

Factors related to the likelihood of psychologists using exposure interventions in the treatment of anxiety disorders.

Simo Lamminpää, 29533

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Supervisor: Minja Westerlund

Faculty of Arts, Psychology and Theology

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AND THEOLOGY**

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Author: Simo Lamminpää	
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Supervisor: Minja Westerlund	
Abstract: <p>Previous literature indicates that exposure interventions, which have been shown to be effective in treating anxiety disorders, remain underused among clinical psychologists. Using a vignette study, the aim of this study was to explore beliefs concerning exposure interventions and assess which factors are associated with the likelihood of using exposure interventions in the treatment of anxiety disorders among Finnish psychologists. A web survey consisting of participants' demographic and background information, six vignettes on fictional clients who were experiencing different types of psychological symptoms, and the 21-item Therapist Beliefs about Exposure Scale (TBES) was sent to Finnish psychologists. A total of 235 psychologists completed the survey. The results indicated that the beliefs about exposure within Finnish psychologists were somewhat positive ($M = 35.1, SD = 9.1$). Psychologists who had a cognitively oriented psychotherapy training were displaying the most positive beliefs ($M = 25.9, SD = 9.8$). Positive beliefs were positively associated with the use of exposure. A cognitively oriented psychotherapy training predicted an increased usage of exposure, whereas work experience as psychologist predicted a slight decrease. The results indicate that Finnish psychologists have positive beliefs about exposure, which has an impact on the usage of exposure. In addition, the results speak for differences regarding beliefs on exposure among psychologists. As the anxiety disorders are common, effective and evidence-based treatment is of high importance. Addressing the negative beliefs and their impact on decision-making requires tailored training targeted to the various groups within Finnish psychologists.</p>	
Keywords: <i>Exposure, anxiety disorders, evidence-based practice, clinical decision-making, Therapist Beliefs about Exposure Scale (TBES)</i>	
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Avhandlingens titel: Faktorer som är relaterade till sannolikheten att psykologen använder exponeringsinterventioner vid behandling av ångeststörningar.	
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Abstrakt: <p>Tidigare litteratur har kommit fram till att exponering, som är en effektiv metod vid behandling av ångeststörningar, är underutnyttjad av kliniska psykologer. Med hjälp av en vinjettstudie, var syftet med denna studie att undersöka finska psykologers uppfattningar om exponeringsinterventioner och vilka faktorer som är relaterade till sannolikheten att psykologen använder sig av exponering vid behandling av ångeststörningar. En enkät som bestod av bakgrundsfrågor, sex vinjetter om fiktiva klienter med olika typer av psykologiska symptom och Therapist Beliefs about Exposure Scale (TBES) som består av 21 flervalsfrågor skickades till finska psykologer. Respondenternas antal var 235. Enligt svaren hade de finska psykologerna något positiva uppfattningar om exponering ($M = 35.1$, $SD = 9.1$). Psykologer som hade en kognitivt orienterad psykoterapeututbildning hade mest positiva uppfattningar ($M = 25.9$, $SD = 9.8$). De positiva uppfattningarna hade ett positivt samband med användning av exponeringsinterventioner. En kognitivt orienterad psykoterapiutbildning predicerade en ökad användning av exponering, medan arbetserfarenhet som psykolog predicerade en minskad användning av exponering. Studien ger vid handen att finska psykologer har en positiv uppfattning om exponering, vilket påverkar deras beslutsfattning. Vidare tyder resultatet på att det finns skillnader angående uppfattningar om exponering hos finska psykologer. Eftersom ångeststörningar är vanliga är effektiv och evidensbaserad behandling viktigt. För att kunna ta itu med de negativa uppfattningarna och dess effekt på klinisk beslutsfattning, krävs välplanerad upplysning och utbildning gentemot de olika grupperna inom finska psykologkåren.</p>	
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1 Introduction

Anxiety disorders have the highest estimated lifetime prevalence (28.8 %) of the psychiatric disorders, according to a study which focused on the disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). Defining what constitutes anxiety disorders has been debated, since the term refers to a set of mental disorders that vary from one context to another (American Psychiatric Association [APA], 2013; U.S. Department of Health & Human Services [HHS], 2014; Mind, 2013). According to the fifth edition of DSM, the DSM-5, anxiety disorders include separation anxiety disorder, selective mutism, specific phobia, social phobia, panic disorder, agoraphobia, and generalized anxiety disorder (APA, 2013). Parker, Waller, Gonzalez-Salas Duhne, and Dawson (2018) focused on post-traumatic stress disorder (PTSD), obsessive-compulsive disorders (OCD) and social anxiety disorder (SAD) as anxiety disorders. Similarly, in another study, Olatunji, Cisler, & Deacon (2010) chose to include PTSD, OCD, social phobia, panic disorder, and generalized anxiety disorder (GAD) in anxiety disorders. In the present study the anxiety disorders of interest are PTSD, OCD, and GAD.

