Professional Self-Efficacy Among Psychotherapists Working with Cancer and Chronic Illness Patients

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Abstract: Background: Professional self-efficacy kind of matters a lot for psychotherapists, it can influ-ence their clinical performance and how effective therapy feels, especially in chronic ill-ness and oncology care. At the same time though, when you look closer, not much research has really been done on professional self-efficacy among psychotherapists who work with people living with long-term illnesses. Objectives This study kind of aimed to look into how high professional self-efficacy levels were, and also how they relate with certain demo-graphic factors, among psychotherapists who work with people that have chronic illness-es. Method: a cross-sectional descriptive, correlational approach was used with 290 psy-chotherapists who work in hospitals, oncology care centres, private clinics and sort of spe-cialized chronic illness environments. Results: We saw a moderate-to-high degree of profes-sional self-efficacy in psychotherapists (M = 68.76 SD = 11.85). In fact, clinical competence (M = 18.94, SD = 3.57) along with communicative effectiveness (M = 14.03, SD = 3.13) turned out to be the top mean scores, like it was pretty clear. When it came to group com-parisons, there were meaningful differences based on age ($p = .012$), educational level ($p = .021$), years of experience ($p = .003$) and workplace setting ($p = .044$). On the other hand, gender didn't show any significant differences ($p > .05$). Structural equation modeling also looked reasonably good in terms of fit: CFI = .94, TLI = .92, RMSEA = .062. The pro-posed framework then accounted for about 57% of the variance in professional self-efficacy ($R^2 = .57$).. Conclusion: Professional experience, educational level, and special-ized clinical settings were associated with higher professional self-efficacy among psy-chotherapists working with individuals with chronic illnesses. The findings support the importance of continuous professional training and clinical development in chronic illness care settings..

Keywords: Professional self-efficacy; psychotherapists; chronic illnesses; oncology care; psychological services; structural equation modeling.

Introduction

Professional self-efficacy has kind of emerged as one of the most influential constructs in contemporary psychological and clinical research, especially when it comes to how we understand the

effectiveness and that general resilience of mental health professionals. It's rooted in Bandura's Social Cognitive Theory, and in this view self-efficacy basically means people's beliefs that they can organize and carry out the necessary actions for handling hard or sticky situations. In psychotherapy settings, those beliefs tend to filter into how therapists think internally, how they manage emotions, how they end up making clinical calls, and also how long they keep going when cases get complicated. A lot of empirical work suggests that higher self-efficacy levels are strongly tied to better therapeutic outcomes, higher clinical competence, and more solid day-to-day professional performance[1-3]. In fact, meta-analytic results often describe a moderate positive link between self-compassion and self-efficacy ($r \approx 0.35$), which kind of implies that internal psychological resources matter a lot when it comes to fortifying professional confidence.

Professional self-efficacy has emerged as a kind of key construct in psychological and clinical research, especially for making sense of how mental health professionals actually function in these pretty complex therapeutic environments. If we follow Bandura's Social Cognitive Theory, self-efficacy is basically the beliefs people have about their capability to organize and carry out the actions that are needed to produce particular outcomes[4] And those beliefs, they do not just sit there quietly. They end up shaping cognitive activities, emotional management, and the overall behavioral performance in professional contexts, in a pretty decisive way. In psychotherapy in particular, higher self-efficacy levels tend to be linked with more confidence in clinical decision making, more suitable coping strategies and also better therapeutic involvement [5-7] So in the end self-efficacy isn't only a personal view. It works as a functional mechanism that steers therapists effectiveness, and their resilience, even when clinical demands get really intense[8]

The value of professional self-efficacy becomes more obvious when you look at therapeutic work with people who live with chronic illnesses. Chronic diseases come with long duration, uneven progress, and heavy psychological and social consequences, and together they generate ongoing obstacles for mental health professionals. Therapists in those situations have to cope with continuing patient distress, recurrent symptom episodes, and those complicated biopsychosocial interactions, no easy one thing to manage. All of this calls for constant emotional investment, plus adaptive coping, and that is where self-efficacy really gets turned up, it helps hold therapeutic effectiveness together over time[3, 9, 10].Also, the empirical work tends to indicate that practitioners with higher self-efficacy are more likely to build stronger therapeutic alliances, and to achieve better treatment outcomes, particularly in long term care contexts[6, 11, 12]

