

Professional Development Processes of Trainee and Experienced Psychotherapists in Turkey



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Summary

Objective: This study explored professional characteristics of psychotherapists in Turkey, examined the changes in their professional developmental processes, and compared the professional characteristics of the trainees and experienced therapists.

Methods: The participants were 88 psychotherapists, including trainee (N=37) and experienced (N=51) psychotherapists in Turkey. They completed the Development of Psychotherapists Common Core Questionnaire (DPCCQ), developed by the Collaborative Research Network.

Results: The participants identified with the cognitive theoretical orientation most often. 30% had more than two salient orientations. The most prevalent therapy modality was individual, followed by couples, family, and group psychotherapy. Ongoing supervision rate was 44%. Trainees scored lower on effectiveness in engaging patients in a working alliance, feeling natural while working with patients, effectiveness in communicating their understanding and concern to their patients, and feeling confident in their role as therapists. Experienced therapists made changes in the therapeutic contract and invited collaboration from families more often compared to the trainees. 63% of the variance in Healing Involvement was explained by Overall Career Development, Currently Experienced Growth, being influenced by the humanistic approach, and the impact of the main therapeutic environment; 26% of the variance in Stressful Involvement was explained by the length of official supervision received and having control over the length of therapy sessions.

Conclusion: Therapists were more cognitively oriented, less eclectic, and had less supervision compared to their international counterparts. Experienced therapists were more flexible, natural, and confident than the trainees. Supervision, a supportive work environment, the humanistic approach, and investment in career development were essential to providing a healing environment.

Keywords: Psychotherapy, supervision, professional development, therapeutic experience, Turkey

INTRODUCTION

Becoming a psychotherapist is an extensive and lifelong process. The development continues as therapist moves across different stages in his or her career, which might last from 30 to 40 years. Supervision (Burke et al. 1999, Watkins 1997, Whitman and Jacobs 1998), personal therapy (Daw and Joseph 2007, Norcross 2005, Williams et al. 1999, Wiseman and Shefler 2001), trainings (Bennett-Levy 2006, Fortune et al. 2001), and personal characteristics (Heinonen and Orlinsky 2013, Messer and Gurman, 2011) are among factors that contribute to the professional development of therapists.

Interpersonal experiences in the personal life domain (early family and adult personal life) and the professional life domain (interacting with clients, professional elders, and peers) were consistently found to be significant sources of influence for professional development (Rønnestad and Skovholt 2003). Perceived therapeutic mastery increased with amount of time spent in practice. On the other hand, therapists at all career cohorts reported high levels of currently experienced growth, which suggests professional development is an ongoing process (Orlinsky et al. 1999).

From a cross-cultural perspective, Orlinsky and Rønnestad (2005) focused on therapist factors, which develop over time.

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Through collaborations with native psychotherapy researchers in the Collaborative Research Network (CRN), therapists from the United States, Germany, Switzerland, Norway, Denmark, Sweden, Portugal, Spain, Belgium, France, Russia, Israel, and South Korea joined their study over two decades and filled out the Development of Psychotherapists Common Core Questionnaire (DPCCQ), which was developed by the CRN. The findings of this comprehensive study, which reports data from above 4000 therapists from multiple studies conducted in various countries can be summarized as follows (Orlinsky and Rønnestad 2005):

Orientation and demographic variables

Mean years of practice was 11 years. Mean age was 42 years; 53% were females. 56% were married. The most salient theoretical orientation was analytic-psychodynamic (58%), followed by humanistic (31%), cognitive (24%), systemic (21%), and behavioral (14%) orientations. 46% had three or more salient orientations.

Therapy modality

93% of the therapists provided individual psychotherapy, 34% provided couples therapy, 34% provided group therapy, 28% provided family therapy, and 9% provided other therapy modalities at least once. 31% of the therapists reported they provided only individual psychotherapy.

Personal psychotherapy and supervision

Therapist self-understanding contributes significantly to professional effectiveness (Orlinsky et al. 2005). Many therapists use personal therapy as a means of self-understanding. Over 59% of the therapists had at least one therapy experience. 75% of psychologists, 72% of social workers, and 67% of psychiatrists reported entering psychotherapy. For 46% of the therapists, their primary motive in entering therapy was training, for 56% the primary motive was personal problems, and for 60% the motive was growth. 85% of psychodynamic therapists, 83% of eclectic/integrative therapists, 82% of interpersonal therapists, 76% of humanistic therapists, and 65% of cognitive-behavioral therapists reported having had a therapy experience.

Supervision is an integral and career-long aspect of psychotherapy profession (LeShan 1996), and there is more need for supervision in the beginning of training. Supervision was noted as the most positive influence on the development of beginner therapists, and as the second most positive influence on the development of experienced therapists, following having experience with patients. International studies showed 96% of therapists in practice received ongoing supervision (Grant and Schofield 2007).