Due to the high prevalence of anxiety disorders, it is imperative to establish effective treatments for the conditions. According to a study by Clark, Hanstock, and Clark (2016), when treating single and co-occurring anxiety disorders, psychologists apply interventions from cognitive behavior therapy (CBT) treatment guides, but not specific evidence-based protocols or interventions. CBT is an effective method for treating anxiety and the central component is exposure (Hofmann, & Smits, 2008). A meta-analysis by Parker et al. (2018) backed up the claim by Hofmann and Smits (2008); they found that various psychotherapies for treating anxiety are indeed effective, especially in the case of PTSD. According to the meta-analysis (Parker et al., 2018), the most important mediator of treatment efficacy for

anxiety disorders is exposure. Similar conclusions about the effect of exposure interventions have been reported in two meta-analyses by Powers and Emmelkamp (2008) and Opris, Pinteá Garcia-Palacios, Botella, Szamosközi, and David (2012) that both stated that virtual reality exposure (VRET) is an effective treatment for anxiety disorders.

Exposure means that the clients are confronted with the feared stimuli (objects, situations, memories, sensations or thoughts) in a controlled, gradual manner until the anxiety they experience toward the stimuli is extinguished (Marks, 1973). One key element in exposure is gradual and systematic desensitization, first introduced by Joseph Wolpe (1961). In this approach, the client is trained to engage in a relaxation response in advance of the exposure. When the distressing stimulus is introduced, the client engages in the relaxation response, which gradually reduces the fear (Wolpe, 1961). In exposure therapy the client is typically first habituated to the source of anxiety through repeated exposure. According to Wolpe (1961) a hierarchy is created that includes stimuli that are increasingly anxiety-provoking. The client starts with less distressing stimuli and moves towards more challenging stimuli as habituation proceeds. In other words, the client becomes accustomed with the stimuli or situation. Secondly, the client's fearful predictions about what will happen when confronted with the stimuli and situation are proven to be inaccurate. Thirdly, client's feelings of mastery and self-efficacy are strengthened (American Psychological Association, 2019).

There are two main types of exposure (American Psychological Association, 2019). Imaginal exposure refers to the process of verbally describing and mentally revisiting the trauma or source of fear (Foa, 2011). For example, clients who fear germs and wash their hands repeatedly could be instructed by the therapist, live during the therapy session or home with the help of a recording, to imagine a situation in which they visit a public restroom without washing their hands.

In vivo exposure means that the client experiences the distressing situation or stimulus in real life. For example, a client who fears elevators could visit, guided by the therapist, a hotel lobby in which there are elevators. The client's task would be to observe, possibly enter an elevator and simultaneously manage the anxiety which is provoked by the situation. Virtual reality therapy, or virtual reality exposure (VRE), is a form of in vivo exposure in which the client is an active participant in a computer-generated, three-dimensional interactive environment which simulates distressing situations. For example, a client who fears snakes could watch, approach or "touch" a virtual snake with the help of virtual technology (American Psychological Association, 2019).

Despite the existing evidence supporting the efficacy of exposure, the intervention seems to be underused among clinicians. This is problematic, when considering the need for effective treatments of anxiety. Prejudices against exposure include that it is unethical, harmful to the client, or harmful to the therapist (Deacon, & Farrell, 2013). Ruzek et al., (2014) reported that clinicians they surveyed expressed concerns that exposure might increase clients' distress. Becker, Zayfert and Anderson (2004) found in their sample of 852 psychologists that over 52 % were familiar with exposure treatment for PTSD, whereas only a minority, 17 % of them, were using it in their clinical work. A study by van Minnen, Hendriks and Olf (2010), conducted with 255 experts on psychological trauma, supported Becker's et al.'s (2004) finding about the underutilization of exposure treatment for PTSD. Van Minnen et al. (2010) concluded that the more training the experts had received in imaginal exposure, the more likely they were to offer it to their clients. According to Minnen et al. (2010), the perceived credibility of imaginal exposure was also higher among those experts. Credibility refers to what the experts themselves think of the rationale and effect of exposure. The client's own preference for trauma-focused therapy led to experts offering imaginal exposure more often compared with clients opting for a non-trauma-focused treatment. Another study

(Farrell, Deacon, Kemp, Dixon, & Sy, 2013), conducted with 53 students from undergraduate psychology classes, concluded that individuals with negative beliefs about exposure intervention had a more cautious approach to the delivery of the treatment compared to individuals with positive beliefs.

The large body of literature supporting exposure interventions in the treatment of anxiety disorders indicates that exposure is an evidence-based treatment for anxiety, and hence, the underuse of the intervention is potentially problematic. Next, we will review existing evidence about exposure interventions for specific anxiety disorders, namely post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD) and generalized anxiety disorder (GAD), as well as factors related to clinicians' likelihood of using exposure interventions.

1.1 Evidence-Based Practice and Treatment of Anxiety Disorders

Practices that are supported by scientific evidence are called evidence-based practices (EBP) or sometimes empirically supported treatments (EST). EBP include “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). EST are a compilation of interventions that suggests the most suitable intervention for specific symptoms for an average client. EST are therefore part of, but not the same as EBP (Spring, 2007).