And yeah, this professional self-efficacy thing becomes even more critical in chronic illness contexts, which is honestly a major global health challenge. Chronic diseases—things like cardiovascular disorders, diabetes, and cancer—are responsible for around 70–75% of deaths worldwide, so they remain the main cause of mortality in general. These conditions usually involve long-term progression, ongoing functional limitations, and persistent psychological distress, so they basically demand continuous psychological support. For psychotherapists, that means a prolonged exposure to patient suffering, repeated relapse cycles, a pretty heavy emotional load, and ongoing uncertainty about whether treatment will actually work. Together these features make a therapy environment that is highly demanding, requiring steady emotional involvement and stronger coping strategies, so self-efficacy becomes sort of a central pillar for professional functioning[13-15]

More recently, research also points to an alarming prevalence of occupational burnout among psychotherapists, which again highlights how important psychological resources are in real life practice. Findings suggest something like 52% to 67% of therapists experience burnout symptoms, and nearly 40% report severe burnout each year. Plus, burnout is reported to reduce therapist productivity

by as much as 35%, and it can worsen treatment outcomes by roughly 22%, so there are serious downstream consequences for both clinicians and patients. Other reports back this up too, noting that more than half of mental health professionals experienced burnout within a 12-month window, with emotional exhaustion and reduced professional efficacy being the most dominant experiences. Systematic reviews then add that emotional exhaustion shows up as the most frequently named dimension of burnout among psychologists, suggesting a kind of long-running strain embedded in therapeutic work. Overall, these results support the idea that professional self-efficacy can act like a buffer against burnout and help therapists stay effective[16-19]

From a theoretical point of view, the transactional model of stress and coping kind of offers a broad map for seeing how self-efficacy shapes what therapists do when work stress shows up. In this view, what counts as "stress" isn't only the situation itself, it's more about how people mentally rate (appraise) what the environment is asking of them, and also what they think they can use as coping resources. So therapists who have higher self-efficacy tend to see clinical problems as more workable, and then they shift toward coping styles that feel more useful, like problem focused coping, and also emotional regulation. [5]This also connects with resilience theory, where resilience isn't treated as something fixed, but rather like a moving process, that helps a person keep psychological balance even when things are rough. Studies often show resilience relates to better psychological well-being, less distress, and more effective coping for people facing ongoing stressors. In chronic illness contexts specifically, resilience has been tied to better health outcomes, higher quality of life, and fewer psychological symptoms, so it keeps looking important for therapists doing this kind of work

Another construct that sits close to professional self-efficacy is self-compassion, and it's become more visible lately in psychological research. Self-compassion is basically the capacity to respond to yourself with kindness, notice that other humans also go through hard moments, and hold an even minded awareness of emotional pain. Evidence suggests self-compassion can cut down anxiety, depression, and stress, while supporting emotional toughness and psychological well-being[3, 7]

There's also meta-analytic work showing self-compassion-based interventions tend to produce mid-level impacts in reducing anxiety ($g \approx 0.46$) and depression ($g \approx 0.40$), which points to real effectiveness for mental health. Furthermore, newer findings indicate self-compassion links with less parenting stress and better well-being, which supports a wider role in psychological adjustment. Importantly, self-compassion seems to help professional self-efficacy too, because it reduces self-criticism and strengthens more adaptable coping, especially in high stress clinical settings[20, 21]

From a theoretical angle, the transactional model of stress and coping laid out by Lazarus and Folkman is often seen as a kind of starting point for teasing apart how self-efficacy fits into professional functioning. In that view, stress is not just "out there", it's tied to how people mentally appraise the situation and how well they think they can deal with it [5]. So, therapists who report higher self-efficacy may be more inclined to treat clinical hurdles as something workable, not necessarily as a wave that crashes over them. That then supports more adaptive coping behaviors, and it can also lower the internal load or psychological strain. This idea fits pretty well with resilience research too, where cognitive reserves—especially self-efficacy—are described as important for shaping responses to stress and adversity [3, 6, 8], Overall, self-efficacy can be understood as a key psychological kind of shield against occupational stress in day-to-day clinical work.

