)	3.1 (0.7)	3.0 (1.0)	3.2 (0.7)	3.0 (0.8)	2.8 (1.1)	NS
Level of Income	2.1 (0.9)	2.0 (0.8)	2.1 (1.1)	2.1 (0.8)	2.3 (0.9)	1.7 (0.6)	1.8 (0.6)	NS
Social Status	2.8 (0.8)	2.7 (0.9)	2.9 (0.9)	2.9 (0.8)	3.2 (0.6)	3.0 (0.8)	2.5 (0.9)	.012 1=2=3=4=5=6
Social Security	2.4 (0.9)	2.3 (1.0)	2.4 (0.7)	2.4 (0.9)	2.6 (0.8)	2.0 (0.8)	2.9 (0.8)	NS
Work Environment	2.7 (0.9)	2.6 (0.9)	2.6 (0.8)	2.9 (1.0)	3.0 (1.0)	2.6 (0.8)	2.5 (0.8)	NS
Professional Organization	1.9 (0.9)	1.8 (0.9)	2.5 (0.9)	1.8 (0.9)	2.0 (0.9)	1.7 (0.9)	2.5 (0.9)	.001 1<2
Total (Combined)	2.5 (0.6)	2.4 (0.6)	2.6 (0.6)	2.5 (0.6)	2.7 (0.6)	2.3 (0.4)	2.5 (0.6)	.018 1=2=3=4=5=6

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Degrees of satisfaction:
1= Not pleased
2= A little pleased
3= Pleased
4= Very Pleased

3.1.4. Client-related Characteristics

The majority of mental health professionals in this study worked with clients who were between ages 19 and 65 as presented in Table17. Based on Chi-square results, there were significant differences among the groups with regard to age groups. It appeared that: 1) Psychologists had mostly been working with young adults (75%), followed by adolescents (71.7%), and the people older than 65 (20.7%). 2) As psychiatrists have mostly been working with adults (93.5%), and young adults (90.3%), they also have been working mostly with the elder people (67.7%). 3) Psychological counselors were the most heterogeneous group in terms of age groups working with. In addition to work with people more than 19 years, they also have been working with people between 7 and 18 years old. 4) Clinical psychologists mostly work with young adults (80.4%), and adults (76.5%). 5) Clinical psychology MA students have mostly been working with young adults (93.1%), and adults (86.2%). 6) The other professional group has mostly been working with adults (84.6%). The others were the second group which worked with elder people mostly (38.5%).

In terms of clinical modality, the majority of the sample offered individual sessions (96.3), and followed by family modality (36.3). Based on Chi-Square results, there were significant differences among groups regarding clinical modalities. The analysis showed that: 1) Individual sessions were used by all the six groups as the highest ranked modality: clinical psychologists (100%), clinical psychology MA students (100%), psychologists (98.9%), psychiatrists (93.5%), psychological counselors

(93.1%), and others (69.2%). 2) Working with a family modality was the second most used modality by the whole sample; psychologists (50%), psychological counselors (44.8%), clinical psychologists (25.5%), psychiatrists (22.6%), others (15.4%), and clinical psychology MA students (13.8%).

Table 17. Age Groups and Clinical Modalities

Age Groups and Modalities (%)	Total	1 Psychologists	2 Psychiatrists	3 Psych. Counselors	4 Clinical Psych	5 Cli.Psy. M.A. St.	6 Others	p (NS, if p>.05)
			Groups					
Age groups working with	**n= 244**	**n= 92**	**n= 31**	**n= 28**	**n= 51**	**n= 29**	**n= 13**	
0-6	34.3	46.7	6.5	44.8	31.4	27.6	15.4	.001
7-12	42.4	54.3	9.7	51.7	41.2	44.8	15.4	.000
13-18	56.7	71.7	38.7	51.7	52.9	51.7	30.8	.005
19-24	76.3	75.0	90.3	48.3	80.4	93.1	61.5	.001
25-65	75.1	69.6	93.5	55.2	76.5	86.2	84.6	.012
65 +	24.9	20.7	67.7	10.3	15.7	17.2	38.5	.000
Clinical modalities	**n= 241**	**n= 92**	**n= 30**	**n= 27**	**n= 51**	**n= 29**	**n= 12**	
Individual	96.3	98.9	93.5	93.1	100.0	100.0	69.2	.000
Group	31.8	27.2	22.6	48.3	29.4	37.9	46.2	NS
Family	36.3	50.0	22.6	44.8	25.5	13.8	46.2	.001
Couple	20.8	27.2	9.7	17.2	23.5	13.8	15.4	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The participants of the study categorized the clients they had worked with so far in terms of drop-out process, with the rates relevant to the timing specified. In order to see the percentages that professionals experience drop out with their clients, one hundred percent was distributed to the drop-out categories as presented in Table 18. The participants (N= 223) who rated totally these four categories between 50 and 130% were included in the analysis.

Almost half of the sample (52.1%) had clients who completed treatment process in appropriate time which mental health professional offered to terminate. Comparing the six groups regarding completing appropriately, it was found that most of the clients of psychological counselors (60.7%) and psychiatrists (59.6%) finished the treatment process in anticipated time.

19.6% of clients of the sample dropped out after started regular visits. Regarding this, there were significant differences among six groups and the groups were ranked as follows: clinical psychology MA students (25.3%), clinical psychologists (22.7%), psychiatrists (20%), psychologists (19.8%), psychological counselors (10%), and others (10%).

Of the drop outs reported, 13.2% were dropped out due to the referral to a different clinician during intake. Regarding this, there were significant differences among the six professional groups, and the groups were ranked as in the following: others (25.1%), psychologists (16.2%), psychological counselors (16.1%), clinical psychologists (9.7%), clinical psychology MA students (9.6%), and psychiatrists (8%).

The study sample overall reported that 14.6% of their clients drop out during intake sessions; and there were no significant differences among six groups in this regard.

Table 18. Drop-out Rates
Groups

Drop-out Rates Mean % (SD)	**Total (n=223)**	**1 Psychologists (n=81)**	**2 Psychiatrists (n=29)**	**3 Psych. Counselors (n=27)**	**4 Clinical Psych (n=48)**	**5 Cli.Psy. M.A. St. (n=29)**	**6 Others (n=9)**	**p** (NS, if p>.05)
Drop-out during intake	14.6 (15.6)	15.2 (14.8)	12.6 (11.1)	11.9 (14.8)	16.4 (16.3)	13.3 (18.1)	18.4 (25.3)	NS
Referral to a different clinician during intake	13.2 (15.3)	16.2 (17.6)	8.0 (6.7)	16.1 (19.9)	9.7 (7.1)	9.6 (9.5)	25.1 (29.0)	.004 1=2=3=4=5=6
Drop out after started regular visits	19.6 (14.5)	19.8 (15.8)	20.0 (14.0)	10.0 (7.1)	22.7 (14.1)	25.3 (13.6)	10.0 (9.4)	.000 3<4=5
Appropriately completed	52.1 (23.9)	48.3 (24.9)	59.6 (23.7)	60.7 (24.7)	51.0 (21.2)	50.4 (19.9)	47.6 (33.2)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The participants reported the drop out reasons that they had experienced so far. There were eight reasons specified in the questionnaire as presented in table 19, and the subjects distributed 100% to the eight possible reasons. The participants who totally distributed between 50 and 130% were included in the analysis (N= 205).

The most common reasons for drop-outs in clinical relationship were financial problems (23.9%) and clientsô unreadiness for clinical intervention (23.6%). With regard to financial problems, the clients of clinical psychologists (31.3%) had the highest drop-out, followed by psychological counselors (26.4%). With regard to being unready for clinical intervention, the clients of clinical psychology MA students (30%) dropped out mostly, followed by clinical psychologists (26.2%).

Comparing the six professional groups, there was a significant difference regarding to ñdifficulties in clinical relationship mostly due to the clinician.ò The groups were ranked as follows: psychiatrists (11.4%), clinical psychology MA students (7.6%), psychologists (6.9%), psychological counselors (6.1%), clinical psychologists (5.3%), and others (3.6%).

Table 19. Reasons for Drop-outs

Reasons for Drop-outs Mean % (SD)	Total (n= 205)	Groups 1 Psychologists (n= 73)	2 Psychiatrists (n= 28)	3 Psych. Counselors (n= 21)	4 Clinical Psych (n=49)	5 Cli.Psy. M.A. St. (n= 27)	6 Others (n= 7)	p (NS, if p>.05)
Client-related reasons								
Financial difficulties	23.9 (25.2)	22.1 (25.8)	20.7 (20.9)	26.4 (30.4)	31.3 (24.9)	17.4 (20.4)	21.4 (31.3)	NS
Not ready for clinical intervention	23.6 (19.3)	22.4 (19.7)	14.2 (14.9)	24.9 (18.4)	26.2 (18.5)	30.0 (21.9)	25.0 (20.6)	NS
Intrusions from significant others	9.6 (10.1)	10.8 (12.0)	9.9 (8.2)	11.4 (10.7)	7.1 (8.7)	8.7 (7.0)	9.4 (10.8)	NS
Transportation difficulties/Relocation	8.2 (11.8)	8.4 (13.1)	12.4 (13.6)	7.1 (11.8)	7.9 (11.4)	5.1 (6.4)	6.0 (5.0)	NS
Therapist-related reasons								
Difficulties in clinical relationship mostly due to the clinician	7.0 (7.4)	6.9 (8.3)	11.4 (8.2)	6.1 (7.8)	5.3 (5.8)	7.6 (5.1)	3.6 (4.8)	.013 4<2
Difficulties in clinical relationship mostly due to the institution	10.7 (16.0)	10.8 (15.3)	15.4 (19.6)	10.8 (17.9)	7.3 (11.7)	8.6 (9.4)	20.7 (36.6)	NS
Theoretical orientation not matching clientôs problems/needs	10.6 (12.3)	9.5 (10.9)	12.6 (14.5)	8.2 (12.3)	9.8 (10.9)	16.5 (15.2)	5.1 (6.3)	NS
Other reasons	4.3 (14.2)	6.2 (18.8)	5.2 (13.0)	1.0 (3.0)	3.9 (13.0)	2.6 (8.1)	1.6 (3.7)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students. **6:** Other professionals (eg. Social workers, nurses etc.)

The participants of this study reported their self perceptions about the healing degrees of their clients due to the clinical interventions they used. The participants distributed 100% into different categories listed in the Table 20. The participants who allocated totally less than 50% and more than 130% were excluded in the analysis (N= 218).

61.1% of the sample attributed more than 50% of the degree of healing to clinical interventions. In terms of estimated degrees of healing, clinical psychologists (74.5%) were the highest group which anticipated more than 50% degrees of healing. Clinical psychology MA students (47.1%) estimated high degrees of healing due to clinical intervention minimum.

With regard to very high degree (100-75%), there was a significant difference among groups, and the six groups were ranked as in the following: psychological counselors (42.5%), clinical psychologists (39.2%), others (34.4), psychiatrists (34.0), psychologists (27.2), and clinical psychology MA students (18.8).

19.1% of the sample estimated moderate degree (49-25%) of healing due to clinical intervention. Regarding to moderate degree of healing, there was a significant difference among the six groups, and the groups were ranked as follows: clinical psychology MA students (29.6%), psychiatrists (20.7%), psychologists (18.7%), psychological counselors (16.9%), clinical psychologists (15.3%), and others (10.6%).

Overall, in order to specify the self-estimated healing degrees of the sample, healing index scores were mentioned in range from -1 to 4, which stood for getting worse than the baseline and healed at a very high degree, respectively. For each participant percentage of very high degree was multiplied by 4, percentage of high degree was multiplied by 3, moderate degree multiplied by 2, low degree multiplied by 1, no difference than the baseline degree was multiplied by 0, and getting worse than the baseline degree was multiplied by -1.

Then, all the outcomes were added, and divided into the number of the group, for each one. According to these results, the perceived healing index scores were found to be significantly different one another. Post hoc Scheffe results showed that clinical psychologists (Mindex= 3.0, SD= 0.6) estimated their clientsô healing degrees significantly more than the clinical psychology MA students (Mindex= 2.3, SD= 0.6) and the psychologists (Mindex= 2.4, SD= 0.9) at an alpha level of $p<.05$ as shown in table 20.

Table 20. Self-Estimated Degrees of Healing Due to Clinical Interventions

Healing degrees Mean % (SD)	Total (n= 218)	Groups 1 Psychologists (n= 78)	2 Psychiatrists (n= 30)	3 Psych. Counselors (n= 24)	4 Clinical Psych (n= 50)	5 Cli.Psy. M.A. St. (n= 28)	6 Others (n= 8)	p (NS, if p>.05)
100-75%- Very high degree	31.8 (26.9)	27.2 (26.3)	34.0 (26.2)	42.5 (34.4)	39.2 (24.5)	18.8 (20.1)	34.4 (23.5)	.004 1=2=3=4=5=6
74-50%- High degree	29.3 (20.0)	28.0 (21.8)	27.3 (14.4)	26.5 (24.8)	35.3 (17.9)	28.3 (18.9)	24.4 (18.4)	NS
49-25%- Moderate degree	19.1 (17.9)	18.7 (16.8)	20.7 (17.9)	16.9 (18.9)	15.3 (14.9)	29.6 (23.6)	10.6 (8.6)	.013 4<5
24-5%- Low degree	9.4 (12.2)	11.9 (16.6)	9.0 (8.3)	6.3 (7.1)	5.7 (5.7)	11.9 (12.1)	11.3 (10.9)	NS
No difference compared to the baseline	8.2 (14.4)	11.1 (20.1)	6.3 (5.6)	6.5 (11.2)	3.9 (5.3)	9.4 (8.9)	15.6 (24.1)	NS
Getting worse than the baseline	1.7 (3.9)	1.7 (4.1)	2.9 (4.5)	0.7 (1.7)	1.1 (3.5)	2.1 (4.6)	3.8 (5.2)	NS
Healing index scores [range -1é 4]	2.6 (0.8)	2.4 (0.9)	2.7 (0.7)	2.9 (0.8)	3.0 (0.6)	2.3 (0.6)	2.4 (1.2)	.000 1=5<4

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Table 21 presented the distribution of number of clients who had experienced another clinician before. 35.6% of the whole sample reported that their clients had experienced another clinician before their current process. Regarding number of clients who had a previous therapy with a different clinician, there was a significant difference among the six groups, and the groups were ranked as: psychiatrists (51.7%), clinical psychology MA students (40.2%), clinical psychologists (35.4%), psychologists (34.2%), psychological counselors (25.8%), and others (17.5%).

The professionals reported the previous experiences of their clients before themselves. In Table 21, the participants distributed the assessments of the clients into 100%. The participants distributed the total rates of the variables between 50 and 130% were included in the analysis.

Half of the sample (50.1%) had clients who had unpleasant experiences with their previous clinician at different levels. The other one fourth of the sample was moderately unpleasant, and other one fourth of the sample was totally unpleasant. Only 9.2% of the sample had clients who defined their experience with previous clinician as pleasant. Other professionals (31%), psychiatrists and clinical psychologists (25% for each) had the highest number of clients who were somewhat unpleased with previous experience.

Table 21. Distribution of Previous Experience with Clinicians Groups

Previous Clinician Experiences	Total (n=234)	1 Psychologists (n=88)	2 Psychiatrists (n=30)	3 Psych. Counselors (n=26)	4 Clinical Psych (n=49)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Number of Clients Experienced Another Clinician Before- Mean % (SD)								
# of clients experienced another clinician before	35.6 (2.5)	34.2 (2.7)	51.7 (2.0)	25.8 (2.3)	35.4 (2.0)	40.2 (2.0)	17.5 (2.6)	.000 1=3=6<2
Experience with Previous Clinician- Mean % (SD)								
Pleased with previous clinician	9.2 (14.8)	8.4 (15.6)	7.7 (12.5)	9.3 (11.5)	8.3 (12.7)	14.4 (20.3)	13.0 (9.7)	NS
Somewhat pleased with previous clinician	17.9 (14.3)	17.3 (15.1)	23.8 (17.4)	14.4 (12.1)	18.1 (12.8)	15.6 (11.7)	18.0 (10.4)	NS
Uncertain about previous clinician	22.5 (16.8)	21.7 (17.1)	23.7 (14.5)	22.6 (21.8)	23.9 (13.4)	20.7 (21.1)	24.0 (8.9)	NS
Somewhat unpleased with previous clinician	25.2 (18.7)	25.9 (20.2)	25.0 (12.1)	23.7 (21.2)	24.3 (18.7)	25.0 (20.6)	31.0 (14.3)	NS
Unpleased with previous clinician	24.9 (21.7)	26.7 (23.5)	18.1 (12.2)	30.2 (24.7)	27.4 (22.3)	20.7 (20.9)	14.0 (11.9)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology 2: Psychiatry interns and residents 3: Those who have a B.A. degree in Guidance and psychological Counseling 4: Those who have clinical psychology M.A. degree 5: Clinical psychology M.A. students. 6: Other professionals (eg. Social workers, nurses, etc.)

Professionals in the mental health field have constituted their therapeutic treatments with therapeutic factors. Eventually, the participants in the study evaluated these therapeutic factors according to their self-estimated importance level for the therapeutic effect in a likert scale format, being from 0 to 4. In the scale, 0 meant that the factor was not important, 1 a little important, 2 moderately important, 3 very important, and 4 extremely important.

These factors that were thought to have therapeutic effectiveness were classified into four groups, which were client related factors, technique related factors, therapist related factors, and therapy relationship related factors as presented in Table 22.

Regarding client related factors, the mental health professionals attributed the highest significance to affective insight (3.5), affective awareness (3.5), cognitive insight (3.3), and internalization of therapy relationship (3.2); whereas the least importance was attributed to catharsis (2.5), implicit relational learning (2.6), and mentalization (2.7).

