DOI: 10.14744/DAJPNS.2023.00220
Dusunen Adam J Psychiatr Neurol Sci
2023;36:168-178

RESEARCH ARTICLE

Professional interests of psychiatrists in Turkiye: Are they consistent with clinical practice and self-efficacy?

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ABSTRACT

Objective: Psychiatrists acquire general professional competencies during their residency training and continue their education in areas of interest thereafter. This study aimed to create a profile of the mental disorders that psychiatrists prefer to engage with and explore in their clinical practice, as well as the treatment methods they employ. Furthermore, the study evaluated the impact of aligning clinical practice with areas of interest on self-efficacy.

Method: Participants were recruited through an online questionnaire designed using Google Forms. The study included a total of 218 psychiatrists who completed the sociodemographic data form, evaluation form, and the General Self-Efficacy Scale.

Results: Psychiatrists in Turkiye showed the greatest affinity for treating patients with bipolar disorder, while showing the least interest in paraphilic disorder. The most frequently examined patients in their clinical practice were those diagnosed with anxiety disorders, and the prevailing treatment method applied was psychopharmacological intervention. A positive correlation was observed between the frequency of examining mental disorders of interest and self-efficacy levels.

Conclusion: Understanding the professional inclinations of psychiatrists is vital for designing effective residency and post-residency training programs. This study, for the first time, examines the professional interests of psychiatrists and their connection to self-efficacy within the context of medical specialties.

Keywords: Psychiatry, residency, training, specialist, self-efficacy, professional inclinations

INTRODUCTION

Psychiatry stands apart from many other medical specialties due to its intricate understanding of complex human behavior, diagnostic methodologies, and the selection of appropriate treatment modalities. Effectively navigating clinical care, supervision and governance, formal/informal mentoring, and peer review are essential for proficient practice (1,2). During their residency training, psychiatrists acquire fundamental professional competencies and further cultivate their expertise by pursuing post-residency education tailored to their interests. Research conducted on psychiatrists in the Netherlands and Belgium indicated that specialization becomes nearly inevitable after formal education (3). Various studies on psychiatrists have explored diverse aspects of the profession, highlighting the challenges faced, levels of burnout, and associated risk factors (1,4,5).

How to cite this article: Civan Kahve A, Asut G, Cakmak IB, Can KC, Kaya H, Goka E. Professional interests of psychiatrists in Turkiye: Are they consistent with clinical practice and self-efficacy? Dusunen Adam J Psychiatr Neurol Sci 2023;36:168-178.

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Received: March 22, 2023; **Revised:** July 12, 2023; **Accepted:** August 26, 2023

According to social cognitive theory, self-efficacy pertains to an individual's perception of how to execute predetermined tasks, organize necessary actions, and manage potential challenges throughout the process (6). This concept reflects a person's belief in their own capabilities (7) and correlates with vital attributes such as self-esteem, conscientiousness, goal setting, and goal commitment (8). Strong self-efficacy fosters well-being, personal growth, and versatility in skills. Individuals with high self-efficacy hold their personal goals in higher regard than externally imposed objectives (9). In the face of obstacles and setbacks, they swiftly rebound and persist in their pursuits, facing challenges with determination and resilience (10). A study involving 122 prospective teachers revealed that low self-efficacy in their profession contributed to decreases productivity in learning and teaching (11). Similarly, a study evaluating 224 intensive care nurses demonstrated a positive correlation between self-esteem and subjective well-being, with higher self-esteem yielding greater subjective well-being (12).

In today's world, where discussions surrounding healthcare practices are on the rise, issues regarding physicians' personal rights and working conditions remain pertinent. The inability to deliver residency education in practice according to established core training curricula, coupled with the prevailing approach of current healthcare policies focusing solely on the quantitative aspects of health services rather than considering qualitative factors, exacerbates the scope of the issues. Physicians' working conditions are predominantly shaped by the characteristics of the institutions they work in, rather than being influenced by their own interests and professional skills (13). Existing literature contains numerous studies that delve into the relationship between physicians' self-efficacy levels and their sociodemographic attributes, working conditions, experiences of workplace violence, levels of psychological resilience, occupational stress, and job satisfaction (14–17).

So, how do these circumstances play out for psychiatrists? What is the impact of working conditions on their overall self-efficacy? Which mental disorders do psychiatrists prefer to handle, and how frequently do they interact with patients diagnosed with these conditions in Turkiye? What treatment methods are commonly utilized in their clinical practice?

This study aims to construct a comprehensive profile of the mental disorders that psychiatrists in Turkiye prefer to treat within their clinical practice, along with the treatment methods they predominantly employ. Furthermore, the study aims to scrutinize the connection between psychiatrists' self-efficacy levels and their working conditions, clinical practices, and the frequency of their involvement in specific disorders of interest.

