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Evaluating the need of regulating the profession of psychotherapy based upon the opinions of Polish psychotherapists

Abstract: 630 Polish psychotherapists participated in a study examining their opinions regarding possible legal regulation of the psychotherapy profession. Participants completed a survey using a five-point Likert scale to rate the favourability of certain issues for inclusion in the legal regulation of the profession of psychotherapy such as patient rights, rights relating to the profession, establishing a professional regulatory body, and other issues. Regardless of the psychotherapeutic approach, the most beneficial outcome of legal regulation of the psychotherapist's profession was the guarantee of the right to patient confidentiality in relations with state authorities and the establishment of unambiguous criteria for waiving it. The participants were also unanimous regarding the most unfavourable effects of regulation, such as increased control over the activities of psychotherapists, mainly by state authorities, which suggests that they prefer a professional self-governing body. Despite differences between psychotherapeutic approaches on specific issues that have been examined here, Polish psychotherapists see a need for legal regulation of their profession. The results are important not only in the context of mental health deterioration but also given that legal regulations for the psychotherapy profession vary worldwide, and in many countries discussions are ongoing.

Keywords: *legal aspects, health policy, legal regulation, profession of psychotherapy, independent professions, ethics in psychotherapy, mental health*

INTRODUCTION

There are differences in legal regulations regarding the psychotherapeutic treatment of mental disorders around the world. In the United States, this activity is mostly attributed to independent counsellors who often perform other types of intervention as well. The title of 'psychotherapist' is less common and is not regulated in the US, but there are conditions and requirements to engage in paid private counselling and these are protected by state licensing statutes (Cottone et al., 2021). The situation is different in Europe, where the term 'counselling' is not well regulated and practitioners conducting psychotherapy are typically designated as 'psychotherapists'. Obtaining this title and practicing psychotherapy are regulated differently across European countries. Many of them have introduced legal regulations for this profession, e.g. Austria, Finland, France, Germany, Italy, the Netherlands and Sweden. In Germany the profession was regulated in the late 1990s after a 30-year-long period, during which psychotherapists made efforts to be able to practice the profession independently and under their own responsibility (Schulte, 2021). This regulation covers licensing requirements, training standards for psychotherapeutic practice (that have been widely revolutionised in the latest regulation from 2020), regulations regarding recognition and enhancement of professional qualifications, payment as well as the role and duties of the professional self-governing body (Psychotherapeutengesetz – PsychThG). However, in countries such as the United Kingdom and Poland this profession is not comprehensively regulated.

Most European countries have been heavily discussing the issue of regulating psychotherapy. An important element of this discussion is to decide whether psychotherapy can be treated as an independent profession. A study performed by Laireiter and Wiese (2019) indicates that psychotherapy can be considered a *specialisation* performed by psychologists or psychiatrists (e.g. in Germany, Italy Romania or Switzerland) or even by many different professions, as is the case in Austria or Croatia (see also Hunt et al., 2021). This implies that psychotherapy is not a separate profession. On the other hand, other authors treat it as a profession embedded in other professions (de Barbaro, 2013; Cottone et al., 2021). This increases regulatory complexity, as psychotherapist's work is often treated using regulations formulated for other professions (e.g. psychologists, physicians, nurses, etc) which increases the risk of confusion. In Poland psychotherapists have tried to solve this by self-organizing in several dozen associations. However, they differ in training and treatment standards. As a result, the social awareness of psychotherapy standards is low and there are no clear guidelines that allow patients to verify the service standards. This may lower the level of mental health in Poland, e.g. when low-quality services or no services are used. In this context, treating psychotherapy as a separate profession with its own comprehensive legal regulations would likely be beneficial. In fact, in the regulation of 7.08.2014 the Polish legislature has defined psychotherapy as a separate profession or specialty falling in the category 'Healthcare professionals not classified elsewhere' (Journal of Laws, 2018, item 227). A follow-up regulation specified the requirements or criteria that must be met by 'persons providing psychotherapy' and by 'persons applying for a psychotherapist's certificate' (Journal of Laws, 2019, item 1285), which have been revised in the acts of 17.08.2023 on certain medical professions (Journal of Laws, 2023, item 1972) and 21.06.2024 on mental health protection (Journal of Laws, 2024). These regulations (especially the last one) specify in detail the conditions for admission to perform psychotherapy, but they are only limited to treatment provided within the framework of the public health care for persons with mental disorders and do not regulate private practice. For these and other important reasons, the existing regulations are far from being comprehensive and the lack of comprehensive regulation of the psychotherapist's activity remains contrary to the Polish constitution (see below and also Hyżorek, 2023).

In the first instance, it should be pointed out that the profession of psychotherapy meets all the determinants of what is defined in the doctrine of law as a profession of public trust (as well as an independent profession[1]), which describes the personal and systematic undertaking of an internally consistent set of activities of an intellectual nature, requiring high qualifications (knowledge and practice), in exchange for remuneration and in accordance with ethical and deontological principles (Wojtczak, 1999). To comply with the Polish Constitution[2], the legislature has been unusually active in recent years, producing legal regulations for various independent professions, including nurses and midwives (2011), physiotherapists (2015), and pharmacists (2020). In the statutes that regulate these professions, the legislature expressly grants legal protection to professional titles and regulates in detail the significant issues related to practicing them. For example, legal protection of the professional title has been provided for the profession of laboratory diagnostician (Journal of Laws, 2022, item 134) or barrister (Journal of Laws, 2022, item 1184). It is of importance that, in the professions regulated by separate statutes, there exist disciplinary mechanisms that allow an individual to be struck off from the professional register. This penalty deprives the person of the right to use the professional title, as a result of which any continued use of that title is unauthorised. It is also important that the profession-related statutes regulate penal provisions for unauthorised use of the professional title (e.g. for pharmacists; Journal of Laws, 2022, item 1873).

For the profession of psychotherapy, there are no legal mechanisms protecting the professional title, and this title may thus in practice be used by any person. One of the consequences of this is that patients are unable to file complaints about the quality of service or breaches of professional obligations. Moreover, there is no agreed upon code of ethics for psychotherapists in Poland. In the event that psychotherapists were obliged to respect the provisions of a code of ethics, it is very likely that the ethical standards and rules of practicing the profession would be unified. The prevention of disciplinary offenses seems especially important in this context. It can be achieved by shaping the belief that committing offenses is unacceptable and unprofitable. This in turn is shaped by the existence of disciplinary penalties, as well as their adjudication and enforcement, confirming that they are indeed applied (Giętkowski, 2013).

Another problem resulting from the lack of a separate statute governing the profession of psychotherapy is the lack of an unambiguous definition of psychotherapy.

[1] The following potential features can be listed as those that are characterised for an independent profession: qualified, special education; specific rules of practice; professional independence; ethos and mission of practice; organizational structure and status; professional ethics; nature of remuneration different from typical payment; professional secrecy; specific civil, disciplinary, or corporate liability; and mandatory membership in a professional self-governing body (Jacyszyn, 2015) These kinds of professions are generally not qualified in the group of professions that provide material services, but as typical for these people are non-material services (Jacyszyn, 2004).

[2] In order for a given professional title to be legally protected in Poland, it must be explicitly stated in the legislation. It is not enough for the legislature to use a given name of a profession to immediately make a given professional title legally protected. As a good example of such protection, one can point to the professional title of a lawyer. Indeed, Article 1(4) of the Law of May 26, 1982 published in the Journal of Laws of 2022 (item 1184) stipulates that the professional title 'lawyer' is protected by law. If someone uses such a title - without having the right to do so, he commits an offense. Further, independent professions, such as nurse, pharmacist or lawyer, require a special protection that makes it possible to form a special relationship with a client based on trust and confidentiality (Szydło, 2016).

