

Mental Health Training Characteristics of Psychiatry and Psychology Professionals and Their Reliance on Training Schools in Turkey

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Abstract

In the study, we aimed to investigate the psychotherapy schools of psychiatrists and psychologists' during their training and daily clinical practice and their confidence in different psychotherapy schools. The sample of the study consists of 430 psychologists and psychiatrists reached. Surveys are prepared by consultation with the accredited psychotherapy supervisors from different psychotherapy schools. When comparing psychiatrists and psychologists, psychiatrists significantly attended more to cognitive-behavioral (CBT), psychodynamic, sexual, group, and supportive therapy training ($p<0.01$), whereas psychologists attended to Eye Movement Desensitization and Reprocessing (EMDR) and family couple therapy training ($p<0.01$). The most trusted psychotherapy school was CBT (4.58 ± 1.11), while the least trusted psychotherapy school was hypnosis (2.63 ± 1.31). As the duration of psychotherapy training increased, the confidence in that psychotherapy method increased ($p<0.001$). The current study has shown that psychotherapy practitioners do not have a homogeneous distribution of their psychotherapy training, and these differences reduce their level of confidence in other psychotherapy approaches.

Keywords: psychotherapy, confidence, education, therapy, psychology, physician

Öz

Türkiye'deki Tıp ve Psikoloji Kökenli Ruh Sağlığı Profesyonellerin Eğitimlerinin Ekollere Göre Dağılımı ve Terapi Ekollerine Güven Düzeyleri Araştırması

Bu çalışmada Türkiye örnekleminde psikoterapi hizmeti veren hekim ve psikologların ruh sağlığı eğitimlerindeki ve uygulamalarındaki terapi ekollerini ve bu ekollere güven düzeylerini karşılaştırmalı olarak incelemeyi amaçlandı. Çalışmanın örneklemini toplam 430 psikolog ve psikiyatristten oluşmaktadır. Katılımcılara Türkiye'de akredite psikoterapi eğitmeni olarak görev yapan eğitmenlere danışılarak hazırlanan anket uygulanmıştır. Tıp ve psikoloji kökenli iki grup karşılaştırıldığında, hekimlerin psikologlara göre istatistiksel olarak bilişsel davranışçı (BDT), psikodinamik, cinsel, grup ve destekleyici terapi eğitimlerini daha yüksek oranda aldıkları saptanırken ($p<0,01$), Göz Hareketleri ile Duyarsızlaştırma ve Yeniden İşleme (EMDR) ve aile çift terapisi eğitimlerini alan psikolog sayısı, hekim sayısına göre daha fazlaydı ($p<0,01$). Katılımcıların en fazla güven duydukları psikoterapi ekolu BDT ($4,58\pm 1,11$) iken en az güven duydukları psikoterapi ekolu hipnozdu ($2,63\pm 1,31$). Psikoterapi eğitimi süresi arttıkça, yöneme olan güven artmaktaydı ($p<0,001$). Mevcut çalışma, psikoterapi uygulayıcılarının, psikoterapi eğitimlerinin homojen dağılıma sahip olmadığını ve bu farklılıkların eğitim alınmayan ekollere güven düzeylerini azalttığını göstermiştir.

Anahtar Kelimeler: psikoterapi, güven, eğitim, terapi, psikoloji, hekim

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INTRODUCTION

Psychotherapy, in broad terms, means changing and improving thoughts, feelings and behaviors by influencing the ways of talking and establishing relationships (Öztürk &

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Uluşahin, 2014). Psychotherapies are proven methods for many mental disorders. (Butler, Chapman, Forman, & Beck, 2006; Leichsenring, Rabung, & Leibing, 2004; Seidler & Wagner, 2006; Tolin, 2010). The effects of psychotherapy have been and continue to be demonstrated by various imaging modalities and biological parameters (Fuchs, 2004; Öztürk, 1998). Despite this, many patients who can benefit from psychotherapy are tried to be treated only with pharmacological agents. Thus, potential benefits of psychotherapy approaches for these patients cannot be seen (Kandel, 2007).

The importance of patient's trust toward psychotherapy has been recognized for many years.⁹ For example in a study, when the therapists were informed that a group's potential to benefit from was higher, although there were three identically selected alcohol groups in a study, the benefits rates of that group were found to be higher than the other group (Miller & Rollnick, 2012). Research has shown that the therapist's confident attitude and reassuring qualities are beneficial for the therapeutic alliance (Ackerman & Hilsenroth, 2001). However, with the increasing number of psychotherapy schools and methods in recent years, as far as we know, psychotherapy practitioners' trust in their own schools and other schools has never been investigated in the literature.