Difficulties in practice and coping strategies

Difficulties in practice consist of professional self-doubt, frustrating treatment case, and having a negative personal reaction to a patient. Difficulties are an integral part of the psychotherapy experience, despite the level and confidence of therapists. On a scale of 0 (never) to 5 (frequently), therapists reported they experienced a difficulty between 1 and 2 on average. Apprentice therapists (those with less than 3.5 years of experience) scored higher than established therapists (those with 7 to 15 years of experience) on professional self-doubt ($M=1.9$, apprentice; $M=1.6$, experienced therapist) and frustrating treatment case ($M=1.6$, apprentice; $M=1.4$, experienced therapist). 76% of the therapists reported 'being unsure how to best deal effectively with a patient' was most difficult for them, followed by 'feeling distressed by their powerlessness to affect a patient's tragic life situation' (59%), and 'lacking in confidence that they can have a beneficial effect on a patient' (58%). The difficulties least experienced were 'feeling afraid that they were doing more harm than good in treating a patient' (17%) and 'unable to find something to like or respect in a patient' (15%).

Coping strategies include exercising reflective control, problem-solving with the patient, seeking consultation, reframing the helping contract, and avoiding therapeutic engagement. The most popular coping strategies included 'reviewing privately with oneself how the problem has arisen' (58%), 'discussing the problem with a colleague' (56%), 'trying to see the problem from a different perspective' (54%), and 'consulting with a more experienced therapist' (53%).

Professional development

Overall Career Development refers to therapist skills transforming throughout their career towards improvement or impairment. Currently Experienced Growth includes feelings of change as a therapist, defining change as progress or improvement, overcoming past limitations as a therapist, becoming more skillful in therapy, feeling a deepening in understanding of therapy, and feeling a growing sense of enthusiasm about doing therapy. Currently Experienced Depletion inquires about a sense of current decline or impairment, performance becoming routine, becoming disillusioned about therapy, and losing capacity to respond empathically. Therapists tend to experience either Currently Experienced Growth or Currently Experienced Depletion or both at different levels in their professional development process.

Therapeutic work experience

Two facets of therapeutic work experience are Healing and Stressful Involvement. Healing Involvement consists of being personally Invested (involved, committed) and Efficacious (effective, organized) in relational agency; being Affirming

(accepting, friendly, warm) and Accommodating (permissive, receptive, nurturant) in relational agency; experiencing Flow states (stimulated, inspired) during therapy sessions and using constructive coping strategies while having difficulty in therapy. Stressful Involvement was described by having frequent difficulties in practice; experiencing Anxiety and Boredom along with the difficulties; Avoiding Therapeutic Engagement upon encountering difficulties (avoiding the problem, hoping it will disappear, considering transferring or terminating the patient). Stressful and Healing Involvement are not simple opposites. Various levels of those two determine whether a therapeutic relationship is helpful for the patient. Effective practice included much Healing Involvement and little Stressful Involvement. With experience and time an increase in Healing Involvement and decrease in Stressful Involvement is observed.

Leading predictors of Healing Involvement were Currently Experienced Growth, Overall Career Development, theoretical breadth, gender, satisfaction with work, and motivation for further development. Leading predictors of Stressful Involvement were Currently Experienced Depletion and dissatisfaction with work. Overall Career Development and Currently Experienced Growth were protective factors for Stressful Involvement.

Findings above indicate that therapist characteristics and factors have been extensively studied in international studies. The DPCCQ was first administered in Turkey by Guneri-Minton (2006), which focused solely on differences in relational styles between therapists in Turkey and the USA. Findings revealed therapists in Turkey perceived themselves as being more directive (regardless of orientation), but less challenging, committed, protective, friendly, and subtle compared to their American counterparts. A qualitative study showed therapists in Turkey were eclectic and highly influenced by Western therapies (Karagoz 2012). As there are few studies in Turkey that focus on therapist factors that facilitate or impede on the therapeutic relationship, we aimed in our study to build on Guneri-Minton's (2006) research, compared the characteristics of psychotherapists in Turkey with their international counterparts, and examined the differences between trainees and experienced psychotherapists regarding therapeutic characteristics. Considering the features of current training opportunities in Turkey, first, the participants were expected to be influenced by the cognitive approach more, have less supervision, and provide group, couples, and family therapy less compared to the international therapists. Second, experienced therapists were hypothesized to be more natural, confident, and flexible compared to the trainees. Third, compared to the trainees, experienced therapists were hypothesized to score higher on coping skills and factors enabling Healing Involvement and lower on difficulties in encountered practice and Stressful Involvement.

METHOD

Participants

The data of the therapists who never treated any patients ($N=2$) were not included in this study. Another participant's data, whose answers were inconsistent, were not included in this study. The participants consisted of 88 trainee (those who were still in academic training) ($N=37$) and experienced (those who have already completed their academic degrees) ($N=51$) psychologists, psychiatrists, and counselors in Turkey who volunteered to participate in this study (82% females, 18% males). Age ranged from 24 to 66 ($M=34$). 44% primarily identified as psychotherapists, 39% identified as psychologists, 6% identified as psychiatrists, 9% identified as counselors, and 1% identified as other. 58% of the participants were experienced therapists and 42% were students. 48% of the participants were single, 38% were married, 6% lived with a partner, and 7% were separated or divorced. 83% of the participants did not have any children. 11% identified as an ethnic minority. 99% reported they were raised in the Muslim religion. 45% did not currently identify with a religion.