According to the Mental Health Protection Act (Journal of Laws, 2024, item 917) 'Psychotherapy is a purposeful and planned psychological intervention aimed at alleviating or eliminating symptoms of a disorder and improving mental and social functioning, supporting the aspirations of an individual or family for health and development, addressed to people with mental disorders'. However, this definition was developed exclusively for the Mental Health Protection Act and therefore applies only within the legal framework of this specific act. It cannot automatically be extended to other legal regulations in which psychotherapy is also referenced (e.g. the Act on Counteracting Drug Addiction). The lack of a definition covering the entire system contributes to conflating psychotherapy with other forms of psychological help, including psychological consultation, psychoeducation, psychological counselling, and psychological rehabilitation. This may lead to the emergence and consolidation of incorrect beliefs about the purpose, scope, and methods of psychotherapy. Laypeople often confuse psychotherapists with both psychologists and psychiatrists. In a recent general population survey conducted on Poles by Boczkowska et al. (2024) only 45% of respondents indicated that a psychologist and a psychotherapist are different professions. This is not surprising, since even the Act of 8 June 2001 on the profession of psychologist and psychologists' professional representative bodies specified psychotherapy as one of the services provided by psychologists, although the actual Act of 23 January 2026 clearly distinguishes between the professions of psychologist and psychotherapist. Subsequent partial regulations opened up the possibility of conducting psychotherapy to other professions, but they were not stable in this respect. The difficulties in defining psychotherapy are also the result of different perceptions of the concept of a human being and of the process of change used by psychotherapists of various psychotherapeutic approaches.

In recent years, numerous attempts have been made to regulate the profession of psychotherapy by a separate law. The Ministry of Health prepared four government bills in 2006, 2008, 2009, and 2010. The main objection raised by some professional bodies to the proposed bills (e.g. Polish Council for Psychotherapy) was that they did not take into account all the psychotherapeutic modalities and that they medicalised the profession, with the last two bills classifying psychotherapists in the same category as, for example, dental technicians—that is, as mid-level medical professions. A part of the psychotherapeutic community is trying to move away from the medicalization of the profession, preferring to position itself as community care: psychotherapy often aims at working on life crises, relationship problems or personal development; psychotherapy itself is also used in many nonmedical areas (e.g. education, rehabilitation, and prison) (e.g. Polish Council for Psychotherapy). This part of the community is concerned about the risk of excessive control from the healthcare system and loss of diversity and interdisciplinarity in the field of psychotherapy if it were subordinated to this system. As a consequence of these concerns, it was proposed that decisions regarding education and conducting psychotherapy should be under the authority of the professional self-regulatory body, similarly to how it is in medicine (Polish Council for Psychotherapy). However, there were voices arguing that self-governance is an inadvisable and unjustified idea (e.g. Executive Board of the Polish Psychological Association). The other part of the psychotherapeutic community emphasises the advantages of medicalization. Here the argument is made that embedding psychotherapy in the area of medicine and the health care system would increase patients` safety and treatment efficacy because it would allow standardizing psychological training and popularizing the use of evidence-based methods (Presidium of Supreme Medical Council, 2025). Unifying educational standards, facilitating public funding and quality control and promoting communication with other healthcare professionals are other arguments raised by proponents of medicalization.

The differences between voices supporting and opposing medicalization reflect various ways of defining psychotherapy, as was previously mentioned. Supporters of medicalization view psychotherapy as treatment of mental disorders, in a similar way as it was defined in the Mental Health Protection Act (Journal of Laws, 2024, item 917). In the literature, however, there are other approaches defining psychotherapy more broadly than medical treatment, e.g. as ameliorating distress related to certain areas of disability or dysfunction (Corsini, 2005) or as assisting the patient in modifying cognitive, emotional or behavioural aspects (Prochalska & Norcross, 2006). The topic is still under discussion and even on the theoretical level has not been resolved.

Although psychotherapists often express their views on the legitimacy of statutory regulation in informal discussions, no research has yet been conducted that would empirically verify the opinions of Polish psychotherapists on this topic. Previous studies mapping the field of psychotherapy in Poland primarily described the characteristics of practitioners, such as gender, age, and education, without addressing views on professional regulation (Suszek et al., 2017). More recent nationwide data provide an updated profile of psychotherapists in Poland but likewise do not address attitudes toward statutory professional regulation (Hermanowski, 2021). This study aims to fill this gap by directly examining psychotherapists' views on statutory professional regulation.

MATERIALS AND METHODS

Participants

Participants were selected in two ways: a request to distribute information about the study was sent to sixteen Polish psychotherapeutic societies (Appendix 1), and an announcement about the study was posted on a psychotherapist's group on a social network.

A total of 996 people who stated that they were professional psychotherapists participated in the study, and 630 of these completed it. Among the respondents, 86.5% were female (n = 545), 13% were male (n = 82), and 0.5%

identified as gender diverse (n = 3). The study participants ranged in age from 22 to 64 (M = 39; SD = 7.64). They represented different psychotherapeutic approaches. A plurality of the respondents stated that they worked in the psychodynamic approach (35.4%, n = 223). Slightly fewer indicated that they worked in the cognitive–behavioural approach (33.5%, n = 211); besides these, 11.6% (n = 73) were systemic psychotherapists and 7.8% (n = 49) were integrative psychotherapists. The humanistic approach was the least represented (n = 34, 5.4%). 6.3% of people indicated that they practice in another psychotherapeutic approach, among others short-term solution-focused therapy (n = 9), Gestalt therapy (n = 7), psychoanalysis (n = 6), and Ericksonian therapy (n = 3). The results of these respondents were not analyseds in comparisons across approaches, due to the insufficient sample size. The average length of practice as a psychotherapist was seven years (SD = 5.8). A total of 11.1% of respondents stated that they were currently training to be psychotherapists. Demographic characteristics are presented in Table 1. Little's MCAR test revealed that non-completion was independent of participants' age, duration of psychotherapeutic practice, gender, and psychotherapeutic approach (ps > .20)

Materials and procedure

The study used a measure of our own authorship to rate 'favourability' and 'unfavourability' of potential aspects that may be included in psychotherapy legal regulation. This measure consists of 24 closed questions answered on a five-point Likert scale (1: *very unfavourable*; 5: *very favourable*) and seven open questions regarding detailed proposals for regulating the profession.

The measure addressed possible effects of legal regulation of the profession of psychotherapy. The basis for the creation of items was (1) existing legal regulations from other countries, (2) existing Polish regulations, e.g. on the profession of physiotherapist, doctor, pharmacist, addiction therapist, (3) the four pillars of legislation: the legal status of the profession (powers, duties), the issue of controlling bodies, professional (disciplinary) responsibility, and the path to achieving professional status. The measure was developed in several stages: (1) legal consultation on various elements of potential regulation, (2) item construction, (3) submission of items to competent judges for review, (4) correction of items, and (5) renewed legal consultation on the final form of the tool. The final version of the measure was divided into three parts: (1) the listed potential effects of regulating the profession with a Likert scale given to each item, (2) a general question, 'Are you for or against statutory regulation?' (3) additional questions about possible details of regulation for those who indicated 'yes' to the previous question. The closed questions dealt with, among other topics, patients' rights, therapists' rights, the rights to practice and supervise psychotherapy, ethics in psychotherapy, and the creation of a professional self-governing body (Appendix 2). A certain ambiguity of the items was planned and we decided to avoid items that would be too specific. If the items were too definite, this might have biased the answers to the open questions put in the second part of the survey. The survey was conducted online using the Qualtrics platform.

The distributions of all 24 Likert-type items were examined using the Shapiro–Wilk test and by inspecting skewness and kurtosis coefficients. For items with kurtosis exceeding 3, Wilcoxon signed-rank tests were conducted to verify the robustness of the paired-samples t tests, yielding identical statistical conclusions. Outliers were selected using standardised *z scores* greater than 3 or lower than − 3, and sensitivity analyses confirmed that their exclusion did not affect the results. Therefore, parametric tests were retained in cases where the assumptions were sufficiently met, and the full dataset was analysed.

In order to determine the differences between individual items, Student's t-test for dependent samples was used, while the Kruskal–Wallis test and post-hoc tests (Dunn's test with Bonferroni's correction) were used to test the differences between individual psychotherapeutic approaches. Pearson's r correlation test was used to control the relation between years of experience and rating the effects.