Comparing the six professional groups regarding client related factors, overall therapeutic factors which were client related were given the least importance by psychiatrists. There were significant differences among the groups. Regarding affective insight, clinical psychologists (3.7), and psychologists (3.6) attributed more significance than psychiatrists (3.0).

2) Regarding affective awareness, psychiatrists (2.8) attributed least significance than the other four groups, except other professionals. 3) Regarding cognitive insight, psychologists and psychological counselors

(3.5 for each), clinical psychologists (3.4), clinical psychology MA students and others (3.2 for each), and psychiatrists (2.8). 4) Regarding internalization of therapy relationship, clinical psychologists attributed more significance than others (2.5).

5) Regarding cognitive awareness, psychologists, psychological counselors (3.5 for each), and clinical psychologists (3.2) attributed more significance than psychiatrists (2.5). 6) Regarding physical awareness, psychologists (3.2), and clinical psychologists (3.1), attributed more significance than psychiatrists (2.4). 7) Regarding behavioral learning, psychologists (3.0) gave more significant importance than psychiatrists (2.2).

Regarding technique related factors, the mental health professionals gave mostly importance to having empathy (3.4), interpretation of resistance (3.2), and cognitive reconstruction (3.1); whereas they gave the least importance to suggestion (1.8), and advice (1.4).

Comparing the six groups regarding technique related factors, there were significant differences among the groups. It was found that: 1) Regarding suggestion, psychologists (2.2) attributed more significance than, clinical psychologists and psychiatrists (1.3 for each). 2) Regarding advice, again psychologists (1.8) attributed more significance than clinical psychologists and psychiatrists (0.9 for each).

All therapist-related factors were given importance more than ñvery importantò level. The mental health professionals gave the highest importance to consistency of therapeutic framework (3.6), neutrality of

therapist, flexibility of therapist, therapistôs unconditional acceptance of clients, and genuineness of therapist (3.5 for each), and objectivity of therapist (3.4).

Comparing the groups regarding therapist related factors, there were significant differences among the groups. They resulted that: 1) Regarding consistency of therapeutic framework, there was a significant difference among the six groups, and the groups were ranked as in the following: clinical psychology MA students (3.8), clinical psychologists (3.7), psychologists and psychiatrists (3.6 for each), psychological counselors (3.4), and others (2.9).

2) Regarding therapistôs unconditional acceptance of clients, psychologists and clinical psychologists (3.7 for each) gave more significance than psychiatrists (3.0).

3) Regarding genuineness of therapist, the groups were attributed similar levels of significance such as: psychologists (3.7), clinical psychologists (3.6), psychological counselors and clinical psychology MA students (3.5 for each), psychiatrists (3.3), and others (2.9).

4) Regarding objectivity of therapist, psychologists (3.6) attributed more significance than psychiatrists (2.9).

Regarding therapy relationship related factor, the mental health professionals attributed highest importance to quality of therapy relationship (3.7). Comparing the six groups regarding to quality of therapy relationship, the groups gave similar significance levels as follows: psychologists,

psychological counselors, clinical psychologists and clinical psychology MA students (3.8 for each), psychiatrists (3.5), and others (3.2).

Table 22. Degrees of the Factors Achieving Permanent Therapeutic Development Groups

Therapeutic Factors Mean (SD) [0= not importanté 4= very important]	Total (n= 233)	1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=44)	5 Cli.Psy. MA St. (n=24)	6 Others (n=13)	p (NS, if p>.05)
Client related factors								
Catharsis/Abreaction	2.5 (1.2)	2.6 (1.2)	2.1 (1.1)	2.7 (1.3)	2.4 (1.3)	2.6 (1.1)	2.7 (1.4)	NS
Insight (Affective)	3.5 (0.8)	3.6 (0.7)	3.0 (0.8)	3.6 (0.7)	3.7 (0.7)	3.6 (0.5)	3.2 (1.5)	.002 2<1=4
Insight (Cognitive)	3.3 (0.9)	3.5 (0.7)	2.8 (0.8)	3.5 (0.8)	3.4 (0.9)	3.2 (0.7)	3.2 (1.5)	.002 2<1=3
Corrective Emotional Experience	3.0 (0.9)	3.0 (0.9)	2.7 (0.8)	3.2 (0.8)	3.3 (0.8)	3.0 (0.8)	2.8 (1.4)	NS
Implicit Relational Learning	2.6 (1.0)	2.5 (1.1)	2.4 (0.9)	2.6 (1.0)	2.9 (1.0)	2.7 (1.0)	2.4 (1.3)	NS
Internalization of Therapy Relationship	3.2 (1.0)	3.1 (0.9)	2.8 (1.0)	3.0 (1.0)	3.5 (0.8)	3.5 (0.6)	2.5 (1.3)	.001 6<4
Mentalization	2.7 (1.1)	2.8 (1.1)	2.3 (0.9)	2.7 (1.1)	3.0 (1.2)	2.8 (0.8)	2.4 (1.4)	NS
Affective Awareness	3.5 (0.7)	3.6 (0.6)	2.8 (0.6)	3.5 (0.7)	3.6 (0.8)	3.6 (0.6)	3.1 (1.5)	.000 2<1=3=4=5
Cognitive Awareness	3.2 (0.9)	3.5 (0.7)	2.5 (0.6)	3.5 (0.7)	3.2 (0.9)	3.0 (1.1)	3.1 (1.5)	.000 2<1=3=4
Physical Awareness	3.0 (0.9)	3.2 (0.9)	2.4 (0.7)	3.1 (0.9)	3.1 (0.9)	3.0 (1.1)	2.8 (1.5)	.003 2<1=4
Behavioral Learning	2.8 (1.1)	3.0 (1.0)	2.2 (0.9)	2.7 (1.2)	2.8 (1.1)	2.3 (1.2)	2.9 (1.5)	.005 2<1
Technique related factors								
Interpretation of Free Association	2.7 (1.2)	2.6 (1.1)	2.9 (1.1)	2.8 (1.2)	2.6 (1.3)	3.0 (1.0)	2.4 (1.3)	NS

Table 22. Degrees of the Factors Achieving Permanent Therapeutic Improvement (contôd)

Therapeutic Factors Mean (SD) [0= not importanté 4= very important]	Total (n= 233)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=44)	5 Cli.Psy. M.A. St. (n=24)	6 Others (n=13)	p (NS, if p>.05)
Interpretation of Transference	3.0 (1.1)	2.9 (1.0)	3.2 (1.0)	3.0 (1.1)	3.0 (1.2)	3.3 (1.0)	2.5 (1.3)	NS
Interpretation of Resistance	3.2 (1.0)	3.1 (1.0)	3.3 (0.8)	3.2 (1.0)	3.1 (1.2)	3.2 (0.9)	2.9 (1.5)	NS
Interpretation of Dreams	2.4 (1.3)	2.2 (1.2)	2.7 (1.2)	2.5 (1.4)	2.4 (1.5)	2.8 (1.2)	1.8 (1.3)	NS
Empathy	3.4 (0.9)	3.4 (0.9)	3.2 (0.9)	3.5 (1.0)	3.5 (0.8)	3.6 (0.5)	2.9 (1.6)	NS
Cognitive Reconstruction	3.1 (1.0)	3.3 (0.9)	2.7 (0.8)	3.2 (1.3)	3.0 (1.1)	3.1 (0.9)	3.1 (1.5)	NS
Exposure	2.3 (1.2)	2.5 (1.1)	2.3 (0.9)	2.0 (1.2)	2.3 (1.4)	2.2 (1.3)	1.7 (1.3)	NS
Suggestion (Telkin)	1.8 (1.3)	2.2 (1.3)	1.3 (0.9)	1.9 (1.4)	1.3 (1.2)	1.4 (1.3)	1.4 (1.2)	.000 2=4<1
Advice	1.4 (1.2)	1.8 (1.3)	0.9 (0.9)	1.4 (1.2)	0.9 (1.0)	1.1 (1.2)	1.2 (0.9)	.000 2=4<1
Confrontation	2.8 (1.0)	2.9 (0.9)	2.5 (0.8)	2.9 (1.2)	2.7 (1.0)	2.8 (1.0)	2.7 (1.4)	NS
Imagining	2.7 (1.1)	2.9 (1.0)	2.4 (0.8)	2.7 (1.3)	2.6 (1.1)	2.5 (1.1)	2.6 (1.3)	NS
Therapist related Factors								
Objectivity of Therapists	3.4 (0.9)	3.6 (0.7)	2.9 (1.0)	3.3 (1.0)	3.4 (1.0)	3.2 (1.0)	3.1 (1.5)	.011 2<1
Neutrality of Therapist	3.5 (0.8)	3.7 (0.6)	3.2 (0.8)	3.6 (0.9)	3.5 (1.0)	3.5 (0.8)	3.3 (1.6)	NS
Flexibility of Therapist	3.5 (0.8)	3.6 (0.6)	3.2 (0.8)	3.5 (0.9)	3.5 (1.1)	3.5 (0.7)	3.1 (1.5)	NS
Consistency of Therapeutic Framework	3.6 (0.8)	3.6 (0.7)	3.6 (0.7)	3.4 (0.9)	3.7 (0.7)	3.8 (0.4)	2.9 (1.4)	.031 1=2=3=4=5=6
Therapeutically Using of Counter-Transference	3.2 (1.0)	3.2 (0.9)	3.3 (1.0)	3.3 (0.9)	3.2 (1.0)	3.5 (0.8)	2.8 (1.4)	NS

Table 22. Degrees of the Factors Achieving Permanent Therapeutic Development (contôd)

Therapeutic Factors Mean (SD) [0= not importanté 4= very important]	Total (n= 233)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=44)	5 Cli.Psy. M.A. St. (n=24)	6 Others (n=13)	p (NS, if p>.05)
Therapistôs Unconditional Acceptance of Clients	3.5 (0.8)	3.7 (0.6)	3.0 (0.9)	3.6 (0.8)	3.7 (0.7)	3.5 (0.6)	3.0 (1.5)	.000 2<1=4
Genuineness of Therapist	3.5 (0.8)	3.7 (0.6)	3.3 (0.9)	3.5 (0.6)	3.6 (1.0)	3.5 (0.7)	2.9 (1.5)	.020 1=2=3=4=5=6
Personality/Style of Therapist	3.1 (1.1)	3.1 (1.0)	3.1 (0.9)	3.3 (1.0)	3.0 (1.2)	3.0 (1.2)	2.8 (1.5)	NS
Therapistôs Having Undergone is/were own psychotherapy	3.3 (1.0)	3.3 (0.9)	3.0 (0.9)	3.3 (1.1)	3.1 (1.1)	3.6 (0.6)	3.2 (1.5)	NS
Therapy relationship-related factor								
Quality of Therapy Relationship	3.7 (0.6)	3.8 (0.4)	3.5 (0.8)	3.8 (0.5)	3.8 (0.7)	3.8 (0.4)	3.2 (1.5)	.003 1=2=3=4=5=6

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Degrees of Significance Levels:
0= Not Important 1= A little Important 2= Moderately Important 3= Very Important 4= Extremely Important

Mental health professionals in the sample have been working with 2021.6 different cases on average from the beginning of their active clinical practices as presented in Table 23. Regarding number of cases mental health professionals have attended to, there was a significant difference among the six professional groups, and the groups were ranked as in the following: psychiatrists (10,016.3), psychological counselors (1,750.2), psychologists (890.0), clinical psychologists (796.3), others (468.8), and clinical psychology MA students (158.9).

From another perspective, year of clinical experience might be the factor that influenced the number of cases. In order to see the effects of experience years in clinical practice and the number of cases were computed by Chi-Square (see Table 23). As expected, it appeared that there was a strong association between the length of clinical experience and number of cases professionals worked with so far.

Table 23. Number of Cases Mental Health Professionals have attended to Groups

Number of Cases	**Total (n=235)**	**1 Psychologists (n=89)**	**2 Psychiatrists (n=30)**	**3 Psych. Counselors (n=27)**	**4 Clinical Psych (n=47)**	**5 Cli.Psy. MA St. (n=29)**	**6 Others (n=13)**	**p** (NS, if p>.05)
# of Cases of the Professionals- Mean (SD)	2021.6 (6950.3)	890.0 (1739.4)	10016.3 (16422.7)	1750.2 (5753.8)	796.3 (1540.0)	158.9 (278.6)	468.8 (815.7)	.000 1=3=4=5=6<2
Number of Cases %	**Total (n=235)**	**1 0-5 yrs of exp (n=137)**	**2 6-10 yrs of exp (n=57)**	**3 11-15 yrs of exp (n=20)**	**4 16-20 yrs of exp (n=17)**	**5 21-38 yrs of exp (n=12)**		**p** (NS, if p>.05)
Number of Cases								.000
0-20	13.1	19.7	8.8	---	---	---		
21-30	5.3	8.8	---	---	---	---		
31-60	10.2	13.9	10.5	---	---	---		
61-100	10.6	13.1	12.3	---	5.9	---		
101-200	13.9	13.9	15.8	15.0	5.9	16.7		
201-500	13.1	8.8	17.5	25.0	17.6	8.3		
500+	33.9	21.9	35.1	60.0	70.6	75.0		

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

3.1.5. Proposed Interventions

Table 24 presented the mental health professionalsô proposed type of primary interventions for the people who experience psychological difficulties in Turkey. The participants who totally distributed between 60% and 130% were included in the analysis (N= 231)

For the people in Turkey having psychological difficulties, mental health professionals proposed mostly getting help from a mental health professional (41.5%), followed by support of family (14.5%), and financial recovery (11.3%) as the primary interventions.

Comparing the six groups, there were significant differences among the groups. It appeared that: 1) With regard to getting help from a mental health professional, the groups were ranked as in the following: psychiatrists (53.0%), others (46.1%), clinical psychologists (44.3%), psychological counselors (40.4%), psychologists (38.1%), and clinical psychology MA students (34.1%). Post-hoc Scheffe results did not yield to any significant differences among the groups, since getting help from a professional was mostly preferred type of intervention with similar percentages.

2) Clinical psychologists (5.1%) and psychiatrists (4%) were significantly less in favor of hobby as the primary intervention than psychological counselors (10.3%) and others (8.2%).

3) Regarding support of friends, there was a significant difference among the groups. Other professionals (4.8%) and psychiatrists (4.7%) were significantly less in favor of support of friends as the primary intervention

than clinical psych MA students (10.9%), psychological counselors (10.0%), psychologists (9.3%), and clinical psychologists (8.1%).

Table 24. Mental Health Professionalsô Proposed Types of *Primary Interventions* for the People who Experience Psychological Difficulties in Turkey Groups

Primary Interventions **Mean % (SD)**	**Total (n= 231)**	**1 Psychologists (n= 86)**	**2 Psychiatrists (n= 30)**	**3 Psych. Counselors (n= 26)**	**4 Clinical Psych (n= 48)**	**5 Cli.Psy. M.A. St. (n= 29)**	**6 Others (n= 12)**	**p** (NS, if p>.05)
Getting help from a mental health professional	41.5 (23.4)	38.1 (21.2)	53.0 (26.8)	40.4 (25.9)	44.3 (22.3)	34.1 (18.2)	46.1 (30.5)	.021 1=2=3=4=5=6
Hobby	6.7 (6.0)	7.1 (5.6)	4.0 (4.9)	10.3 (9.8)	5.1 (3.8)	7.4 (4.6)	8.2 (7.3)	.001 2=4<3
Support of friends	8.5 (7.5)	9.3 (7.4)	4.7 (3.9)	10.0 (10.6)	8.1 (6.3)	10.9 (8.4)	4.8 (4.3)	.006 1=2=3=4=5=6
Support of family	14.5 (9.9)	15.4 (9.1)	12.4 (11.3)	11.7 (8.4)	14.3 (10.6)	17.8 (9.5)	12.1 (11.9)	NS
Support of work place	4.1 (4.4)	4.6 (4.6)	3.5 (3.2)	3.0 (3.9)	3.3 (3.4)	4.8 (6.2)	4.7 (4.4)	NS
Support of spirituality/religion	4.6 (5.8)	5.4 (6.1)	3.0 (3.6)	4.9 (8.6)	4.4 (4.6)	4.4 (6.5)	2.8 (3.2)	NS
Financial recovery	11.3 (10.7)	11.7 (11.7)	11.5 (9.1)	10.9 (12.2)	10.5 (8.6)	9.9 (8.4)	15.9 (15.3)	NS
Reading/Being Informed/Education	9.2 (8.4)	9.4 (8.2)	8.8 (10.7)	8.6 (8.3)	9.3 (7.4)	10.7 (8.7)	5.9 (7.3)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The distribution of primary clinical interventions proposed by the mental health professionals for the people experiencing psychological difficulties in Turkey were presented in Table 25. The participants who rated different types of primary clinical intervention totally between 90 and 120% were included in the analysis (N= 232)

Almost half of the sample proposed psychotherapy (42.7%), followed by psychopharmacology (20.6%), and psychological counseling (17.7%). Comparing the six groups, there were significant differences among the groups. It appeared that: 1) Regarding psychotherapy as the primary clinical intervention, there was a significant difference among the six groups, and the groups were ranked as follows: clinical psychologists (49.9%), clinical psychology MA students (48.3%), psychologists (42.2%), psychiatrists (38.3%), psychological counselors (34.4%), and others (30.5%). 2) Regarding psychopharmacology, there was a significant difference among the six groups, and the groups were ranked as in the following: psychiatrists (37.7%), clinical psychologists (20.3%), clinical psychology MA students (18.9%), psychologists (18.7%), others (17.7%), and psychological counselors (11.1%). 3) Regarding psychological counseling, there was a significant difference among the six groups, and the groups were ranked as in the following: psychological counselors (37.2%), others (24.1%), psychologists (17.6%), clinical psychology MA students (14.0%), clinical psychologists (13.2%), and psychiatrists (9.8%).