In our study in the light of all this information; mental health workers originated in medical and psychology in Turkey based on the hypothesis that there is a difference in their professional's trust in different psychotherapies, it is aimed to investigate the psychotherapy practitioners' levels of psychotherapy training, which is commonly used in Turkey and the link between their confidence on the effectiveness of therapy.

METHOD

Sample

The sample of the study consists of physicians and psychologists who are still working in the mental health area in the borders of Turkey. In this study, an online web site address system formed out www.turkiyepsikoterapiarastirmasi.com and physicians and psychologists working in the mental health area across the Turkey were invited by accessing social networking sites via which they are members. 36 volunteers participating in the study were excluded from the study due to the filling the forms incompletely and providing incorrect information. As a result, a total of

430 volunteers including 206 physicians working in the mental health area and 224 psychologists working in mental health area were included in the study. Physicians who volunteered to participate in the study were classified as a adult mental health and disease specialists and assistants, child and adolescent mental health and disease specialists and assistants, physicians working in the field of mental health. Considering psychologists; they were classified as those who have graduated from the psychology and psychological counseling and guidance departments of universities and/or have a master's degree in clinical psychology after graduating from the legally recognized undergraduate degree and still working in the field of mental health and psychologist working in the mental health area.

The results were checked through the online system in order to prevent duplicate participation and inappropriate responses to the study. As the inclusion criteria for the study; a) Working in the field of mental health, b) Having graduated from the appropriate undergraduate department to legally study psychotherapy, c) Volunteering was determined to participate in the study. The study was approved by the Marmara University Faculty of Medicine clinical studies ethics committee. The study was conducted in accordance with the Helsinki Declaration criteria.

Research Design

An online questionnaire form was applied to the volunteers invited to the study. In order to create a questionnaire form, the relevant literature was first scanned and the psychotherapy training announcements made in the mail groups in which a significant part of psychologists and psychiatrists were included in our country were studied. The questionnaire, which was prepared by a team of three experienced in the area of psychotherapy and consulted with the trainers working as psychotherapy instructors on cognitive behavioral therapy, psychoanalysis, supportive psychotherapy, family therapy and EMDR (Eye Movement Desensitization and Reprocessing) therapy, consists of three parts. The first part of the questionnaire consists of a sociodemographic form that questions the age, gender, duration of service in the area of mental health, the place of work, and the orientation of the volunteers and the educational institution. The second part of the questionnaire questions the psychotherapy training of the participants so far. In this section, the hours of their education in accordance with the literature were questioned by the researchers. Participants who did not receive training and received training for up to 30 hours were identified as the group that did not receive competent

Table 1: Sociodemographic data of the participants					
	<i>Total</i>	<i>Physician in the area of Mental Health n=206 (%47.9)</i>	<i>Psychologist in the area of Mental Health n=224 (%52.1)</i>	<i>Statistics</i>	<i>p</i>
Age; years, Mean.±SD	32.19±9.11	35.73±9.28	29.05±7.40	8.202	^a ≤0.001**
Gender; n(%)					
Women	278 (64.7)	103 (37.1)	175 (62.9)	37.143	^c ≤0.001**
Male	152 (35.3)	103 (67.8)	49 (32.2)		
Working time in the area of mental health; n(%)					
0-3 Years	163 (37.9)	44 (21.4)	119 (53.1)	47.214	^c ≤0.001**
4-6 Years	98 (22.8)	56 (27.2)	42 (18.8)		
7-10 Years	70 (16.3)	46 (22.3)	24 (10.7)		
11-20 Years	69 (16.0)	42 (20.4)	27 (12.1)		
20 Years and above	30 (7.0)	18 (8.7)	12 (5.4)		
Place of practice; n(%)					
Training Hospital	96 (22.3)	71 (34.5)	25 (11.2)	246.564	^c ≤0.001**
University Hospital	79 (18.4)	66 (32.0)	13 (5.8)		
Clinic	37 (8.6)	17 (8.3)	20 (8.9)		
Special Hospital	18 (4.2)	13 (6.3)	5 (2.2)		
Public Hospital	43 (10.0)	39 (18.9)	4 (1.8)		
Consulting C.	76 (17.7)	0	76 (33.9)		
School Counseling C.	30 (7.0)	0	30 (13.4)		
Other Institution	24 (5.6)	0	24 (10.7)		
Not working	27 (6.3)	0	27 (12.1)		
The predominant orientation of your institution of education; n(%)					
Biological Approach	172 (40.0)	150 (72.8)	22 (9.8)	177.433	^c ≤0.001**
Psychodynamic-Analytical	96 (22.3)	48 (23.3)	48 (21.4)	0.217	^c 0.641
Cognitive Behavioral	272 (63.3)	82 (39.8)	190 (84.8)	93.559	^c ≤0.001**
Your own theoretical and practical orientation; n(%)					
Biological Approach	140 (32.6)	128 (62.1)	12 (5.4)	157.554	^c ≤0.001**
Psychodynamic-Analytical	127 (29.5)	64 (31.1)	63 (28.1)	0.447	^c 0.504
Cognitive Behavioral	271 (63.0)	120 (58.3)	151 (67.4)	3.862	^c 0.049*
Couple- Family	55 (12.8)	19 (9.2)	36 (16.1)	4.512	^c 0.034*
EMDR	17 (4.0)	4 (1.9)	13 (5.8)	4.215	^c 0.040*
Eclectic	20 (4.7)	8 (3.9)	12 (5.4)	0.515	^c 0.469