METHOD

This study adheres to the principles outlined in the Declaration of Helsinki and received approval from the University of Health Sciences Ankara City Hospital Clinical Research Ethics Committee (IRB Approval Date: 31.03.2021; Number: E1-21-1697). It adopts a cross-sectional design and encompasses psychiatry professionals (residents or specialists) residing in Turkiye. Utilizing the snowball sampling technique, individuals were initially contacted through an online questionnaire created using Google Forms. The questionnaire was subsequently distributed via email and instant messaging platforms (WhatsApp, Telegram, Google and Yahoo groups) between April 15 and June 15, 2022. The study reached out to psychiatrists working in university hospitals, training/research hospitals in Turkiye, and those in academic positions. These individuals were encouraged to share the questionnaire with their respective clinical settings. Additionally, the survey was disseminated among psychiatrists associated with professional organizations, further broadening its reach. All responses were anonymous, with no identifiable information collected from participants. A total of 3,400 individuals were provided with a brief information letter containing describing the study (Email groups: n=1800, WhatsApp and Telegram groups: n=1600). Of the respondents, 248 individuals engaged with the questionnaire. However, 23 individuals declined to participate, and the responses of seven participants were deemed invalid, resulting in their exclusion from the study. Ultimately, the study included responses from 218 individuals who completed the questionnaire (Fig. 1).

The initial part of the questionnaire provided an overview of the study. Participants were required to give informed consent before proceeding with the online questionnaire. This consent was indicated by ticking the "Yes, I agree and hereby give my informed consent" box on the online form, while the "No thanks, I do not give my consent" box was available for those declining to participate. Each participant was granted the opportunity to complete the survey once. Following the acquisition of informed consent, participants completed the sociodemographic data form, evaluation form, and General Self-Efficacy Scale (GSE).

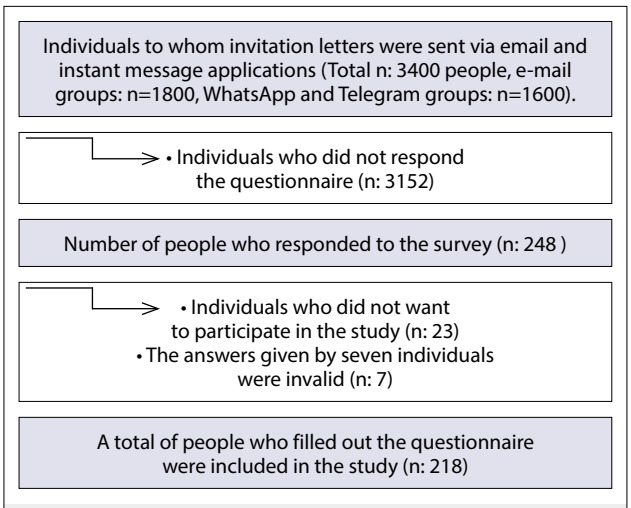

Figure 1. Flowchart of the patients' inclusion process.

Measurement Tools

Sociodemographic Data Form

This form comprises 25 questions, collecting information such as age, gender, educational status, weekly working hours, and shift hours.

Evaluation Form

The self-report form's initial section contains questions aimed at identifying the mental disorders and treatment methods that participants primarily find intriguing. The first question lists mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), while the second question outlines potential treatment options applicable to these disorders. In this section, participants indicate the mental disorders/treatment options they are interested in handling. In the second part, the initial question inquiries about the frequency of their interactions with patients/clients diagnosed with these mental disorders, while the second question assesses how frequently they employ the listed treatment methods in their clinical practice. The second part employs a five-point Likert scale, ranging from 1 (never) to 5 (always), for evaluating both the daily number of patient examinations and the application of treatment methods.

General Self-Efficacy Scale

This self-evaluation scale employs a five-point Likert-type system and consists of 17 questions, rated from 1 (Not at all) to 5 (Very well). The scale encompasses three sub-dimensions: initiative (GSE-I), effort (GSE-E), and persistence (GSE-P). The total scores on the scale can range between 17 and 85, with higher scores indicating stronger self-efficacy. The Turkish version of the scale demonstrates a robust internal consistency coefficient of 0.8 (7).

Statistical Analysis

Statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) for Windows version 22.0. The Kolmogorov-Smirnov test assessed variable normal distribution, while Levene's test evaluated variance homogeneity. Descriptive statistics were presented as mean±standard deviation or as median (minimum–maximum) for continuous numerical variables. For categorical variables, the number of cases was indicated as (n) and (%). The Mann-Whitney U test was used to compare two independent groups, while the Kruskal-Wallis test examined more than two independent groups for the variables with non-normal distributions. Spearman's ordinal number correlation test investigated the correlation between the frequency of examining preferred mental disorders among psychiatrists and their GSE scores. A significance level of $p<0.05$ was adopted.

RESULTS

A total of 218 participants took part in the study, with 33.5% male and 66.5% female, and an average age of 35.34±7.86 years. Among the participants, 28.9% were residents, 55.5% were specialists, 6.9% were lecturers, 4.1% were associate professors, and 4.6% were professors. To stay updated professionally, 76.1% (n=166) of psychiatrists utilized textbooks/journals, 75.2% (n=164) attended online training, and 67.4% (n=147) participated in congresses/symposiums. A minority of psychiatrists, 3.7% (n=8), reported no efforts in this regard.