The participants consisted of therapists who had treated at least one patient in his or her career. Among 37 trainees, 24 were working on a master's degree (with 18 of them working on a master's in Clinical Psychology, and two of them working on a master's degree in Guidance and Counseling Psychology), and 13 were working on a doctorate degree (with ten of them working on a doctorate in Clinical Psychology, one of them working on a doctorate in Guidance and Counseling Psychology, and one of them working on a doctorate in Forensic Psychology). Among 51 experienced therapists, 20 had an undergraduate degree in either Psychology or Guidance and Counseling Psychology; 13 had a master's degree in either Clinical Psychology ($N=9$), Guidance and Counseling Psychology ($N=2$), or Forensic Psychology ($N=1$); 18 had either a doctorate in Clinical Psychology ($N=10$), Guidance and Counseling Psychology ($N=2$), or they were psychiatrists ($N=6$). One fourth of the participants did not have master's degree in psychology or were not working towards one. Their mean years of practice was 8. All of the participants, particularly the experienced therapists with only undergraduate degrees, reported having extensive trainings in psychotherapy in addition to having received formal training, some of which included certified couples and family therapy, gestalt therapy, schema therapy, and psychodrama training.

Measures

Development of Psychotherapists Common Core Questionnaire: The DPCCQ includes 392 items with 11 sections. The first two sections gather information on date of birth, gender, psychotherapists' professional identification, qualifications, organizational memberships, hours of work and hours of

therapy per week, location of work, academic degrees and certifications held, past and current supervision, and training in different therapy modalities. The third section gathers information on duration and types of clinical experiences in different settings, and treatment and supervision of other therapists. The fourth section gathers information on therapists' estimates of their overall career development, including their initial and current estimates of clinical skill levels. The fifth section explores the therapists' own experiences in personal therapy. The sixth section investigates therapists' current theoretical orientation, treatment goals, and ideal manner of relating to their patients. The seventh section focuses on therapists' sense of their current professional development, their experiences that had a positive or negative influence on their development, and feelings they have with their patients in the sessions. The eighth section asks about therapists' current practice including the type and number of settings where they work (i.e. inpatient, outpatient, university, private); the number of patients they treat in different treatment modalities (i.e. individual, group, couples, family), and the support they experience in their main work setting. The ninth section includes difficulties therapists experience while working with patients and the coping strategies they employ, flexibility or strictness of managing boundaries of the treatment, and their interpersonal manner of relating to the patients. The tenth section explores therapist personal characteristics, including marital and minority status, life satisfaction, emotional well-being, and interpersonal style in close relationships. The eleventh section asks therapists to describe ideas relevant to the topics indicated in the questionnaire (Orlinsky and Rønnestad 2005).

The DPCCQ was previously translated to Turkish in 2006. The initial draft of the translation was checked by three bilingual consultants using the DPCCQ Translation Rating Form, which was developed by CRN members to evaluate previous translations. The rating form assessed exactness of translation and correctness of expression, ranging from 1 (excellent) to 4 (poor). The level of translation was above 91% at the level of good or excellent (Guner-Minton 2006). In this study, the authors re-translated the DPCCQ to improve the first version. The revised DPCCQ was administered to three psychotherapists to get feedback on the translation and was modified accordingly. In the Turkish translation two questions were added to the original questionnaire, one inquiring about the student status and the second one inquiring about years spent in the degree program.

Procedure

The DPCCQ was published online. The link to the questionnaire was emailed to the listservs that had access to the psychotherapists working in academic and clinical settings. The DPCCQ was also provided to the therapists in paper and

pencil form in case their preferred choice of medium was not online. Participation was voluntary and the participants were not compensated for their participation.

RESULTS

Length of experience, education, orientation

Mean months of practice was 37.69 ($N=36$, $SD=35.82$) for trainees and 134.02 ($N=49$, $SD=108.31$) for experienced therapists, $F(1, 84)=26.28$, $p=0.00$, $\eta^2=0.24$. 23% of the participants reported having an undergraduate degree, 42% had a master's and 35% had a PhD or MD degree or were working towards one. 57% of the therapists were moderately to highly influenced by psychodynamic, 57% by behavioral, 74% by cognitive, 56% by humanistic, 35% by systems, 45% by person-centered, and 77% by eclectic or integrative psychotherapy framework. 30% of the participants had 3 or more salient orientations. 17% of them noted their work was influenced by other theoretical approaches, including EMDR, gestalt, relational, psychodrama, arts, and schema therapy.

The therapists were asked about their current salient theoretical orientation and initial salient theoretical orientation. A Repeated Measures ANOVA test showed there was a significant main effect of time, $F(1, 59)=5.56$, $p=0.02$, $\eta^2=0.09$, ($M=2.21$, $SE=0.10$, initial), ($M=2.42$, $SE=0.11$, current); and a main effect of theoretical orientation, $F(5, 59)=22.58$, $p=0.00$, $\eta^2=0.28$, with cognitive theoretical orientation ($M=3.43$, $SE=0.17$), scoring higher than analytical/psychodynamic ($p=0.03$; $M=2.25$, $SE=0.23$), behavioral ($p=0.00$; $M=2.71$, $SE=0.20$), humanistic ($p=0.01$; $M=2.35$, $SE=0.19$), systemic ($p=0.00$; $M=1.21$, $SE=0.18$), and person-centered ($p=0.00$; $M=1.93$, $SE=0.20$) theoretical orientations; and systems theoretical approach scoring lower than analytical/psychodynamic ($p=0.06$), behavioral ($p=0.00$), cognitive ($p=0.00$), humanistic ($p=0.00$), and person-centered ($p=0.01$) theoretical orientations. There were no interaction effects, $F(5, 59)=0.64$, $p=0.42$, $\eta^2=0.01$.