Beyond that, resilience frameworks help clarify the "how" behind why therapists keep their well-being and remain effective even when stress stretches on for a long time. Resilience has been framed less like a fixed personality marker, and more as a moving process that involves positive adaptation, even when adversity is present (Kalisch et al., 2015). Within this lens, self-efficacy works like a safeguard that boosts a person's ability to manage difficulties, keep emotional steadiness, and continue in exhausting circumstances (Kalisch et al., 2017; Folkman, 2020; Porter et al., 2025). For psychotherapists who work with chronic illness groups, resilience matters a lot because exposure to patient suffering is ongoing, and the therapeutic demands do not really "switch off." In that sense, the meeting point between resilience and self-efficacy allows clinicians to stay engaged and effective even while stressors keep coming [3, 9, 11]

Even with the growing literature, there are still some noticeable gaps. For one thing, many studies have leaned toward general healthcare professionals or caregivers, but psychotherapists working with chronic illness groups get less focus, even though the demands there are pretty sustained and specific. Also, a lot of prior work has looked at self-efficacy, resilience, and self-compassion separately, rather than weaving them together in one integrated way, so we don't yet have a full view of how these factors jointly matter. Finally, there still isn't enough research on how these psychological resources interact inside real clinical environments, where long-term care and heavy emotional load are routine. Overall, these limits suggest a strong need for more empirical research on how professional self-efficacy and psychological resources work together among psychotherapists serving chronic illness populations

2. Materials and methods

2.1. Materials

The study tools consist of several sections, each targeting different aspects:

Demographic information: This section collects basic information about the respondent, such as: gender, workplace, specialization, years of experience, degree.

Self-processor efficiency scale Prepared by [22] It is a self-report questionnaire designed to measure the professional self-efficacy of a mental health therapist. Consists of 21 elements Distributed in six dimensions: Communicative effectiveness, clinical competence, psychological competence, relational competence, influence regulation, and diagnostic skills. Degree calculated T-SES Comprehensive by collecting item scores, and the tool is corrected on a 5-point Likert scale, ranging from 1 (not on Launch) to 5 (a lot).

Validity and Reliability of the Professional Self-Efficacy Scale

The validity of the Professional Self-Efficacy Scale (T-SES) was checked with confirmatory factor analysis, (CFA) in order to look at the factorial arrangement of the instrument and how well the suggested six-dimensional model actually fits. What the CFA showed was pretty encouraging in terms of the model fit indices, so it overall supported the construct validity of the scale, and it also basically confirmed that the latent dimensions behind professional self-efficacy were adequate for psychotherapists working with people who have chronic illnesses.

For reliability, internal consistency was considered, using Cronbach's alpha coefficients for both the whole instrument and each subdimension. The outcomes pointed to satisfactory to rather high

reliability levels across all areas, with Cronbach's alpha values between .78 and .91. Meanwhile, the overall alpha for the full scale was .93. So, taken together these results imply that the T-SES had acceptable psychometric features and it held up in terms of internal consistency, for use in the present study.

Also, composite reliability, (CR) was above the usual recommended cutoff of .70, which adds more weight to the idea that the measurement model is reliable and stable. Overall, the set of findings indicate the scale has an acceptable balance of validity and reliability, especially when the goal is to evaluate professional self-efficacy in psychotherapists in clinical healthcare environments.

2.2. Method

This study used a sort of cross-sectional descriptive correlational design to look at the levels of professional self-efficacy and, also, how it links with certain demographic variables among psychotherapists who work with people that have chronic illnesses. A quantitative, survey-style method was taken to gather the information from psychotherapists employed in clinical as well as healthcare settings.

The participants were brought in through purposive sampling, from hospitals, private clinics, oncology care centers, and other specialized medical institutions that offer psychological and psychosocial support for individuals with chronic illnesses. For collecting the data, an electronic way was used, with an online survey that was sent out to the targeted group, but only after informed consent was secured from every participant.

To be included, the participants had to be actively involved in delivering psychological services to persons with chronic illnesses, hold a valid professional license that allows clinical psychology practice, and agree willingly to take part in the study. During the whole process, the study followed ethical principles tied to confidentiality, anonymity, and participation being completely voluntary.

Participants

The study sample consisted of (290) psychotherapists and psychological specialists working in hospitals, private clinics, oncology care centers, and specialized medical institutions that provide psychological and psychosocial services for people with chronic illnesses, especially patients diagnosed with cancer and other long-term medical conditions that need ongoing psychological support and therapeutic follow-up. In other words, the participants were professionals engaged in clinical psychological practice, counseling services, psychotherapy, behavioral intervention, and psychosocial rehabilitation within healthcare environments.