Regarding the mental disorders that participants were inclined to engage with in clinical practice, bipolar and related disorders (59.2%) were the most common interests, followed by anxiety disorders (57.8%) and depressive disorders (52.8%). On the other hand, paraphilic disorders (4.1%) garnered the least attention compared to other psychiatric disorders. Among preferred treatment methods, psychopharmacological interventions (84%) ranked first, followed by dynamically oriented/psychoanalytic psychotherapies (60.6%) and cognitive behavioral therapies (59.2%). A summary of the mental disorders and treatment preferences of Turkish psychiatrists is provided in Table 1.

Table 1: Mental disorders and preferred treatment options among psychiatrists in Turkiye

Mental disorders preferred to deal with	n	%
Bipolar and related disorders	129	59.2
Anxiety disorders (social phobia, panic disorder, generalized anxiety disorder)	126	57.8
Depressive disorders	115	52.8
Schizophrenia spectrum disorders and other psychotic disorders	98	45.0
Obsessive-compulsive and related disorders (OCD, body dysmorphic disorder, hoarding disorder, trichotillomania, skin picking disorder)	83	38.1
Sexual dysfunctions	75	34.4
Post-traumatic stress disorder/acute stress disorder	68	31.2
Attention deficit hyperactivity disorder	58	26.6
Consultation – liaison psychiatry	49	22.5
Neurocognitive disorders	46	21.1
Sleep - wake disorders	40	18.3
Eating disorders	38	17.4
Geropsychiatry	38	17.4
Forensic psychiatry	38	17.4
Dissociative disorders	34	15.6
Alcohol and substance use disorders	30	13.8
Somatic symptoms and associated disorders (somatic symptom disorder, illness anxiety disorder, conversion disorder, factitious disorder)	29	13.3
Behavioral addictions (internet addiction, game addiction, etc.)	19	8.7
Autism spectrum disorder or specific learning disability	16	7.3
Paraphilic disorders	9	4.1
Preferred treatment options		
Psychopharmacological treatment	185	84.9
Dynamically oriented/psychoanalytic psychotherapies	132	60.6
Cognitive behavioral therapies	129	59.2
Sex therapy	82	37.6
Other(s)	69	31.7
Family and couple therapy	33	15.1
Interpersonal psychotherapy	30	13.8

n: Number of people; %: Percentage.

When examining the frequencies of patient examinations based on specific mental disorders, the prevalence of anxiety disorders was found to be 60.1%, followed by depressive disorders (53.7%), and schizophrenia spectrum disorders (39.4%). The frequencies of mental disorders evaluated by psychiatrists in Turkiye and the treatment options they prefer to utilize are outlined in Table 2.

In evaluating psychiatrists' GSE scores, those who consciously chose psychiatry as a career plan demonstrated statistically significantly higher self-efficacy compared to those who unintentionally entered the field (p=0.01, Z=-2.46). In terms of current professional titles, specialists had lower self-efficacy levels compared to professors and lecturers (p=0.02, H=11.805). Participating in regular exercise was associated with significantly higher self-efficacy compared to non-participants (p=0.01, Z=-2.60). Self-efficacy did not exhibit significant variations according to the duration of psychiatrists' professional experience (H=0.36, p=0.84). An overview of GSE scores distributed across participants' sociodemographic characteristics is presented in Table 3.

A statistically significant negative correlation was identified between the mean number of shifts in a month and the total GSE score of psychiatrists (r=-0.269, p<0.05).

Table 2: Frequency of examination of mental disorders and application of treatments in clinical practice

Mental disorders	Never (%)	Rarely (%)	Sometimes (%)	Often (%)	Always (%)
Anxiety disorders (social phobia, panic disorder, generalized anxiety disorder)	0.5	0.0	5.5	33.9	60.1
Depressive disorders	0.9	0.5	6.4	38.5	53.7
Schizophrenia spectrum disorders and other psychotic disorders	0.5	8.7	18.3	33.0	39.4
Bipolar and related disorders	0.5	6.4	18.3	38.5	36.2
Obsessive-compulsive and related disorders (OCD, body dysmorphic disorder, hoarding disorder, trichotillomania, skin picking disorder)	0.9	5.0	24.8	43.6	25.7
Paraphilic disorders	6.0	14.2	22.5	39.0	18.3
Forensic psychiatry	15.1	15.6	24.3	27.1	17.9
Somatic symptoms and associated disorders (somatic symptom disorder, illness anxiety disorder, conversion disorder, factitious disorder)	1.4	20.6	32.6	30.3	15.1
Consultation – liaison psychiatry	11.0	16.1	33.0	28.4	11.5
Behavioral addictions (internet addiction, game addiction, etc.)	7.8	28.4	35.8	19.7	8.3
Alcohol and substance use disorders	12.4	32.1	31.2	16.1	8.3
Dissociative disorders	6.9	29.8	38.5	18.3	6.4
Autism spectrum disorder or specific learning disability	6.9	36.7	32.1	17.9	6.4
Attention deficit hyperactivity disorder	6.9	36.7	32.1	17.9	6.4
Post-traumatic stress disorder/acute stress disorder	2.3	26.6	47.7	18.3	5.0
Sleep - wake disorders	12.4	42.2	30.3	10.1	5.0
Eating disorders	10.1	58.3	22.5	5.5	3.7
Geropsychiatry	32.1	48.2	12.8	4.1	2.8
Neurocognitive disorders	23.4	49.1	18.8	6.9	1.8
Sexual dysfunctions	67.0	27.1	3.2	2.8	0.0
Treatment options					
Psychopharmacological treatment	0.0	1.4	2.8	35.8	60.1
Cognitive behavioral therapies	9.6	28.0	39.0	19.7	3.7
Dynamically oriented/psychoanalytic psychotherapies	33.0	25.7	27.5	11.0	2.8
Sex therapy	41.3	25.2	22.5	9.2	1.8
Interpersonal psychotherapy	74.8	13.3	5.0	6.0	0.9
Other(s)	80.3	6.4	7.8	4.1	1.4
Family and couple therapy	67.0	17.9	10.1	5.0	0.0