A Multivariate Analysis of Variance (MANOVA) test showed there were marginally significant differences between experienced therapists and trainees on being currently influenced by the cognitive theoretical framework, $F(1, 49)=3.05$, $p=0.09$, $\eta^2=0.06$, trainees ($M=3.95$, $SD=1.09$), experienced therapists ($M=3.24$, $SD=1.66$), with trainees being more influenced by the cognitive framework; and the degree of eclectic or integrative practice they had, $F(1, 49)=3.41$, $p=0.07$, $\eta^2=0.07$, trainees ($M=3.82$, $SD=1.10$), experienced therapists ($M=3.10$, $SD=1.54$).

Therapy modality

97% of therapists had at least one individual, 61% had at least one couples, 53% had at least one family, and 51% had

Table 1. Differences in therapy modalities provided between trainees and experienced therapists

	Trainees			Experienced therapists			F	p	η^2
	n	M	SD	n	M	SD			
Individual ¹	26	3.63	2.02	37	5.30	1.45	14.81	0.00	0.20
Group ²	26	0.81	1.47	37	2.03	2.43	5.19	0.03	0.08
Couples ³	26	1.46	2.12	37	2.86	2.36	5.87	0.02	0.09
Family ⁴	26	0.92	1.81	37	2.26	2.26	4.06	0.05	0.06

¹M=1 (provided 1-3 individual psychotherapy), M=2 (provided 4-9 individual psychotherapy), M=3 (provided 10-15 individual psychotherapy), M=4 (provided 16-24 individual psychotherapy), M=5 (provided 25-49 individual psychotherapy) and M=6 (provided 50+ individual psychotherapy)

²M=1 (provided 1-3 group psychotherapy), M=2 (provided 4-9 group psychotherapy), M=3 (provided 10-15 group psychotherapy), M=4 (provided 16-24 group psychotherapy), M=5 (provided 25-49 group psychotherapy) and M=6 (provided 50+ group psychotherapy)

³M=1 (provided 1-3 couples psychotherapy), M=2 (provided 4-9 couples psychotherapy), M=3 (provided 10-15 couples psychotherapy), M=4 (provided 16-24 couples psychotherapy), M=5 (provided 25-49 couples psychotherapy) and M=6 (provided 50+ couples psychotherapy)

⁴M=1 (provided 1-3 family psychotherapy), M=2 (provided 4-9 family psychotherapy), M=3 (provided 10-15 family psychotherapy), M=4 (provided 16-24 family psychotherapy), M=5 (provided 25-49 family psychotherapy) and M=6 (provided 50+ family psychotherapy)

at least one group psychotherapy experience. 39% of the therapists never provided couples therapy, 47% never provided family therapy, and 49% never provided group psychotherapy. 54% of trainees had less than 16 individual, 65% had less than 4 couples, 78% had less than 4 family, and 81% had less than 4 group therapy experience in the past. 74% of experienced therapists had 50 or more individual, 53% had less than 16 couples, 55% had less than 10 family, and 63% had less than 10 group therapy experience in the past. As shown in Table 1, a MANOVA test demonstrated that experienced therapists provided significantly more individual, $F(1, 63)=14.81, p=0.00, \eta^2=0.20$; group, $F(1, 63)=5.19, p=0.03, \eta^2=0.08$; couples, $F(1, 63)=5.87, p=0.02, \eta^2=0.09$; and family therapy, $F(1, 63)=4.06, p=0.05, \eta^2=0.06$, compared to the trainees.

Personal psychotherapy and supervision

82% of the therapists were not currently under personal psychotherapy, and 43% had never entered psychotherapy. 46% of the therapists worked with one therapist before, 33% worked with 2 therapists, 15% worked with 3 therapists, 2% worked with 4 therapists, and 4% worked with 6 therapists. Therapists had an average of 32 months of personal therapy ($SD=32$). Mean years of age at onset was 24.75 ($SD=4.86$). When the most significant personal therapy was considered, 83% reported their therapy was highly important for them. The purpose for entering first personal therapy was training (5%), development (42%), and personal problems (50%). Of all therapy experiences, when the most significant personal therapy was taken into account, therapists entered therapy for training (72%), development (14%), and personal problems (14%). Both trainees and experienced therapists were equally likely to be in therapy, $F(1, 87)=1.68, p=0.20, \eta^2=0.02$.

69% of the trainees and 27% of the experienced therapists reported receiving regular ongoing supervision. Overall, 44% received ongoing supervision. 71% of the trainees and 70% of the experienced therapists had 3 or fewer supervisors. 3%

of the trainees and 9% of the experienced therapists had 10 or more supervisors.

Goals of therapy

Therapists indicated the most important goals in therapy included having a strong sense of self-worth and identity (55%), understanding one's own feelings and behaviors (54%), being effective when encountering difficulties (38%), and having a good reality-testing about the self (32%).