According to Hudson (2009), the main idea connected with EBP is that mental health professionals “have a responsibility to account for the methods that they use based on the best evidence available” (2009, p. 156). The metaphor for EBP is a three-legged-stool and it is often illustrated with the help of three circles, see Figure 1. The first circle is the best available research evidence, the second is clinical expertise and the third patient values,

preferences, characteristics, and circumstances. Clinical decision-making should take into account all the three areas (Spring, 2007). Client-related factors such as the clients' personal preferences are important to be considered when delivering EBP. An in-depth discussion of client-related factors when delivering treatment for anxiety is, however, beyond the scope of the present thesis.

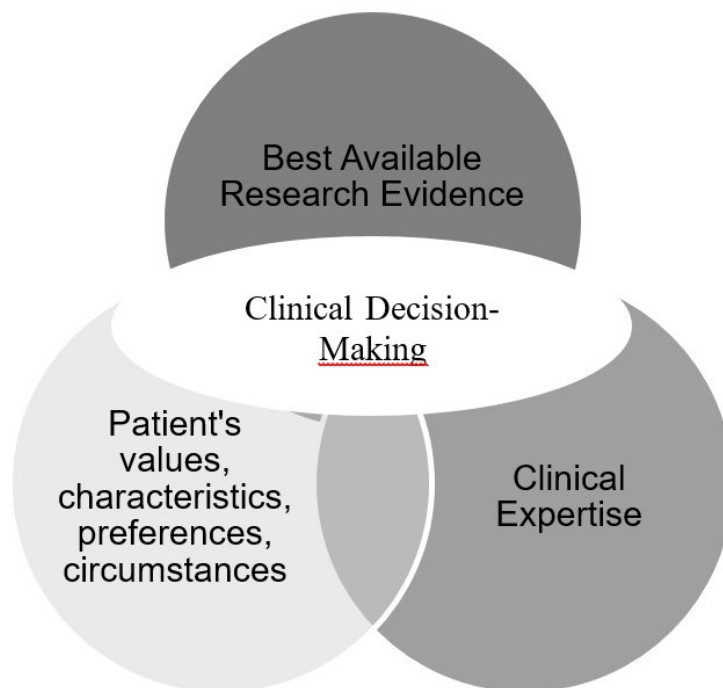


Figure 1. The three circles of evidence-based clinical practice (Spring, 2007)

The following section briefly summarizes the psychological treatment methods of PTSD, OCD, and GAD that have strongest empirical support.

1.1.1. Posttraumatic stress disorder

Exposure is the key component in the treatment of PTSD (Parker et al., 2018) and among the different methods, prolonged exposure (PE) is the most studied (Ruzek et al., 2014). PE has the most empirical evidence in terms of treatment efficacy (Foa, 2011). PE contains four main elements that are imaginal exposure, in vivo exposure, psychoeducation

and breathing exercises (Ruzek et al., 2014). PE is typically conducted over 8-15 therapeutic sessions during which the above-mentioned elements are alternated (Foa, 2011). A study that was conducted among war veterans (Goodson, Lefkowitz, Helstrom, & Gawrysiak, 2013) found that PE reduced symptoms of PTSD and depression. Intensive prolonged exposure, in which a patient attends in several sessions within one week, instead of weekly sessions, might be effective with trauma patients who have had multiple treatment attempts, and who suffer from multiple trauma (Hendriks, de Kleine, Broekman, Hendriks, & van Minnen, 2018). Jerud, Farach, Bedard-Gilligan, Smith, Zoellner, & Feeny (2016) found that patients who have been repeatedly exposed to traumatic events benefitted from exposure therapy as much as patients with single-exposure trauma. Psychological treatments that combine cognitive restructuring, imaginal exposure and in vivo exposure, or just imaginal exposure with in vivo exposure have shown to be most effective in the treatment of PTSD (Diehle, Schmitt, Daams, Boer, & Lindauer, 2014). Exposure can be used even with PTSD clients who have other severe mental illnesses, such as schizophrenia (Long, Grubaugh, Elhai, Cusak, Knapp, & Frueh, 2010), or various comorbidities, such as major depression, substance use disorder or suicidality (van Minnen, Harned, Zoellner, & Mills, 2012; van Minnen, Zoellner, Harned, & Mills, 2015). There are, however, also other therapeutic approaches that relieve PTSD symptoms. In an attempt to identify the common factors of the empirically supported psychotherapies for trauma survivors, Schnyder et al. (2015) found six: offering psychoeducation; teaching emotion regulation and coping skills; conducting imaginal exposure; supporting cognitive processing, restructuring and/or meaning making; targeting emotions; and enhancing memory processing.