%: Percentage.

Among psychiatrists interested in schizophrenia spectrum disorders and other psychotic disorders, a statistically significant positive correlation was observed between the frequency of patient examinations in this area and their self-efficacy levels (n=98) (r=0.235, p=0.02).

A statistically significant positive correlation emerged between the frequency of examining patients within the obsessive-compulsive and related disorders (Obsessive-Compulsive Disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania, skin picking disorder) domain and self-efficacy levels (n=83). (r=0.236, p=0.03).

Furthermore, a statistically significant positive correlation was noted between the frequency of examining patients with post-traumatic stress disorder/acute stress disorder and self-efficacy levels among those interested in this area (n=68) (r=0.301, p=0.01).The correlation between the frequency of examining preferred mental disorders by psychiatrists and their GSE scores for all mental disorders are detailed in Table 4.

Regarding treatment methods, there was no statistically significant relationship found between the frequency of employing the preferred treatment

Table 3: Distribution of general self-efficacy (GSE) scores by sociodemographic characteristics of participants

	n (%)	GSE Mean (min–max)	p
Gender (n,%)			Z:1.14, p:0.25
Male	73 (33.5)	62.0, (30-82)	
Female	145 (66.5)	65.0, (34-83)	
Marital status (n,%)			Z:0.76, p:0.45
Single	65 (29.8)	60.0, (34-83)	
Married	153 (70.2)	63.0, (30-80)	
Have a child			Z:-0.16, p:0.87
Yes	110 (50.5)	63.0, (30-80)	
No	108 (49.5)	62.0, (34-83)	
Household status			H:2.23, p:0.33
With family member(s)	168 (77.1)	63.0, (30-80)	
With friend(s)	6 (2.8)	54.5 (48-77)	
Single	44 (20.2)	64.5, (35-83)	
Current professional title			H:11.805, p:**0.02***
Resident	63 (28.9)	64.0, (34-82)	
Specialist	121 (55.5)	61.0, (30-77)	(Specialist<Lecturer) (Specialist<Professor)
Lecturer	15 (6.9)	64.0, (57-77)	
Associate professor	9 (4.1)	67.0, (57-83)	
Professor	10 (4.6)	68.0, (53-80)	
Was psychiatry a career choice?			Z:-2.46, p:**0.01***
Yes	176 (80.7)	64.0, (34-83)	
No	42 (19.3)	60.0, (30-75)	
Institution			H:13.99, p:**0.01***
State/public hospital	47 (21.6)	61.0, (30-77)	
Training and research hospital	82 (37.6)	61.0, (33-80)	(University Hospital > State Hospital) (University Hospital > Education and Research Hospital)
University hospital	60 (27.5)	66.0, (46-83)	
Private hospital	15 (6.9)	60.0, (39-75)	
Office	14 (6.4)	65.0, (52-78)	
Number of patients examined/per day			H:10.43, p:**0.03***
<10	47 (21.6)	62.0, (39-83)	
10-20	45 (20.6)	66.0, (37-80)	(31-40 < 10-20) 21-30 < 10-20)
21-30	55 (25.2)	60.0, (33-82)	
31-40	45 (20.6)	61.0, (30-80)	
>41	26 (11.9)	67.5, (41-76)	
Duration of patient interview, minutes			H:17.85, p<**0.05***,+
<10	68 (31.2)	60.0, (33-80)	
10-20	88 (40.4)	61.0, (30-79)	
21-30	24 (11.0)	68.0, (39-82)	
>31	38 (17.4)	67.0, (42-83)	
Duration in profession, years			H:0.36, p:0.84
<5	64 (29.4)	62.0, (34-82)	
5-10	83 (38.1)	62.0, (33-80)	
>11	71 (32.6)	63.0, (30-83)	