A post-hoc power analysis was conducted with G*Power 3.1.9.7 (Faul et al., 2009) for the paired-samples t tests that compared the perceived benefits of each regulatory effect. The observed t statistics (t_{range} = 1.50 - 7.23) were converted to effect sizes d_z; the mean d_z was .11. With N = 630 and a two-tailed significance level of α = .05, the achieved power was $1 - \beta$ = .82, which exceeded the common criterion of .80 suggested by Cohen (1992). Thus, the study was adequately powered to detect effects of average magnitude. The use of post-hoc power analysis for paired t tests follows current practice in psychological research (see Yagi & Inoue, 2018).

Table 1. Demographic Characteristics

N	Gender	Age *M (SD)*	Age range	Psychotherapy approach	Seniority *M* (*SD*)	Seniority range
630	Female - 86.5% (n = 545) Male - 13.0% (n = 82) Gender diverse - 0.5% (n=3)	39.26 (7.84)	22-64	psychodynamic - 35.4% (n = 223) cognitive-behavioural - 33.5% (n = 211) systemic - 11.6% (n = 73) integrative - 7.8% (n = 49) humanistic - 5.4% (n = 34) other - 6.3% (n = 40)	7.41 (5.80)	0.8–34

Because G*Power does not offer a Kruskal–Wallis option, each H statistic was first converted to an η^2 estimate and then to Cohen's f following the procedure described by Fritz et al. (2012). The resulting f values (f_{range} = .11- .43) were entered into G*Power 3.1.9.7 with k = 5 groups, N = 630, and α = .05. Achieved power ranged from 1 - β = .68 for the smallest effect to ≈ 1.00 for the largest; for the mean effect (f = .33) power was 1 - β = .99. An a-priori calculation indicated that a total sample of N = 155 (≈ 31 participants per group) would yield a conventional power of .80, a condition that was met in the present study.

The study was not preregistered. All data have been made publicly available at the PsyArXiv and can be accessed at: https://osf.io/5h2xq?view_only=0b2cf441784a4fdebcfcf8db8a9fb455

RESULTS

Quantitative results

A total of 90.0% (n = 567) of participants indicated that the profession of psychotherapy should be regulated by law. A total of 6.3% (n = 40) did not have an opinion on this subject, and 3.2% (n = 20) believed that there was no need to introduce legal regulations in this regard. Three participants (0.5%) did not answer this question (see Figure 1).

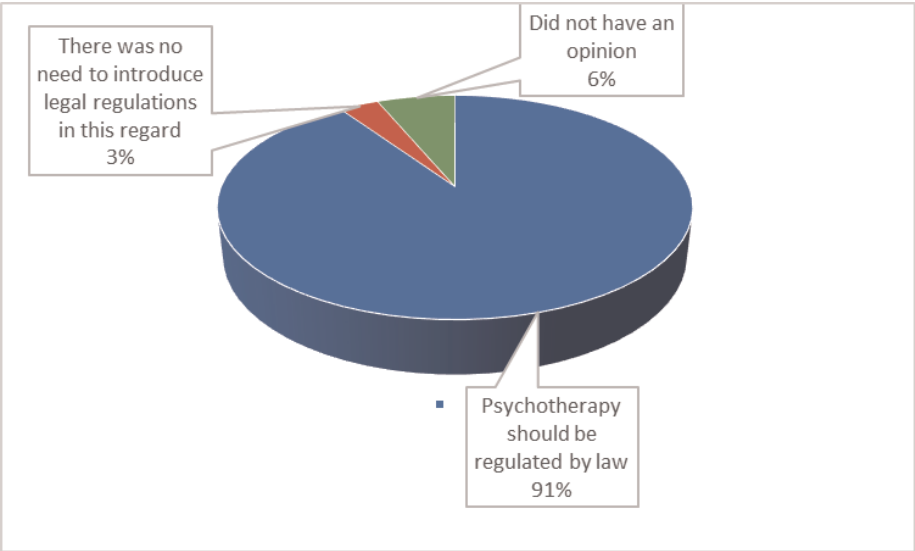

Figure 1. Distribution of participants' opinions on whether the profession of psychotherapy should be regulated by law

The potential effect of regulation that was rated most beneficial by respondents turned out to be the guarantee of the right to patient confidentiality in relations with state authorities[3], and the establishment of unambiguous criteria for waiving it (M = 4.81; SD = 0.48). This was equally important for representatives of all the various psychotherapeutic approaches, with each of them indicating this as the most advantageous outcome (ps < .001; Hs > 4.7). Representatives of all approaches were nearly unanimous on the issue of the most unfavourable effect of regulation, which they stated to be control over the activities of psychotherapists, mainly by state institutions (M = 2.35; SD = 1.11) (ps < .001; Hs < 7.23). The results are presented in Table 2. Items are ranked from most to least favorable. Each row contains items with no significant differences; Single rows contain items with no significant differences while significant differences were observed between the raws (p < .05).

Other most beneficial effects of regulation were the definition of the minimum requirements needed to practice and supervise psychotherapy (respectively: M = 4.69; SD = 0.61 and M = 4.69; SD = 0.58) as well as to train psychotherapists and supervisors (M = 4.66; SD = 0.63). These issues were equally important for the respondents, but they were rated less favourable than patients confidentiality and more favourable than other issues (listed in the following); ps < .003; ts > 3.00.

The creation of an overarching code of ethics that would apply to all psychotherapists (M = 4.57; SD = 0.70), as well as the right to refuse therapy when the therapist has a conscientious objection (M = 3.80; SD = 1.06) or where the practitioner would require more specific competences to deal with the particular patient (M = 4.22; SD = 0.80), were also indicated as potentially beneficial effects of the regulation. Both issues were rated more favourable than those discussed below (ps < .004; ts > 2.00).

[3] Those providing psychotherapy today are not subject to any rules of professional confidentiality. It is contrary to other professions which are legally regulated. For example, Article 9(3) of the Act of September 25, 2015 on the profession of physiotherapist (unified text, Journal of Laws of 2022, item 168, as amended), indicates that a physiotherapist is obliged to keep secret information related to the patient, obtained in connection with the practice of the profession in accordance with the provisions of the Act of November 6, 2008 on Patient Rights and Patient Ombudsman; as well as Article 17(1) of the Act of July 15, 2011 on the professions of nurse and midwife (consolidated text, Journal of Laws of 2022, item 2702, as amended), according to which a nurse and midwife are obliged to keep patient-related information obtained in connection with the practice of their profession confidential. Thus, there is no legal requirement in Poland today that information said during a therapy session will remain secret. There is neither such an obligation nor sanctions for its violation.

Table 2. Ratings of potential effects of legal regulation on the favourability-unfavourability scale: means, standard deviations and differences between items (regardless of psychotherapeutic approach)

Favourability of legal regulation effects (from most to least favourable order)	***M* (*SD*)**
The guaranteed right to patient confidentiality in relations with state authorities, and the establishment of unambiguous criteria for waiving such confidentiality	4.81 (.48)
Definition of the minimum training requirements for conducting psychotherapy	4.69 (.61)
Definition of the minimum training requirements for supervising psychotherapy	4.69 (.58)
Definition of the minimum requirements for training psychotherapists	4.66 (.63)
Establishment of a code of ethics applicable to all psychotherapists	4.57 (.70)
The guaranteed right for psychotherapists to refuse therapy when they lack the skills to work with a particular patient	4.22 (.80)
License withdrawal for people insufficiently qualified	4.17 (.99)
Strengthening the protection of the rights of patients/ clients (for example, by creating a patients' ombudsman).	4.15 (.86)
The obligation on the part of the psychotherapist to provide the patient with a therapeutic contract specifying the principles and course of the treatment	4.10 (.95)
Establishment of an authority (such as a disciplinary court) that could decide sanctions for unethical conduct	4.09 (.90)
Promoting models of psychotherapy based on empirical evidence	3.86 (1.14)
Control over the psychotherapists' activities, mainly by the psychotherapeutic community (e.g. professional self-governing body)	3.72 (.99)
The ability for psychotherapists to actively participate in setting up and running a professional self-governing body (including participating in the body's work, visiting educational centres and psychotherapy units, etc.)	3.83 (.86)
The guaranteed right for psychotherapists to refuse to provide to a particular patient when the therapist has conscientious objections to doing so	3.80 (1.06)
Control over psychotherapists' lifelong learning	3.79 (1.04)
Periodic verification of certified psychotherapists' skills	3.38 (1.10)
Periodic verification of certified supervisors' skills	3.56 (1.09)
A requirement to contribute financially to the running of a professional self-governing body	3.05 (1.07)
Requiring psychotherapists to take examinations organized by supervisory institutions.	3.65 (1.11)
Limiting the number of institutions authorized to train psychotherapists, and consequently lengthening waiting lists for training	2.77 (1.21)
Extending the length of psychotherapists' training	2.87 (1.04)
Limiting access to the right to conduct psychotherapy in certain psychotherapeutic approaches	2.80 (1.20)
Limiting access to the right to supervise in certain psychotherapeutic approaches	2.84 (1.23)
Control over psychotherapists' activities, mainly by state institutions	2.35 (1.11)