The study focused on psychotherapists and psychological specialists who were graduates of postgraduate programs, including Master's and Doctoral degrees in psychology, counseling, clinical psychology, and adjacent mental health disciplines. The sample also included individuals who were in the final stages of postgraduate qualification, and actively involved in supervised clinical practice inside institutions treating patients with chronic illnesses.

Participants were chosen using a purposive sampling approach, guided by professional and clinical criteria that matched the goals of the study. Data collection was done electronically, through an online survey link that was sent to the targeted population after obtaining informed consent from participants. This electronic administration helped reach psychotherapists working across different clinical and healthcare settings, while keeping confidentiality, anonymity, and voluntary participation.

The inclusion criteria required that participants agree voluntarily to take part and finish the questionnaire, currently work with individuals diagnosed with chronic illnesses, including oncology patients and people needing long-term medical and psychological care, and hold an official professional license issued by the relevant governmental or ministerial authority. This license should authorize them to provide psychological and clinical mental health services, as well as practice clinical psychotherapy with these populations. Participants were excluded if they did not meet these professional requirements, lacked official licensure, were not actively involved in clinical work with the targeted populations, or submitted incomplete responses.

To make the demographic characteristics easier to understand, Table 1 shows how participants were distributed by gender, age, educational level, years of professional experience, and workplace setting.

Table 1

Table 1. Characteristics of Study Sample

Variable	Category	n	%
Gender	Male	138	47.6
	Female	152	52.4
Age	< 30 years	74	25.5
	30–39 years	121	41.7
	≥ 40 years	95	32.8
Educational level	Bachelor's degree	118	40.7
	Master's degree	109	37.6
	Doctoral degree	63	21.7
Years of experience	< 5 years	81	27.9
	5–10 years	116	40.0
	> 10 years	93	32.1
Workplace	Private clinics	97	33.4
	Hospitals	104	35.9
	Specialized medical centers	89	30.7

Table 1 suggests that the study sample showed a certain diversity when you look at both demographic and professional traits. In particular, female psychotherapists made up a bit more of the group than the males, though not dramatically. Most of the participants were roughly in the 30 to 39 age range, so overall it seems like an actually practicing category of professionals, with ongoing clinical involvement. About education, most participants reported bachelor's as well as master's degrees, while only a smaller part had doctoral qualifications, so, you know, the highest level was less common

When it comes to professional experience, most psychotherapists said they had around 5 to 10 years of clinical background, and then after that came the group with more than 10 years. This pattern implies that the sample was mostly practitioners with a solid amount of practical exposure. Employment settings were also varied, since participants worked in hospitals, private clinics, and specialized medical centers that provide psychological or psychosocial services for people living with chronic illnesses. It also included oncology care settings, which in general strengthens the idea that the sample is both diverse and clinically relevant.

2.3. Statistical analysis

Data were analysed with SPSS version 27 and AMOS version 24, sort of standard. First the descriptive stuff like means, standard deviations, frequencies, and percentages were computed to show participants' characteristics along with professional self-efficacy levels. Then internal consistency was checked through Cronbach's alpha coefficients, while construct validity relied on confirmatory factor analysis (CFA) .

To look at group differences by demographic variables, a multivariate analysis of variance (MANOVA) was applied, and if needed Scheffé post hoc comparisons were run too. After that the whole causal idea was tested using structural equation modeling (SEM) and path analysis. For model adequacy we used χ^2/df, CFI, TLI, RMSEA, and SRMR indices. For deciding whether results were statistically meaningful, significance was fixed at $p<.05$.

3. Results

Table 2. Arithmetic averages and standard deviations of the responses of the study subjects on the psychotherapist efficiency scale

Table 2. Descriptive statistics of professional self-efficacy dimensions among psychotherapists working with individuals with chronic illnesses (N = 290)

Dimension	M	SD	Rank
Clinical Competence	18.94	3.57	1
Communicative Effectiveness	14.03	3.13	2
Psychological Competence	11.37	2.07	3
Relational Competence	11.08	2.95	4
Affect Regulation	6.83	1.84	5
Diagnostic Skills	6.51	1.84	6
Total Professional Self-Efficacy	68.76	11.85	—

The findings sort of revealed that psychotherapists who work with people living with chronic illnesses showed a moderate to high level of professional self-efficacy, in general. Clinical competence came in first, then communicative effectiveness followed it, and diagnostic skills got the lowest mean score, basically. Altogether, the results suggest fairly satisfactory levels of professional competencies across the different dimensions they looked at