1.1.2. Obsessive-compulsive disorder

For OCD, the treatment that has most evidence (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000) is called exposure and ritual prevention (EX/RP). During EX/RP, the patient is both exposed to the distressing stimuli and also asked to avoid the rituals that the patient has (Franklin et al., 2000). Nowadays the treatment is called exposure and response prevention (ERP) which is has shown to be highly effective (Hezel, & Simpson, 2019). The previously mentioned example of clients who visit a public restroom without washing their hands is an example response prevention.

1.1.3. Generalized anxiety disorder

Current consensus about treating GAD is that patients benefit most from cognitive behavior therapy (CBT) in terms of reduced anxiety, but also reduced secondary symptoms such as reduced worry and depression (Hunot, Churchill, Teixeira, & Silva de Lima, 2007). However, most of the studies regarding the effective treatment of GAD have been conducted by comparing CBT with other psychological therapies. The sample of the studies is therefore homogenous (Hunot et al., 2007). A meta-analysis by Cuijpers, Sijbrandij, Koole, Huibers, Berking, and Andersson (2014) of 41 studies, of which 22 included some type of exposure, supported the findings of Hunot et al. (2007) about the effectiveness of CBT in treating GAD. Cuijpers et al. (2014) stated that the specific CBT techniques that are effective are a mix of exposure, cognitive restructuring, problem-solving, and relaxation exercises.

1.2 Factors Related to the Likelihood of the Therapist Using Exposure

A frequently mentioned reason for why mental health professionals do not provide the most evidence-based psychological treatment relates to the training they have received.

Practices that are not supported by scientific evidence are overrepresented in the training of

mental health professionals and cognitive behavioral techniques should be emphasized more, because they have more scientific support when treating anxiety disorders than other orientations (Deacon & Farrell, 2013). In a review article Hudson (2009) listed several reasons why scientific findings do not find their way into mental health professionals' daily work. Some mental health professionals choose to follow existing workplace protocols, apply only one popular theoretical framework or embrace a thinking that whatever treatment works is fine. The gap between the aims of researchers and practitioners is an additional factor. Translating the group-based results into individualized treatment plans is difficult. Researchers are typically interested in knowledge that can be generalized and applied to a large range of situations, problems and persons. Interventions that one is able to specify, monitor and replicate are the focus in research. To raise the probability of generalizable research results, researchers tend to focus on uncomplicated cases, often excluding persons who have prior treatments, comorbidities and/or other features that might risk the validity of the research. The final sample of a given study therefore includes cases that are low in complexity compared with the everyday clinical reality of a practitioner. However, practitioners are usually more interested in tailoring their interventions according to the needs of the individual client and helping him or her to reach goals that are relevant (Hudson, 2009).

Hudson's (2009) conclusions have been supported by other literature. Researchers have found several factors that hinder the implementation of EBP in a work setting. These can be categorized into four categories: working environment; the professionals themselves; the presentation and distribution of the research results; the research itself (Dunn, Crichton, Roe, Seers, & Williams, 1998). The working environment refers, according to Dunn et al. (1998), to limitations in facilities and lack of time or cooperation that are required to implement new ideas or ways of working that are suggested in research. McCaughan, Thompson, Cullum, Sheldon and Thompson (2002) refer to the same issue as absence of organizational support to

try new interventions. The professionals themselves refer to the persons' incapability to determine the quality of the research or unawareness of the research (Dunn et al, 1998), which McCaughan et al. (2002) called incompetence to interpret and utilize the results and/or lack of motivation to apply research results in one's own work. The presentation and distribution of the research entails that relevant literature is not found in one place, the statistical analyses are not comprehensible and the research is not reported clearly (Dunn et al., 1998). The research itself refers to the qualities of the research (Dunn et al., 1998) or low clinical credibility of the researchers and research results (McCaughan et al., 2002).

Specifically, as stated by Becker et al. (2004) and van Minnen et al. (2010), exposure is an empirically supported intervention that is underused among clinicians. Sars and van Minnen (2015) conducted a study about the frequency of use of exposure therapy for anxiety disorders. They also analyzed how variables such as therapist's education or attitude affected the application of exposure. The target group consisted of the members of Dutch Association for Behavioral Cognitive Therapy. Of the 490 respondents, 97.8 % ($n = 450$) reported using some type of exposure for the treatment of anxiety (social anxiety, phobia, OCD, and panic disorder). The most frequently used type of exposure was exposure-based homework assignments. Thus, most of the exposure took place outside the formal therapy session. As motives for applying exposure, the participants reported that exposure is both effective and empirically supported. In general, the participating Dutch behavioral cognitive therapists had a positive attitude towards exposure therapy. The study found that a positive attitude toward exposure was positively associated with the application of the intervention. The more positive the attitudes, the higher the likelihood of applying exposure therapy when treating anxiety disorders. Variables that correlated positively with the frequency of application of in vivo exposure and exposure-based homework were therapist's willingness, personal preference and the perceived credibility of the treatment. When comparing the selected disorders, it was

shown that the use of exposure therapy depended on the disorder. About 22 % of the patients with panic disorder rarely received the guideline-recommended exposure exercises (Sars & van Minnen, 2015). Deacon et al (2013) found that therapists who had more negative beliefs about exposure therapy more frequently selected actions that would reduce the client's anxiety during exposure activities. These actions included among others reducing arousal or selecting an easier exposure item. Positive beliefs were associated with more confident and less cautious delivery of exposure therapy. An important factor for the positive attitude among the therapists seemed to be training (Deacon et al., 2013; Sars & van Minnen, 2015). Sars and van Minnen (2015) suggested that impacting thoughts and beliefs about exposure therapy will lead to even more frequent use.