Table 3 (cont.): Distribution of general self-efficacy (GSE) scores by sociodemographic characteristics of participants

	n (%)	GSE Mean (min–max)	p
Sleep time, hours			H:10.16, p<**0.05***
<6	25 (11.5)	70.0, (51-83)	(Less than 6 Hours>6-8 hours> 9 Hours or More)
6-8	180 (82.6)	63.0, (33-80)	
>9	13 (6.0)	53.0, (30-70)	
Regular exercise			Z:-2.60, p:**0.01***
Yes	70 (32.1)	65.5, (34-83)	
No	148 (67.9)	61.0, (30-80)	
Scientific meetings attended/in a year			H:4.94, p:0.17
None	28 (12.8)	61.0, (30-77)	
1	71 (32.6)	61.0, (33-78)	
2	83 (38.1)	63.0, (39-82)	
3 and more	36 (16.5)	66.0, (34-83)	
History of mental disorder			Z:-3.21, p<**0.05***
Yes	77 (35.3)	61.0, (33-73)	
No	141 (64.7)	64.0, (30-83)	
Current mental disorder			Z:-2.56, p:**0.01***
Yes	30 (13.8)	57.0, (33-71)	
No	188 (86.2)	63.0, (30-83)	
Use of psychotropics			Z:-2.30, p:**0.02***
Yes	46 (21.1)	57.5, (35-74)	
No	172 (78.9)	63.0, (30-83)	
Family history of mental disorder			Z:-1.90, p:0.06
Yes	115 (52.8)	62.0, (33-82)	
No	103 (47.2)	64.0, (30-83)	
Smoking			Z:0.83, p:0.41
Yes	48 (22.0)	60.0, (30-83)	
No	170 (78.0)	63.0, (33-82)	
Alcohol/substance use disorder			Z:0.89, p:0.37
Yes	13 (6.0)	60.0, (35-76)	
No	205 (94.0)	63.0, (30-83)	
GSE Scores (n: 218)			
Initiation		35.0 (17-45)	
Effort		17.0 (8-24)	
Persistence		10.0 (3-15)	
Total		63.0 (30-83)	

*: p<0.05, statistically significant; n: number of people; %: percentage; +: The difference is between under 10 minutes and 30 minutes and more, under 10 minutes and 21-30 minutes 11-20 minutes and 21-30 minutes.

method and self-efficacy (r=0.167, p=0.06) among those favoring dynamically oriented/psychoanalytic psychotherapies (n=132). However, a statistically significant positive correlation emerged between GSE-E scores and the frequency of employing the preferred treatment method (r=0.206, p=0.02).

Analyzing the connection between preferred treatment methods and self-efficacy levels revealed that the total self-efficacy score demonstrated a consistent distribution across the treatment methods favored by physicians (χ^2=11.544; p=0.073). This pattern extended to the sub-components of self-

Table 4: Correlation between frequency of examining preferred mental disorders and gse scores for all mental disorders

Mental disorders	r	p
Schizophrenia spectrum disorders and other psychotic disorders	0.187	0.07
Bipolar and related disorders	0.109	0.22
Depressive disorders	0.137	0.14
Anxiety disorders (social phobia, panic disorder, generalized anxiety disorder)	0.079	0.38
Obsessive-compulsive and related disorders (OCD, body dysmorphic disorder, hoarding disorder, trichotillomania, skin picking disorder)	0.236	**0.03***
Post-traumatic stress disorder/acute stress disorder	0.301	**0.01***
Dissociative disorders	0.315	0.07
Somatic symptoms and associated disorders (somatic symptom disorder, illness anxiety disorder, conversion disorder, factitious disorder)	0.402	**0.03***
Eating disorders	0.312	0.06
Autism spectrum disorder or specific learning disability	-0.025	0.93
Attention deficit hyperactivity disorder	0.065	0.63
Sleep - wake disorders	0.332	**0.04***
Sexual dysfunctions	-0.043	0.71
Alcohol and substance use disorders	0.388	**0.03***
Behavioral addictions (internet addiction, game addiction, etc.)	0.128	0.60
Paraphilic disorders	0.323	0.40
Neurocognitive disorders	-0.373	**0.01***
Consultation – liaison psychiatry	-0.172	0.24
Geropsychiatry	-0.188	0.26
Forensic psychiatry	0.103	0.54

*: $p<0.05$, statistically significant.

efficacy: initiation (χ^2=9.670; p=0.139), persistence (χ^2=10.252; p=0.114), and perseverance (χ^2=6.419; p=0.378). Notably, the sub-components of self-efficacy did not display significant differences concerning the various treatment methods favored by physicians.

Among those favoring cognitive-behavioral psychotherapies (n=129), a statistically significant positive correlation emerged between the frequency of employing the preferred treatment method and self-efficacy levels (r=0.238, p=0.01). Furthermore, a moderately strong and statistically significant positive correlation was observed between GSE-E scores and the frequency of employing the preferred treatment method (r=0.318, $p<0.05$).