Difficulties in practice and coping strategies

The mean of difficulties experienced in practice was 1.10 ($N=88, SD=0.68$). 'Lacking in confidence that one can have a beneficial effect on a patient' was the most difficult aspect of the practice, ($N=87, M=2.05, SD=1.49$), followed by being 'unsure how best to deal effectively with a patient', ($N=87, M=1.85, SD=1.33$), being 'demoralized by their inability to find ways to help a patient', ($N=87, M=1.78, SD=1.43$), and being 'distressed by their powerlessness to affect a patient's tragic life situation' ($N=87, M=1.60, SD=1.50$). Feeling 'afraid of doing more harm than good in treating a patient' was the least difficult aspect of the therapeutic relationship, ($N=73, M=0.58, SD=0.87$). Overall, the experienced therapists ($N=51, M=1.11, SD=0.68$) and trainees ($N=37, M=1.09, SD=0.68$) scored similarly on difficulties experienced. However, when subgroups were investigated, a test of MANOVA showed there was a marginal significant difference between trainees and experienced therapists on professional self-doubt, $F(1, 86)=3.23, p=0.08, \eta^2=0.04$, trainees ($M=1.88, SD=0.94$), experienced therapists ($M=1.51, SD=0.94$). There were no differences between trainees and seniors on having Frustrating Treatment Case, $F(1, 86)=0.53, p=0.47, \eta^2=0.01$, trainees ($M=1.11, SD=0.74$), experienced therapists ($M=0.97, SD=0.92$); and having negative personal reaction to a patient, $F(1, 86)=0.15, p=0.70, \eta^2=0.00, (M=0.79, SD=0.72)$ trainees, ($M=0.73, SD=0.77$) experienced therapists.

Table 2. Differences between trainees and experienced therapists regarding therapeutic competence at the onset of training

	Trainees			Experienced therapists			F	p	η^2
	n	M	SD	n	M	SD			
How effective were you at engaging patients/clients in a working alliance?	36	2.86	0.93	51	2.84	1.05	0.01	0.93	0.00
How 'natural' (authentically personal) did you feel while working with patients/clients?	36	2.47	1.08	51	2.76	1.32	0.20	0.28	0.01
How good was your general theoretical understanding of therapy?	36	2.86	0.99	51	2.86	1.04	0.00	0.99	0.00
How empathic were you in relating to patients/clients with whom you had relatively little in common?	36	2.78	0.99	51	3.02	1.03	1.20	0.28	0.01
How much mastery did you have of the techniques and strategies involved in practicing therapy?	36	2.19	1.03	51	2.12	1.16	0.10	0.75	0.00
How effective were you in communicating your understanding and concern to your patients/clients?	36	3.31	1.09	51	3.45	1.01	0.41	0.52	0.01
How well did you understand what happened moment-by-moment during therapy sessions?	36	2.36	1.17	51	2.65	0.99	1.50	0.22	0.02
How confident did you feel in your role as a therapist?	36	2.33	1.31	51	2.61	1.22	1.01	0.3	0.01

Upon encountering a difficulty, therapists were most likely to discuss the problem with a colleague ($N=87$, $M=3.74$, $SD=1.39$), see the problem from a different perspective ($N=87$, $M=3.71$, $SD=1.06$), consult about the case with a more experienced therapist, ($N=87$, $M=3.63$, $SD=1.49$), and consult relevant articles or books ($N=87$, $M=3.61$, $SD=1.29$). There were significant differences between trainees and experienced therapists on how they would cope with difficulties that arise in therapy. A test of MANOVA showed that the differences were in making changes in the therapeutic contract with a patient, $F(1, 83)=5.41$, $p=0.02$, $\eta^2=0.06$, trainees ($M=0.65$,

$SD=1.04$), experienced therapists ($M=1.22$, $SD=1.16$); consulting about the case with a more experienced therapist, $F(1, 83)=12.74$, $p=0.00$, $\eta^2=0.14$, trainees ($M=4.26$, $SD=1.14$), experienced therapists ($M=3.14$, $SD=1.57$); inviting collaboration from patient's friends or relatives, $F(1, 83)=4.98$, $p=0.03$, $\eta^2=0.06$, trainees ($M=0.56$, $SD=0.99$), experienced therapists ($M=1.12$, $SD=1.22$). There was a marginally significant difference on 'seeing whether therapist and patient can together deal with the difficulty', $F(1, 81)=3.66$, $p=0.06$, $\eta^2=0.04$, trainees ($M=2.32$, $SD=1.43$), experienced therapists ($M=2.92$, $SD=1.37$).

Table 3. Differences between trainees and experienced therapists regarding current therapeutic competence

	Trainees			Experienced therapists			F	p	η^2
	n	M	SD	n	M	SD			
How effective are you at engaging patients/clients in a working alliance?	37	3.59	1.07	48	4.06	0.70	5.96	0.02	0.07
How 'natural' (authentically personal) do you feel while working with patients/clients?	37	3.76	1.01	48	4.29	0.62	9.07	0.00	0.10
How good is your general theoretical understanding of therapy?	37	3.70	0.74	48	3.90	0.86	1.19	0.28	0.01
How empathic are you in relating to patients/clients with whom you had relatively little in common?	37	3.65	0.95	48	3.96	0.71	2.95	0.09	0.03
How much mastery do you have of the techniques and strategies involved in practicing therapy?	37	3.30	1.10	48	3.60	1.05	1.72	0.19	0.02
How effective are you in communicating your understanding and concern to your patients/clients?	37	3.81	0.94	48	4.33	0.66	9.05	0.00	0.10
How well do you understand what happened moment-by-moment moment during therapy sessions?	37	3.62	0.95	48	3.77	0.81	.61	0.44	0.01
How much precision, subtlety and finesse have you attained in your therapeutic work?	37	3.59	0.99	48	4.27	0.74	13.13	0.00	0.13
How confident do you feel in your role as a therapist?	37	3.43	1.02	48	3.83	0.81	4.11	0.05	0.05