Table 25. Mental Health Professionalsô Proposed Types of *Primary Clinical Interventions* for the People who Experience Psychological Difficulties in Turkey Groups

Primary Clinical Intervention Mean % (SD)	Total (n=232)	1 Psychologists (n= 87)	2 Psychiatrists (n= 30)	3 Psych. Counselors (n= 26)	4 Clinical Psych (n= 49)	5 Cli.Psy. M.A. St. (n= 29)	6 Others (n= 11)	p (NS, if p>.05)
Psychopharmacology	20.6 (14.4)	18.7 (11.2)	37.7 (14.4)	11.1 (8.3)	20.3 (14.9)	18.9 (13.7)	17.7 (13.1)	.000 1=3=4=5=6<2
Other biological treatments	3.2 (4.4)	3.8 (4.9)	4.2 (3.8)	1.9 (3.4)	2.7 (4.7)	2.4 (3.4)	3.7 (4.9)	NS
Psychotherapy	42.7 (18.4)	42.2 (16.7)	38.3 (17.9)	34.4 (19.4)	49.9 (19.6)	48.3 (16.7)	30.5 (13.1)	.000 3<4
Psychological Counseling	17.7 (15.5)	17.6 (13.2)	9.8 (13.0)	37.2 (20.7)	13.2 (9.4)	14.0 (10.8)	24.1 (18.7)	.000 1=2=4=5<3
Special Education	5.8 (6.8)	6.9 (7.5)	4.6 (3.3)	6.3 (7.7)	4.8 (6.4)	5.3 (7.3)	5.0 (6.3)	NS
Psycho-education	9.4 (10.6)	10.1 (11.1)	5.2 (5.5)	8.4 (12.2)	9.7 (12.1)	9.8 (6.8)	16.4 (12.3)	NS
Others	0.9 (4.5)	1.0 (5.6)	0.3 (1.8)	0.8 (3.7)	---	1.9 (6.3)	2.6 (5.1)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

Table 26 presented types of secondary clinical interventions proposed by mental health professionals. The participants who rated totally between 76% and 120% were included in the analysis (N= 218).

29.6% of the sample proposed psychopharmacology as the secondary clinical intervention, followed by psychotherapy (24.3%), psychological counseling (14.8%), psycho-education (12.9%), and other biological treatment (9.9%).

Comparing the six professional groups, there were significant differences. It appeared that: 1) Regarding psychotherapy, there was a significant difference among the six groups, and the groups were ranked as follows: psychiatrists (34.9%), clinical psychologists (33.3%), psychologists (20.7%), clinical psychology MA students (19.5%), psychological counselors (16.3%), and others (14.5%). 2) Regarding psycho-education, there was a significant difference among the six groups, and the groups were ranked as follows: clinical psychology MA students (20.2%), clinical psychologists (14.2%), psychological counselors (12.7%), psychologists (12.1%), psychiatrists (8.5%), and others (6.4%). 3) Regarding other biological treatment, there was a significant difference among the six groups, and the groups were ranked as follows: others (26.4%), psychological counselors (12.8%), psychologists (12.4%), clinical psychology MA students (8.3%), clinical psychologists (4.9%), and psychiatrists (4.3%).

Table 26. Mental Health Professionalsô Proposed Types of *Secondary Clinical Interventions* for the People who Experience Psychological Difficulties in Turkey Groups

Secondary Clinical Intervention Mean % (SD)	Total (n=218)	1 Psychologists (n= 78)	2 Psychiatrists (n= 28)	3 Psych. Counselors (n= 26)	4 Clinical Psych (n= 48)	5 Cli.Psy. M.A. St. (n= 27)	6 Others (n= 11)	p (NS, if p>.05)
Psychopharmacology	29.6 (22.2)	31.8 (20.6)	32.0 (21.7)	27.8 (28.5)	27.9 (20.2)	25.6 (21.5)	29.5 (29.9)	NS
Other biological treatment	9.9 (15.9)	12.4 (16.8)	4.3 (5.1)	12.8 (17.9)	4.9 (10.6)	8.3 (11.7)	26.4 (31.3)	.000 2=4<6
Psychotherapy	24.3 (20.2)	20.7 (17.5)	34.9 (19.1)	16.3 (16.2)	33.3 (10.6)	19.5 (15.9)	14.5 (19.2)	.000 1=3<2=4
Psychological Counseling	14.8 (14.8)	12.8 (11.1)	13.3 (15.2)	20.9 (22.8)	14.1 (12.6)	19.3 (16.3)	11.4 (15.8)	NS
Special Education	7.0 (8.9)	8.2 (9.9)	5.9 (7.9)	8.3 (9.3)	5.4 (7.6)	4.9 (6.2)	10.5 (12.9)	NS
Psycho-education	12.9 (14.9)	12.1 (13.4)	8.5 (8.7)	12.7 (17.1)	14.2 (15.5)	20.2 (19.8)	6.4 (8.1)	.038 1=2=3=4=5=6
Others	1.4 (5.6)	2.1 (7.0)	0.4 (1.9)	1.4 (5.9)	0.4 (2.0)	1.9 (7.9)	1.4 (3.2)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology
2: Psychiatry interns and residents
3: Those who have a B.A. degree in Guidance and psychological Counseling
4: Those who have clinical psychology M.A. degree
5: Clinical psychology M.A. students.
6: Other professionals (eg. Social workers, nurses etc.)

The professionals proposed the types of psychotherapy for the people who would benefit from psychotherapy, as presented in Table 27. They distributed 100% into the different kinds of psychotherapy types, according to their clinical perspective believed to be effective for the people for psychotherapy sessions. The participants who distributed totally between 50 and 130 were included in the analysis (N= 226).

Almost one fifth of the sample proposed cognitive behavioral psychotherapy (21.9%), and the other one fifth of the sample proposed psychodynamic psychotherapy (20.9%) for the people who would benefit from psychotherapy. Comparing the six professional groups, it was found that: 1) Regarding cognitive behavioral psychotherapy, there was a significant difference among the groups, and the groups were ranked as in the following: psychiatrists (27.5%), psychologists (25.3%), clinical psychologists (19.9%), psychological counselors (18.3%), clinical psychology MA students (15.2%), and others (15.0%). 2) Regarding psychodynamic psychotherapy, there was a significant difference among the groups, and the groups were ranked as in the following: psychiatrists (30.4%), clinical psychologists (28.4%), clinical psychology MA students (26.0%), others (25.6%), psychological counselors (17.2%), and psychologists (12.3%).

Except than cognitive behavioral and psychodynamic psychotherapies, the others were proposed by the mental health professionals with similar amounts, less than 10% per each. In comparison between the six professional groups, there were significant differences.

These appeared that: 1) Regarding behavioral psychotherapy, there was a significant difference among the groups, and the groups were ranked as in the following: psychiatrists and psychological counselors (6.2% for each), others (5.6%), psychologists (4.7%), clinical psychologists (3.0%), clinical psychology MA students (1.6%).

2) Regarding transactional analysis, there was a significant difference among the groups, and the groups were ranked as in the following: others (5.9%), psychological counselors (3.9%), psychologists (2.2%), clinical psychologists (1.5%), clinical psychology MA students (1.2%), and psychiatrists (0.4%).

3) Regarding integrative psychotherapy, there was a significant difference among the groups, and the groups were ranked as in the following: clinical psychology MA students (13.8%), psychologists (8.0%), clinical psychologists (7.3%), psychological counselors (5.6%), others (2.3%), and psychiatrists (2.2%).

4) Regarding art therapy, there was a significant difference among the groups, and the groups were ranked as in the following: others (10.9%), psychological counselors (5.0%), clinical psychologists (4.5%), clinical psychology MA students (4.1%), psychologists (3.5%), and psychiatrists (1.1%).

Table 27. Mental Health Professionalsô Proposed Types of Psychotherapy for the People Who Would Benefit from Psychotherapy Groups

Type of Primary PT M % (SD)	Total (n= 226)	1 Psychologists (n= 85)	2 Psychiatrists (n= 30)	3 Psych. Counselors (n= 25)	4 Clinical Psych (n= 48)	5 Cli.Psy. M.A. St. (n= 29)	6 Others (n= 9)	p (NS, if p>.05)
Psychoanalysis	8.9 (12.9)	8.2 (14.2)	10.1 (12.4)	7.5 (9.0)	9.9 (14.0)	10.2 (12.1)	4.4 (5.3)	NS
Psychodynamic PT	20.9 (20.6)	12.3 (16.3)	30.4 (20.1)	17.2 (21.3)	28.4 (23.4)	26.0 (16.1)	25.6 (24.8)	.000 1<2=4
Humanistic PT	6.3 (9.8)	6.7 (9.9)	4.4 (11.7)	8.4 (13.7)	5.4 (6.7)	7.4 (9.0)	4.4 (4.6)	NS
Behavioral PT	4.3 (6.6)	4.7 (6.1)	6.2 (8.2)	6.2 (9.3)	3.0 (5.6)	1.6 (3.0)	5.6 (6.8)	.035 1=2=3=4=5=6
Cognitive PT	5.1 (8.3)	5.5 (8.1)	7.4 (11.2)	6.2 (8.3)	3.3 (6.5)	2.6 (6.9)	7.8 (10.3)	NS
Cognitive Behavioral PT	21.9 (18.0)	25.3 (18.5)	27.5 (16.6)	18.3 (25.6)	19.9 (14.7)	15.2 (13.4)	15.0 (11.7)	.023 1=2=3=4=5=6
Systemic PT	3.0 (6.2)	3.2 (5.8)	1.2 (4.1)	5.4 (7.6)	2.4 (4.5)	2.1 (4.1)	6.1 (16.5)	NS
Art Therapy	3.9 (6.8)	3.5 (6.6)	1.1 (2.4)	5.0 (6.9)	4.5 (8.1)	4.1 (5.7)	10.9 (9.5)	.006 2<6
Somatic PT	2.3 (4.8)	2.6 (5.3)	0.6 (2.0)	2.8 (4.9)	2.5 (5.2)	2.2 (3.9)	2.9 (5.0)	NS
Transactional Analysis	2.0 (4.8)	2.2 (5.2)	0.4 (1.8)	3.9 (7.3)	1.5 (3.8)	1.2 (2.9)	5.9 (6.1)	.010 1=2=3=4=5=6
EMDR	3.9 (8.2)	4.8 (8.5)	2.1 (4.2)	2.4 (4.8)	4.5 (10.2)	4.5 (9.9)	1.2 (3.3)	NS
Eclectic PT	8.3 (15.0)	9.9 (17.6)	6.2 (13.5)	8.9 (13.4)	6.6 (14.0)	8.8 (13.5)	4.0 (6.4)	NS
Integrative PT	7.3 (14.4)	8.0 (16.9)	2.2 (3.7)	5.6 (9.9)	7.3 (14.4)	13.8 (16.7)	2.3 (3.6)	.046 1=2=3=4=5=6
Other	1.1 (6.7)	2.4 (10.6)	0.3 (1.8)	0.4 (2.0)	---	0.2 (0.9)	2.2 (6.7)	NS

Groups: 1: Those who have a B.A. or M.A. degree other than clinical psychology in psychology 2: Psychiatry interns and residents 3: Those who have a B.A. degree in Guidance and psychological Counseling 4: Those who have clinical psychology M.A. degree 5: Clinical psychology M.A. students. 6: Other professionals (eg. Social workers, nurses etc)

3.2 Results of Multiple Regression Analyses

In the study, stepwise multiple regression analyses were also computed in order to see the effects of variables on different results. The analyses were computed between the entry criteria for the probability of F values between .1 and .15 for all the analyses.

Age, gender, having an MA or PhD degree or not, total number of hours in theoretical training based on clinical subfields, total number of years in clinical experience, receiving supervision currently, total number of supervision hours per month, total number of supervision hours so far, total personal psychotherapy sessions, theoretical orientation (psychoanalytic/psychodynamic, humanistic, CBT), and professional group were identified as independent variables.

Then, multiple regression analyses were performed on the following dependent variables: healing index scores, the percentage of clients completed the clinical service in appropriate time, the percentage of drop-outs due to the clinician, the percentage of drop-outs due to the mismatch in theoretical orientation and clientôs problems/needs, the percentage of clients for whom professionals proposed getting help from a mental health professional as primary intervention, the percentage of clients for whom professionals proposed psychotherapy as primary clinical intervention; and total level of difficulty mental health professionals experience in performing their clinical work.

Table 28. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Perceived Healing Scores

Variables	B	SE B	ß	cpR²
# of Experience yrs	.022	.008	.175	.083
Existential-Humanistic Approach	.006	.002	.198	.061
Having MA degree	.351	.119	.199	.051
Total # of Hrs in Theoretical Training based on Clinical Subfields	.000	.000	.144	.016
Cognitive Behavioral Approach	.003	.002	.129	.013
Psychoanalytic Approach	.002	.001	.114	.012

Adj. R²= .212 , (ps< .05)

Table 28 presented the results of multiple regression analysis for variables predicting mental health professionalsô perceived healing scores. Results showed that higher perceived healing scores were predicted by higher number of years in clinical experience, having a weighed theoretical orientation in existential-humanistic, psychoanalytic and CBT approaches, having an MA degree, and more theoretical training. All these variables explained 21 % of the overall variance for the perceived healing index scores.

Table 29 presented the results of multiple regression analysis for variables predicting the percentage of clients completed the clinical service in appropriate time. Results showed that higher percentage of clients completed the clinical service in appropriate time were predicted by higher number of years in clinical experience, and having a weighed theoretical orientation in cognitive behavioral approach. These variables explained 8 % of the overall variance.

Table 29. Summary of Stepwise Multiple Regression Analysis for Variables Predicting The Percentage of Clients Completed the Clinical Service in Appropriate Time

Variables	B	SE B	ß	cpR²
# of Experience yrs	.975	.231	.281	.073
Cognitive Behavioral Approach	.085	.044	.130	.017

Adj. R²= .081 , (ps< .05)

Table 30 demonstrated the results of multiple regression analysis for variables predicting the percentage of drop-out reason of difficulties in clinical relationship mostly due to the clinician. Results showed that higher percentages of drop-out reason of difficulties in clinical relationship mostly due to the clinician were predicted by being a psychiatrist, but not having a PhD degree (these two variables, taken together, means being a psychiatry intern in our study). These two variables accounted for approximately 7% of the overall variance.

Table 31 presented the results of multiple regression analysis for variables predicting the percentage of drop-outs due to the mismatch between theoretical orientation and clientôs problems/needs. Results showed that higher percentages of drop-outs due to mismatch of theoretical orientation and clientôs problems/needs were predicted by being a clinical psychology MA student, being a psychiatrist, and being younger. These variables explained approximately 6 % of the overall variance.

Table 30. Summary of Stepwise Multiple Regression Analysis for Variables Predicting the Percentage of Drop-outs mostly due to the Clinician

Variables	B	SE B	ß	cpR²
Being a Psychiatrist	6.944	1.728	.314	.052
Having a PhD degree	-4.547	2.010	-.177	.024

Adj. R²= .067 , (ps< .05)

Table 31. Summary of Stepwise Multiple Regression Analysis for Variables Predicting the Percentage of Drop-outs due to the Mismatch of Theoretical Orientation and Clientôs Problems/Needs

Variables	B	SE B	ß	cpR²
Being a Clinical psychology MA student	6.860	2.650	.183	.040
Age	-.250	.108	-.167	.019
Being a Psychiatrist	4.569	2.588	.125	.015

Adj. R²= .060 , (ps< .05)

Table 32 presented the stepwise multiple regression analysis for variables predicting the percentage of clients for whom professionals proposed getting help from a mental health professional as primary intervention. Results showed that higher percentage of clients for whom participants proposed getting help from a mental health professional as primary intervention was predicted by being elder, higher numbers of total personal psychotherapy sessions, and having a weighed theoretical orientation in cognitive behavioral and biological psychiatry approaches. These variables accounted for the 14 % of the overall.

Table 32. Summary of Stepwise Multiple Regression Analysis for Variables Predicting The Percentage of Clients for whom Professionals Proposed Getting Help from a Mental Health Professional for the People who Experience Psychological Difficulties in Turkey as *Primary Intervention*

Variables	B	SE B	ß	¢pR²
Age	.594	.205	.200	.059
Any Cognitive Behavioral Approach	.170	.042	.262	.058
Total Personal Psychotherapy Sessions	.022	.010	.160	.020
Biological Psychiatry Approach	.188	.100	.121	.014

Adj. R²= .135 , (ps< .05)

Table 33 demonstrated the results of multiple regression analysis for variables predicting the percentage of clients for whom professionals proposed psychotherapy as primary clinical intervention for the people who experience psychological difficulties in Turkey. Results showed that higher percentage of clients for whom participants proposed psychotherapy as primary clinical intervention was predicted by having a weighed theoretical orientation in psychoanalytic and existential-humanistic approaches, higher number of total personal psychotherapy sessions, not being a psychological counselor and other professional group, and not having a PhD degree. These variables together explained the 21 % of the overall variance.