When comparing the self-efficacy levels of those who attended scientific meetings to maintain their professional knowledge and those who did not, no statistically significant difference was found between the two groups (Z=1.88, p=0.06). Similarly, there was no statistically significant difference those who followed and those who did not follow textbooks/journals to stay updated professionally (Z=1.74, p=0.08).

However, when comparing those who regularly followed the literature to enhance their professional knowledge and those who did not, those who engaged with the literature demonstrated significantly higher self-efficacy scores (Z=6.31, $p<0.05$).

Furthermore, those who reported making no effort to keep their professional knowledge up to date exhibited significantly lower self-efficacy scores compared to those who actively made an effort (Z=-2.35, p=0.02). A similar statistically significant difference was observed for GSE-I and GSE-E scores (Z=-2.278, p=0.02 and Z=-2.01, p= 0.05, respectively).

DISCUSSION

In this study, we investigated the correlation between psychiatrists' sociodemographic characteristics, working conditions, their preferred areas of interest, and their levels of self-efficacy.

Our study revealed no significant relationship between participants' sociodemographic attributes such as gender, marital status, having children, household structure, and their self-efficacy levels.

However, participants with a past or present diagnosis of a mental disorder exhibited lower self-efficacy levels than those without such a diagnosis. Physical and mental well-being significantly contributes to the development of self-efficacy (18). Individuals might construe symptoms like anxiety, stress reactions, and arousal as indications of inadequacy (19). Research indicates a strong link between the presence of a mental disorder and impairment in social and occupational domains (20,21). Mental disorders can erode self-efficacy directly through diminished mental well-being and indirectly through symptoms like reduced attention and cognitive functions, lowered self-esteem and motivation, social withdrawal, and functional decline. Our study's findings corroborate the direct association between self-efficacy and mental well-being. Another finding supporting this relationship is the higher self-efficacy reported by participants engaging in regular exercise. Studies establish a connection between regular exercise and mental well-being, which likely contributes to elevated self-efficacy among these individuals (22,23).

The present study demonstrated that specialists with academic titles (professor, associate professor, lecturer) exhibited higher self-efficacy compared to those without such titles. Although this finding could suggest that individuals with academic titles have accrued more experience in the field, potentially boosting self-efficacy, our study revealed no link between years of professional experience and self-efficacy. Moreover, physicians practicing in private clinics or university hospitals exhibited greater self-efficacy than those working in public hospitals, training institutions, or research hospitals. As far as our knowledge extends, no study has been encountered in the literature that investigates the connection between professional title and self-efficacy. The positive influence of working in private practice or university hospitals on self-efficacy might be attributed to the flexibility these settings afford, allowing psychiatrists to focus on their preferred areas and evaluate patients under optimal conditions.

Our study revealed that psychiatrists who reported examining between 10 and 20 patients per day had higher self-efficacy levels compared to those who examined 21 to 30 and 31 to 40 patients daily. Correspondingly, physicians who reported spending between 21 and 30 minutes or over 30 minutes per patient interview displayed higher self-efficacy than those spending less than 10 minutes or between 10 and 20 minutes. In Turkiye, the daily number of patient examinations and the allocated time per patient consultation are institution-dependent and influenced by academic titles, with institutions determining these parameters according to their own protocols. However, examining a higher number of patients in shorter timeframes could have adverse effects on functioning, leading to burnout symptoms, heightened workload, perceived stress, and potentially a decline in physicians' self-efficacy. Research indicates that physicians experiencing burnout symptoms and occupational stress tend to exhibit decreased self-efficacy (14,16,17).

An intriguing finding in our study is the absence of significant differences in self-efficacy levels between residents and psychiatrists holding specialist and academic positions. In Turkiye, residents undergo practical training in patient evaluation and treatment under academic supervision and responsibility, in accordance with the regulations set by medical specialization boards. This structured training, facilitated by experienced supervisors and shared responsibilities, could be factors positively influencing self-efficacy levels among residents.

Drawing from social cognitive theory, performative experiences constitute one of the four main sources contributing to the development of self-efficacy (18). People often gravitate toward activities they feel competent in, while avoiding those they believe they cannot perform (19). Clement argued for a significant connection between professional interests and self-efficacy, suggesting that this link can serve as a potent predictor of career choices, comparable to the influence of self-efficacy itself (24). In this context, the psychiatrists in our study who devoted more time to examining patients within their areas of interest might have cultivated an enhanced professional experience, potentially shaping their focus, raising self-awareness of their skills, and consequently boosting their self-efficacy. Supporting this notion, a study involving medical students revealed a positive correlation between elevated self-efficacy levels and a stronger aspiration and dedication to a specific specialty (25). Consistent with this, our study demonstrated that individuals who opted for psychiatry as a career plan exhibited higher self-efficacy compared to their counterparts who did not. Interestingly, an inverse correlation was detected between the frequency of examination within the area of interest and self-efficacy among participants specializing in neurocognitive disorders. Given the heightened demand for multidisciplinary treatments in neurocognitive disorders, along with their intricate and challenging nature, these factors could potentially exert a negative influence on the self-efficacy of psychiatrists interested in this field.