Among the other aspects rated as favourable were the potential withdrawal of psychotherapy license by those lacking the appropriate qualifications (M = 4.17; SD = 0.99), strengthening client's rights (such as through the creation of a patients' ombudsman) (M = 4.15; SD = 0.86), the obligation for the therapist to provide patients with a therapeutic contract defining the principles and course of the treatment process (M = 4.10; SD = 0.61), and the establishment of an authority (such as a disciplinary court) to decide on sanctions for unethical behavior (M = 4.09; SD = 0.90). All these aspects proved to be equally important (ps > .115; ts < 1.60), and were viewed as significantly more favourable than the effects discussed below (ps = .001; ts > 4.38).

Other effects of regulation that were also rated beneficial by respondents included the promotion of psychotherapy models based on empirical evidence (M = 3.86; SD = 1.14), the active participation of representatives of particular psychotherapeutic approaches in the professional self-governing body (M = 3.83; SD = 0.86), a guarantee of the right to refuse therapy when the case raises conscientious objections in the practitioner (M = 3.80; SD = 1.06), and control over the lifelong learning of psychotherapists (M = 3.79; SD = 1.04). It was also seen as beneficial that regulations would likely empower the professional self-governing body to control the quality of psychotherapists' activities (M = 3.72; SD = 0.99). All these aspects were held to be equally important (ps > .14; ts < 1.50), except that the promotion of models based on empirical evidence was considered more favourable than the control of the self-governing body over the quality of psychotherapists' activities (p = .014; t = 2.47). Also, the possibility of active participation in the professional self-governing body was rated more favourable than controlling the quality of psychotherapists' activities by the self-governing body (p = .002; t = 3.15).

Less favourable than those listed above, but still rated as beneficial, were periodic verification of the competence of certified psychotherapists and supervisors (respectively: M = 3.38; SD = 1.1 and M = 3.56; SD = 1.09), and obligatory financial contributions to support the professional self-governing body (M = 3.05; SD = 1.07), as well as undertaking examinations organised by supervising institutions (M = 3.65; SD = 1.11) (ps < .04; ts > 2.00).

There were, however, potential effects of regulation that were rated negatively. Extending the length of psychotherapists' training (M = 2.87; SD = 1.04) and limiting the rights to conduct psychotherapy and supervision in certain psychotherapeutic approaches (M = 2.80; SD = 1.20 and M = 2.84; SD = 1.23) were rated as unfavourable. Possible limitations on the number of institutions authorised to conduct training and, consequently, extended waiting lists for training (M = 2.77; SD = 1.21) were also rated negatively. Apart from only one significant difference between extending the length of psychotherapists' training and limiting the number of institutions authorised to conduct training (p = .04; t = 2.05), these items were rated similarly unfavourable (ps > .14; ts < 1.79), but significantly more unfavourably than the items specified in the previous paragraph (ps = .001; ts > 3.35).

There were significant correlations between rating the effects as favourable and years of experience as a psychotherapist. The longer the seniority of the participants, the higher they rated as beneficial the following effects: definition of the minimum training requirements for conducting psychotherapy (r = .08; p < .05), extending the length of psychotherapists' training (r = .22; p < .05), license withdrawal for people insufficiently qualified (r = .08; p < .05), a requirement to contribute financially to the running of professional self-governing body (r = .08; p < .05), the establishment of an authority (such as a disciplinary court) that may decide sanctions for unethical conduct (r = .08; p < .05). On the contrary, the more years of work experience the participants had, the less favourably they viewed the guaranteed right for psychotherapists to refuse to provide to a particular patient when the therapist has conscientious objections to doing so (r = -.10; p < .05).

The results of the study show that psychotherapists differ slightly in terms of their perceptions of the advantages and disadvantages of regulation, and that these differences depend on the psychotherapeutic approach they work in. They are presented in Table 3.

For cognitive–behavioural therapists, guaranteeing the right to refuse treatment due to conscientious objections (M = 3.88; SD = 1.04) or a lack of skills (M = 4.34;

Table 3. Kruskal – Wallis Test results for differences in rating favourability of legal regulation effects among representatives of psychotherapeutic approaches

			***M* (*SD*)**	***Mdn***	**Kruskal-Wallis Test**	
					p	*H*
The guaranteed right for psychotherapists to refuse therapy when they lack the skills to work with a particular patient	CBT > integrative	CBT	4.34 (.75)	4	< .047	> 73.21
		integrative	3.98 (.83)	4		
The guaranteed right for psychotherapists to refuse to provide to a particular patient when the therapist has conscientious objections to doing so		CBT	3.88 (1.04)	4		
		integrative	3.41 (1.08)	4		

			M (*SD*)	*Mdn*	Kruskal-Wallis Test	
					p	*H*
Definition of the minimum training requirements for conducting psychotherapy	psychodynamic > integrative, systemic	psychodynamic	4.80 (.47)	5	< .016	> 54.98
		integrative	4.53 (.68)	5		
		systemic	4.53 (.73)	5		
Definition of the minimum training requirements for supervising psychotherapy	psychodynamic > systemic	psychodynamic	4.77 (.50)	5	< .026	> 53.43
		systemic	4.55 (.65)	5		
Extending the length of psychotherapists' training	psychodynamic > CBT, integrative	psychodynamic	3.13 (.99)	3	< .035	> 74.96
		CBT	2.66 (1.09)	3		
		integrative	2.65 (.95)	3		
Limiting the number of institutions authorized to train psychotherapists, and consequently lengthening waiting lists for training	psychodynamic > integrative, humanistic	psychodynamic	3.03 (1.10)	3	< .007	> 102.76
		integrative	2.24 (1.15)	2		
		humanistic	2.29 (1.19)	2		
Limiting access to the right to conduct psychotherapy in certain psychotherapeutic approaches	psychodynamic, CBT > humanistic, systemic, integrative	psychodynamic	3.14 (1.12)	3	< .044	> 61.02
		CBT	3.05 (1.25)	3		
		humanistic	1.82 (1.06)	1		
		systemic	2.42 (1.11)	2		
		integrative	2.27 (1.09)	2		
Limiting access to the right to supervise in certain psychotherapeutic approaches	psychodynamic, CBT > humanistic, systemic, integrative	psychodynamic	3.07 (1.09)	3		
		CBT	3.05 (1.25)	3		
		humanistic	1.91 (1.19)	1		
		systemic	2.45 (1.08)	2		
		integrative	2.20 (1.06)	2		
License withdrawal for people insufficiently qualified	psychodynamic, CBT > systemic, integrative, humanistic	psychodynamic	4.30 (.93)	5		
		CBT	4.27 (.96)	5		
		systemic	3.86 (1.13)	4		
		integrative	3.82 (1.11)	4		
		humanistic	3.76 (.86)	4		
Promoting models of psychotherapy based on empirical evidence	CBT > all others; psychodynamic> humanistic, integrative	CBT	4.38 (.86)	5	<.004	> 80.00
		psychodynamic	3.87 (1.06)	4		
		systematic	3.59 (.97)	4		
		humanistic	2.62 (1.28)	3		
		integrative	3.12 (1.32)	3		
Requiring psychotherapists to take examinations organized by supervisory institutions		CBT	3.96 (.95)	4	< .048	> 44.44
		psychodynamic	3.64 (1.12)	4		
		systematic	3.36 (1.06)	3		
		integrative	3.18 (1.22)	3		
		humanistic	3.21 (1.18)	3		
Periodic verification of certified psychotherapists' skills	CBT > systemic, integrative	CBT	3.58 (1.08)	4	< .023	> 68.16
		systematic	3.03 (1.08)	3		
		integrative	2.96 (1.06)	3		
Control over psychotherapists' lifelong learning		CBT	3.99 (.92)	4		
		systematic	3.51 (1.13)	4		
		integrative	3.43 (1.16)	4		
Periodic verification of certified supervisors' skills	CBT > integrative	CBT	3.72 (1.04)	4	< .009	> 86.20
		integrative	3.14 (1.08)	3		

SD = 0.75) turned out to be more favourably rated than for the representatives of the integrative approach (respectively: *M* = 3.41; *SD* = 1.08 and *M* = 3.98; *SD* = 0.83; *ps* < .047; *Hs* > 73.21; see Figure 2, 3).