Another study focused on the dissemination and use of exposure therapy by analyzing therapists' beliefs about exposure and other therapist-related characteristics (Schumacher, Weiss, & Knaevelsrud, 2018). The study focused on the treatment of panic disorder, phobia and PTSD, and was conducted among 331 German cognitive behavioral therapists. The participants reported how frequently they applied certain treatment options. As a treatment option for each disorder Schumacher et al. (2018) selected the key procedure for each disorder that was in accordance with respective evidence-based cognitive behavioral therapy protocol. Schumacher et al. (2018) found that 33 % of the therapists frequently used therapist-directed interoceptive exposure¹ in the treatment of panic disorder, 45 % frequently used therapist-directed in vivo exposure in the treatment of phobia and 53 % frequently used therapist-directed imaginal exposure in the treatment of PTSD. "Frequent use" meant that the therapists reported that they used the key procedure between 81 and 100 % of the cases. The percentage of therapists who applied the procedures between 1 and 80 % of the cases was 53 % for panic disorder, 47 % for phobia, and 33 % for PTSD. The number of so-called non-users, meaning

¹ Interoceptive exposure is an exposure strategy which "involves deliberately and repeatedly producing feared bodily sensations" (Walker & Furer, 2008, p. 366)

therapists who did not use the selected exposure interventions at all, was 14 % for panic disorders, 8 % for phobia, and 15 % for PTSD. In general, fewer negative beliefs about exposure predicted more frequent use of the selected therapist-guided exposure treatments. In the case of panic disorder and phobia, the frequent application of exposure was additionally significantly predicted by the therapist's younger age. Therapist's gender, educational level or number of exposure sessions completed during therapist's clinical training had none or low predictive value in the application of exposure. Less frequent application of exposure was predicted by therapist's older age (Schumacher et al., 2018). Deacon et al. (2013) found that positive beliefs about exposure therapy were associated with self-reported anxiety specialist status, doctoral degree, younger age and male gender. According to Davis (1980) gender differences in attitudes toward exposure might be influenced by women's higher levels of emphatic concern.

1.3 Aims of the Study

The research shows that anxiety disorders are common, effective treatment for them often requires exposure and that exposure is underused by clinicians (Kessler et al., 2005; Parker et al., 2018; Becker et al., 2004; van Minnen et al., 2010). Our aim was to examine beliefs about the exposure intervention among Finnish psychologists and investigating factors that may be associated with the use of exposure. In the present study, unless otherwise specified, “exposure”, “exposure tasks”, “exposure treatment”, “exposure therapy” and “exposure intervention” refer to any type of therapeutic approach or technique, short or long, that involves exposure when treating individuals with psychological symptoms. To our knowledge, no prior study has explored the attitudes and beliefs about exposure among Finnish psychologists. The results can be used for planning and developing training initiatives and targeting communication among the Finnish psychologists.

We formulated the following research questions:

1. What types of beliefs do psychologists in Finland have towards exposure intervention?
What type of impact does the orientation of the psychotherapy training have on the beliefs?
2. Are positive beliefs towards exposure associated with an increased use of the exposure intervention? Does the amount of clinical work experience have an impact?
3. Which factors relate to the likelihood of psychologists using the exposure intervention?

2 Method

2.1 Procedure

We created a web survey consisting of three parts. The survey was in Finnish and titled “Clinical decision making”, and no reference to exposure was made in the introduction. The first part of the survey included demographic and background information of the participants (gender, psychotherapeutic education, additional education, type of current employer, years of experience in the field and the average amount of client work in hours per week).

The second part of the survey contained six vignettes on fictional clients who were experiencing different types of psychological symptoms. The participants’ task was to familiarize themselves with the vignette and choose among the given 11 treatment options the most adequate and essential treatment for the described symptoms. The options were the same for all of the vignettes. The vignettes are available in Finnish and in English in Appendix 1.

The third part of the web survey included the 21-item Therapist Beliefs about Exposure Scale (TBES; Deacon et al., 2013) in Finnish.

The estimated time for the respondent for completing the web survey was 15 minutes. The actual average time used by the participants to complete the survey was 14 minutes and 19 seconds. All participants answered the same questions in the same order. All data were collected using Survey Analytics and the data were stored and archived on Åbo Akademi University’s protected servers.

The study was approved by the Institutional Review Board of the Departments of Psychology and Logopedics, Åbo Akademi University.