An association has been demonstrated between maintaining updated professional knowledge by following the literature and having high self-efficacy. Bandura asserts that basic knowledge and skills alone are insufficient for effective human functionality; self-efficacy is also crucial for optimal functionality. He highlights the interdependence of self-efficacy and the process of acquiring knowledge and skills, asserting that they develop in tandem (26,27). Given the exponential growth of medical knowledge, it can be argued that staying current with contemporary professional knowledge is intrinsically linked to sound medical practices and self-efficacy (28). Previous studies indicate that short-term, focused training programs aimed at enhancing professional knowledge and skills lead to improved self-efficacy among physicians (29–31).

Our study should be taken into account with certain limitations. It represents the first attempt to create professional profiles of psychiatrists in Turkiye. However, it's important to note that reaching participants through platforms like mail groups, WhatsApp, and Telegram might limit the representation of all psychiatrists and the generalization of our findings. The relatively small sample size could also be considered a limitation, as well as the smaller number of participants within subgroups, potentially affecting the statistical evaluation's power. Future research could address these limitations by incorporating sample size estimation and involving a broader range of professionals working within the mental health field.

Given that our data was collected online, we were unable to assess certain aspects, such as the duration of mental disorders, their specific diagnoses, and the treatment details of participants with mental health conditions. To gain a better understanding of how these variables impact self-efficacy, future studies could employ face-to-face interviews, diagnostic evaluations, and longitudinal follow-up periods. Objective information about participants' mental health history could be obtained from their medical records. Furthermore, investigating the impact of clinician's proficiency and knowledge level in the psychotherapeutic interventions they prefer to apply in clinical settings could a promising avenue for future research. Finally, given that our study is the first to evaluate the professional interests of psychiatrists and their relevance to self-efficacy, it is believed that it would be appropriate to reconsider much of the data following similar studies conducted in different countries.

CONCLUSION

This is the first research to investigate mental disorders and treatment methods that psychiatrists in Turkiye prefer to engage with, alongside the mental disorders they frequently encounter in clinical practice and the treatment methods they employ, while also assessing their relationship with self-efficacy. The identification of psychiatrists' areas of interest holds significant potential for shaping residency training programs. Encouraging psychiatry residents to actively participate in patient assessment and treatment within specialized areas, such as sexual dysfunctions, could prove valuable. Sustaining clinical practice within fields of interest might also bolster self-efficacy levels. Based on our study's findings, it becomes evident that enhanced focus on specialized psychiatric domains within clinical practice, particularly within residency training, is warranted. This extends beyond conventional outpatient settings, enabling residents to gain prolonged clinical experience within their chosen domains. Moreover, within Turkiye, psychiatrists within academic positions can be motivated to enhance their expertise within specialized domains, thereby expanding the scope of psychiatric services within these areas. The work of psychiatrists in their areas of interest may have a significant correlation with both life satisfaction and job satisfaction. Furthermore, job satisfaction can also exert an influence on self-efficacy. In light of this, future research endeavors could explore the impact of working within one's area of interest on both job satisfaction and self-efficacy.

Contribution Categories		Author Initials
Category 1	Concept/Design	A.C.K., G.A., I.B.C., H.K.
	Literature review	K.C.C., H.K., G.A.
	Data analysis/Interpretation	A.C.K., H.K., I.B.C.
Category 2	Drafting manuscript	A.C.K., G.A., I.B.C., K.C.C.
	Critical revision of manuscript	H.K., E.G.
Category 3	Final approval and accountability	A.C.K., G.A., I.B.C., K.C.C., H.K., E.G.
Other	Supervision	E.G.

Ethical Approval: This study was approved by University of Health Sciences Ankara City Hospital Clinical Research Ethics Committee (IRB Approval Date: 31.03.2021; Number: E1-21-1697).

Informed Consent: Informed consent was obtained from all participants.

Peer-review: Externally peer-reviewed.

Conflict of Interest: The authors declare that they have no conflict of interest.

Financial Disclosure: The authors declare that they have no financial support.