^a Student t testi.

^c Pearson ki-kare testi

training, and those who received more than 30 hours of training were determined as the group with competent training. This categorization, after reviewing the available period of psychotherapy training in Turkey, it was decided to exclude introductory training. In the last part, there are questions questioning the participants' confidence in the effectiveness of psychotherapy. For this purpose, the types of psychotherapy were asked by the volunteers to score (1=I don't trust at all-6=I completely trust) on a scale between 1 and 6. The data obtained as a result were recorded in the appropriate data set and analyzed.

Statistical Analysis

Continuous variables from the sociodemographic data of the volunteers included in the study were analyzed as

mean ± standard deviation, and categorically as n (%). In the comparison of physician psychologists working in the area of mental health, Student's T test was used for continuous variables that were compatible with the normal distribution, and the Mann-Whitney U test was used for those who did not comply with the normal distribution. Chi-square test was used in comparison of categorical data. All analyzes were made with SPSS-22 package program and $p \leq 0.05$ was considered statistically significant.

RESULT

Sociodemographic and professional data of the participants are presented in Table 1. 430 physicians and psychologists working in the field of mental health were

Table 2: Comparison of the training durations of the participants according to the types of psychotherapy education between physicians and psychologists working in the area of psychotherapy.

		Psychotherapy training hours of the participants						χ^2 value	P value
		Did not take n (%)	1-30 Hour n (%)	31-60 Hour n (%)	61-150 Hour n (%)	151-300 Hour n (%)	300 Hour and above n (%)		
Cognitive Behavioral Therapy	Physician	40 (19.4)	26 (12.6)	35 (17.0)	35 (17.0)	29 (14.1)	41 (19.9)	31.957	<0.001**
	Psychologist	75 (33.5)	46 (20.5)	41 (18.3)	30 (13.4)	9 (4.0)	23 (10.3)		
Psychoanalysis	Physician	164 (79.6)	17 (8.3)	9 (4.4)	5 (2.4)	2 (1.0)	9 (4.4)	3.916	0.562
	Psychologist	178 (79.5)	27 (12.1)	7 (3.1)	6 (2.7)	1 (0.4)	5 (2.2)		
Psychodynamic Psychotherapy	Physician	103 (50.0)	18 (8.7)	17 (8.3)	33 (16.0)	16 (7.8)	19 (9.2)	25.033	<0.001**
	Psychologist	140 (62.5)	32 (14.3)	11 (4.9)	11 (4.9)	7 (3.1)	23 (10.3)		
EMDR	Physician	117 (56.8)	64 (31.1)	7 (3.4)	10 (4.9)	6 (2.9)	2 (1.0)	46.197	<0.001**
	Psychologist	158 (70.5)	18 (8.0)	29 (12.9)	8 (3.6)	6 (2.7)	5 (2.2)		
Family-Couple Psychotherapy	Physician	122 (59.2)	55 (26.7)	15 (7.3)	7 (3.4)	5 (2.4)	2 (1.0)	40.397	<0.001**
	Psychologist	156 (69.6)	16 (7.1)	13 (5.8)	11 (4.9)	10 (4.5)	18 (8.0)		
Sexual Psychotherapy	Physician	77 (37.4)	63 (30.6)	24 (11.7)	16 (7.8)	16 (7.8)	10 (4.9)	101.461	<0.001**
	Psychologist	185 (82.6)	15 (6.7)	15 (6.7)	8 (3.6)	1 (0.4)	0		
Group Psychotherapy	Physician	126 (61.2)	33 (16.0)	22 (10.7)	12 (5.8)	7 (3.4)	6 (2.9)	10.270	0.068
	Psychologist	163 (72.8)	29 (12.9)	16 (7.1)	6 (2.7)	2 (0.9)	8 (3.6)		
Supporting Psychotherapy	Physician	134 (65.0)	35 (17.0)	7 (3.4)	14 (6.8)	7 (3.4)	9 (4.4)	26.774	<0.001**
	Psychologist	188 (83.9)	24 (10.7)	5 (2.2)	3 (1.3)	0	4 (1.8)		