Development of therapeutic skills

As shown in Tables 2 and 3, MANOVA tests indicated, while there were no differences between trainees and experienced therapists at the onset of practice, there were significant differences in their current skills. Trainees scored lower on effectiveness in engaging patients in a working alliance, $F(1, 83)=5.96, p=0.02, \eta^2=0.07$, trainees ($M=3.59, SD=1.07$), experienced therapists ($M=4.06, SD=0.70$); feeling natural (authentically personal) working with patients, $F(1, 83)=9.07, p=0.00, \eta^2=0.10$, trainees ($M=3.76, SD=1.01$), experienced therapists ($M=4.29, SD=0.62$); effectiveness in communicating their understanding and concern to their patients, $F(1, 83)=9.05, p=0.00, \eta^2=0.10$, trainees ($M=3.81, SD=0.94$), experienced therapists ($M=4.33, SD=0.66$); and feeling confident in their role as a therapist, $F(1, 83)=4.11, p=0.05, \eta^2=0.05$, trainees ($M=3.43, SD=1.02$), experienced therapists ($M=3.83, SD=0.81$).

Therapeutic work experience

MANOVA showed that there were no differences between trainees and experienced therapists on Healing Involvement. Both scored equally on being invested with patients, $F(1, 83)=0.19, p=0.66, \eta^2=0.00$; being efficacious, $F(1, 83)=0.11, p=0.74, \eta^2=0.00$; being affirming, $F(1, 83)=0.13, p=0.72, \eta^2=0.00$; flow states, $F(1, 83)=0.02, p=0.89, \eta^2=0.00$; and using constructive coping, $F(1, 83)=0.34, p=0.56, \eta^2=0.00$. When subcategories of Stressful Involvement were investigated, a test of MANOVA showed there was a marginally significant difference between trainees and experienced therapists on professional self-doubt, $F(1, 86)=3.23, p=0.08, \eta^2=0.04$, as mentioned above.

Bivariate correlations were computed to determine variables that were correlated with Healing and Stressful Involvement. A broad range of variables included gender, professional versus trainee status, professional identity, experience in individual, couples, family and group therapy, time spent in supervision, number of supervisors one worked with, duration of psychotherapy experience, number and duration of personal psychotherapy experiences, having control in number and selection of patients in arranging their schedule, the duration of therapy offered, setting fees, how closely they worked with other professionals, duration of administrative hassles, support in their work environment, currently experienced growth, currently experienced depletion, overall career development, and motivation for further development. Variables showing significant correlations ($r>0.15$) to healing and stressful involvements were chosen for multiple regression analyses.

A Multiple Regression test using forward method showed that there was a substantial positive correlation between four predictor variables and the dependent variable Healing Involvement ($R=0.81$). About 63% of the variance in Healing Involvement was explained by the four predictor variables, $R^2=0.41, F(4,$

$46)=21.95, p<0.001$. Overall Career Development had the greatest influence on Healing Involvement ($\beta=0.41$), followed by Currently Experienced Growth ($\beta=0.34$), being influenced by humanistic theoretical framework ($\beta=0.28$), and the impact of the main therapeutic environment (how well it allows one to function as a therapist) ($\beta=0.25$).

A Multiple Regression test using forward method showed that there was a substantial negative correlation between the two predictor variables and the dependent variable Stressful Involvement ($R=0.54$). About 26% of the variance in Stressful Involvement was explained by the two predictor variables, $R^2=0.26, F(2, 48)=9.65, p<0.001$. Length of official supervision had the greatest influence on Stressful Involvement ($\beta=-0.45$), followed by having control over therapy session length, ($\beta=-0.31$). Main findings are summarized in Table 4.

DISCUSSION

Orientation, therapy modality, personal psychotherapy, and supervision

Our first and third hypotheses were partially, and second hypothesis was fully, supported. The psychotherapists in Turkey did not identify with a single theoretical orientation but perceived themselves as integrating multiple orientations. However, when adherence to more than two theoretical orientations was considered, therapists tended to be less integrative or eclectic compared to their international counterparts. Their salient theoretical orientation was cognitive, with trainees being slightly more influenced by it compared to experienced therapists, which suggest that the dominant orientation of the clinical programs in Turkey is cognitive. This finding differs from international samples where the most salient theoretical orientations are analytic-dynamic and humanistic. Cognitive theoretical orientation ranks third in international studies (Orlinsky and Rønnestad 2005). Therapists' most salient theoretical orientation was cognitive, which stayed relatively stable over time. On the other hand, they were least influenced by the systemic orientation. This tendency could result from opportunities provided to them during training, as one's training tends to influence one's theoretical orientation. As therapists gained more experience, being influenced by a specific theoretical orientation increased. Opportunities to practice within a certain theoretical framework that arise in time might enable therapists to develop stronger ties to that particular framework.