Table 3 Differences in Professional Self-Efficacy According to Demographic Variables

Table 3. MANOVA results for differences in professional self-efficacy according to demographic variables (N = 290)

Variable	Test Statistic	F	p	Effect Size (η^2)
Gender	Wilks' Lambda	1.84	.071	.038
Age	Wilks' Lambda	3.27	.012*	.081
Educational Level	Wilks' Lambda	2.94	.021*	.067
Years of Experience	Wilks' Lambda	4.11	.003*	.095
Workplace	Wilks' Lambda	2.16	.044*	.052

$p < .05$

The MANOVA results indicated statistically significant differences in professional self-efficacy based on age, educational level, years of experience and workplace. Still, no statistically significant differences showed up when looking at gender. The biggest effect size seemed to link to years of experience, which suggests that professional experience does matter a lot, in other words it helps shape psychotherapists professional self-efficacy, especially when they work with people who have chronic illnesses.

Table 4. Differences in Professional Self-Efficacy According to Demographic Variables

Table 4. Scheffé post hoc analysis of professional self-efficacy according to demographic variables (N = 290)

Variable	**Comparison**	**Mean Difference**	**p-value**
Age	≥40 years vs. <30 years	4.82	.012*
Educational level	Doctorate vs. Bachelor	5.27	.021*

Years of experience	>10 years vs. <5 years	6.14	.003*
Workplace	Specialized centers vs. private clinics	3.75	.044*

*Statistically significant at p<.05.

In the Scheffé post hoc comparisons it showed that psychotherapists, who were 40 years old or more, mentioned clearly higher professional self-efficacy than participants in the under 30 years group. There were also significant differences, leaning in the same direction, for people holding doctoral degrees, for those with over 10 years of professional experience, and for psychotherapists employed in specialized medical centers. So overall these findings hint that professional maturity, advanced academic background, and this specialized clinical exposure might be part of the reasons why professional self-efficacy feels stronger among psychotherapists who work with individuals coping with chronic illnesses.

Table 5. Structural model fit indices for the proposed causal model of professional self-efficacy among psychotherapists working with individuals with chronic illnesses (N = 290)

Fit Index	Obtained Value	Recommended Value	Model Fit
χ^2/df	2.11	< 3.00	Acceptable
CFI	.94	≥ .90	Good
TLI	.92	≥ .90	Good
RMSEA	.062	≤ .08	Acceptable
SRMR	.051	≤ .08	Good

the structural equation modeling (SEM) outcomes showed that the causal model we proposed had a decent to very good fit with the data we actually saw. The fit indices basically suggested that demographic variables played a meaningful role in accounting for differences in professional self-efficacy for psychotherapists who work with people dealing with chronic illnesses. In general, these results lend support to the adequacy of that structural setup, when it comes to explaining how demographic characteristics connect with professional self-efficacy

Table 5 Structural Model of Professional Self-Efficacy.

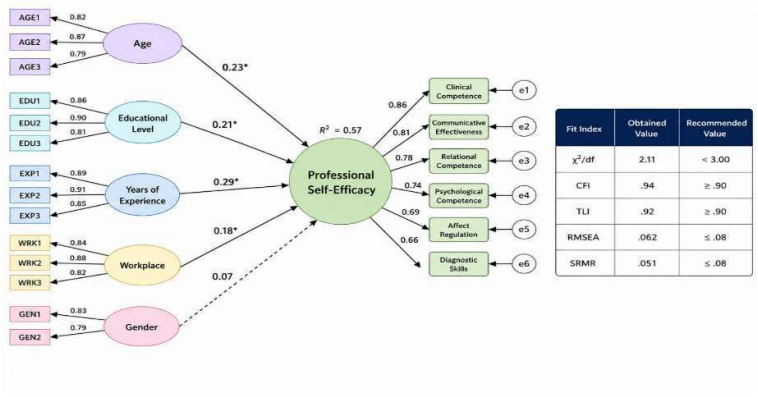

Figure 1. Structural equation model of demographic predictors of professional self-efficacy among psychotherapists working with individuals with chronic illnesses (N = 290)