Table 33. Summary of Stepwise Multiple Regression Analysis for Variables Predicting The Percentage of Clients for whom Professionals Proposed Psychotherapy as *Primary Clinical Intervention* for the People who Experience Psychological Difficulties in Turkey

Variables	B	SE B	ß	cpR²
Any Psychoanalytic Approach	.067	.020	.223	.093
Others (Professional Groups)	-14.040	5.376	-.162	.030
Total Personal Psychotherapy Sessions	.026	.008	.230	.023
Any Existential Humanistic Approach	.132	.043	.204	.031
Being a Psychological Counselor	-10.974	3.758	-.182	.030
Having a PhD Degree	-10.492	4.386	-.154	.021

Adj. R²= .206 , (ps< .05)

Table 34 presented the results of multiple regression analysis for variables predicting total level of difficulty mental health professionals experience in performing their clinical work. Results showed that higher levels of difficulty were predicted by being younger, not being an other professional, not having an MA degree, and fewer hours in theoretical trainings. These variables all together explained the 11 % of the overall.

Table 34. Summary of Stepwise Multiple Regression Analysis for Variables Predicting Total Level of Difficulty Mental Health Professionals Experience in Performing their Clinical Work

Variables	B	SE B	ß	$_{p}R^2$
Age	-.010	.005	-.142	.076
Others (Professional Groups)	-.388	.166	-.155	.016
Total # of Hrs in Theoretical Training based on Clinical Subfields	-8.949	.000	-.138	.019
Having a MA degree	-.142	.079	-.127	.014

Adj. R^2= .108 , (ps< .05)

CHAPTER IV. DISCUSSION

4.1. Presentation of Discussion

This study presented the main issues of the mental health professionals in Turkey. These issues were the socio-demographic characteristics, educational and training background, experience-related characteristics, client-related characteristics, and proposed interventions. Regarding these information, the professional picture of the mental health professionals in Turkey was taken, although there was a limited number of professionals (N= 245) being reached.

Regarding socio-demographic characteristics, the sample of the study was constituted by younger professionals (Mage= 32), especially with younger psychologists and clinical psychology MA students. The majority of the sample was made by females (79.6%). The dominance of females can also be observed in the field, yet only psychiatrists consisted of more males (61.3%) than females (38.7%) in the group. Thus, there was a gender difference among the groups.

In terms of divorce rate, the sample seemed to have a high rate, which was almost half of the sample (47.4%). It was, unexpectedly, higher in the groups of psychologists and clinical psychology MA students,

although they were the two youngest groups. Since the divorce rate seemed to be higher than the general Turkish population, it might be interesting to compare the divorce rates between mental health professionals and other professionals from different professions. This may show the divorce rates associated among the various occupations.

In terms of birth place, comparing the six professional groups, psychiatrists and other professionals came from cities, towns, and villages. On the other hand, the other four groups were mostly born in metropolises, such as Istanbul, Ankara, and Izmir. This might show that mental health field has a variety of cultural background. In addition, mental health might be given priority from different cultures.

These people who had a different cultural background defined themselves mostly an Earth-citizen, and individuals from Turkey from the geography-based identity point of view. In terms of national/ethnic identity, the participants defined themselves as Turkish mostly. These might reflect that although mental health professionals in the study come from different cultures, they position themselves as a member of the whole.

Regarding educational background of BA degrees, psychiatrists were the most homogeneous group, since all of them graduated MD. Yet, in the other five professional groups, there was heterogeneity, especially in the group of psychological counselors. In this group, the distribution of other BA degrees was with limited percentages such as psychological counseling BA (79.3%), psychology BA (13.8%), pedagogy BA (10.3%), and other BA (3.4%). Moreover, they had MA degrees from different programs, such as,

other psychology MA (10.3%), other MA (6.9%) neuropsychology, and (3.4%). This might indicate that there is transitivity among the five professional groups in terms of study fields, and mostly psychological counselors have been dealing with a variety of BA and MA degrees. In the mental health field in Turkey, it can also be observed that psychological counselors, who had a BA degree in counseling, might also be interested in the other MA degrees or BA degrees as a double major.

In terms of the other part of the educational and training background, the mental health professionals in the sample has on average 704.3 hours of theoretical training based on clinical subfields, especially on psychoanalytic/psychodynamic psychotherapy (103.7), and techniques of clinical interview (103.3). The most trained group was psychiatrists (1,359.6). This might be due to longer years of education to get specialization in the field. Moreover, since psychiatrists were the most experienced group with more year of practice, they could have had more hours for training in the field. During undergraduate years of psychology, there is limited opportunity to have experience with clients. Yet, on the other hand, psychiatrists have the chance to work with clients during their internship in hospitals. This may influence the relationship with their profession since the undergraduate years. Moreover, psychologists have limited number of courses directly on clinical issues during undergraduate period.

The other groups had received less hours of training. Clinical psychologists (921.5) had approximately one and a half times less than the

hours of the psychiatrists, and psychological counselors (611.7) had nearly one third hours of the psychiatrists. Moreover, in terms of reading materials, the sample has been reading articles (7.8 per month), and books (1.8 per month). Types of materials read by the mental health professionals were different from one another. Although the professionals have been reading articles in a month with various amounts, the number of books that they read in a month was very similar to one another. Psychiatrists (10.9) read the most number of articles, and psychological counselors (5.3) read the half the amount of psychiatrists. This might reflect an association between the number of training hours in subfields and the number of articles read. The more number of training hours in clinical subfields might lead to read more numbers of articles about the field. To be actively participating in trainings might motivate professionals to read more professional articles related with clinical subfields.

Regarding personal therapy, more than half of the sample (58.8%) had received or have been receiving personal therapy. Among the six professional groups, clinical psychologists (72.5%) were mostly in the process of personal therapy, whereas psychiatrists (42%) and others (38.5%) were the least. Although the number of psychiatrists were the least involved in personal therapy, the total amount of personal therapy sessions were the most (331.6) of the other six professional groups. This might be due to the theoretical orientation of their personal therapy, because psychiatrists received mostly psychoanalysis (25.8%) with a mean number of 6.5 sessions in a month. Lastly, since psychiatrists were elder than the other

groups this might also be the other factor that psychiatrists had more number of sessions in their personal therapies.

Clinical psychologists were the group that had the second most hours in personal therapy (204.2). They seemed to have personal therapy which was based mostly on psychodynamic psychotherapy (31.4%) with a mean number of 5.5 sessions in a month.

Regarding language status, four abilities which were reading, writing, speaking, and ability to use in clinical practice were evaluated. English was the most used second language among the mental health professionals in all these four groups, such as reading (87.3%), writing (79.2%), speaking (73.9%), and ability to use in clinical practice (44.5%). In the second place, French was used in reading (10.6%), writing (8.2%), speaking (7.8%), and clinical practice (5.3%). And thirdly, mental health professionals could use German in reading (11%), writing (8.6%), speaking (7.8%), and clinical practice (1.2%). Comparing the six professional groups, the group of clinical psychology MA students was the best equipped group in using English, French, German, and additionally Spanish regarding the four abilities, reading, writing, speaking, and using in clinical practice. This might be due to the younger age of the clinical psychology MA student group. Since they were younger than the others, they might be fresh about using second languages; also, this finding might reflect betterment in the language education in Turkey.

In terms of experience-related characteristics, active clinical practice was one of the main issues. In terms of active clinical practice, all the

defined types of clinical practice stood for a specific occupation, such as psychiatrist, psychologist, and clinical psychologist. Yet, only psychotherapist did not define any specific duty of occupation. Hill, Nutt, & Jackson (1994, p. 365) defined psychotherapist as ñone who has been specifically trained as a professional therapistò. Among the six professional groups, clinical psychologists (41.2%), and clinical psychology MA students (34.5%) set a high value on defining them as psychotherapist. Being a psychotherapist might indicate an implementation of them, thus by defining themselves as psychotherapist; they might imply the specific unique duties with their clients in the field.

Moreover, the clinical psychology MA students defined them as ñclinical psychologistò at a very low degree (6.9%). This might be related with being in the education process of the profession. Clinical psychology MA students may pay attention to define themselves as a specialist after they got the MA degree. Otherwise, they might have not care about their educational process.

Mental health professionals could have been working in a variety of clinical work settings either full time or part time status. As expected, psychiatrists and others (such as psychiatry nurses and social workers) mostly worked in state and/or private hospitals. Clinical psychologists and clinical psychology MA students have been working mostly in private psychological counseling centers. Psychological counselors mostly have been working in private psychological counseling centers and guidance research center, in addition to elementary schools.

The participants have been working in the settings related with the type of their occupational characteristics. As in Guineeôs (2000) study, the majority of the mental health professionals worked in university counseling centers, hospital clinics, and mental health centers. These people had the clinical psychology or psychological counseling training. Thus, the work setting may play an important role for the implementation of the treatment program. As can be seen, the work settings of mental health professionals in Turkey are parallel with Guineeôs (2000) study findings.

As it was a young sample (mean age: 32), the number of active clinical experience (6.8 years) was also not high. The most experienced groups were psychiatrists (10) and others (10.1); whereas clinical psychology MA students (2.2) and psychologists (5) were the least experienced groups. Since one of the occupational features of mental health field was experience, the definition of it could be remarkable. Guinee (2000) argued that whether experience was the number of experience year, or the number of experience year with supervision. It might be believed that the more experienced mental health professionals may get better solutions in the treatment programs. In this regard, psychiatrists (367.3) and clinical psychologists (353.4) received the highest number of supervision hours. Thus, this might show that psychiatrists may be the more experienced group from two points of view.

Regarding types of clinical practice that mental health professionals utilized, psychotherapy (41.5%), psychological counseling (25.3%), and psycho-education (11.3%) were mostly preferred. Among the six

professional groups, psychotherapy was the most preferred type of clinical practice for clinical psychologists, and clinical psychology MA students. Clinical psychologists and clinical psychology MA students employed psychotherapy (71.6%, 56.7%, respectively) to their clients mostly. As can be anticipated, since the occupational duties for these two groups were more related with psychotherapy, and the self-definitions of these two groups were mostly ñpsychotherapistsò, the amount of this type of clinical practice would be higher than the others.

In addition, the half amount of the clinical practice of psychiatrists was constituted drug treatment (49.5%), and approximately one third of the clinical practice that psychiatrists employed was psychotherapy (38.4%). It might be interesting for psychiatrists to utilize psychotherapy at a high value, other than drug treatment. It may be also interesting that psychiatrists preferred to utilize drug treatment due to mostly work setting. Since there is limited time and several types of patients, employing drug treatment may also facilitate their job.

Mental health professionals provide psychotherapy sessions based on theories. Every theory is based on various hypotheses. The theoretical orientation, that the professionals adapted their clinical intervention types into, may differ according to the professionalsô experiences and beliefs about effectiveness of psychotherapy for the people being in need. Parallel with the results proposed types of psychotherapy, psychoanalytic (41.6%) and cognitive behavioral (22.5%) approaches were mostly used by the mental health professionals in the study. Among the six professional groups,

clinical psychology MA students (61.3%) and clinical psychologists (53.6%) used psychoanalytic approaches in their clinical practice at most. This might indicate that the clinicians in the study mostly based their clinical practice on psychoanalytic approaches. This might have also influenced the results regarding therapeutic factors which were believed to be effective for permanent changes in clients.

Difficulty degrees with different cases were at varying levels for professionals. There were numbers of cases, with significant characteristics. Professionals experienced various degrees of difficulty with different cases. The sample had the most difficulty while working with sexual abusers/rapists (3.8), followed by anti-social personality (3.3), and schizophrenic patients (3.2). Comparing the six professional groups regarding these three cases, psychiatrists and others have been experiencing less difficulty than the other four groups. Sexual abusers/rapists, anti-social personality and schizophrenic patients are mostly attended in hospitals. Psychiatrists and others (mostly psychiatric nurses, social workers) who have mostly been working in hospitals, have more possibility to work with these cases. Thus, the more practice possibility with them, the less difficulty they may experience.

The professionals experienced least difficulty with people with different ethnic identity (1.2), religious beliefs (1.3) than the professional, and people in poverty (1.3). These variables are mostly related with socio-cultural backgrounds, rather than the characteristics of an illness such as schizophrenia or anti-social personality. The results showed that the mental

health professionals could mostly focus on symptoms of cases, rather than social identities. This might also indicate the mental health professionalsô endorsement of unconditional acceptance and positive regard to their clients which are the components of therapeutic standing.

Yet, in Turkey, anecdotal observations do not confirm these findings. Having least difficulty while working with people with different religion, or ethnic identity, or people in poverty do not seem to be realistic when compared with the observations of current relationships among people being from different ethnic or socio-cultural characteristics.

The professionals might experience less difficulty with them because of the type of practice among the professionals. When the treatment is decided as psychopharmacology, then the difficulty degree would diminish. With parallel to current observations, people in poverty mostly apply to state hospitals, where mostly psychiatrists are employed and drug treatment is utilized. In addition, people in poverty, people with different religion, or ethnic identity than the professional might most likely to have professional admiration to mental health workers. Since they perceive that the professionals are dealing with them and healing them, expectations of the clients may become lower.

Regarding satisfaction degrees in different professional dimensions, the mental health professionals were mostly pleased by professional satisfaction (2.9) and social status (2.8). The field of mental health is dealing with the problems individuals experience psychologically, thus the professionals in this field intend to help these people to get rid of their

problems in different ways of their job duties. To be able to help people may naturally provide professional satisfaction, as parallel with the results. In addition, to be able to help people experiencing psychological difficulties may also lead high levels of satisfaction in social status. On the other hand, the mental health professionals were least pleased with level of income (2.1) and professional organization (1.9) which were more related with material things.

Among the six professional groups, psychiatrists were most pleased with their professional organization which can also be observed in Turkey among the other organizations of professional groups. Psychiatristsô organization is the most cohesive, and active among the others. This cohesiveness and being active as an organization may influence the satisfaction in the field.

Regarding client-related characteristics, there were different features to mention. In terms of age groups and clinical modalities, all the five professional groups have been mostly working with elder than 19 year-old clients, except psychological counselors. Since psychological counselors mostly worked in elementary schools, their clientsôage groups naturally decreased to 7-18 years.

Mental health professionals in the sample had been working with 2021.6 different cases on average from the beginning of their active clinical practices. Although the number of the cases dealt by the psychiatrists (10,016.3) might seem to be incredibly high, there might be some reasons that may lead to this finding. For instance, psychiatrists working in the state

hospitals, because of the patient overload, could spend very brief time with each patient; and they could examine 50-100 patients each day. Hence, these might be the factors to increase the number of the cases of psychiatrists in the sample.

With respect to drop-out rates of professional topics, more than half of the mental health professionalsôclients (52.1%) completed the clinical service in appropriate time. The other half of the clients (47.4%) dropped out in other timings, such as during intake (27.8%), or after started regular visits (19.6%). Comparing the groups regarding appropriately completed, psychological counselors (60.7%), psychiatrists (59.6%) completed their clinical process with their clients in appropriate time more often than the other professional groups. This might be dependent on the type of clinical practice that the professionals employed. Since psychological counselors mostly utilized psychological counseling in their active clinical practice, the total amount of this type of practice lasted in a limited time. In addition, psychiatrists who employed mostly drug treatment also spent limited time in their clinical practice to reach their target in treatment program. These two professional groups, who had clients that completed the clinical service in an appropriate time, implemented their clinical practice in a more limited time. Thus, when the clinical practice needs a small period of time, then the number of clients who completed the clinical service in the anticipated time may increase.

The second most drop-out rates were seen after started regular visits (19.6%), especially for clinical psychology MA students (25.3%). This

might be due to lack of active clinical experience in terms of years and being in an education process. The less experience might cause professionals not to be able to hold the clients therapeutically along the process.

Regarding reasons for drop-outs, financial difficulties (23.9%), and clientsô being not ready for clinical intervention (23.6%) were the two major reasons. These two reasons for drop-outs were valid for the clients of all the six professional groups. Yet, among the six professional groups, clinical psychologists (31.3%) experienced drop-outs mostly due to financial difficulties. This might be due to clinical work setting of professionals. Since they have been mostly working in private psychological counseling centers, the fees of clinical service in this setting might be more expensive than the others.

In addition, clinical psychology MA students (30.0%) experienced drop-outs mostly due to clientsô not being ready for clinical intervention. Clinical psychology MA students, who had the least active clinical experience (2.2), lost clients due to clientsô being unready. Yet, clients might have dropped out not because of their own being unready for clinical intervention, but their therapistsô not being ready to intervene clinical intervention. This might be a projection of the clinical psychology MA students themselves. Self-evaluations for mental health professionals about losing clients as drop-outs would be interesting to understand this dilemma.

Regarding healing degrees due to clinical intervention that the mental health professionals estimated, more than half of the sample (61.1%)

anticipated very high (31.8%) and high (29.3%) degrees of healing in their clients. Among the six professional groups, clinical psychologists (74.5%), psychological counselors (69.0%), and psychiatrists (61.3%) estimated the highest degrees of healing in clients due to clinical interventions. In this regard, the definition of healing might be noteworthy. For psychiatrists who mostly utilized drug treatment, to eliminate the symptoms of an illness by drugs could be the healing indicator. For clinical psychologists who mostly employed psychotherapy to their clients might plan on proper changes according to his/her clinical formulation. This may point the healing of the clients. For psychological counselors who mostly utilized psychological counseling to their clients might aim to provide support to cope with daily lifeôs problems, or change a specific behavior or cognition. Thus, although the targets for healing in clinical practice were somewhat different from one another, these three professional groups had similar amount of healing degrees.

In addition to type of clinical practice, there might be other factors that might influence the healing degrees which were estimated by the mental health professionals. These factors might be experience years, experience with supervision, being familiar with the cases, and personal therapy. In order to see the effects of possible other factors, it may be interesting to investigate the associations among them in future researches.

In terms of distribution of numbers of clients experienced another clinician before, more than one third of the mental health professionals (35.6%) in the study had clients who had experienced another clinician

before. Among the six professional groups, psychiatrists (51.7%) had the most number of clients who had experienced previous clinician, currently working with psychiatrists. That is, the clients who currently have been working with psychiatrists had mostly experienced another clinician before. This might indicate that the clients who currently work with psychiatrists were not satisfied with previous clinician, or the clients might prefer to visit psychiatrists as the last resort. In order to see which reasoning might be more valid, satisfaction degrees of previous clinicians that the current clientsô mental health professionals work through might be remarkable.