Therapists in Turkey primarily provided individual followed by couples, group, and family psychotherapy, similar to their international counterparts. Half of them had never provided group and family psychotherapy, while almost half of them never provided couples therapy. Students had extremely limited experiences of group, couples, and family therapy practice. Even though experienced therapists had more group

Table 4. Main differences in findings between the participants in Turkey and international participants

	Turkey	International participants (Orlinsky & Rønnestad, 2005)
Most salient theoretical orientation	cognitive	analytic-psychodynamic
Most prevalent therapy modality	individual	individual
Ongoing supervision	44%	96%
Most important goal in therapy	having a strong sense of self-worth & identity	having a strong sense of self-worth & identity
Most difficult aspect of current practice	lacking in confidence of having a beneficial effect	unsure how to best deal effectively with a patient
Best coping strategy	discuss the problem with a colleague	reviewing privately how the problem has arisen
Leading Predictors of Healing Involvement	Currently Experienced Growth, Overall Career Development, humanistic theoretical framework, support in the therapeutic environment	Currently Experienced Growth, Overall Career Development, theoretical breadth, gender, satisfaction with work as a therapist, motivation or further development
Leading Predictors of Stressful Involvement	length of official supervision (-) having control over therapy session length (-)	Currently Experienced Depletion, dissatisfaction with work as a therapist, Overall Career Development (-), Currently Experienced Growth (-)

therapy experience compared to the trainees, their experience was also limited. This finding is remarkable considering previous studies have shown individual and group psychotherapy are equally effective for various psychological disorders (Burlingame et al. 2004, McRoberts et al. 1998, Nevenon and Broberg 2005, Nitsun et al. 2005). This finding suggests that the need for group, family, and couples therapy training in academic programs in Turkey might be reassessed, because it might be indicative of limited academic training opportunities (including setting and supervision) for formal group, couples, and family therapy in Turkey.

57% of the therapists have previously been to psychotherapy. This figure is similar to the personal therapy experience rate (59%) observed among international therapists. Participants entered therapy at a relatively early age and tended to stay in therapy for an extended period of time. While personal problems were the primary reason for entering first therapy, training was a prominent reason for the most significant therapy experience. This suggests that as therapists gained experience, they used psychotherapy as a tool for training. Previous studies showed therapists reported improvements in self-understanding, enhanced therapeutic skills, and symptom alleviation upon entering therapy (Bellows, 2007) and perceived personal psychotherapy to be the second most important factor in their professional development after clinical experience (Rachelson and Clance 1980). Unlike the personal therapy rate, which is similar to international counterparts, supervision rate (44%) was below half of the rate observed in international therapists (96%), which suggests that therapists in Turkey underuse a significant resource, supervision, for their professional development.

Goals in therapy

Having a strong sense of self-worth and identity was the most important goal of therapy for 55% of the therapists. 60% of the therapists selected this item as the first-ranked choice

in the United States, Germany, South Korea, Switzerland, and Portugal. This choice was the most highly endorsed goal by therapists of all theoretical orientations (Orlinsky and Rønnestad 2005). This finding adds to the existing information that, regardless of culture and theoretical orientation, therapists believe patients need to develop a strong sense of self-worth and identity for a good outcome. However, the second and third most important goals of therapy differed from those observed in international samples. In this study, therapists believed the second and third most important goals of therapy were understanding one's own feelings and behaviors and being effective when encountering difficulties. Whereas, "improving the quality of the relationships" was the second- and third-ranked choice by the American, Swiss, Portuguese, and Spanish therapists. It is striking that therapists in a more collective culture (i.e. Turkey) focused on individualistic goals while therapists in more individualistic cultures focused on collectivistic goals as the second most important goal in therapy. Future research might investigate cultural elements that remain missing in fulfilling human needs regarding psychological well-being.

Difficulties in practice and coping strategies

When encountering difficulties, feeling lacking in confidence that one can have a beneficial effect on a patient was the most prevalent feeling among therapists in our study, which was ranked the third among international participants. In both groups, the therapists tended to investigate their own capabilities upon encountering a difficulty rather than getting angry at the patient or having difficulty respecting the patient. The trainees exhibited more professional self-doubt compared to the experienced therapists, which might be caused by having less experience and less developed skills compared to the experienced therapists. There was a lack of differences on Frustrating Treatment Case between trainees and experienced therapists. The participants reported much lower means on

it compared to the means of international participants, suggesting difficulties identifying countertransference issues among therapists in Turkey, specifically acknowledging negative feelings that arise while working with patients in therapy. This finding might be related to lower rates of supervision in Turkey, as supervision is a crucial resource to process therapist feelings that come up in therapy.