The structural equation model showed an acceptable -to-good kind of fit, so it looks like there's a reasonable link between the proposed model and what we actually saw in the data. In terms of the predictors, years of experience came out with the strongest positive influence on professional self-efficacy ($\beta = .29$, $p < .05$), then age also mattered ($\beta = .23$, $p < .05$), educational level followed ($\beta = .21$, $p < .05$), and workplace had a smaller but still positive effect ($\beta = .18$, $p < .05$). Meanwhile, gender didn't show any clear statistically meaningful effect ($\beta = .07$, $p > .05$). Overall, the model accounted for 57% of the variability in professional self-efficacy ($R^2 = .57$). Looking at the observed parts, clinical competence together with communicative effectiveness had the highest factor loadings, which kind of suggests they contribute a lot to the latent idea of professional self-efficacy

4. Discussion

He presents study found that psychotherapists working with people who live with chronic illnesses showed moderate-to-high levels of professional self-efficacy, with clinical competence and communicative effectiveness getting the highest scores. And yes, this result can be read using Bandura's Social Cognitive Theory, it says that self-efficacy grows from repeated mastery experiences, better emotional regulation, and successful professional adaptation inside hard environments [1, 4] Psychotherapists working in oncology and chronic illness contexts are basically, constantly placed in emotionally taxing therapeutic moments that ask for long term psychological involvement, flexible coping strategies and a multidimensional way of communicating. Over time, this kind of repeated clinical exposure may slowly reinforce therapists' trust in their own professional capabilities, and also their therapeutic knows how.

The current findings line up with what Gori et al. (2022) [22] described, they reported that when psychotherapists had higher professional self-efficacy, they tended to show stronger therapeutic effectiveness, more capable emotional regulation, and higher levels of professional competence during psychotherapy sessions. In a similar direction, McCormack et al. (2018) [14]found that psychotherapists with higher professional competence and more clinical exposure experienced lower occupational burnout, plus they also showed greater resilience in psychological demanding therapeutic settings. Kalisch et al. (2017) [13]added that resilience along with self-efficacy act like protective psychological resources, which means clinicians can manage occupational stress better, and keep therapeutic effectiveness even when chronic psychological pressure stays around.

The prominence of clinical competence and communicative effectiveness in this present study might reflect, kinda, the kind of chronic illness care, itself, not just some abstract factor. Patients with cancer and other chronic diseases frequently live with prolonged emotional unease, fear about deterioration, lots of uncertainty about treatment outcomes, and then again recurrent medical interventions. So, it is plausible that psychotherapists who work with these groups lean more heavily on advanced communication strategies, emotional containment, empathy and the whole therapeutic alliance building, skillset. If you look a bit deeper, communicative effectiveness may show up not only as a therapeutic "tool", but as a kind of central pathway where psychological stabilization and emotional support are actually carried out in chronic illness contexts, for real.[4, 23, 24]

Also, the results showed statistically meaningful differences when it comes to age, educational level, years of professional experience, and workplace setting. These outcomes could be interpreted through the cumulative effect of professional exposure plus advanced clinical training. More experienced psychotherapists, for instance, may have wider therapeutic repertoires, better emotional

modulation, and more confidence during clinical decision-making. In a similar way, practitioners with doctoral degrees may have received longer supervised clinical preparation and specialized academic preparation, which could strengthen how they view their own professional efficacy, more or less.

Further, the results showed that clinical competence, plus communicative effectiveness, were actually the top-rated dimensions tied to professional self-efficacy. I mean it fits the kind of therapeutic work you usually see in chronic illness contexts, because in those environments, communication that really lands and solid clinical know-how are essential for handling long term patient care. This outcome also feels in line with Norcross and Lambert (2019),[25] who basically underlined that the therapeutic alliance, along with solid effective communication abilities, tends to be among the most dependable predictors for favorable treatment results. In the same way, Gori et al. (2022) [26] stated that therapists who hold higher self-efficacy often display better relational communication and, in turn, greater therapeutic effectiveness. These findings seem to be consistent with Lent and Brown (2019)[27] , who proposed that professional self-efficacy tends to develop step by step through accumulated mastery experiences, reinforcement, and specialized professional practice. Likewise, Sharma et al. (2025) [21]also pointed out that resilience and long term professional adaptation in chronic disease management are strongly linked with higher levels of occupational competence and psychological efficacy among healthcare professionals.