included in the study. The mean age of the participants was 32.19 ± 9.11 years. 278 (64.7%) of the volunteers were female and 152 (35.3%) were male. When comparing the data between physicians and psychologists, there was a statistical difference between age, gender, duration of work, and place of work (p values; ≤ 0.001 , ≤ 0.001 , ≤ 0.001 and ≤ 0.001 , respectively). On the other hand, when we look at how the participants define the educational tendencies of the institutions they receive training, 172 (40%) of the institutions are biologically oriented, 96 (psychodynamic-analytical) and 272 are cognitive behavioral therapy oriented. In the comparison between the two groups, physicians defined their institutions as biologically oriented statistically more than psychologists ($p \leq 0.001$). Psychologists, on the other hand, received training from institutions that they defined as statistically more cognitive behavioral tendency than physicians ($p \leq 0.001$). There was no statistically significant difference between the two groups' orientation definitions in educational institutions in terms of psychodynamic-analyticals. ($p = 0.641$)

When the theoretical and practical tendencies of the participants were examined, there was a statistically significant difference between the two groups in biological,

cognitive behavioral, couple-family and EMDR tendencies ($p < 0.05$). There was no difference between eclectic and psychodynamic-analytical ($p > 0.05$).

The therapy training received by the participants is presented in Table 2. When the two groups were compared, it was found that physicians received statistically higher rates of cognitive behavioral therapy, psychodynamic therapy, sexual therapy, group therapy and supportive therapy compared to psychologists ($p < 0.01$), while psychologists received more training in EMDR and family-couple therapy than physicians ($p < 0.01$).

The presentation of the participants' trust in the types of psychotherapy is presented in Table 3. Accordingly, the psychotherapy school that the participants trusted the most was CBT (4.58 ± 1.11), while the psychotherapy school they trusted the least was hypnosis (2.63 ± 1.31). In the comparison of the two groups, it was found that physicians had higher confidence in CBT, Sexual Therapy and Supportive Therapy than psychologists. ($p < 0.05$) Psychologists have higher confidence in psychoanalysis, EMDR, family-couple and hypnosis than physicians. ($p < 0.05$)

Table 3: Participants' confidence in types of psychotherapy and comparison between the two groups

Types of Psychotherapy	Total mean±SD	Physician in the area of Mental Health mean±SD	Psychologist in the area of Mental Health mean±SD	t value	p
Cognitive Behavioral Therapy	4.58±1.11	4.78±0.88	4.40±1.27	3.560	^a ≤0.001**
Psychoanalysis	3.28±1.36	3.09±1.33	3.46±1.36	-2.874	^a 0.004**
Psychodynamic Psychotherapy	3.80±1.29	3.70±1.28	3.90±1.29	-1.607	^a 0.109
EMDR	3.91±1.29	3.57±1.21	4.22±1.29	-5.350	^a ≤0.001**
Family-Couple Psychotherapy	4.26±0.99	4.13±0.91	4.37±1.05	-2.593	^a 0.01**
Sexual Psychotherapy	4.46±0.99	4.63±0.87	4.31±1.06	3.406	^a 0.001**
Group Psychotherapy	4.12±1.02	4.11±0.96	4.14±1.08	-0.304	^a 0.761
Supporting Psychotherapy	4.08±1.08	4.20±1.06	3.97±1.08	2.234	^a 0.026*
Solution Focused Therapy	3.82±1.13	3.78±1.08	3.87±1.17	-0.793	^a 0.428
Hypnosis	2.63±1.31	2.46±1.20	2.77±1.39	-2.451	^a 0.015*