When therapists experienced a difficulty with their patients, they consulted other resources, including more experienced therapists, books, and articles, tended to reflect on the problem themselves, and saw it from a different perspective, all of which were very similar to the coping strategies of their international counterparts. Discussing the problem with a colleague was the best coping strategy in this study, as opposed to reviewing privately how the problem has arisen observed in international samples. This disparity might have originated from cultural differences. Therapists in Turkey, which is considered to be more on the collectivistic side of the continuum (Hofstede 1980), tend to pull for interpersonal help upon encountering difficulties, and therapists in individualistic countries tend to first resort to personal resources. Experienced therapists were more flexible than trainees while using the coping mechanisms, were more authentic, had easier time inviting collaboration from patient's relatives and friends, collaborated with the patient while working on the problem, and made changes in the therapeutic contract with a patient. This suggests increased flexibility in interacting with the patients comes through increased experience. Literature also showed that in the developmental process of therapists, a more flexible structure of practice was formed (Gabbard 2007). Trainees learned skills in didactic classes, role-playing with other trainees, and getting feedback. Then, they transformed their skills to clinical use. More experienced therapists, on the other hand, were able to refine existing knowledge and engage in when-then rules, plans, skills, reflect on their therapeutic experiences, and improvise their procedural knowledge, skills, and strategies accordingly (Binder 1999, Bennett-Levy 2006). Both trainees and experienced therapists consulted a more experienced therapist upon encountering a difficulty, with trainees receiving supervision more than the experienced therapists.

Development of therapeutic skills

Therapists improved in engaging patients in the therapeutic alliance over time. As they gained more experience, they felt more natural interacting with the patients; communicated their understanding and concern to their patients more effectively; attained more precision, subtlety and finesse; and felt more confident in their work. These findings suggest that acquiring therapeutic skills develops in time with experience (Bennett-Levy 2006). The more clinical experience a therapist has, the better therapeutic skills will develop. This study showed that general understanding of theory and mastery of the techniques and strategies involved in practicing therapy

have not increased over time, which invites a question regarding the amount of time and resources therapists dedicate for continued education in Turkey after graduation, as well as the availability and necessity of such resources. More experienced therapists did not show changes in how well they understood what happened moment-by-moment during therapy sessions. This finding again invites questions regarding process orient- edness of therapists in this study and the priority provided for it by the training programs. Lack of increase in understanding of theory and mastery of techniques in time might also be related to low levels of ongoing supervision.

Therapeutic work experience

Findings showed there were no differences between experienced therapists and trainees regarding providing Healing and Stressful Involvement except professional self-doubt. Lack of difference on Healing Involvement might have resulted from trainees' social desirability bias, as one would have expected trainees to score lower on it, especially on efficacy. Future research using indirect questioning might help to explore this issue further. Future research might also investigate the relationship between increased hours of supervision and Healing Involvement. Both trainees and experienced therapists reported mild professional self-doubt, which tended to be lower among experienced therapists. This finding supports previous research, which indicates that Stressful Involvement decreases with increased experience.

A sense of current and overall development in the profession, having a humanistic approach in treating patients, and a supportive environment where therapist works accounted for the majority of the healing experience a therapist could offer to a patient. The findings indicated investment in career development predicted engaging in healing involvement with patients. Therapists were able to provide a more nurturing experience for their patients when they improved their therapeutic skills, felt they overcame their limitations, and had a deeper understanding of therapy. This again draws attention to the need for continued education of therapists in Turkey. It appears availability and necessity of continued education for therapists in Turkey will enable therapists feel more secure and also help patients receive a better quality service. Incorporating a humanistic standpoint, through respecting the boundaries needed in a therapeutic relationship, appears to benefit patients greatly. Thus, academic training programs might consider incorporating humanistic approaches in their curricula. Previous research has also shown that accepting, friendly, warm, and genuine therapists had better alliance with the patients (Ackerman and Hilsenroth 2003, Henry 1997, Henry et al. 1986, Luborsky 1984, Mitchell et al. 1977, Najavits and Strupp 1994, Orlinsky et al. 2004, Schedin 2005) and helped patients stay in therapy longer to achieve goals in therapy (Kasrabada et al. 2002). Working in a supportive environment appears to encourage healing

involvement. Therefore, clinical settings in Turkey, such as hospitals and counseling centers, might make creating a supportive environment a priority for their therapists.

Trainees learn a great deal from supervision and consider it as one of the most influential factors on their clinical practice (Lucock et al. 2006). It is at the heart of clinical training and provides support, stimulation, and challenge for therapists (Grant and Schofield 2007). It provides acquisition of therapeutic skills, quality control, transmission of culture of psychotherapy, and professional growth (Bernard and Goodyear 2013). For all these reasons, it seems to lower Stressful Involvement. This finding emphasizes the need for providing career-long supervision to trainees and experienced therapists. When therapists felt in control of determining the aspects of therapy process, such as duration of sessions, they could provide less of a Stressful Involvement to their patients, which suggest that having control over logistics of therapy positively contributes to the therapeutic process.

There are several limitations of this study. First, the cross-sectional method design of this study prevented us from following the same therapists over time. Longitudinal studies might be designed to overcome these limitations. Second, we asked the participants their own perspective of professional development. Self-report questionnaires might be subjected to adversities caused by social-desirability and misrepresentation effects. Third, 75% of the participants had at least a master's degree in psychology or were working towards one. One-fourth of the participants without a master's degree had extensive trainings in Psychology and a mean of eight years of experience in therapy. Therefore, we had a group of therapists who were mostly well-trained in psychology and open to improving skills. Our findings may not extend to those without extensive training in the field. Next, the number of participants was limited considering the availability of the therapist population. Part of this limitation resulted from the lengthiness of the questionnaire administered. Finally, since our measure was lengthy, we were able to collect data from a small subset of therapists in Turkey. Larger samples, especially from other schools of theoretical orientations, might yield different patterns of professional development for psychotherapists.

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