The current findings could also be understood via Self-Determination Theory [28-30] suggesting that competence, autonomy, and relational connectedness form the core psychological needs that feed into professional functioning . In chronic illness contexts, these elements might get emphasized in a slightly different way since psychotherapists are often expected to use autonomous clinical judgment, keep up emotionally meaningful therapeutic ties, and show competence even when the situation is mentally demanding. If these needs are satisfied again and again, over time this may gradually help build stronger views of professional self-efficacy beliefs, like a sort of gradual reinforcement[31, 32]

On the other hand, the lack of statistically significant gender differences suggests that self-efficacy among psychotherapists may be shaped more by professional exposure and clinical development than by gender related characteristics. This result also fits with modern psychological views, where therapeutic competence is thought to be shaped mainly through professional socialization, sustained clinical work, and accumulated therapeutic experiences, rather than demographics alone.

From a more interpretive angle, the findings might indicate that chronic illness settings create a particular therapeutic environment where psychotherapists gradually renovate their professional identity through repeated exposure to suffering, uncertainty, and emotionally intense clinical meetings. Within this kind of setting, professional self-efficacy may act not only as a cognitive belief system but also as a psychological adaptive mechanism that helps therapists stay emotionally balanced, remain therapeutically engaged, and keep clinical effectiveness even when occupational stressors keep showing up.

5. Conclusion

This study looked at how high (or low) professional self-efficacy is, and how it might link up with certain demographic things among psychotherapists who work with people dealing with chronic illnesses. The results showed that the psychotherapists had moderate to high levels of professional self-efficacy, especially when it came to clinical capability and communicative effectiveness. When comparisons were made, there were noticeable differences connected to age, education level, how many years they had been working professionally, and also the place where they work. As for gender, it

turned out not to matter in a statistically meaningful way, not really.

Then the structural model part added more detail, suggesting that demographic factors along with professional characteristics helped explain the different levels of professional self-efficacy among these psychotherapists in chronic illness care contexts. Psychotherapists with more years of experience tended to report stronger self-efficacy, and those with higher academic degrees also showed greater confidence in their work. Employment in more specialized medical institutions also seemed to line up with higher self-efficacy ratings.

Taken all together, the findings point to how crucial professional preparation, real clinical immersion, and specialized health environments can be for improving psychotherapists' self-belief in their professional role, especially with individuals facing chronic, even life-threatening conditions. The study also stresses the value of ongoing professional development and psychological training programs that are adapted to the practical demands of chronic illness and oncology-related care.

6. Difficulties, Challenges, and Limitations

Some limitations should be kept in mind when reading the outcomes of this study. First of all, the whole project used a cross-sectional design, so it sort of restricts the ability to claim causal links between demographic factors and professional self-efficacy. Second, the information was gathered through self-report instruments, which can be affected by social desirability effects and also by more general subjective answering habits.

Another issue is related to the electronic data collection approach. Participation basically depended on voluntary online responses from psychotherapists employed in clinical and healthcare environments. Because of that, people who had limited access to electronic platforms, or who simply engaged less with online questionnaires, might be missing from the sample.

Also, the study was centered on psychotherapists who work with individuals who have chronic illnesses, with a special emphasis on oncology and long-term medical care settings. So, applying these results to psychotherapists in different clinical, or even mental health contexts, might be less appropriate than we would hope.

Furthermore, differences in workplace conditions, institutional resources, and clinical responsibilities across hospitals, private clinics, and specialized medical centers may have shifted how participants viewed their professional self-efficacy. Even with these restrictions though, the study still offers useful insights into professional self-efficacy among psychotherapists operating in demanding healthcare scenarios where chronic illness management and psychosocial support are strongly involved.

Conflict of interest

The authors declare no competing interests.

Author contributions

Y.M.K. contributed to conceptualization, methodology, data collection, formal analysis, original draft preparation, and final manuscript approval. B.S.A. contributed to conceptualization, formal analysis, supervision, review and editing of the manuscript, and final approval. A.J.A. contributed to

the review and final approval of the manuscript. W.M. contributed to methodology, review and editing of the manuscript, and final approval.

Ethics approval and consent to participate

The study procedures were carried out in line with the ethical principles used in scientific research with people taking part. Each person joined voluntarily, and before any data was gathered, informed consent was gotten electronically from all participants. They were told what the study was about, that their answers would stay confidential, and also that they could choose to stop participating at any moment, with no repercussions. No personally identifying information was collected, and later the data were assessed in an anonymous way, strictly for research aims only.

Availability of Data

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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