There were several items regarding the quality of psychotherapeutic education and they were considered more favourable by the representatives of the psychodynamic approach than by those of other psychotherapeutic approaches. The effect relating to the minimum training requirements for conducting psychotherapy was rated more favourably by psychodynamic therapists (*M* = 4.80; *SD* = 0.47) than by integrative (*M* = 4.53; *SD* = 0.68) or systemic therapists (*M* = 4.53; *SD* = 0.73) (*ps* = .016; *Hs* > 54.98; see Figure 4). The potential effects on the minimum qualifications required to conduct supervision were rated more favourably by psychodynamic psychotherapists (*M* = 4.77; *SD* = 0.50) than by systemic therapists (*M* = 4.55; *SD* = 0.65) (*p* = .026; *H* = 53.43), with no differences between psychodynamic (*M* = 4.77; *SD* = 0.50) and integrative psychotherapists (*M* = 4.57; *SD* = 0.58) (*p* = .78; *H* = 55.26). Interestingly, none of the psychotherapeutic approaches differed from one another in terms of regulations on the minimum qualifications needed to train psychotherapists (*p*= .081; *Hs* = 8.30).

Integrative therapists (*M* = 2.65; *SD* = 0.95) rated the potential extension of training time more unfavourably than did psychodynamic therapists (*M* = 3.13; *SD* = 0.99) (*p* = .035; *H* = 74.96). Humanistic (*M* = 2.29; *SD* = 1.19) and integrative psychotherapists (*M* = 2.24; *SD* = 1.15) rated potential limitations in the number of institutions authorised to train psychotherapists more unfavourably than did psychodynamic therapists (*M* = 3.03; *SD* = 1.10) (*ps* < .007; *Hs* > 102.76).

Representatives of the psychodynamic and cognitive–behavioural approaches agreed to a similar extent on the issue of limiting the right to conduct psychotherapy and supervision in certain psychotherapeutic approaches (respectively: psychodynamic *M* = 3.14; *SD* = 1.12; *M* = 3.07;

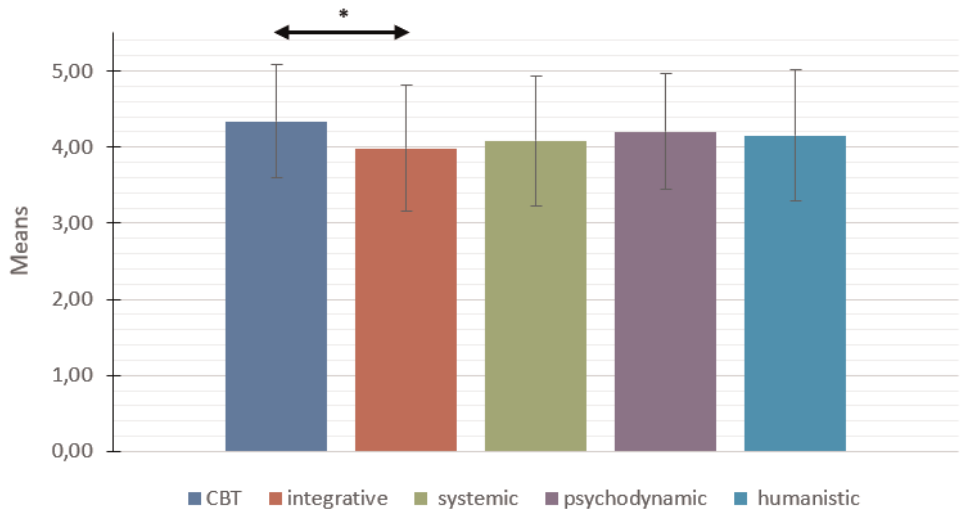

Figure 2. The guaranteed right for psychotherapists to refuse therapy when they lack the skills to work with a particular patient

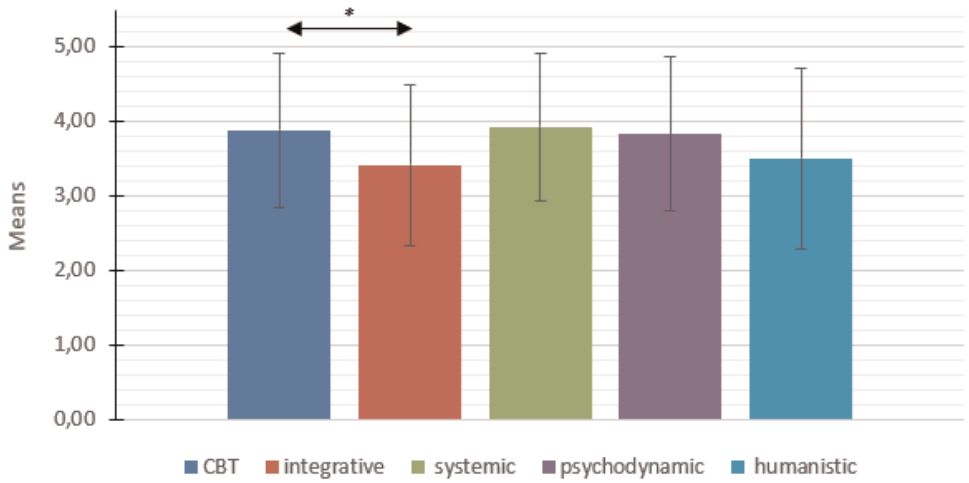

Figure 3. The guaranteed right for psychotherapists to refuse to provide to a particular patient when the therapist has conscientious objections to doing so

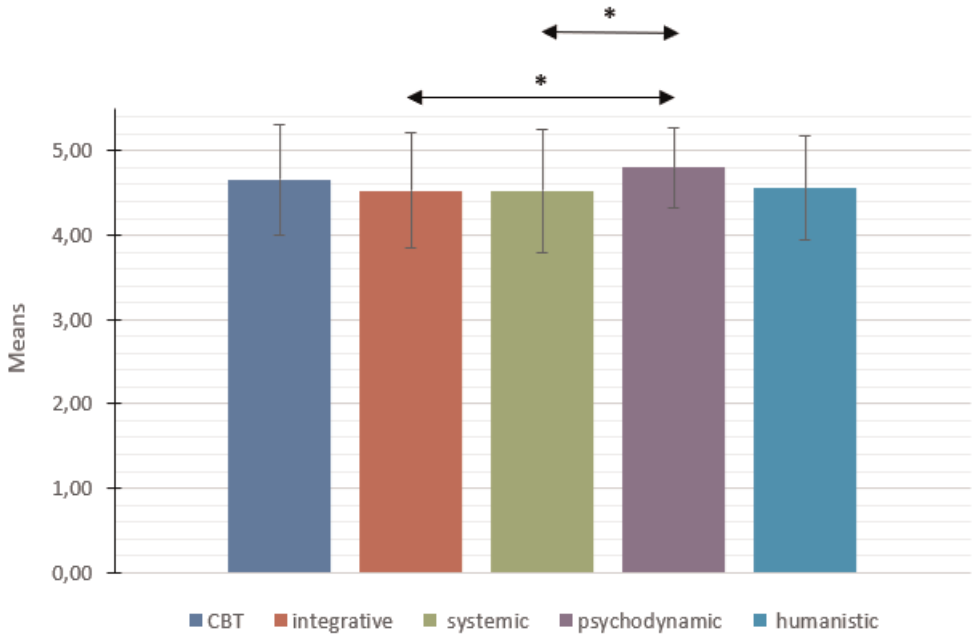

Figure 4. Definition of the minimum training requirements for conducting psychotherapy

SD = 1.09, cognitive–behavioural *M* = 3.05; *SD* = 1.25; *M* = 3.05; *SD* = 1.20). They also evaluated license withdrawal for insufficiently qualified practitioners more favourably than did representatives of other approaches (psychodynamic: *M* = 4.30; *SD* = 0.93; cognitive–behavioural: *M* = 4.27; *SD* = 0.96) considering these effects significantly more favourable than did representatives of other approaches (*ps* > .044; *Hs* > 61.02).