^a Student t testi

Table 4: Relationship between the amount of psychotherapy education and trust in that method

		Trust Level	
		Correlation coefficient value	P value
Education Level	Cognitive Behavioral Therapy	0.348	<0.001
	Sexual Therapy	0.233	<0.001
	Psychodynamic Psychotherapy	0.470	<0.001
	Psychoanalysis	0.292	<0.001
	EMDR	0.377	<0.001
	Couple-Family Therapy	0.207	<0.001
	Supportive Psychotherapy	0.214	<0.001
	Group Psychotherapy	0.155	<0.001

The relationship between the duration of psychotherapy training and trust is presented in Table 4. Accordingly, the longer the duration of the relevant psychotherapy training, the greater the confidence in the method ($p < 0.001$).

DISCUSSION

Sense of trust is important for both psychotherapists and clients. It can be thought that the sense of trust will increase the benefit seen from the method and the comfort of the practitioner. Psychotherapy may be recommended to the person for whom psychotherapy is indicated, by a trained therapist who has completed the therapy training and supervision, from a school whose effectiveness has been demonstrated for the current diagnosis. The positive qualities in terms of competence for the therapy practitioners are defined as being in practice, having the opportunity to work directly with patients, receiving training

with control mechanisms and the therapist's own experience of therapy (Orlinsky, Botermans, & Rønnestad, 2001). It is thought that the therapist's experience in clinical psychotherapy and the belief in the effectiveness of the therapy method therapist applied may have a positive role in the course of the psychotherapy process. It can be thought that the therapeutic alliance of mental health professionals and their clients who receive effective therapy training for an appropriate diagnosis is better and can provide the recommended effective treatment by adhering to the school.

With this study, professionals working in the area of mental health were asked to define the dominant psychotherapy schools in the institutions where they were trained. It has been observed that both psychologists and psychiatrists vary in terms of the therapy schools in their institutions and the therapy training they have attended individually. One of the most striking findings in our study

is that there are differences between physicians and psychologists working in the area of mental health in terms of the duration of psychotherapy training and the trust in therapy schools. In addition, it is striking that as the duration of education increases, the trust in the type of psychotherapy that is trained increases. However, it was found that the practitioners reported that they trust CBT, Sexual Therapy, Family-couple therapy the most, and the least to hypnosis, psychoanalysis and psychodynamic psychotherapy. We consider that our study will lead new studies on trust in psychotherapy and psychotherapy education, since psychotherapy orientations and mental health professionals from different professions' views on various therapy schools have been investigated for the first time.

It seems understandable that CBT, which is defined as the gold standard in the guidelines for many diseases today, is the most trusted therapy school for all mental health professionals (Arch et al., 2012; David, Cristea, & Hofmann, 2018; Leichsenring & Steinert, 2017). Despite this, it is interesting that hypnosis, which is less included in the guidelines today, is reported as the least trusted school in our study, although various studies have shown that hypnosis and hypno-CBT are safe for certain diseases and were very popular in the early years of the discovery of psychotherapy (Ginandes, 2005; Taylor, 2010). An important difference was that psychiatrists had greater confidence in CBT, sexual therapy, and supportive therapy. Another important difference between the two groups was the higher confidence of psychologists in psychoanalysis, EMDR, Family, couple and hypnosis compared to psychiatrists. The significant difference in trust levels between the two groups with EMDR and family-couple therapy may be related to the distribution of education from different schools of the two groups with physician and psychology backgrounds. Psychology-based mental health professionals who are trained in family-couple therapy with EMDR may therefore rely more on these schools. The fact that physicians rely more on supportive psychotherapy, sexual therapy and CBT therapy, which are more suitable for application in outpatient clinic conditions (duration, etc.), may be related to these practice conditions. In other words, for both disciplines, the service provision-application conditions (duration, economic gain) may also determine the orientations they receive in relation to this and the orientations they trust. In addition, when we consider our findings as a whole, a positive relationship was found between the duration of education received and trust. Therefore, practitioners' less trust in various schools of psychotherapy may be related to less training.