2.2 Sample

The web survey was distributed through the mailing list of the members of the Finnish Psychological Association on April 9, 2019. The Finnish Psychological Association is an organization for Finnish psychologists and it has currently around 5500 licensed psychologists as members, which is ca 90 % of all psychologists in Finland (Finnish Psychological Association, n.d.). The link to the web survey was distributed via email. The total number of members who were reached via email was 4951. In total 235 answers were submitted during the survey period, resulting in a response rate of 4.7 %.

The participation was voluntary. We used a convenience sampling in which the participants were selected based on their availability, i.e. being listed on the mailing list, and willingness to participate. There were no exclusion criteria, so that all licensed psychologists on the mailing list were welcome to respond to the survey. The survey was open for two weeks until April 23, 2019. No reminders were sent to the target group during the survey period.

2.3 Instruments

2.3.1 Vignettes

Six vignettes were created for the purpose of this study. The objective was to create short and simple descriptions of the selected disorders, using the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) as a reference for characteristic symptoms. In addition, one psychologist-psychotherapist with cognitive orientation, one psychologist-psychotherapist with psychodynamic orientation, and a group of Master's level psychology students were consulted when the vignettes and the treatment options were created. The vignettes described six different invented client cases, focusing on the client's symptoms. The psychological symptoms described were single trauma (PTSD),

multiple trauma (PTSD), depression, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), and eating disorder. The depression and eating disorder vignettes served the purpose of masking the primary focus area of the survey and the answers to these two vignettes were not analyzed. No information about the fictional client's age, gender, preferences or other background was given in the vignettes. The decision of minimizing the client related variables was made that we could limit the amount of variables that would impact the decision-making and focus on the intervention alternatives.

2.3.2. Therapist Beliefs about Exposure Scale (TBES)

The TBES scale (Deacon et al., 2013) contains 21 statements to which the participant responded using a five-point-scale from 0 to 4. The scale includes questions such as “Most clients have difficulty tolerating the distress exposure therapy evokes” and “It is unethical for therapists to purposely evoke distress in their clients”. The total score of an independent responder can range from 0 to 84. Lower scores indicate fewer negative beliefs about exposure, whereas higher scores indicate more negative beliefs. Guidelines for interpreting the TBES scores did not exist, and no subscales for TBES have been reported. Therefore, the total score range from 0 to 41 was considered as positive beliefs, 42 neutral, and the range from 43 to 84 as negative beliefs.

Deacon et al. (2013) administered a series of studies in order to develop the TBES. In the first study, Deacon et al. (2013) introduced and tested the psychometric properties and validity of TBES. In total, 637 U.S.-based therapists who provided psychotherapy to individuals who suffered from anxiety disorders completed the scale. The results indicated that the final 21-item TBES seemed to have a clear single-factor structure and excellent internal consistency. The second study, conducted with 113 therapists from the first study, demonstrated that the TBES had an exceptionally high test-retest validity. In the third study,

Deacon et al. (2013) came to the conclusion that not only does the TBES scale have excellent psychometric features, but that the therapists' beliefs about exposure can be reshaped by academic training. In conclusion, Deacon et al. (2013) developed a valid and reliable scale for analyzing therapists' beliefs about exposure therapy. In addition, they stated that negative beliefs about exposure forms a considerable obstacle in utilization and delivery style of exposure tasks.

In our sample, the Cronbach's α for the Therapist Beliefs about Exposure Scale (TBES) was .85, which can be considered as good. We obtained permission to translate the scale into Finnish for the present study from the first author of the original article (Deacon et al., 2013). The survey was translated to Finnish by a native Finnish speaker, and reviewed by a cognitively oriented psychotherapist and a group of master's level psychology students.

2.4 Data Analyses

All analyzes were conducted using SPSS 24.0. We tested the gender differences in the TBES score with a *t* test. To analyze the influence of the psychotherapy orientation we used one-way analysis of variance (ANOVA). Since we had no prior hypotheses, we continued our analyses with Bonferroni post hoc tests.

To assess whether there was an association between positive beliefs towards exposure and the use of the exposure intervention we conducted Pearson's correlation tests. We used partial correlation to control the strength of the correlation regarding the effect of work experience and amount of clinical work per week.

To assess which factors relate to the likelihood of psychologists using the exposure intervention we used a multivariate linear regression model. The categorical variable psychotherapy training was dummy coded using the option "no psychotherapy training" as a baseline variable. We also analyzed the regression diagnostics for multicollinearity and

possible outliers. The tests showed that the data met the assumption of collinearity, thus multicollinearity was not a concern (Cognitively oriented psychotherapy training, Tolerance = .78, VIF = 1.28; Work experience, Tolerance = .64, VIF = 1.56). There was one outlier in the sample. Since we had no prior hypothesis on the influence of the variables, we chose a forced entry for the analysis, in which all the variables were entered in the model at the same time.

3 Results

A total of 235 Finnish psychologist completed the web survey. Table 1 presents the background information and the results on the TBES.