REFERENCES

1. Looi JC, Finlay AJ, Heard DS. Reflections on how to approach early career psychiatrist roles and challenges. Australas Psychiatry 2021; 29:554-557. [CrossRef]
2. Looi JC, Finlay AJ. Why it's worthwhile training as a psychiatrist. Australas Psychiatry 2020; 28:664-666. [CrossRef]
3. Nijs M, Sabbe B. Should the psychiatrist of the future become a multi-specialist or a super-specialist? Tijdschr Psychiatr 2019; 61:159-163. [Dutch]
4. Katschnig H. Are psychiatrists an endangered species? Observations on internal and external challenges to the profession. World Psychiatry 2010; 9:21. [CrossRef]
5. Rotstein S, Hudaib AR, Facey A, Kulkarni J. Psychiatrist burnout: A meta-analysis of Maslach Burnout Inventory means. Australas Psychiatry 2019; 27:249-254. [CrossRef]
6. Bandura A. Self-efficacy mechanism in human agency. Am Psychol 1982; 37:122. [CrossRef]
7. Yildirim F, Ilhan IO. The validity and reliability of the general self-efficacy scale-Turkish form. Turk Psikiyatri Derg 2010; 21:301-308. [Turkish]
8. Judge TA, Erez A, Bono JE. The power of being positive: The relation between positive self-concept and job performance. Hum Perform 1998; 11:167-187. [CrossRef]
9. Scott WD, Dearing E, Reynolds WR, Lindsay JE, Baird GL, Hamill S. Cognitive self-regulation and depression: Examining academic self-efficacy and goal characteristics in youth of a Northern Plains tribe. J Res Adolesc 2008; 18:379-394. [CrossRef]
10. Schunk DH, DiBenedetto MK. Academic self-efficacy. In: Furlong MJ, Gilman R, Huebner ES, editors. Handbook of Positive Psychology in Schools. Second ed., New York: Routledge/Taylor & Francis Group, 2014, 115-130.
11. Sahin Taskin C, Haciomeroglu G. Examining elementary preservice teachers' self-efficacy beliefs: Combination of quantitative and qualitative methods. Inonu Univ J Fac Educ 2010; 11:21-40.
12. Liu H, Zhang X, Chang R, Wang W. A research regarding the relationship among intensive care nurses' self-esteem, job satisfaction and subjective well-being. Int J Nurs Sci 2017; 4:291-295. [CrossRef]
13. Wada K, Arimatsu M, Yoshikawa T, Oda S, Taniguchi H, Higashi T, et al. Factors on working conditions and prolonged fatigue among physicians in Japan. Int Arch Occup Environ Health 2008; 82:59-66. [CrossRef]
14. Yao Y, Wang W, Wang F, Yao W. General self-efficacy and the effect of hospital workplace violence on doctors' stress and job satisfaction in China. Int J Occup Med Environ Health 2014; 27:389-399. [CrossRef]
15. Lee K. Communication problems and solutions at the health care facilities. Korean J Health Commun 2006; 1:33-45.
16. Liu Y, Zhang M, Yang L. The mediating effect of self-efficacy between the perceived stress and work well-being of doctors. Chinese J Behav Med Brain Sci 2017; 26:852-855.
17. Ghosh S, Kaul I. Comparative study of burnout and self-efficacy among male and female doctors of Himachal Pradesh. Int J Pure Appl Sci Technol 2017; 2:160-166.
18. Bandura A. Cultivate self-efficacy for personal and organizational effectiveness. In: Locke EA, editor. Handbook of Principles of Organizational Behavior: Indispensable Knowledge for Evidence-Based Management. Second ed., West Sussex, UK: John Wiley & Sons, Ltd., 2009, 179-200. [CrossRef]
19. Van Dinther M, Dochy F, Segers M. Factors affecting students' self-efficacy in higher education. Educ Res Rev 2011; 6:95-108. [CrossRef]
20. Kupferberg A, Bicks L, Hasler G. Social functioning in major depressive disorder. Neurosci Biobehav Rev 2016; 69:313-332.
21. Rehm J, Shield KD. Global burden of disease and the impact of mental and addictive disorders. Curr Psychiatry Rep 2019; 21:1-7. [CrossRef]
22. Lubans D, Richards J, Hillman C, Faulkner G, Beauchamp M, Nilsson M, et al. Physical activity for cognitive and mental health in youth: A systematic review of mechanisms. Pediatrics 2016; 138: e20161642. [CrossRef]
23. Peluso MA, Guerra de Andrade LH. Physical activity and mental health: The association between exercise and mood. Clinics (Sao Paulo) 2005; 60:61-70. [CrossRef]
24. Clement S. The self-efficacy expectations and occupational preferences of females and males. J Occup Psychol 1987; 60:257-265. [CrossRef]
25. Goodin JB, Duffy RD, Borges NJ, Ulman CA, D'Brot VM, Manuel RS. Medical students with low self-efficacy bolstered by calling to medical speciality. Perspect Med Educ 2014; 3:89-100. [CrossRef]
26. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. Psychol Rev 1977; 84:191-215. [CrossRef]
27. Artino AR. Academic self-efficacy: From educational theory to instructional practice. Perspect Med Educ 2012; 1:76-85.
28. Densen P. Challenges and opportunities facing medical education. Trans Am Clin Climatol Assoc 2011; 122:48-58.
29. Nørgaard B, Ammentorp J, Ohm Kyvik K, Kofoed PE. Communication skills training increases self-efficacy of health care professionals. J Contin Educ Health Prof 2012; 32:90-97.
30. Gulbrandsen P, Jensen BF, Finset A, Blanch-Hartigan D. Long-term effect of communication training on the relationship between physicians' self-efficacy and performance. Patient Educ Couns 2013: 91:180-185. [CrossRef]
31. Ammentorp J, Sabroe S, Kofoed PE, Mainz J. The effect of training in communication skills on medical doctors' and nurses' self-efficacy: A randomized controlled trial. Patient Educ Couns 2007; 66:270-277. [CrossRef]