Regarding the satisfaction degrees of previous clinician, the sample described that half of their clients (50.1%) were unpleased with their previous clinicians at some level. Approximately one fourth of their clients (27.1%) were pleased with their previous experience with clinician at some degree of pleasant. And the other one fourth of the clients was uncertain about the previous clinician. Among the six professional groups, psychiatrists had the least number of clients who were unpleased with previous clinician (43.1%) at some level, whether somewhat or totally.

Although psychiatrists had the most number of clients who had worked with other clinicians before, they had the least number of clients who were unsatisfied with previous experience at some level. Thus, it might reflect that the current clients of psychiatrists may prefer to get clinical support from the psychiatric point of view at the last resort.

The highest rated therapeutic factor that achieves permanent therapeutic development was quality of therapy relationship (3.7). The

higher the quality of the therapy relationship, the more the therapeutic improvement. In the second place, according to the mental health professionals, therapist related factors achieved permanent therapeutic development. Consistency of framework was the factor that made permanent changes and development in clients therapeutically. This may show that being from any professional group, and endorsing any theoretical orientation, mental health professionals believed the importance of consistency of therapeutic framework for permanent therapeutic development. In addition to framework, genuineness, unconditional acceptance of clients, neutrality, and flexibility of therapists were the factors that lead permanent changes in clients. These factors were also therapist-related factors, which were mostly associated with art of therapist, rather than techniques.

In terms of therapeutic factors, the technique related therapeutic factors were the least important factors which achieved permanent therapeutic changes. Techniques are more related with the science part of psychotherapy, yet the quality of relationship and therapist related factors are mostly related with the art part of psychotherapy. Thus, this may show that participants of this study believe that psychotherapy achieves permanent changes therapeutically with art, more than science.

In terms of proposed interventions, mental health professionals in the study were asked proposed primary, clinical primary, clinical secondary types of interventions for the people who had psychological difficulties in Turkey.

Regarding proposed types of primary intervention, the mental health professionals in Turkey, as expected, proposed mostly getting help from a mental health professional (41.5%). Since they are the members who can help people having psychological difficulty, it is naturally expected. When comparing the professional groups, mostly psychiatrists (53%) proposed getting help from a professional as the primary intervention. In addition, psychiatrists have proposed professional help for most of their clients than the clinical psychology MA students, although this difference is very little. Yet, this might show that psychiatrists, who are elder and have more experience years than the others, might have become medication-oriented in years. On the other hand, the ones who have been in the mental health field for a shorter period of time than the others seemed to be more open for other interventions rather than professional help. This might show that, the more year of clinical practice might lead mental health workers become more bound to profession.

In the second place, despite of being insignificant in statistics results, the mental health professionals offered support of family (14.5 %) for the people having psychological difficulties. This might indicate that even mental health professionals may believe the strength of family support for the people having psychological difficulties. This may also reflect the collectivist attitude of Turkish culture while having some difficulties and coping with them.

In the third place, the mental health professionals proposed financial recovery (11.3%) for the people experiencing psychological difficulties.

That is, mental health professionals might believe that the more economic welfare the clients had the less psychological difficulties they may experience. This might also indicate the financial problems that has been currently experiencing in Turkey.

When the importance of getting help from a mental health professional was mentioned, then the type of clinical intervention became another important point. The sample proposed psychotherapy (42.7%), psychopharmacology (20.6%), and psychological counseling (17.7%) as primary clinical intervention for their clients experiencing psychological difficulties. Among the six professional groups, psychiatrists, interestingly, proposed psychotherapy (38.3%) more than psychopharmacology (37.7%). Although in their clinical practice, they mostly utilized drug treatment, which constituted nearly half of their clinical practice, they mostly offered psychotherapy for their clients. Since the psychiatry group experienced their own therapeutic process with the longest period, they might have experienced better solutions concerning about their psychological problems. Thus, they may propose psychotherapy more than the other types of clinical intervention due to their own experiences.

Regarding secondary clinical intervention, the mental health professionals proposed the same triple with the primary clinical intervention, which were psychopharmacology (29.6%), psychotherapy (24.3%), and psychological counseling (14.8%). Still, among the six professional groups, psychiatrists proposed psychotherapy (34.9%) more than psychopharmacology (32%) as the secondary clinical intervention. This

finding might also reflect the strong belief in psychotherapy from the psychiatric point of view.

Since mental health professionals proposed psychotherapy at most as both primary and secondary types of clinical intervention, type of psychotherapy appeared as the other important issue. The professionals in the sample mostly proposed cognitive behavioral (21.9%) and psychodynamic (20.9%) psychotherapy for the people who would benefit from psychotherapy. Among the six professional groups, psychiatrists (30.4%), clinical psychologists (28.4%), and clinical psychology MA students (26%) proposed psychodynamic psychotherapy at most. In addition, almost other one third of psychiatrists (27.5%) proposed the other commonly offered psychotherapy, which was cognitive behavioral at most. It was interesting that psychiatrists proposed these two types of psychotherapy at most levels among the groups. This might indicate that psychiatrists could value different types of psychotherapy for their clients commonly.

In addition, clinical psychologists and clinical psychology MA students offered psychodynamic psychotherapy more than the other types of psychotherapy. This might be due to their personal psychotherapy orientation. Since these two groups mostly experienced psychodynamic psychotherapy, they seemed to offer the same type of orientation for the people who would benefit from psychotherapy. This may also reflect the association of own therapeutic orientation on building oneôs professional theoretical orientation.

Regarding explorative statements, the mental health professionalsô perceived level of healing for their clients is increased by more (longer) clinical experience, more theoretical training, having an MA degree, and having a weighted orientation in existential, cognitive behavioral, and psychoanalytic approaches. These findings show that, at least subjectively from the mental health professionalsôpoint of view, their capacity to help people clinically increase with experience and training, as well as with having a solid affiliation with a major school of psychotherapy.

The higher percentage of clients seemed to complete the clinical service in appropriate time, when working with more experienced clinicians, and with the professionals who endorse cognitive behavioral approach more commonly. This might be due to characteristic of cognitive behavioral therapy, which contained limited number of sessions. Since clinical service with a CBT approach is designed with a limited number of sessions, the more number of clients may naturally complete the clinical service in appropriate time.

During clinical service, one of the common issues is drop-outs. Premature termination of treatments might also hinder the effectiveness of clinical service for the clients (Barrett & Thompson, 2008). Many studies also mentioned that premature terminations may occur in various timings, such as after the intake sessions, or the first session (Affleck & Medwick, 1959; Rogers, 1951). The ones who dropped out after the first session were constituted 20% and 57% (Baekeland & Lundwall, 1975). Study findings showed that approximately 65% of clients might end psychotherapy before

the 10th session (Garfield, 1994), because the clients did not take the psychotherapy sessions in adequate frequency.

People in clinical relationship may drop out due to different reasons. Study findings show that likelihood of ñdrop-outs mostly due to the clinicianò is increased when working with psychiatrists and with professionals who do not have a PhD degree. In this study, the group of people having a PhD degree was constituted of the ones who had a PhD degree in different areas and the resident psychiatrists. Thus, being a psychiatrist and not having the PhD degree indicates the participants being intern psychiatrists. Then, being an intern in psychiatry may increase the probability of not providing the adequate type of intervention that the clients might assume before the clinical service.

On the other hand, individuals who are in a clinical relationship with clinical psychology MA students, younger professionals, and psychiatrists, drop out mostly due to difficulties in theoretical orientation which does not match with clientsô problems/needs. Being a younger professional and a professional whose education period continues may lead to mismatch the clientsô problems or needs. This might be due to lack of experience years. In addition, the lack of experience might lead to lack of flexibility for the mental health professionals. Since in the first few years of the profession, the professionals try to find out the specific theoretical orientation by the method of trial and error, they may have higher probability of having problems with it. They may feel anxious about how to approach to clients and to formulate the clients. This might project on the clients as if there had

been lack of improvements and additional psychotherapy sessions would not be helpful (Hunsley, Aubry, Verstervelt, & Vito 1999).

In the mental health field, the type of intervention is one of the crucial features during clinical work. In this regard, study findings show that the mental health professionalsô likelihood of proposing ñgetting help from a mental health professional as primary interventionò is increased when the participants are elder, when they received longer (with more hours) personal psychotherapy, and when having a weighted theoretical orientation in cognitive behavioral and biological psychiatry approaches. These findings show that, the elder professionals and the ones who have undergone personal psychotherapy with more hours, and who have based their clinical practice on CBT or biological psychiatry propose getting help from a mental health professional for people having psychological difficulties. This might also indicate that the elder professionals have been in affair with the profession more than the younger professionals. This might lead them to engage with the professional help more often besides the other types of primary intervention, such as owning a hobby, having financial recovery, or support of a family.

There becomes also the dilemma between socio-cultural factors and professional knowledge of the mental health professionals. The professionals propose professional help for the people having psychological difficulties less; this might indicate that these professionals may be more engaged with the socio-cultural factors. Yet, the more engagement with the profession in terms of experience years, chronological year of professionals,

personal psychotherapy and working based on a psychotherapy school which were CBT or biological psychiatry might increase the probability of engaging with professional help more than the others.

According to the study findings, mental health professionalsô likelihood of proposing ñpsychotherapy as the primary clinical intervention for people experiencing psychological difficultiesò is increased by having a weighed theoretical orientation in psychoanalytic and existential approaches, having more total personal psychotherapy sessions, not being psychological counselors and others, and not having a PhD degree. These findings show that, the professionals who experienced/have been experiencing personal psychotherapy for a specific period of time, and additionally who have a strong affiliation to psychoanalytic or humanistic approaches, propose psychotherapy as the primary clinical intervention. This finding is valid except the professionals who have a PhD degree, and who is a psychological counselor and an ñotherò professional.

Study findings show that the likelihood of mental health professionalsô ñtotal level of difficulty mental health professionals experience in performing clinical workò is increased by mental health professionalsô being younger, not being from ñotherò professionals, having less number of hours in theoretical training, and not having a MA degree, experience difficulties in different cases more commonly. To be able to work with clients with minimum difficulty, experience in the field in terms of both practically and theoretically seems to be important.

4.2. Limitations and Recommendations for Future Research

The purpose of the current study was to take a picture of mental health field, regarding specified characteristics of mental health professionals. These characteristics were socio-demographic information, educational background, and occupational information, political and religious related social identities. To see the mental health professionals in Turkey, the number of professionals reached was important. The major limitation of the current study is the limited number of sample consisting of mental health professionals in Turkey. Since the time and opportunities were limited, it was difficult to conduct the study to reach more number of people. The findings of the current study may be used to conduct further research in order to get more detailed information regarding the Turkish mental health professionals.

The second limitation is about the limited number of cities that mental health professionals are reached. Since the number of the sample is limited, the professionals in the sample come from few big cities mostly in Western part of Turkey. Although there is limited number of mental health professionals in the Eastern part of Turkey, it cannot be included in the study. This might have also influenced the results of the study.

The sizes of the six professional groups, which are psychologists, psychiatrists, psychological counselors, clinical psychologists, clinical psychology MA students, and others (such as psychiatry nurses, social workers) were not similar to one another, and some groupsôsizes were

rather small. More sizeable and representable professional groups should be sought in the future research.

Data collection method can be considered as the last type of limitation. There were two types of collecting data. The first one was fairer, in which the mental health professionals who prefer to join the questionnaire did join. In addition, all professionals had the possibility to be reached because of the facility of internet. Yet, in the second type of data collection, convenience sampling was additionally used. Mental health professionals who had personal contacts with the research team joined the study. This shows the homogeneity of people being mostly in Istanbul and mostly clinical psychologists.

Findings of the current study will hopefully give an idea to the mental health professionals in the study and inspire researchers to conduct new studies aiming to explore the mental health field in Turkey further.

REFERENCES

Affleck, D. C., & Garfield, S. L. (1960). Predictive judgments of therapists and duration of stay in psychotherapy. *Journal of Consulting Psychology,* 134-137.

Affleck, D. C., & Medwick, S. A. (1959). The use of the Rorschach Test in the production of the abrupt terminator in individual psychotherapy. *Journal of Counseling Psychology, 23,* 125-128.

Anthony, W. A. (1982). Explaining ñpsychiatric rehabilitationò by an analogy to ñphysical rehabilitationò. *Psychosocial Rehabilitation Journal, 5*(1), 61-65.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82,* 738-783.

Barrett, M. S., & Thompson, D. (2008). Practice Review. Early Withdrawal form mental health treatment: Implications for psychotherapy practice. *Psychotherapy Theory, Research, Practice, Training, 45*(2), 247-267.

Bayülkem, F. (2002). *Historical development of psychiatry, neurology and neurosurgery in Turkey.* 4th ed. Istanbul: Kardeкler Matbaasē

Breakey, W. R., (1996). The rise and fall of the state hospital. In Berkeley WR, ed. *Integrated mental health services.* New York: Oxford University Press.

Dilik, S. (1971). Social security system in Turkey: An analysis of economics. *Publication of Faculty of Political Sciences, 315,* 4-20.

Funk, M., Saraceno, B., & Pathare, S. (2003). *The mental health in context.* Singapore: World Health Organization.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 190-228). New York: Wiley.

Garfield, S. L., & Kurtz, R. (1976). Clinical psychologists in the 1970s. *American Psychologist,* 1-9.

Garfield, S. L., & Kurtz, R. (1976). Personal therapy for the psychotherapist: Some findings and issues. *Psychotherapy: Theory, Research, and Practice, 13*(2), 188-192.

Goodwin, S. (1997). *Comparative mental health policy: from institutional to community care.* London: Sage Publications.

Gökalp, R. P., & Aküzüm, Z. N. (2007). Community mental health services in Turkey. *International Journal of Mental Health, 36*(3), 7-14.

Guinee, J. P. (2000). Brief report. The reporting of therapist sample data in the Journal of Counseling Psychology. *Journal of Counseling Psychology, 47*(2), 266-270.

Hill, C. E., Nutt, E. A., & Jackson, S. (1994). Trends in psychotherapy process research: Samples, measures, researchers, and classic publications. *Journal of Counseling Psychology, 41,* 364-377.

Hunsley, J., Aubry, T. D., Verstervelt, C. M., & Vito, D. (1999). Comparing therapist and client perspectives on reasons for psychotherapy

termination. *Psychotherapy: Theory, Research, Practice, Training, 36,* 380-388.

Jones, K. (1972). *A history of the mental health services.* London: Tingling.

Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health and Social Behavior, 43,* 207-222.

Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology, 73*(3), 539-548.

Kilonzo, G. P., & Simmons, N. (1998). Development of mental health services in Tanzania: A reappraisal for the future. *Social Science and Medicine, 47,* 419-428.

Kolodny, A. (2007). Psychiatrists as administrators: The perspective of a mental health department psychiatrist. *Psychiatric Quarterly, 78,* 193-198.

Kraft, D. P. (2009). The growth of mental health in the American college health association. *Journal of American College Health, 58*(3), 267-275.

Lim, S. L., Lim, B. K. H., Michael, R., Cai, R., & Schock, C. K. (2010). The trajectory of counseling in China: Past, present, and future trends. *Journal of Counseling and Development, 88,* 4-8.

Maslow, A. H. (1987). *Motivation and personality.* New York: Harper and Row.

Moldovan, R. (2006). The psychological profile of psychotherapists. Preliminary results in investigating the predictors of psychotherapistsô performance. *Journal of Cognitive and Behavioral Psychotherapies, 6*(2), 129-140.

Norcross, J., & Wogan, M. (1987). Values in psychotherapy: A survey of practitionersô beliefs. *Professional Psychology: Research and Practice, 18,* 5-7.

Rogers, C. P. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.

Rubinstein, G. (1994). Political attitudes and religiosity levels of Israeli psychotherapy practitioners and students. *American Journal of Psychotherapy, 48*(3), 441-453.

Terry, J. (2006). Emotional health work with schools by primary mental health workers in Wales. *Primary Care Mental Health, 4,* 273-283.

Turner, J. E., & TenHoor, W. J. (1978). The NIMH community support program: Pilot approach to a needed social reform. *Schizophrenia Bulletin, 4,* 319-348.

Vasco, A. B., & Dryden, W. (1994). The development of psychotherapistsô theoretical orientation and clinical practice. *British Journal of Guidance & Counseling, 22*(3), 327-342.

World Health Organization (2005). Promoting Mental Health: Concepts, Emerging evidence, Practice: A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva.

WHO (2006). http://www.who.int/governance/eb/who_constitution_en.pdf, Constitution of the world health organization.

APPENDICES

Appendix A

Questionnaire of the Study

ARAŞTIRMA ANKETİ: TÜRKİYE'DEKİ RUH SAĞLIĞI ÇALIŞANLARININ PROFESYONEL VE PSİKO-SOSYAL PROFİLLERİ

Lütfen bu araştırma anketine internet üzerinden KATILMAMIŞ iseniz devam ediniz.

Bu araştırmanın amacı Türkiye'deki ruh sağlığı çalışanlarının (psikolog, psikiyatr, psikolojik danışman, sosyal hizmet uzmanı vb.) profesyonel ve psiko-sosyal profillerini tanımlamaya yöneliktir. Ülkemizde bu tarz kapsamlı bir profil çalışması bulunmamaktadır. Bu araştırmayla ruh sağlığı mesleklerinin her biri ve bütünü için değerli veriler elde etmeyi ve bu verileri bilimsel eser formatında meslek camialarımızla paylaşmayı hedefliyoruz. Meslek dallarımızın ihtiyaçlarını ve ülkemizin ruh sağlığı politikalarını tartışırken bu tür verilere çok ihtiyacımız olduğunu düşünüyoruz. O yüzden bu ankete Türkiye'de ruh sağlığı alanında çalışan bütün meslek erbabı davetlidir. Katılımınızla bu araştırmada mesleğinizin temsili niteliğini arttırmış olacaksınız.