The requirement to undergo examinations organised by supervising institutions was rated significantly more favourable as significantly more beneficial by cognitive–behavioural psychotherapists (*M* = 3.96; *SD* = 0.95) than by therapists of the other psychotherapeutic approaches (*ps* < .048; *Hs* > 44.44). Similarly, the results regarding the promotion of evidence-based psychotherapy models were rated by cognitive–behavioural therapists (*M* = 4.38; *SD* = 0.86) than representatives of other psychotherapeutic approaches (*ps* = .004; *Hs* > 80.00). Periodic verification of the skills of certified therapists and control over the lifelong learning of psychotherapists were rated as significantly more beneficial by cognitive–behavioural therapists (respectively: *M* = 3.58; *SD* = 1.08; *M* = 3.99; *SD* = 0.92) than by systemic (*M* = 3.03; *SD* = 1.08; *M* = 3.51; *SD* = 1.13) or integrative therapists (*M* = 2.96; *SD* = 1.06; *M* = 3.43; *SD* = 1.16) (*ps* < .023; *Hs* > 68.16). On the other hand, periodic verification of the competences of certified supervisors turned out to be rated less beneficial by integrative therapists (*M* = 3.14; *SD* = 1.08) than by cognitive–behavioural therapists (*M* = 3.72; *SD* = 1.04) (*p* = .009; *H* = 86.20).

Qualitative results

The participants were also asked to specify the details of potential legal regulation. Psychotherapists were asked about a possible educational pathway, as well as about the bodies that would verify this education, and overarching authorities that would supervise the operation of these bodies. Respondents also identified the types of behaviour of psychotherapists that would be subject to disciplinary responsibility. The final issue analysed was the legitimacy of the existence of a professional self-governing body and its possible role.

The most difficult topic was that of the psychotherapy qualification pathway (regarding training time, one's own practice, and clinical internships). The responses to this were so varied that it was difficult to create categories. Some psychotherapists indicated the need for a university degree in psychology or medicine, while some did not refer to the necessity of a university degree at all. The most frequently indicated length of psychotherapeutic training was 4 years, although the range of suggestions was large. As for their own psychotherapy, the duration indicated by psychotherapists oscillated between 30 and 300 hours (or between a year and a minimum of 5 years, if the answer was given in years). Psychotherapists also suggested very different durations of clinical internship. Especially with this item, one can see a huge range of proposals: from two months to 5 years (if the number of hours was given, the range oscillated between 160 and 600 hours).

When asked about the composition of the panel overseeing this qualification pathway, the respondents suggested psychotherapists, supervisors, and other bodies appointed either by a given psychotherapeutic approach or teams of representatives of various psychotherapeutic approaches or did not specify which psychotherapeutic approaches should be represented. Psychotherapists also pointed to external committees or individuals (e.g., the Ministry of Health, psychiatrists, patients) as a guarantee of not depending on training centres. There were a relatively large number of voices pointing to the need

for relevant experience and length of service for members of the training verification team, although the responses were also highly varied and not always clear.

When asked about the institution or organization that should supervise the operation of this oversight panel, the respondents predominantly pointed to psychological and psychiatric associations. State institutions and professional self-governing body were less frequently mentioned. There were also voices calling for the establishment of a new or interdisciplinary institution to supervise the operation of the oversight panel.

Regarding the question of what behaviours on the part of psychotherapists should lead to disciplinary review, the responses generally pointed to any behaviour that was inconsistent with either ethical codes or the Criminal Code. Where the responses were more detailed, they specified, for example, violation of basic human rights, violation of patient confidentiality, false presentation of qualifications, role conflict or assuming dual roles. Therapists also included in this a lack of concern for the quality of work (e.g., issues related to the lack of self-development, a failure to improve skills and qualifications, a lack of supervision of therapeutic work, and the use of scientifically unproven methods). The respondents also emphasised that disciplinary matters should also deal with subjective harm to the patient (which at present is dealt with only by civil law in Poland).

The body responsible for disciplinary proceedings should be a self-regulatory organization, a panel of professional peers, a psychotherapists' union or bodies appointed by specific psychotherapeutic associations. A few respondents pointed to the state as the body responsible for disciplinary reviews of psychotherapists, but the vast majority of participants indicated (and sometimes even stressed) that this authority should not be controlled by the state authorities. Respondents did not always use unambiguous terms. For example, they would specify 'a court' without indicating what type of court. Even when more detail was given—such as 'a disciplinary court'—it remained unclear whether the reference was to a new body operating under the self-governing body or under a psychotherapeutic association, and at what level. This may indicate that the psychotherapeutic community lacks fully precise views of this matter.

Similarly, very diverse answers were received in response to the question on the role of a professional self-governing body in overseeing qualifications and assessing the activities of psychotherapists and supervisors. These responses ranged from rating it as 'important, key, and leading,' through those suggesting an advisory and supporting function, to voices clearly indicating that a professional self-governing body should have no role in overseeing skills and discipline. The detailed answers reveal that respondents confirmed the necessity of the disciplinary and competency-overseeing role indicated in the question, but also provided their own proposals for the functions of this body: that it should be opinion-forming and representative, and that it should cooperate with state bodies in developing qualification programs.

DISCUSSION

Psychotherapy requires frequent ethical decision making. All over the world psychotherapists are commonly expected to make decisions about patients' credibility (e.g. in the case of ensuring non-suicidality) or about the limits of confidentiality (Braun & Cox, 2005). Even when regulations are available these decisions are quite difficult, as they often require relying on specific legal solutions or precedents and uncertain information from the patient. The present study suggests that the rules regarding the limits of patient confidentiality may be the most burdensome in countries that do not regulate the profession of psychotherapy. The lack of regulations makes it unclear how the patient's confidentiality is to be treated. It doesn't even help when a practicing psychotherapist has qualified as a psychologist, and psychological confidentiality is regulated in a given country, as it is the case in Poland. In this case confusion arises e.g. when judges erroneously state at hearings that psychotherapists are not bound by patient confidentiality. In this regard, it is worth recalling that the obligation to maintain confidentiality applies to many other professions, such as a notary, advocate, legal adviser, tax advisor, medical advisor, journalist, statistician or Public Prosecutor General (Journal of Laws, 2022, item 1375). In the case of health care services the justice administration may expect disclosing facts covered by patient confidentiality if these facts cannot be established from other evidence and if it is clear that the interests of this administration exceptionally justify such a violation (Decision of Łódź Court of Appeal of 30 December 2019). Bearing in mind the importance of the decisions psychotherapists must make, the issues they raise during psychotherapy and the information they get from their clients (often very sensitive and confidential) – the legislature, in drawing up any future statute regulating the profession of psychotherapy, should protect therapists and patients in decision making accompanying psychotherapy. Our research shows that this is particularly important in the area of psychotherapeutic confidentiality. As a caveat it has to be noted that the lack of legal regulations does not only confuse the issue of confidentiality towards the administration of justice but also towards insurers, other professionals or family members. The circumstances might be critical when the need to waive confidentiality for patient safety exists, but the decision is risky due to other regulations, e.g., General Data Protection Regulation (GDPR). Nowadays problems also arise when there are contradictions between the ethical or professional codes of psychological/ psychotherapeutic associations and the provisions of law or the rules of an insurer, which can pose difficulties in clearly recognizing the boundaries of confidentiality and the waiving of confidentiality, while also generating numerous ethical and legal dilemmas.