It is noteworthy that although physician-based mental health professionals have received more training in CBT, dynamic therapy, group therapy and supportive therapy than psychology-based professionals, psychology-based mental health professionals have attended more EMDR and Family Couple Therapy trainings. Indeed, when looking at the certified therapists of the EMDR association, it is seen that there are few physician-based professionals (EMDR Derneği, 2021). The titles of the long-term training organized by the Psychiatric Association of Turkey is located CIS Therapy and Supportive education are analyzed and these schools are also widely used among psychiatrists (Türkiye Psikiyatri Derneği, 2021). The training required to become a practitioner in these therapy schools is several years. Unlike physicians, it is thought that one of the reasons why psychology graduates, who have to look for a job when they graduate and have less job opportunities than physicians, turn to EMDR training may be due to the fact that EMDR training provides practitioner certification in a shorter time compared to other therapy trainings. This difference in family-couple therapy is thought to be related to the psychiatry service providing services with 5–15 minutes of examination and interview times, which are mostly structured according to individual treatment in hospitals. It is thought that it may be less preferred since physicians cannot be applied in outpatient clinic service periods of 5–15 minutes. At the same time, it is thought that psychiatrists gain experience faster due to their specialization in the use of psychopharmacological agents and their access to patients compared to psychology graduates. As physicians of psychiatrists have more knowledge about medical conditions that may cause physiology and psychopathology than psychology graduates, it is thought that they can approach the patient more in a holistic way as biopsychosocial. Considering all these reasons, it is thought that some of the reasons why both groups head towards different therapy schools can be revealed.

In addition, in our study, it was observed that the number of women was statistically higher than the number of men in both groups. The difference between the ratio of women and men is thought to be due to the fact that 66% of the physicians who gained psychiatry specialization in 2018 were women, and similar for psychology education, according to OSYM data (ÖSYM, 2021).

It is thought that the fact that psychiatry is a specialty training received after the biological medical education and that it is different from the social sciences

with psychology origin may have been effective for physician-based mental health service providers to identify themselves with biological origin. Despite this, the fact that 25% of physician-based mental health service providers still did not define their institutions as biological origin stands out as an important finding. While there is no statistically significant difference between psychology and physician-based institutions that define dynamic origin, we can consider that the fact that physicians define significantly more biological origin and psychologists significantly more CBT origin is associated with the decrease in popularity of dynamic psychotherapies compared to the past (Yakeley, 2018). It is thought that both psychologists and psychiatrists have started to make a decision by considering empirical studies in their therapy school preferences. In the comparison of the participants' own inclinations, the lack of significant difference between those who define it as dynamic and eclectic may again be due to a similar reason. The fact that physicians marked more biological orientation when determining their own orientation may be due to the reasons we've mentioned above. Nevertheless, in our form that allows more than one marking, it is seen that psychologists are statistically significantly more defined as CBT origin, couple family therapy origin, or EMDR origin. According to the same literature, this difference in the sense of trust levels of the two groups who used treatment is interesting. It is thought that the fact that physicians have a drug option in addition to psychotherapy and come from a biological-based education, that psychologists have less biological emphasis in their education and only psychotherapy option as a treatment option may play a role in this situation.

The results of our study should be considered within some limitations. First of all, our data are susceptible to manipulation since they are based on the subjective thoughts of physicians and psychologists. In addition, the fact that our data is collected through online forms may increase the number of participants and the number of institutions, but it can be thought that it may affect our data. In addition, it is certain that psychotherapy trainings are taken from different units, making it difficult to compare. Finally, it is thought that the use of a known and valid and reliable scale during the examination of the sense of trust level in psychotherapy may increase the value of our data. However, the fact that there is a separate confidence rating for each type of therapy made us think that it would be very difficult.

CONCLUSION

Psychotherapies are considered to be an indispensable treatment method in the treatment of psychiatric disorders. It is thought that the application of an effective and safe method with an appropriate diagnosis by an experienced psychotherapist will maximize the benefit from the therapy. The present study showed that although both physicians and psychologists define themselves as practitioners, there are deficiencies in psychotherapy training and such deficiencies reduce their level of confidence in unknown therapy approach. In addition, it is thought that new data may emerge in addition to the data found in studies investigating the causes of distrust towards psychotherapies. It is thought that education institutions supervised by professional associations will provide psychotherapy training in accordance with the criteria standardized by these professional associations, in terms of the implementation of effective psychotherapy to patients.

Ethics Committee Approval: The study was approved by the Clinical Research Ethics Committee of Marmara University Faculty of Medicine (date and number of approval: 01.02.2019/09.2019.130).

Informed Consent: Informed consent was obtained from all individual participants included in the study.

Peer-review: Externally peer-reviewed.

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