Cevaplayacağınız anket her biri farklı özellikleri ölçen 5 ayrı modülden oluşmaktadır. Anketin tamamlanma süresi 30 ile 45 dk. arasında değişmektedir.

Bu çalışmaya katılmak tamamen gönüllülük esasına bağlıdır. Katılımcıların kimlik bilgileri ve bireysel cevapları kesinlikle saklı tutulacaktır. Anketteki soruların doğru ya da yanlış cevabı yoktur. Lütfen kendinize en yakın gelen, kendiniz için en uygun olduğunu düşündüğünüz cevabı yazınız ya da işaretleyiniz.

İlginiz ve desteğiniz için şimdiden teşekkür ederiz.

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1) Yukarıda belirtilen kartlar çerçevesinde bu çalışmaya katılmayı

Ĭ Kabul ediyorum. Ĭ Kabul etmiyorum.

2) Aktif olarak ruh sağlığı alanında çalışıyor musunuz?

Ĭ Evet Ĭ Hayır

Modül 1: Sosyo-demografik özellikler

3) Yaşınız: _____

4) Cinsiyetiniz:
☐ Kadın ☐ Erkek

5) Medeniz durumunuz:
☐ Bekar ☐ Evli ☐ Birlikte yaşıyor

6) Daha önce boşandıysanız, kaç kez: _____

7) Kaç çocuğunuz var: _____

8) Doğduğunuz yer:
☐ Köy ☐ Bucak ☐ İlçe merkezi ☐ İl merkezi ☐ Büyükşehir

9) Yaşadığınız il neresidir: _____

10) Yaşadığınız yer neresidir:
☐ İl merkezi ☐ İlçe merkezi ☐ Bucak ☐ Kırsal kesim

Modül 2: Eğitim

11) Herhangi bir üniversite mezuniyet dereceniz var mı?
☐ Evet ☐ Hayır

12) Aşağıdaki lisans derecelerinden hangisine/hangilerine sahip olduğunuzu ve bu dereceleri yurt içinde mi, yurt dışında mı aldığınızı lütfen işaretleyiniz.

	Evet	**Yurt içinde**	**Yurt dışında**
4 yıllık Psikoloji lisans			
6 yıllık Tıp Fakültesi			
4 yıllık PDR lisans			
4 yıllık Pedagoji lisans			
4 yıllık Sosyal Hizmet lisans			
4 yıllık Okul Öncesi Öğretmenliği lisans			
4 yıllık Hemşirelik Lisans			
4 yıllık herhangi bir lisans (_____)			

13) Yukarıda işaretlemiş olduğunuz lisans diploma(larınız)ın hangi yılda aldığınızı lütfen belirtiniz.aldığınızı lütfen belirtiniz.

Lisans Derecesi	**Mezuniyet Yılı**
4 yıllık Psikoloji lisans	
6 yıllık Tıp Fakültesi	
4 yıllık PDR lisans	
4 yıllık pedagoji lisans	
4 yıllık Sosyal Hizmet Lisans	
4 yıllık Okul Öncesi Öğretmenliği Lisans	
4 yıllık Hemşirelik Lisans	
4 yıllık herhangi bir lisans (_____)	

14) Aşağıdaki yüksek lisans derecelerinden sahip olduğunuzu/olduklarınızı lütfen işaretleyiniz.

	Evet	**Eğitimim devam ediyor**	**Yurt içinde**	**Yurt dışında**
Klinik Psikoloji YL				
Nöropsikoloji YL				
Sağlık Psikolojisi YL				
Başka bir Psikoloji alanında YL				
PDR YL				
Adli Tıp YL				
Okul Öncesi Öğretmenliği YL				
Pedagoji YL				
Sosyal Hizmet YL				
Psikiyatri Hemşireliği YL				
Diğer YL (_____)				

15) Yukarıda işaretlemiş olduğunuz yüksek lisans diploma(larınız)ın hangi yılda aldığınızı lütfen belirtiniz.

Yüksek Lisans Derecesi	**Mezuniyet Yılı**
Klinik Psikoloji YL	
Nöropsikoloji YL	
Sağlık Psikolojisi YL	
Başka bir Psikoloji alanında YL	
PDR YL	
Adli Tıp YL	
Okul Öncesi Öğretmenliği YL	
Pedagoji YL	
Sosyal Hizmet YL	
Psikiyatri Hemşireliği YL	
Diğer YL (_____)	

16) Aşağıdaki doktora veya uzmanlık derecelerinden sahip olduğunuzu/olduklarını lütfen işaretleyiniz.

	Evet	**Eğitimim devam ediyor**	**Yurt içinde**	**Yurt dışında**
Nöropsikiyatri Uzmanlığı				
Yetişkin Psikiyatrisi Uzmanlığı				
Çocuk Psikiyatrisi Uzmanlığı				
Başka bir tıp alanında uzmanlık				
Klinik Psikoloji Doktora (Ph.D)				
Klinik Psikoloji Doktora (Psy.D)				
Çocuk Klinik Psikoloji Doktora (Ph.D)				
Çocuk Klinik Psikoloji Doktora (Psy.D)				
Nöropsikoloji Doktora (Ph.D)				
Sağlık Psikolojisi Doktora (Ph.D)				
PDR Doktora (Ph.D)				
Adli Tıp Doktora (Ph.D)				
Pedagoji Doktora (Ph.D)				
Sosyal Hizmet alanında doktora (Ph.D)				
Başka bir Psikoloji alanında doktora (Ph.D)				
Psikiyatri Hemşireliği Doktora (Ph.D)				
Diğer Ph.D (_____)				
Klinik Psikoloji Post-doc (doktora sonrası eğitimi)				
Diğer Post-doc				

17) Yukarıda işaretlemiş olduğunuz doktora veya uzmanlık diploma(lar)ını hangi yılda aldığını lütfen belirtiniz.

Doktora Derecesi	**Mezuniyet Yılı**
Nöropsikiyatri Uzmanlığı	
Yetişkin Psikiyatrisi Uzmanlığı	
Çocuk Psikiyatrisi Uzmanlığı	
Başka bir tıp alanında Uzmanlık	
Klinik Psikoloji Doktora (Ph.D)	
Klinik Psikoloji Doktora (Psy.D)	
Çocuk Klinik Psikoloji Doktora (Ph.D)	
Çocuk Klinik Psikoloji Doktora (Psy. D)	
Nöropsikoloji Doktora (Ph. D)	
Sağlık Psikolojisi Doktora (Ph. D)	
PDR Doktora (Ph. D)	
Adli Tıp Doktora (Ph. D)	
Pedagoji Doktora (Ph. D)	
Sosyal Hizmet alanında Doktora (Ph. D)	
Başka bir Psikoloji alanında Doktora (Ph. D)	
Psikiyatri Hemşireliği Doktora (Ph. D)	
Diğer Ph. D (_____)	
Klinik Psikoloji Post-doc (doktora sonrası eğitim)	
Diğer Post-doc (_____)	

18) Şu anki klinik pratiğinizi ne olarak sürdürüyorsunuz? (Uygunsa, birden çok işaretleme yapabilirsiniz.)

Ĭ Yetikkin psikiyatrē
Ĭ Çocuk ve Ergen psikiyatrē
Ĭ Nöropsikiyatr
Ĭ Yetikkin psikiyatrisi asistanē
Ĭ Çocuk ve Ergen psikiyatrisi Asistanē
Ĭ Pratisyen hekim
Ĭ Bakka bir uzmanlēk derecesine sahip hekim (lütfen belirtiniz)
Ĭ Psikolog (4 yēllēk Psikoloji lisans mezunu)
Ĭ Uzman Klinik Psikolog (en az 2 yēllēk YL mezunu)
Ĭ Uzman Nöropsikolog (en az 2 yēllēk YL mezunu)
Ĭ Uzman Saĵ lēk Psikoloĵ u (en az 2 yēllēk YL mezunu)
Ĭ Psikolojik Danēkman (4 yēllēk lisans mezunu)
Ĭ Uzman Psikolojik Danēkman (en az 2 yēllēk YL mezunu)
Ĭ Sosyal Hizmet Çalēkanē(4 yēllēk lisans mezunu)
Ĭ Uzman Sosyal Hizmet Çalēkanē(en az 2 yēllēk YL mezunu)
Ĭ Pedagog (4 yēllēk lisans mezunu)
Ĭ Uzman Pedagog (en az 2 yēllēk YL mezunu)
Ĭ Okul öncesi öĵ retmeni (4 yēllēk lisans mezunu)
Ĭ Uzman okul öncesi öĵ retmeni (en az 2 yēllēk YL mezunu)
Ĭ Psikanalist
Ĭ Psikanalist adayē
Ĭ Psikoterapist
Ĭ Psikiyatri hemkiresi (En az 2 yēllēk YL mezunu)
Ĭ Diĵ er (lütfen belirtiniz) _____

19) Ruh saĵ lēĝ alanēnda çalēkmaya bakmadan önce bakka bir mesleĵ iniz var mēydē?

Ĭ Hayē

Ĭ Evet (lütfen belirtiniz) _____

20) Şu anda aktif klinik pratiĵ inizi nasē bir ortamda sürdürüyorsunuz? (Uygunsa, birden çok ikaretleme yapabilirsiniz.)

	Yarēzamanlē	**Tam zamanlē**
Devlet Tēp Fakültesi Psikiyatri Bölümü		
Devlet Tēp Fakültesi Psikiyatri-dēkē bir bölüm		
Özel Tēp Fakültesi Psikiyatri Bölümü		
Özel Tēp Fakültesi Psikiyatri-dēkē bir bölüm		
Devlet Ruh Hastalēklarē Hastanesi		
Özel Ruh Hastalēklarē Hastanesi		
Devlet Hastanesi		
Özel Hastane		
Devlet Saĵ lēk Ocaĵ ē/Dispanser		
Özel Tēp Merkezi/Poliklinik		
Belediye Saĵ lēk Merkezi		
Anne - Çocuk Saĵ lēĝ ē/ Aile Planlama Merkezleri		
Özel Psikoterapi Merkezi		
Özel Psikolojik Danēkmanlēk Merkezi		
Özel Eĵ itim ve Rehabilitasyon Merkezi		
Devlet okul-öncesi çocuk yuvasē		
Devlet ilköĵ retim okulu		
Devlet orta öĵ retim okulu (lise)		

Devlet Üniversitesi		
Özel okul-öncesi çocuk yuvasē		
Özel ilköğ retim okulu		
Özel ortaöğ retim okulu (lise)		
Özel/Vakēf Üniversitesi		
Dershane		
Cezaevi		
Adli Tēp Kurumlarē		
Mahkemeler		
Huzurevleri		
Kadēn Sığ ēnma Evi		
Sivil Toplum Kuruluklarē (dernek, vakēf vb.)		
Rehberlik Araktērma Merkezleri		
Diğ er devlet kurumlarē		
Diğ er özel sektör kuruluklarē (kirket vb.)		
Özel muayenehane		

21) Üniversitelerde öğ retim üyesi olarak çalēğ yor musunuz?
Ĭ Hayēr
Ĭ Yarē zamanlē olarak çalēğ yorum.
Ĭ Tam zamanlē olarak çalēğ yorum.

22) Nasēl bir üniversitede çalēğ yorsunuz?
Ĭ Devlet
Ĭ Özel/Vakēf
Ĭ Çalēğ mēyorum.

23) Alanda üniversite dēğ ēnda eğ itim veriyor musunuz?
Ĭ Evet Ĭ Hayēr

24) Klinik süpervizyon veriyor musunuz?
Ĭ Evet, ortalama HAFTADA kaç saat (lütfen belirtiniz): _____
Ĭ Hayēr

25) Kaç yēllēk aktif klinik deneyiminiz var? (Psikolojik sorunlara yönelik danēğ manlēk, psikoterapi ve/veya ilaç tedavisi gibi hizmetleri kaç yēldēr veriyorsunuz? Eğ itiminiz sērasēnda aktif klinik faaliyette bulunduysanēz onlarē da ekleyiniz.

_____

26) Akademik unvanēnēz nedir?

Ĭ Yok
Ĭ Profesör
Ĭ Doçent
Ĭ Yardēmcē Doçent
Ĭ Doktor
Ĭ Öğ retim Görevlisi

27) Şu anki aktif klinik faaliyetiniz, yaklakēk yüzdelik oranlar üzerinden akağ ēdaki hizmet türlerine göre nasēl dağ ēlmaktadē r? (Toplamda % 100 olmasē gerekmektedir. Size uygun olmayan kategoriler için de "0" girmeniz gerekmektedir).

Klinik Faaliyet Türü	**%**
İlaç tedavisi (psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (_____)	
Toplam	**100**

28) Hastalarınızın/danışanlarınızın yaklaşık % kaçını başka uzmanlara aşağıdaki klinik müdahaleler için yönlendiriyorsunuz?

Klinik müdahale türü	%
Psikiyatrik değerlendirme/ilaç tedavisi	
Bireysel psikoterapi	
Çift psikoterapisi	
Aile psikoterapisi	
Grup psikoterapisi	
Psikolojik testler	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (_____)	
Toplam	**100**

29) Şu anda klinik süpervizyon alıyor musunuz? Alıyorsanız, lütfen AYDA ortalama kaç saat aldığınızı belirtiniz.

- Hayır
- Bireysel süpervizyon, AYDA ortalama kaç saat: _____
- Grup süpervizyon, AYDA ortalama kaç saat: _____
- Akran süpervizyonu, AYDA ortalama kaç saat: _____

30) Mesleğe başladığınızdan bugüne kadar kaç değişik süpervizörden DÜZENLİ
(en az 3 ay ve haftada 1) klinik süpervizyon aldınız?

_____

31) Mesleğe başladığınızdan bugüne kadar yaklaşık olarak toplam kaç saat klinik süpervizyon aldınız?

_____

32) Devam ettiğiniz okullarda ve okul-dışı eğitimlerde aldığınız bütün teorik eğitimleri düşünerek, aşağıdaki her bir başlık için yaklaşık kaç SAAT teorik aldığınızı lütfen belirtiniz. (Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

Teorik Eğitim	**Saat**
Klinik görüşme teknikleri	

Psikofarmakoloji	
Biyolojik psikiyatri	
Tanısal değerlendirme	
Psikanaliz/psikanalitik terapi	
Humanistik terapi	
Davranışçı terapi	
Bilişsel terapi	
Bilişsel-davranışçı terapi	
Sistemik terapi	
Yaratıcı sanat terapisi	
Somatik (beden yönelimli) terapi	
Transaksiyonel analiz	
Bütünleşik (integrative) terapi	
Psikolojik değerlendirme (testler)	
EMDR	
Diğer (_____)	

33) Kendi terapinizden geçtiniz mi?

Ĭ Evet

Ĭ Hayır

Ĭ Devam ediyor

34) Bugüne kadar kaç farklı terapistten terapi aldınız? _____

35) En uzun terapinizi düşünerek, toplamda kaç seans gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz ñ0ò yazınız.)

_____

36) En uzun terapinizi düşünerek, toplamda/şu ana kadar kaç ay gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz ñ0ò yazınız.)

_____

37) En uzun terapinizi düşünerek, ortalama AYDA kaç seans gittiğinizi lütfen belirtiniz. (Kendi terapinizden geçmediyseniz ñ0ò yazınız.)

_____

38) En uzun terapinizi düşünerek, terapistinizin teorik yönelimi nedir? (Uygunsa, birden çok işaretleme yapabilirsiniz.)

Ĭ Kendi terapimden geçmedim.
Ĭ Psikanaliz
Ĭ Psikanalitik/Psikodinamik
Ĭ Hümanistik
Ĭ Davranışçı
Ĭ Bilişsel
Ĭ Bilişsel-Davranışçı
Ĭ Sistemik Terapi
Ĭ Yaratıcı Sanat Terapisi
Ĭ Somatik (beden yönelimli) terapi
Ĭ Transaksiyonel analiz
Ĭ EMDR
Ĭ Eklektik
Ĭ Bütünleşik (Integrative)
Ĭ Diğer (Lütfen belirtiniz: _____)

39) Çalıştığınız yaş gruplarını lütfen işaretleyiniz. (Uygunsa, birden çok işaretleme yapabilirsiniz).

- ☐ 0-6
- ☐ 7-12
- ☐ 13-18
- ☐ 19-24
- ☐ 25-65
- ☐ 65 ve üstü

40) Çalıştığınız modaliteleri lütfen belirtiniz. (Uygunsa, birden çok işaretleme yapabilirsiniz).

- ☐ Bireysel
- ☐ Grup
- ☐ Aile

41) Şimdiye kadar kaç adet ULUSAL bilimsel kongre/sempozyum tarzı toplantıya İŞTİRAKÇİ olarak katıldınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

_____

42) Şimdiye kadar kaç adet ULUSAL bilimsel kongre/sempozyum tarzı toplantıda sunum yaptınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

_____

43) Şimdiye kadar kaç adet ULUSLARARASI bilimsel kongre/sempozyum tarzı toplantıya İŞTİRAKÇİ olarak katıldınız? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

_____

44) Şimdiye kadar kaç adet ULUSLARARASI bilimsel kongre/sempozyum tarzı toplantıda sunum yaptınız? (Tam olarak sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

_____

45) ULUSAL Yayınlarda bilimsel/mesleki yayınlarınızın olduğu grubu ve o işaretlediğiniz grupta kaç adet çalışmanızın olduğunu lütfen belirtiniz.