The present study showed that most psychotherapists are reluctant to subject themselves to the control of state authorities. This may be due to a fear of limiting the autonomy of the profession and the fear of potential

conflicts of interest between the state and psychotherapists and their clients/patients. This may be seen in the context of a low level of trust in state institutions in countries with relatively young democracies. It is also possible that psychotherapists are worried by the possibility of excessive interference in the workings of the psychotherapeutic process by officials who do not understand the specifics of the profession. This worry may be justified considering the fact that governmental principles of refunding and regulating psychotherapy were constantly changing over the 30-year discussion on these issues. In addition to the bills aimed at regulating the psychotherapists' profession from 2006, 2008, 2009, and 2010 as well as the newest one from 2025 and several partial regulations that have been established in recent years, the Ministry of Health introduced the title of specialist in psychotherapy (Journal of Laws, 2023, item 1187) that is related to the public health care for persons with mental disorders and does not regulate private practice. It is very likely that this 20-year regulatory chaos is causing a lack of confidence in politicians' ability to manage the issue of psychotherapy. Our data suggest that psychotherapists would prefer to be regulated by a body that is largely independent of executive authorities and grants them self-governance. A similar situation occurs in Poland in many legally regulated professions, such as the professional self-governing body of medical doctors and dentists, the professional self-governing body of physiotherapists or the professional self-governing body of paramedics.

Our results suggest that the current instability is highly unfavourable not only with regard to the issue of confidentiality but also regarding the requirements for psychotherapy training. Clear training criteria (at least its minimal requirements) would increase transparency regarding psychotherapist competences, the lack of which is associated with various risks (e.g. Hoffmann et al., 2008). We also suggest that they may improve the mental health care situation which is dramatically insufficient: in countries with low and middle economic status 76 to 85% of the population and in countries with high economic status, between 35 and 50% of the population has no access to psychotherapy (World Health Organisation, 2011). First, stable training requirements would encourage investment in psychotherapeutic education. Second, clear standards would facilitate governmental or insurance reimbursement for training costs. Third, transparent regulations would increase patient confidence in psychotherapy services, ultimately reducing long-term mental health care costs.

The present study demonstrated that psychotherapists working in different psychotherapeutic approaches differ significantly from each other in their rating of many of the possible effects of regulation. The benefits of guaranteeing the right to refuse therapy when the therapist lacks sufficient competence to work with a given patient or when the patient's behaviour raises conscientious objections in the therapist, were considered more favourably by the cognitive–behavioural therapists than by the integrative psychotherapists. In the cognitive–behavioural approach, specific protocols for working on specific patient problems are often used. Representatives of this psychotherapeutic approach may thus have a greater need to redirect the patient to another therapist who knows a given protocol and can put it into practice. In turn, this may be a less important issue for integrative therapists, who are trained to flexibly combine techniques from different psychotherapeutic approaches.

Issues of increasing minimum training time and training requirements for being licensed as psychotherapist or supervisor turned out to be rated significantly more beneficial by psychodynamic therapists than by systemic, integrative, and humanistic therapists; this can be explained by the high standards of education that already characterise this psychotherapeutic approach (including the need for several years of self-therapy and the submission of session transcripts as case reports to supervisors during psychotherapy training). On the other hand, the requirement to take exams organised by supervisory institutions was rated more favourably by the representatives of the cognitive–behavioural approach than by the representatives of the other psychotherapeutic approaches. Considering this result in the context of similar aspects that were also rated highly by therapists of this psychotherapeutic approach (i.e., periodic verification of the skills of certified psychotherapists and supervisors and control over the lifelong learning of psychotherapists) leads to a similar conclusion: these standards already exist in the world of cognitive–behavioural psychotherapy.

Some psychotherapeutic approaches – namely, the humanistic, systemic, and integrative ones – considered restriction of the right to conduct psychotherapy and supervision to be more unfavourable than did the cognitive–behavioural and psychodynamic therapists. We find this disagreement quite surprising. A similar one was found for the possibility of disallowing individuals who lack qualifications specified in the regulations from practicing psychotherapy. This effect was again more beneficial for the representatives of the cognitive–behavioural and psychodynamic approaches than for those of the humanistic, systemic, and integrative psychotherapists. The question then arises as to whether the representatives of these three psychotherapeutic approaches consider restrictions on the right to practice and the barring of unqualified individuals from practice to be simply less important or whether they have concerns about these regulatory effects. Such considerations can be justified taking into account that these psychotherapeutic approaches have been excluded from financial reimbursement in some countries. For example, after introducing the legal psychotherapy regulations in 1999 in Germany, these psychotherapeutic approaches have been excluded and the systemic psychotherapists needed 20 years to get recognised (Malich, 2020).

Various psychotherapeutic approaches differed in their ratings of the potential promotion of empirical evidence-based psychotherapy models: cognitive–behavioural therapists held this possibility to be very beneficial, but this psychotherapeutic approach differed significantly

in this matter from all the others. This result might not be surprising in the light of many studies demonstrating the effectiveness of this psychotherapeutic approach. Although the question of why the cognitive-behavioural approach excels in effectiveness studies is a separate issue, one common explanation deserves mention. Research may be easier to conduct in this approach because variables can be more precisely operationalised and aligned with mainstream information-processing paradigms (David et al., 2018). Additionally, its intervention procedures are highly structured and often manualised, making them relatively easy to standardise and monitor across studies (Curtiss et al., 2021; Hayes & Hofmann, 2021).

The four effects - definition of the minimum training requirements for conducting psychotherapy, as well as extending the length of psychotherapists' training, establishing sanctions for unethical conduct and licence withdrawal for insufficiently qualified practitioners – were viewed as more beneficial by psychotherapists with longer seniority in comparison with those with less years of experience. Similarly, contributing financially to the running of a professional self-governing body is positively correlated with seniority. A possible explanation for these correlations may be that seniority is typically accompanied by greater self-reflection and insight into professional skills. The more experience psychotherapists gain, the more conscious and critical of their own and other colleagues' skills they become. As a consequence, increasing the standards of the profession might be viewed as more beneficial and valuable by more experienced psychotherapists because they are more conscious of how challenging the work with clients/ patients might be and also that training professional skills requires time and supervision and self-reflection. On the other hand, the more experienced one is, the higher one's earnings might be, and possibly in turn, the less one views financial contribution to the professional self-governing body as unfavourable. However, the right for psychotherapists to refuse to provide to a particular patient due to conscientious objections was viewed less favourably by psychotherapists with longer seniority. Again, this result may be explained by gaining experience through years of practice. The more experienced the psychotherapists are, the greater their skills to work with various people become. Further, along with the length of seniority, they might gain higher ability to separate their own value system from the patient's and have a greater understanding of the ethical principle of helping the patient regardless of their value system.

Psychotherapists are in agreement regarding the existence, operation, and self-financing of a professional representative body (professional self-governing body); this is not a surprising result given psychotherapists' reluctance to allow the profession to be controlled by state authorities. Psychotherapists in all the psychotherapeutic approaches considered here mostly agreed on the need for an overarching code of ethics, of appointing a body to decide on the sanctions for unethical conduct, of introducing a requirement to provide patients with a therapeutic contract that defines the principles and course of treatment, while separately strengthening the protection of the rights of the patients/clients (e.g. by a patients' ombudsman). This is an important conclusion that indicates that psychotherapists are unanimous in their concern for the quality of the services they provide to their patients and clients. There are at present cases of individuals in Poland advertising psychotherapeutic services, despite the fact that these people lack the appropriate qualifications. These days only the various psychotherapeutic associations are responsible in Poland for disciplinary proceedings in the event of unethical conduct by a psychotherapist, but membership in such associations is not obligatory. This means that psychotherapists who do not belong to any psychotherapeutic association can avoid disciplinary liability in general. Presumably for this reason, the creation of an overarching code of ethics for psychotherapists along with the establishment of a single independent body with disciplinary powers over psychotherapists seems to be an important need for Polish psychotherapists, regardless of the psychotherapeutic approach in which they work.