Table 1
Participants' background information and TBES score (M, SD) (n = 235)

	<u>N</u>	<u>%</u>	<u>TBES Score (M)</u>	<u>TBES (SD)</u>
<u>Total</u>	235	100.0	35.1	9.1
<u>Gender</u>				
Female	188	80.0	35.3	8.9
Male	47	20.0	34.2	10.0
<u>Additional training</u>				
Specialized psychologist (licentiate degree)	21	8.9	35.8	7.8
Specialized psychologist (current degree)	6	2.6	36.0	10.0
PhD in psychology	9	3.8	36.2	8.9
Currently in training	32	13.6	30.9	8.9
MSc or BSc from another field	19	8.1	37.8	8.6
Other	185	78.7	34.8	8.6
No additional training	114	48.5	35.1	8.5
<u>Orientation of psychotherapy training</u>				
Psychoanalytic	13	5.5	43.8	9.6
Psychodynamic	15	6.4	38.1	6.7
Cognitively oriented	30	12.8	25.9	9.8
Crisis and trauma therapy	2	.9	36.5	3.5
Family therapy	9	3.8	40.2	7.9
Integrative therapy	10	4.3	34.6	8.1
Other	11	4.7	34.0	12.0
No psychotherapy training	145	61.7	35.6	7.7
<u>Primary employer</u>				
State, municipality or hospital district	171	72.8	34.9	8.1
Private company or cooperative	21	8.9	33.3	12.2
Entrepreneur	35	14.9	35.5	11.3
Other	5	2.1	39.4	11.4
Currently not working	3	1.3	41.3	4.0

Note. Participants were allowed to select several alternatives on additional training.

The data file included 474 responses of which 239 were incomplete and were removed. The participants' self-reported work experience as a psychologist ranged from 0 to 50 years ($M = 13.9$, $SD = 11.4$). The amount of client work per week ranged from 0 to 50 hours ($M = 21.6$, $SD = 10.0$).

We started the analyses by examining the beliefs psychologists in Finland have towards the exposure intervention, measured with the TBES scale. The total scores ranged from 3 to 62, with the mean score being 35.1 ($SD = 9.1$), indicating somewhat positive attitudes towards exposure. The difference between females ($M = 35.3$, $SD = 8.9$) and males ($M = 34.2$, $SD = 10.0$) was not statistically significant ($t(233) = .744$, $p = .458$, $d = .12$). The item that had the highest score ($M = 3.2$, $SD = .7$) was the item 12 "Arousal reduction strategies, such as relaxation or controlled breathing, are often necessary for clients to tolerate the distress exposure therapy evokes". The item with the second highest score ($M = 2.2$, $SD = 1.0$) was the item 3 "Exposure therapy works poorly for complex cases, such as when the client has multiple diagnoses". The item 19 "Exposure therapy is inhumane" had the lowest score ($M = .8$, $SD = .7$).

The orientation of psychotherapy training was significant when analyzing the differences between groups, $F(7, 227) = 8.22$, $p < .001$. Levene's test showed that the variances within the psychotherapy training groups were equal, $F(7, 227) = 1.78$, $p = .091$. Cognitively oriented psychotherapists had the lowest TBES scores ($M = 25.9$, $SD = 9.8$), indicating the most positive attitudes towards exposure in the present sample. The largest significant differences between psychotherapy orientations were found between cognitively oriented psychotherapists and psychoanalytical psychotherapists ($M = 43.8$; $SEM = 9.6$; $p < .001$; $d = 1.85$), between cognitively oriented and psychodynamic psychotherapists ($M = 38.1$; $SD = 6.7$; $p < .001$; $d = 1.45$), between cognitively oriented and family psychotherapists ($M =$

40.2; $SD = 7.9$; $p < .001$; $d = 1.61$), and between cognitively oriented and those who currently have no psychotherapeutic training ($M 35.6$; $SD 7.7$; $p < .001$; $d = 1.10$).

Next, we turned to our second research question. We assessed whether there was an association between positive beliefs towards exposure and the use of the exposure intervention. Table 2 presents the participants' treatment choices for the cases presented in the vignettes.

Table 2

The distribution of prioritized treatments in each of the vignettes (n = 235).

Question: In an ideal situation, which is the single most important intervention for patient's recovery. Select one.

<u>Intervention</u>	V1. Single trauma		V2. Depression		V3. Multiple trauma		V4. GAD*		V5. Eating disorder		V6. OCD**	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
1. Supportive counselling	68	28.9	26	11.1	49	20.9	11	4.7	10	4.3	8	3.4
2. Detecting personality structures	0	.0	4	1.7	12	5.1	44	18.7	53	22.6	39	16.6
3. Brainstorming alternative solutions with the patient	12	5.1	63	26.8	34	14.5	6	2.6	16	6.8	10	4.3
4. Exposure (in vivo, imaginal and/or virtual)	75	31.9	0	.0	33	14.0	14	6.0	0	.0	101	43.0
5. Increasing self-awareness and self-understanding	18	7.7	87	37.0	53	22.6	78	33.2	120	51.1	36	15.3
6. Hypnosis	2	0.9	0	.0	1	.4	0	.0	0	.0	0	.0
7. Mindfulness	7	3.0	6	2.6	19	8.1	32	13.6	8	3.4	5	2.1
8. Psychoeducation	45	19.1	7	3.0	16	6.8	35	14.9	7	3.0	15	6.4
9. Behavioral activation and organizing everyday life	2	.9	40	17.0	10	4.3	2	.9	1	.4	18	7.7
10. Self-compassion exercises	6	2.6	2	.9	8	3.4	2	.9	16	6.8	2	.9
11. Appealing to patient's common sense and challenging his/her behavior	0	.0	0	.0	0	.0	11	4.7	4	1.7	1	.4
Total	235	100.0	235	100.0	235	100.0	235	100.0	235	100.0	235	100.0