- ☐ Yok
- ☐ Hakemsiz dergi makalesi
- ☐ Hakemli dergi makalesi
- ☐ Kitap bölümü
- ☐ Kitap

46) ULUSLARARASI Yayınlarda bilimsel/mesleki yayınlarınızın olduğu grubu ve o işaretlediğiniz grupta kaç adet çalışmanızın olduğunu lütfen belirtiniz.

- ☐ Yok
- ☐ Hakemsiz dergi makalesi
- ☐ Hakemli dergi makalesi
- ☐ Kitap bölümü
- ☐ Kitap

47) Bir AYDA ortalama kaç bilimsel/mesleki makale okuma imkanınız oluyor? _____

48) Bir AYDA ortalama kaç bilimsel/mesleki kitap okuma imkanınız oluyor? _____

49) Şu anda aratırmacı olarak kaç bilimsel çalışmaya dahilsiniz? _____

50) Aşağıdaki dillerden İYİ veya ÇOK İYİ derecede bildiklerinizi OKUMA, YAZMA, KONUŞMA ve KLİNİK FAALİYET YÜRÜTEBİLME boyutlarında belirtilen kolonlarda (X) ile işaretleyiniz.

	Okuma	**Yazma**	**Konuşma**	**Klinik Faaliyet Yürütebilme**
Almanca				
Arapça				
Arnavutça				
Azeri				
Bulgarca				
Boşnakça				
Çerkez				
Ermenice				
Farsça				
Fransızca				
Gürcüce				
İbranice				
İngilizce				
İspanyolca				
İtalyanca				
Kürtçe				
Ladino				
Lazca				
Rumca				
Rusça				
Diğer 1: _____				
Diğer 2: _____				

51) İşlenimlerinize göre size gelen danışanların/hastaların yaklaşık yüzdelerini aşağıdaki kategorilere göre yazabilir misiniz? (Toplamda % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
İlk değerlendirme seanslarından sonra (ya da sırasında) kendi istekleriyle size gelmeye devam etmeyenler	
İlk değerlendirme seanslarında sizin başka bir klinisyene gönderdikleriniz	
İlk değerlendirmeden sonra size düzenli gelmeye başladığı halde verdiğiniz klinik hizmeti yarıda bırakıp ayrılanlar	
Size düzenli gelip verdiğiniz klinik hizmeti uygun bulduğunuz süre içinde tamamlayanlar	
Toplam	**100**

52) Sizden klinik hizmet almaya başlayıp yarıda bırakanların % kaçının aşağıdaki sebeplerden dolayı bıraktıklarını lütfen belirtiniz. (Toplamda hepsinin % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Ekonomik nedenlerle	
Klinik müdahaleye hazır olmadıklarından	
Kişilikte olduklarını diğer kişilerin engellemeleri nedeniyle	
Ulaşım/yer değiştirme gibi faktörler nedeniyle	
Klinik ilişkideki ağırlıkla sizden kaynaklanan zorluklar nedeniyle	
Klinik ilişkideki ağırlıkla çalıştığınız yerden/kurumdan kaynaklanan zorluklar nedeniyle	
Klinik/teorik yöneliminizin danışanın/hastanın sorunlarına/ihtiyaçlarına hitap etmemesi nedeniyle	
Diğer nedenlerle (_____)	
Toplam	**100**

53) Size düzenli gelip verdiğiniz klinik hizmeti uygun bulduğunuz süre içinde tamamlayanlar arasından % kaçının aşağıdakilerden dolayı tamamladıklarını belirtiniz. (Toplamda % 100 olmalı ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Kişik başlangıç zamanlarına göre % 75-100 oranında (oldukça yüksek derecede) iyileşme gösterdiği	
Kişik başlangıç zamanlarına göre % 50-74 oranında (yüksek derecede) iyileşme gösterdiği	
Kişik başlangıç zamanlarına göre % 25-49 oranında (orta derecede) iyileşme gösterdiği	
Kişik başlangıç zamanlarına göre % 5-24 oranında (az derecede) iyileşme gösterdiği	
Kişik başlangıç zamanlarına göre durumlarında pek bir değişiklik olmadığı	
Kişik başlangıç zamanlarına göre durumlarının daha da kötüye gittiği	
Toplam	**100**

54) Size klinik hizmet almak için başvuran danışanların/hastaların yaklaşık % kaçı daha önce başka bir klinisyene gitmiş oluyorlar? (Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

_____

55) Sizden önce başka bir klinisyene gitmiş olanların % kaçının aşağıdakilere göre bu deneyimlerinden ne kadar memnun olduklarını lütfen belirtiniz. (Toplamda % 100 olmalı ve size uygun olmayan kategoriler için "O" girmeniz gerekmektedir).

	%
Önceki klinik deneyimlerinden bir miktar memnun	
Önceki klinik deneyimleri konusunda belirsiz/ortada	
Önceki klinik deneyimlerinden bir miktar memnuniyetsiz	
Önceki klinik deneyimlerinden çok memnuniyetsiz	
Toplam	100

56) Sizce Türkiye'de psikolojik sorun/zorluk yaşayan insanların % kaçı için bunlarla çözmede aşağıdaki etkinliklerin BİRİNCİL derecede faydalı olacağını düşünürsünüz? (Toplamda % 100 olmalı ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir.)

	%
Ruh sağlığı profesyonelinden yardım almak	
Hobi	
Arkadaş desteği	
Aile desteği	
İşyeri desteği	
Dini/manevi destek	
Ekonomik düzelme	
Okuma/bilgilenme/eğitim	
Toplam	100

57) Sizce Türkiye'de profesyonel ruh sağlığı hizmeti almak gerekenlerin % kaçı için aşağıdaki klinik müdahaleler BİRİNCİL derecede tercih edilmelidir? (Toplamda hepsinin % 100 olmalı ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir.)

	%
İlaç tedavisi (Psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (Lütfen belirtiniz)	
Toplam	100

58) Sizce Türkiye'de profesyonel ruh sağlığı hizmeti almak gerekenlerin % kaçı için aşağıdaki klinik müdahaleler İKİNCİL derecede tercih edilmelidir?(Toplamda hepsinin % 100 olmalı ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
İlaç tedavisi (Psikofarmakoloji)	
Diğer biyolojik tedaviler (EKT gibi)	
Psikoterapi	
Psikolojik danışmanlık	
Özel eğitim	
Psiko-eğitim	
Diğer (Lütfen belirtiniz)	
Toplam	100

59) Psikoterapiden faydalanacağını düşündüğünüz danışanların/hastaların yaklaşık % kaçı için aşağıdaki psikoterapi türleri BİRİNCİL tercih olmalıdır? (Tercihlerinizin toplamda % 100 olmalı ve size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Psikanaliz	
Psikanalitik/Psikodinamik	
Humanistik	
Davranışçı	
Bilişsel	
Bilişsel-Davranışçı	
Sistemik terapi	
Yaratıcı Sanat Terapisi	
Somatik (Beden Yönelimli) terapi	
Transaksiyonel analiz (Berne)	
EMDR	
Eklektik	
Bütünleşik (Integrative)	
Diğer (Lütfen belirtiniz:_____)	
Toplam	**100**

60) Aşağıdaki yaklaşımlardan hangileri kendi teorik/klinik yöneliminizi yaklaşık ne oranda (%) şekillendirmektedir? (İşaretlediklerinizin toplamda % 100 olmasına lütfen dikkat ediniz. Size uygun olmayan kategoriler için "0" girmeniz gerekmektedir).

	%
Biyolojik psikiyatri	
Klasik/Freudçu psikanaliz	
Klasik nesne ilişkileri ekolü (M. Klein)	
Bağımsız nesne ilişkileri ekolü (Fairbairn, Winnicott, vb.)	
Ego psikolojisi (Anna Freud, Hartmann, vb.)	
Kişilerarası psikanaliz (Sullivan)	
Çağdaş Fransız Psikanalizi	
Lacancı psikanaliz	
Kendilik psikolojisi (Kohut)	
Öznelliklerarası psikanaliz (Stolorow, vb.)	
Bağlanma Kuramı	
İlişkisel psikanaliz (Mitchell, Aron, vb.)	
Diğer psikanalitik ekoller (Lütfen belirtiniz) _____	
Varoluşçu psikoterapi (Rollo May, vb.)	
Gestalt psikoterapi (Perls, vb.)	
Danışan-merkezli psikoterapi (Rogers, vb.)	
Diğer humanistik ekoller (Lütfen belirtiniz)_____	
Davranışçı terapi (Skinner, Lindsley, Solomon, Wolpe, Eysenck, vb.)	
Bilişsel terapi (Beck, Ellis, vb.)	
Bilişsel-Davranışçı terapi (Clark, Barlow, Lazarus, vb.)	
Sistemik terapi	
Yaratıcı Sanat terapisi	
Somatik (Beden yönelimli)	
Transaksiyonel analiz (Berne)	
EMDR	
Eklektik	
Bütünleşik (Integrative)	
Diğer (lütfen belirtiniz) _____	
Toplam	**100**

61) Şu ana kadar alanda gördüğünüz toplam vaka sayısını kaçtır? (Tam sayısını hatırlayamıyorsanız lütfen yaklaşık bir sayı giriniz.)

_____

62) Aşağıda klinik ortamda karşılaşılabilecek bazı durumlar belirtilmiştir. Bu durumlarla klinik ortamda karşılaştığınızda ne derece kolay/zor çalışabileceğinizi aşağıda verilen ölçeğe göre lütfen değerlendiriniz.

1= Pek zorlanmadan çalışabilirim
2= Biraz zorlanarak çalışabilirim
3= Zorlanarak da olsa çalışabilirim
4= Çok fazla zorlanacağım için çalışmayı tercih etmem
5= Çalışamam

Lütfen her bir durumda ne kadar kolay/zor çalışabileceğinizi yukarıdaki ölçeğe göre değerlendirip, uygun kutuyu yuvarlak içine alınız.

Alkol/madde baş ımlılığı	1	2	3	4	5
Anti-sosyal kişilik ön planda olanlar	1	2	3	4	5
Ciddi intihar riski taşıyanlar	1	2	3	4	5
Cinsel taciz maş duru çocuklar	1	2	3	4	5
Cinsel taciz maş duru kadınlar	1	2	3	4	5
Dini inançları sizden farklı olanlar	1	2	3	4	5
Eş itimsiz ya da az eş itimli olanlar	1	2	3	4	5
Eşcinseller	1	2	3	4	5
Etnik kimliş i sizden farklı olanlar	1	2	3	4	5
Fiziksel ve psikolojik şiddet maş duru çocuklar	1	2	3	4	5
Fiziksel ve psikolojik şiddet maş duru yetişkinler	1	2	3	4	5
Fiziksel ve psikolojik şiddet uygulayanlar	1	2	3	4	5
Ş eri yaş grubunda olan kişiler	1	2	3	4	5
Narsisistik kişilik örgütlenmesi ön planda olanlar	1	2	3	4	5
Politik şiddet/işkence maş durları	1	2	3	4	5
Seyri kötü kanser hastaları	1	2	3	4	5
Sınır kişilik örgütlenmesi ön planda olanlar	1	2	3	4	5
şizofreni hastaları	1	2	3	4	5
Tacizci/tecavüzcüler	1	2	3	4	5
Yoksullar	1	2	3	4	5

63) Verdiş iniz ruh saş lığı hizmetleri çerçevesinde aşaş ıdaki boyutlardaki memnuniyet derecenizi belirtilen ölçeş e göre lütfen deş erlendiriniz.
1= Hiç memnun deş ilim 2= Biraz memnunum 3= Memnunum 4= Çok memnunum.

	1	2	3	4
Mesleki tatmin	1	2	3	4
Ekonomik gelir düzeyi	1	2	3	4
Sosyal statü	1	2	3	4
Sosyal güvence	1	2	3	4
Çalışma ortamı	1	2	3	4
Meslek örgütü	1	2	3	4

Deş işik terapi ekolleri tarafından psikoterapide KALICI terapötik dönüşüm saş lamada önemli olduş u ileri sürülen aşaş ıdaki faktörlerin her birinin sizce ne kadar önemli olduş unu işaretleyiniz.
0= Hiç önemli deş il
1= Biraz önemli
2= Orta derecede önemli
3= Oldukça önemli
4= Çok önemli

64) Danışanda gelişimlere dair faktörler					
Katarsis/Abreaksiyon	0	1	2	3	4
Ş görü (duygulanımsal)	0	1	2	3	4
Ş görü (bilişsel)	0	1	2	3	4
Düzeltici duygusal yaşantı	0	1	2	3	4

Örtük (implicit) ilişkisel öğrenme	0	1	2	3	4
Terapi ilişkisinin içselleştirilmesi	0	1	2	3	4
Zihinselleştirme (mentalization)	0	1	2	3	4
Duygusal farkındalık	0	1	2	3	4
Bilişsel farkındalık	0	1	2	3	4
Bedensel farkındalık	0	1	2	3	4
Davranışsal öğrenme	0	1	2	3	4
65) Terapi tekniklerine dair faktörler					
Serbest çağrışımların yorumlanması	0	1	2	3	4
Aktarımın yorumlanması	0	1	2	3	4
Dirençlerin yorumlanması	0	1	2	3	4
Rüyaların yorumlanması	0	1	2	3	4
Empati	0	1	2	3	4
Bilişsel yeniden yapılandırma	0	1	2	3	4
Sakından korkulara maruz bırakma (exposure)	0	1	2	3	4
Telkin	0	1	2	3	4
Tavsiye/Öneri	0	1	2	3	4
Yüzleştirme (Confrontation)	0	1	2	3	4
Kışkırtma (Imagining)	0	1	2	3	4
66) Terapiste dair faktörler					
Terapistin nesnelliği	0	1	2	3	4
Terapistin yansızlığı (neutrality)	0	1	2	3	4
Terapistin esnekliği	0	1	2	3	4
Terapi çerçevesinin tutarlılığı/sürekliliği	0	1	2	3	4
Karşı-aktarımın terapötik kullanımı	0	1	2	3	4
Terapistin danışanı koşulsuz kabulü	0	1	2	3	4
Terapistin içtenliği	0	1	2	3	4
Terapistin kişiliği/tarzı	0	1	2	3	4
Terapistin kendi terapisinden geçmiş olması	0	1	2	3	4
67) Kişiye dair faktörler					
Terapist-danışan ilişkisinin terapötik kalitesi	0	1	2	3	4

Modül 4: Sosyal Kimlik
Bu bölümde, aşağıda sıralanan kimliklerin sizi ne kadar tanımladığı ya da bu kimliklere kendinizi ne kadar bağlı hissettiğinizi merak ediyoruz. Lütfen her bir kimlik için, sizi ne kadar tanımladığını düşünerek, aşağıdaki ölçeğe göre değerlendiriniz.

0= Bu kimlik beni **HİÇ** tanımlamıyor
1= Bu kimlik beni **BİRAZ** tanımlıyor
2= Bu kimlik beni **ORTA DERECEDE** tanımlıyor
3= Bu kimlik beni **OLDUKÇA İYİ** tanımlıyor
4= Bu kimlik beni **ÇOK UYGUN** biçimde tanımlıyor

68) Lütfen aĸaĵ ēdaki kimlikleri yukarēda belirtildiĵ i gibi yanētlayēnēz.					
Dünyalē	0	1	2	3	4
Asyalē	0	1	2	3	4
Avrupalē	0	1	2	3	4
Ortadoĵ ulu	0	1	2	3	4
Türkiyeli	0	1	2	3	4
Türk	0	1	2	3	4
Kürt	0	1	2	3	4
Arap	0	1	2	3	4
Çerkez	0	1	2	3	4
Boĸnak	0	1	2	3	4
Laz	0	1	2	3	4
Pomak	0	1	2	3	4
Gürcü	0	1	2	3	4
Arnavut	0	1	2	3	4
Ermeni	0	1	2	3	4
Roman (Çingene)	0	1	2	3	4
Musevi/Yahudi	0	1	2	3	4
Rum	0	1	2	3	4
Süryani	0	1	2	3	4
Müslüman	0	1	2	3	4
Sünni	0	1	2	3	4
Alevi	0	1	2	3	4
ķii	0	1	2	3	4
ķafi	0	1	2	3	4
Hēristiyan	0	1	2	3	4
Ortodoks	0	1	2	3	4
Katolik	0	1	2	3	4
Protestan	0	1	2	3	4
Budist	0	1	2	3	4
Dinsiz/Ateist/Agnostik	0	1	2	3	4
Doĵ up büyüdüĵ ünüz ĸehre baĵ lēhemĸehrilik (örneĵ in, "Kayserili")	0	1	2	3	4
Halen yaĸadēĝ ēnēz ĸehre baĵ lēhemĸehrilik (örneĵ in, "Ķstanbullu")	0	1	2	3	4
Saĵ cē	0	1	2	3	4
Solcu	0	1	2	3	4
Merkezci	0	1	2	3	4
Milliyetçi	0	1	2	3	4
Muhafazakar	0	1	2	3	4
Ķslamcē	0	1	2	3	4
Faĸist	0	1	2	3	4
Komünist	0	1	2	3	4
Sosyalist	0	1	2	3	4
Devrimci	0	1	2	3	4

Liberal	0	1	2	3	4
Sosyal Demokrat	0	1	2	3	4
Demokrat	0	1	2	3	4
Kemalist	0	1	2	3	4
Atatürkçü	0	1	2	3	4
Anadolulu	0	1	2	3	4
Trakyalɛ	0	1	2	3	4
Heteroseksüel	0	1	2	3	4
Eкcinsel	0	1	2	3	4
Biseksüel	0	1	2	3	4