There are certain limitations of our study. First, we did not control for participants' educational background, so we cannot indicate the percentage of participants who are psychologists, psychiatrists or members of other professions. Although the main focus of the study was to investigate what are the views of participants conducting psychotherapy on potential regulation of the profession of psychotherapy, regardless of their basic graduate studies, this is an important limitation of our study.

The second limitation concerns the pronounced gender imbalance that emerged from our convenience-based recruitment. Because Poland still lacks statutory criteria for the title psychotherapist, no central register documents either the number of practitioners or their demographic characteristics. Two available benchmarks have notable limitations: an online survey by Suszek et al. (2017), whose authors explicitly caution that their sample is unlikely to be representative, and a more recent nationwide dataset by Hermanowski et al. (2021), which provides an updated demographic profile of Polish psychotherapists but likewise does not constitute a fully representative sampling frame. Lacking a reliable reference point, we cannot ascertain whether the gender structure of our sample mirrors that of the profession at large. In our study, women accounted for 86.5 % of respondents, men for 13.0 %, and 0.5 % self-identified as 'other.' This predominance of female participants may reflect the true composition of the field or may be an artefact of self-selection and recruitment channels. Accordingly, findings that involve gender or variables correlated with gender, such as preferred theoretical approach - should be interpreted with particular caution.

A further methodological limitation is the absence of an a-priori sample-size calculation. Because the study was exploratory and no reliable population parameters or effect-size estimates were available, any such calculation would not have been methodologically justified; statistical power was therefore assessed only post hoc.

Another limitation of the study concerns the comparative analyses were correlational rather than causal.. There may be a third factor, e.g. personality or temperamental traits of the psychotherapists which may possibly account for both psychotherapeutic approach and the attitude toward legal regulation. Focusing on causality of the differences would be essential in future research. Last but not least, the study was not pre-registered which is another limitation.

Regulations regarding fundamental issues such as mental health should be developed in consultation with the affected community. As our study shows, such research can identify topics particularly worth regulating, as well as controversial areas that require special caution. The definition of the minimum training requirements for conducting psychotherapy is one such issue. Our results clearly demonstrate that the evaluation of certain regulatory aspects depends on one's psychotherapeutic approach, which should be taken into account when introducing or modifying regulations.

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ETHICAL STANDARDS

Declaration of conflicts of interest

Author 1 has declared no conflicts of interest.
Author 2 has declared no conflicts of interest.
Author 3 has declared no conflicts of interest.
Author 4 has declared no conflicts of interest.
Author 5 has declared no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee [Research Ethics Committee at the *masked* University, decision 2022-148] and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed consent

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

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APPENDICES

Appendix 1 List of psychotherapeutic associations who received the study or a link to the study

1. Polskie Towarzystwo Terapii Poznawczej i Behawioralnej [Polish Society for Cognitive and Behavioral Therapy],
2. Polskie Towarzystwo Psychologiczne [Polish Psychological Society],
3. Polskie Towarzystwo Psychoterapii Psychodynamicznej [Polish Society for Psychodynamic Psychotherapy],
4. Polskie Towarzystwo Psychoterapii Integratywnej i Systemowej [Polish Society for Integrative and Systemic Psychotherapy],
5. Polskie Stowarzyszenie Psychoterapii Integracyjnej [Polish Association for Integrative Psychotherapy],
6. Polskie Towarzystwo Psychoterapii Gestalt [Polish Society for Gestalt Psychotherapy],
7. Wielkopolskie Towarzystwo Terapii Systemowej [Society for Systemic Therapy of Wielkopolska],
8. Polskie Towarzystwo Psychoterapii Psychoanalitycznej [Polish Society for Psychoanalytic Psychotherapy],
9. Polskie Towarzystwo Psychoterapii Integratywnej [Polish Society for Integrative Psychotherapy],
10. Stowarzyszenie Psychologów Chrześcijańskich [Association of Christian Psychologists],
11. Polskie Towarzystwo Psychoterapii Skoncentrowanej na Rozwiązaniu [Polish Society for Solution-Focused Psychotherapy],
12. Polskie Towarzystwo Psychoterapii Humanistyczno – Egzystencjalnej [Polish Society for Humanistic and Existential Psychotherapy],
13. Association of Contextual Behavior Science Poland;
14. Wielkopolska Szkoła Psychoterapii Gestalt [School of Gestalt Psychotherapy of Wielkopolska],
15. Stowarzyszenie Psychoterapii Egzystencjalnej GLE-Polska [GLE Association for Existential Psychotherapy, Poland],
16. Ośrodek Pomocy i Edukacji Psychologicznej Intra [Intra Center for Assistance and Psychological Education].

Appendix 2 Original questionnaire examining the attitude of psychotherapists to the potential effects of regulation of the profession

The potential effects of legal regulation of the profession of psychotherapist are described below. Please rate each effect on a scale from 'very favourable' to 'very unfavourable.' You are also encouraged to suggest and evaluate other effects that have not been included in the list below by filling in the 'other' field.

- The guaranteed right for psychotherapists to refuse therapy when they lack the skills to work with a particular patient.
- The guaranteed right for psychotherapists to refuse to provide to a particular patient when the therapist has conscientious objections to doing so.
- The guaranteed right to patient confidentiality in relations with state authorities, and the establishment of unambiguous criteria for waiving such confidentiality.
- Strengthening the protection of the rights of patients/ clients (for example, by creating a patients' ombudsman).
- The obligation on the part of the psychotherapist to provide the patient with a therapeutic contract specifying the principles and course of the treatment.
- Definition of the minimum training requirements for conducting psychotherapy.
- Definition of the minimum training requirements for supervising psychotherapy.
- Definition of the minimum requirements for training psychotherapists.
- Extending the length of psychotherapists' training.
- Limiting the number of institutions authorised to train psychotherapists, and consequently lengthening waiting lists for training.
- Limiting access to the right to conduct psychotherapy in certain psychotherapeutic approaches.
- Limiting access to the right to supervise in certain psychotherapeutic approaches
- License withdrawal for people insufficiently qualified
- Promoting models of psychotherapy based on empirical evidence.
- Requiring psychotherapists to take examinations organised by supervisory institutions.
- Periodic verification of certified psychotherapists' skills.
- Periodic verification of certified supervisors' skills.
- Control over psychotherapists' lifelong learning.
- Control over psychotherapists' activities, mainly by state institutions.
- Control over the psychotherapists' activities, mainly by the psychotherapeutic community (e.g. professional self-governing body).
- The ability of psychotherapists to actively participate in setting up and running a professional self-governing body (including participating in the body's work, visiting educational centers and psychotherapy units, etc.).
- A requirement to contribute financially to the running of professional self-governing body
- Establishment of a code of ethics applicable to all psychotherapists.

• the establishment of an authority (such as a disciplinary court) that may decide sanctions for unethical conduct.
• other (please specify).

Do you think that the profession of psychotherapist should be regulated by law?

• Yes
• No
• I have no opinion

Thank you for answering these questions. Below are some additional open-ended questions regarding some of the possible details of statutory regulation. We would be very grateful if you may answer these questions as well. It should take no more than about fifteen minutes.

1. What should the qualification pathway to the status of a professional psychotherapist be like? (e.g., in terms training time, one's own practice, and clinical internship)
2. What should the qualification pathway to the status of a professional supervisor be like? (e.g., in terms training time, one's own practice, and clinical internship)
3. Who should be on the panel that oversees the qualification pathways to the professions of psychotherapist and supervisor?
4. What institution or organization should supervise the operation of this team?
5. What behaviors on the part of psychotherapists should be subject to disciplinary review by the profession?
6. Which authority should be responsible for enforcing disciplinary reviews?
7. What role should a professional self-governing body play in verifying the education and assessing the activities of psychotherapists and supervisors?