Appendix B

Table 4. Social Identities of Mental Health Professionals

Table 4. Social Identities of Mental Health Professionals

Social identities- Mean (SD) [0= no identificationé 4= high identification]	Total (n=244)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Geography-based identities								
Earth citizen	3.1 (1.1)	3.3 (1.0)	3.0 (1.0)	3.1 (1.2)	2.9 (1.3)	3.5 (0.8)	2.7 (1.4)	NS
Asian	1.2 (1.2)	1.4 (1.3)	1.3 (1.1)	1.3 (1.3)	1.1 (1.1)	1.0 (1.2)	1.1 (1.7)	NS
European	1.7 (1.3)	1.7 (1.2)	1.9 (1.2)	1.8 (1.4)	1.9 (1.3)	1.7 (1.4)	1.3 (1.5)	NS
Middle Eastern	0.9 (1.2)	0.9 (1.2)	1.4 (1.2)	0.5 (1.0)	1.1 (1.3)	0.6 (1.0)	0.3 (0.8)	.010 1=2=3=4=5=6
From Turkey (Türkiyeli)	2.7 (1.3)	2.8 (1.3)	3.0 (1.0)	2.4 (1.5)	2.7 (1.3)	2.7 (1.4)	3.0 (1.0)	NS
Anatolian	1.1 (1.3)	1.3 (1.4)	1.6 (1.3)	1.0 (1.2)	0.8 (1.2)	0.4 (0.9)	1.3 (1.4)	.005 5<2
Thracian	0.4 (0.9)	0.4 (1.0)	0.3 (0.7)	0.3 (0.8)	0.3 (0.9)	0.4 (0.9)	0.7 (1.1)	NS
National/Ethnic Identities								
Turkish	2.2 (1.5)	2.3 (1.6)	2.0 (1.4)	2.3 (1.6)	2.0 (1.5)	1.8 (1.5)	3.2 (1.2)	NS
Kurdish	0.3 (0.8)	0.3 (0.8)	0.7 (1.2)	0.2 (0.6)	0.2 (0.8)	0.2 (0.8)	0.2 (0.6)	NS
Arabian	0.1 (0.6)	0.2 (0.8)	0.03 (0.2)	0.2 (0.6)	0.02 (0.1)	0.03 (0.2)	---	NS
Circassian	0.1 (0.5)	0.1 (0.5)	0.1 (0.6)	0.2 (0.5)	0.1 (0.4)	0.1 (0.4)	0.2 (0.6)	NS
Bosnian	0.1 (0.5)	0.1 (0.3)	0.1 (0.3)	0.2 (0.5)	0.1 (0.4)	0.5 (1.1)	---	.005 1=4<5
Laz	0.2 (0.6)	0.3 (0.7)	0.1 (0.3)	0.3 (0.9)	0.02 (0.2)	---	0.2 (0.6)	NS
Pomak	0.1 (0.4)	0.1 (0.6)	0.1 (0.4)	0.1 (0.3)	0.02 (0.1)	---	0.2 (0.6)	NS
Georgian	0.1 (0.5)	0.2 (0.6)	---	0.2 (0.8)	0.02 (0.1)	0.1 (0.4)	0.2 (0.6)	NS
Albanian	0.2 (0.6)	0.2 (0.6)	---	0.1 (0.3)	0.1 (0.6)	0.5 (1.2)	0.2 (0.4)	NS
Armenian	0.1 (0.3)	0.1 (0.4)	0.1 (0.4)	0.1 (0.3)	---	0.1 (0.4)	0.1 (0.3)	NS

Table 4. Social Identities of Mental Health Professionals (contôd)

Social identities- Mean (SD) [0= no identificationé 4= high identification]	Total (n=244)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Roman (Gipsy)	0.1 (0.4)	0.1 (0.4)	---	0.2 (0.6)	---	---	0.2 (0.6)	NS
Jewish	0.1 (0.5)	0.1 (0.3)	---	0.2 (0.8)	0.1 (0.7)	0.2 (0.9)	0.1 (0.3)	NS
Greek	0.1 (0.3)	0.1 (0.3)	0.03 (0.2)	0.2 (0.6)	0.04 (0.3)	---	0.1 (0.3)	NS
Assyrian	0.1 (0.4)	0.04 (0.3)	0.1 (0.7)	0.1 (0.3)	0.1 (0.5)	---	---	NS
Religious Identities								
Muslim	1.5 (1.5)	1.7 (1.6)	1.2 (1.4)	1.7 (1.5)	1.0 (1.3)	1.4 (1.5)	2.5 (1.5)	.015 1=2=3=4=5=6
Sunni	1.0 (1.4)	1.2 (1.6)	0.9 (1.3)	1.1 (1.5)	0.5 (1.1)	0.7 (1.1)	1.8 (1.8)	.016 1=2=3=4=5=6
Alawite	0.2 (0.8)	0.3 (0.8)	0.1 (0.3)	0.3 (0.6)	0.3 (0.9)	0.2 (0.7)	1.7 (0.6)	NS
Shiite	0.1 (0.4)	0.1 (0.5)	0.03 (0.2)	0.1 (0.3)	---	---	0.5 (1.0)	.008 4=5<6
ķafi	0.9 (0.5)	0.1 (0.6)	0.2 (0.8)	0.1 (0.3)	---	---	---	NS
Christian	0.02 (0.2)	0.02 (0.1)	---	0.1 (0.3)	0.02 (0.2)	0.04 (0.2)	---	NS
Orthodox	0.01 (0.1)	0.01 (0.1)	---	0.1 (0.3)	---	---	---	NS
Catholic	0.01 (0.1)	0.01 (0.1)	---	0.1 (0.3)	---	---	---	NS
Protestant	0.02 (0.2)	0.02 (0.1)	---	0.1 (0.3)	0.1 (0.4)	---	---	NS
Buddhist	0.1 (0.5)	0.2 (0.7)	0.03 (0.2)	0.1 (0.4)	0.04 (0.2)	0.1 (0.4)	0.2 (0.6)	NS
Atheist/Agnostic	1.0 (1.5)	0.9 (1.4)	1.5 (1.6)	0.8 (1.4)	1.0 (1.6)	1.0 (1.6)	0.8 (1.4)	NS
Political Identities								
Right-winger	0.2 (0.6)	0.2 (0.7)	0.1 (0.4)	0.2 (0.8)	0.1 (0.5)	---	0.2 (0.4)	NS
Left-winger	1.4 (1.5)	1.3 (1.5)	1.7 (1.4)	1.4 (1.5)	1.6 (1.4)	1.4 (1.5)	1.2 (1.5)	NS

Table 4. Social Identities of Mental Health Professionals (contôd)

Social identities- Mean (SD) [0= no identificationé 4= high identification]	Total (n=244)	Groups 1 Psychologists (n= 92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. MA. St. (n=29)	6 Others (n=12)	p (NS, if p>.05)
Centralist (Merkezci)	0.3 (0.7)	0.4 (0.9)	0.3 (0.6)	0.4 (0.9)	0.2 (0.6)	0.1 (0.3)	0.3 (0.6)	NS
Nationalist	0.6 (1.1)	0.7 (1.1)	0.5 (1.0)	1.1 (1.4)	0.5 (1.1)	0.4 (0.9)	0.8 (1.1)	NS
Conservative	0.2 (0.7)	0.3 (0.8)	0.3 (0.7)	0.4 (0.9)	0.1 (0.6)	0.03 (0.2)	0.2 (0.4)	NS
Islamist	0.2 (0.6)	0.3 (0.7)	0.2 (0.7)	0.2 (0.8)	0.02 (0.1)	---	0.1 (0.3)	NS
Fascist	0.02 (0.2)	0.02 (0.2)	0.1 (0.3)	0.03 (0.2)	---	---	0.1 (0.3)	NS
Communist	0.4 (0.9)	0.3 (0.8)	0.7 (1.1)	0.3 (0.7)	0.4 (0.8)	0.2 (0.6)	0.5 (1.0)	NS
Socialist	1.1 (1.3)	1.0 (1.3)	1.2 (1.2)	1.1 (1.4)	1.4 (1.4)	0.9 (1.3)	0.8 (1.3)	NS
Revolutionary	0.7 (1.1)	0.4 (0.9)	1.0 (1.2)	0.6 (1.0)	0.8 (1.3)	0.7 (1.2)	1.0 (1.4)	NS
Liberal	0.6 (1.0)	0.5 (0.9)	0.8 (1.1)	0.8 (1.3)	0.7 (1.0)	0.7 (1.2)	0.2 (0.4)	NS
Social-Democrat	1.2 (1.3)	1.0 (1.2)	1.0 (1.2)	1.4 (1.5)	1.3 (1.3)	1.3 (1.5)	1.6 (1.5)	NS
Democrat	1.5 (1.5)	1.6 (1.6)	1.5 (1.3)	1.2 (1.4)	1.9 (1.6)	1.1 (1.5)	1.3 (1.6)	NS
Kemalist	1.2 (1.5)	1.4 (1.5)	1.0 (1.3)	1.1 (1.5)	1.1 (1.4)	0.9 (1.2)	1.8 (1.7)	NS
Ataturkist	1.7 (1.6)	1.9 (1.6)	1.3 (1.5)	1.7 (1.6)	1.7 (1.5)	1.6 (1.6)	2.0 (1.7)	NS
Sexual Identities								
Heterosexual	2.5 (1.6)	2.5 (1.8)	2.4 (1.5)	2.6 (1.6)	2.5 (1.5)	2.5 (1.7)	2.3 (1.8)	NS
Homosexual	0.1 (0.4)	0.04 (0.4)	0.1 (0.5)	0.1 (0.3)	---	0.1 (0.7)	---	NS
Bisexual	0.1 (0.4)	0.1 (0.4)	0.1 (0.4)	0.2 (0.8)	0.02 (0.2)	0.04 (0.2)	0.1 (0.3)	NS

Appendix C

Table 7. Personal Therapy

Table 7. Personal Therapy Groups

Characteristics of Personal Therapy	Total	1 Psychologists	2 Psychiatrists	3 Psych. Counselors	4 Clinical Psych	5 Cli.Psy. M.A. St.	6 Others	p (NS, if p>.05)
Received personal therapy %	**n= 244**	**n= 92**	**n=31**	**n=29**	**n=51**	**n=29**	**n=13**	.006
Yes	35.1	37.0	22.6	44.8	43.1	24.1	23.1	
Continuing	23.7	15.4	19.4	24.1	29.4	48.3	15.4	
# of different therapists- M (SD)	1.9 (1.3)	1.9 (1.5)	1.6 (0.9)	2.7 (2.1)	1.8 (0.8)	1.7 (0.8)	2.0 (0.7)	.040 1=2=3=4=5=6
Longest personal therapy	**n= 243**	**n= 92**	**n=31**	**n=29**	**n=50**	**n=29**	**n=13**	
Mean # of sessions (SD)	137.8 (203.3)	62.3 (122.2)	331.6 (311.7)	87.2 (122.5)	204.2 (216.9)	138.2 (219.9)	78.8 (123.8)	.001 1<4
Mean # of months (SD)	22.7 (22.0)	16.4 (20.0)	35.1 (29.5)	14.8 (11.3)	33.7 (23.8)	18.7 (17.8)	21.2 (12.1)	.001 1<4
Mean # of sess./mo. (SD)	4.6 (3.6)	3.4 (3.2)	6.5 (3.6)	4.5 (3.6)	5.5 (3.9)	5.7 (3.5)	2.0 (0.7)	.001 1=2=3=4=5=6
Theoretical Orientation of the longest personal therapy %	**n= 245**	**n= 92**	**n=31**	**n=29**	**n=51**	**n=29**	**n=13**	
Psychoanalysis	14.3	7.6	25.8	10.3	27.5	10.3	---	.005
Psychodynamic PT	25.7	20.7	16.1	27.6	31.4	44.8	15.4	NS
Humanistic PT	6.9	8.7	---	10.3	7.8	6.9	---	NS
Behavioral PT	4.1	8.7	3.2	---	2.0	---	---	NS
Cognitive PT	6.5	12.0	6.5	3.4	2.0	3.4	---	NS
Cognitive-Behavioral PT	16.7	29.3	3.2	17.2	7.8	10.3	7.7	.002
Systemic Therapy	1.6	1.1	---	6.9	2.0	---	---	NS
Art Therapy	3.7	3.3	3.2	6.9	3.9	---	7.7	NS

Table 7. Personal Therapy (contôd)

Characteristics of Personal Therapy	Total	Groups 1 Psychologists	2 Psychiatrists	3 Psych. Counselors	4 Clinical Psych	5 Cli.Psy. M.A. St.	6 Others	p (NS, if p>.05)
Somatic Therapy	1.2	2.2	---	3.4	---	---	---	NS
Transactional Analysis	---	---	---	---	---	---	---	NS
EMDR	2.4	3.3	---	6.9	2.0	---	---	NS
Eclectic	9.0	14.1	---	13.8	3.9	3.4	15.4	NS
Integrative Therapy	3.3	3.3	3.2	10.3	---	3.4	---	NS
Others	0.4	1.1	---	---	---	---	---	NS

Appendix D

Table 9. Knowledge of Second Language Other than Turkish

Table 9. Knowledge of Second Language Other than Turkish

Languages (%)	Total (n=245)	1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
German								
Reading	11.0	10.9	9.7	13.8	11.8	13.8	---	NS
Writing	8.6	7.7	9.7	13.8	7.8	10.3	---	NS
Speaking	7.8	6.5	12.9	6.9	9.8	6.9	---	NS
Able to use in clinical pract.	1.2	1.1	3.2	---	---	3.4	---	NS
Arabian								
Reading	1.2	2.2	3.2	---	---	---	---	NS
Writing	0.4	1.1	---	---	---	---	---	NS
Speaking	0.4	1.1	---	---	---	---	---	NS
Able to use in clinical pract.	0.8	---	---	---	2.0	3.4	---	NS
Albanian								
Speaking	0.4	1.1	---	---	---	---	---	NS
Azerbaijani								
Reading	1.2	2.2	3.2	---	---	---	---	NS
Writing	1.2	2.2	3.2	---	---	---	---	NS
Speaking	1.6	3.3	3.2	---	---	---	---	NS
Able to use in clinical pract.	0.8	1.1	3.2	---	---	---	---	NS
Bosnian								
Speaking	0.4	---	---	---	---	3.4	---	NS
Persian								
Able to use in clinical pract.	0.4	---	---	---	---	3.4	---	NS

Table 9. Knowledge of Second Language Other than Turkish (contôd)

Languages	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
French								
Reading	10.6	4.3	12.9	6.9	17.6	24.1	---	.015
Writing	8.2	4.3	6.5	3.4	15.7	17.2	---	NS
Speaking	7.8	4.3	9.7	3.4	13.7	13.8	---	NS
Able to use in clinical pract.	5.3	4.3	9.7	3.4	7.8	13.8	---	NS
Georgian								
Reading	0.4	1.1	---	---	---	---	---	NS
Writing	0.4	1.1	---	---	---	---	---	NS
Speaking	0.8	2.2	---	---	---	---	---	NS
Able to use in clinical pract.	0.4	1.1	---	---	---	---	---	NS
Hebrew								
Reading	0.8	1.1	---	---	---	3.4	---	NS
Writing	0.8	1.1	---	---	---	3.4	---	NS
Speaking	0.8	1.1	---	---	---	3.4	---	NS
Able to use in clinical pract.	0.4	1.1	---	---	---	---	---	NS
English								
Reading	87.3	84.8	87.1	79.3	96.1	96.6	69.2	.037
Writing	79.2	73.9	74.2	72.4	90.2	93.1	69.2	NS
Speaking	73.9	68.5	71.0	75.9	86.3	89.7	30.8	.001
Able to use in clinical pract.	44.5	30.4	64.5	37.9	56.9	69.0	7.7	.000
Spanish								
Reading	2.9	3.3	---	---	---	13.8	---	.006
Writing	2.9	2.2	---	---	2.0	13.8	---	.011
Speaking	2.9	1.1	---	---	2.0	17.2	---	.000
Able to use in clinical pract.	0.8	---	---	---	2.0	3.4	---	NS

Table 9. Knowledge of Second Language Other than Turkish (contôd)

Languages	Total (n=245)	Groups 1 Psychologists (n=92)	2 Psychiatrists (n=31)	3 Psych. Counselors (n=29)	4 Clinical Psych (n=51)	5 Cli.Psy. M.A. St. (n=29)	6 Others (n=13)	p (NS, if p>.05)
Italian								
Reading	1.2	---	---	3.4	3.9	---	---	NS
Writing	0.4	---	---	---	2.0	---	---	NS
Speaking	0.8	---	---	---	3.9	---	---	NS
Kurdish								
Reading	3.3	1.1	9.7	---	3.9	3.4	7.7	NS
Writing	2.4	1.1	6.5	---	2.0	3.4	7.7	NS
Speaking	4.5	3.3	12.9	---	3.9	3.4	7.7	NS
Able to use in clinical pract.	1.6	1.1	6.5	---	---	3.4	---	NS
Ladino								
Reading	0.8	---	---	---	2.0	3.4	---	NS
Writing	0.4	---	---	---	2.0	---	---	NS
Speaking	0.8	---	---	---	2.0	3.4	---	NS
Laz								
Speaking	0.8	1.1	---	3.4	---	---	---	NS
Russian								
Reading	1.2	3.3	---	---	---	---	---	NS
Writing	1.2	3.3	---	---	---	---	---	NS
Speaking	0.8	2.2	---	---	---	---	---	NS
Other								
Reading	0.4	1.1	---	---	---	---	---	NS
Speaking	0.4	1.1	---	---	---	---	---	NS