Note. * Generalized Anxiety Disorder, ** Obsessive-compulsive disorder

The replies to the depression vignette and eating disorder were left out from the analyses. Each of the four remaining vignettes indicating exposure treatment were scored in order to obtain an exposure usage score. A selected exposure intervention equaled one point and other interventions equaled zero, yielding a maximum of four points. There was a moderate negative correlation between the TBES score and the exposure usage score ($r = -.49, p < .001$). When controlling the correlation with participants' self-reported work experience as psychologist and hours of client work per week the correlations remained similar ($r = -.47, p < .001$ and $r = -.49, p < .001$, respectively).

We proceeded to assess our third research question about what factors relate to the likelihood of psychologists using the exposure intervention. The factors in focus were the psychologist's gender, psychotherapy education, work experience as psychologist in years, and the average amount of client work in hours per week. The dependent variable for the regression analysis was the exposure usage score. The regression model was significant, $F(10, 224) = 5.63, p < .001$, and explained 20.1 % of the variation in the participants' use of exposure. The data met the assumption of independent errors (Durbin-Watson value = 1.95). The strongest predictor for the use of exposure was the participant's cognitively oriented psychotherapy training compared with those who had no psychotherapy training ($\beta = .85, t = 4.42, p < .001$), followed by the work experience as a psychologist ($\beta = -.03, t = -3.99, p < .001$). Cognitively oriented psychotherapy training increased the exposure use score by .85 points ($SE = .19$), whereas each one year of service decreased the score by .03 ($SE = .01$). Gender or the average amount of client work in hours per week did not significantly predict the use of exposure ($\beta = .23, t = 1.58, p = .116$ and $\beta = -.00, t = -.09, p = .929$, respectively).

4 Discussion

Many attempts have been made to help mental health professionals to become more evidence-based in their decision making. One such attempt is by Abramowitz (2006), who suggested that empirically supported treatments (EST) show the best direction for treating psychological disorders. However, this does not mean that the mental health professional needs to do exactly as is stated in a manual, but should understand “how to apply the experimentally established principles of behavior (including the behavior of cognition) to clinical problems” (Abramowitz, 2006, p. 164).

In the present study, using the vignette method within a sample of Finnish psychologists, we explored the beliefs concerning exposure and studied what factors are associated with the likelihood of using exposure interventions in treating anxiety disorders. The mean score of Finnish psychologists’ attitudes towards exposure suggested that Finnish psychologists have a somewhat positive attitude towards exposure. The score is similar compared with the study made by Deacon et al. (2013), which also assessed a national sample and used the same measure as in the present study. On the other hand, a study among cognitive behavioral therapists by Schumacher et al. (2018), showed clearly lower mean TBES scores than our study, indicating that their sample expressed more positive attitudes toward exposure interventions. However, the sample of Schumacher et al. (2018) focused on cognitive behavioral therapists. In our sample the corresponding group would be the cognitively oriented psychotherapists who had a lower mean score, suggesting that cognitive therapists have more positive beliefs on exposure. Findings by Deacon et al. (2013) indicating that low scores in TBES would be associated with a doctoral degree or male gender were not replicated in this sample. Our study found that the difference in the TBES scores was significant when comparing the cognitively oriented psychotherapists with psychoanalytical,

psychodynamic, and family psychotherapists. The difference was also significant between cognitively oriented psychotherapists and those who had no psychotherapeutic training.

A lower TBES score, indicating more positive attitudes towards exposure, was associated with the use of exposure. We found a moderate negative correlation between the TBES score and the use of exposure. The more positive the beliefs were the more likely the psychologists were to choose exposure as an intervention when treating anxiety disorders. This supports the findings of Sars and van Minnen (2015), who reported that positive beliefs are associated with the higher likelihood of using exposure.

The strongest factor associated with the use of exposure was if the participant had undergone cognitively oriented psychotherapy training, compared with those who had no psychotherapy training. Work experience as psychologist also had an impact on the use of exposure. More experienced psychologists, in terms of work experience in years, were less likely to use exposure than their colleagues who had been working fewer year in the field. A plausible explanation for this finding could be the strong psychoanalytical and psychodynamic traditions in Finland. The approach in these traditions towards anxiety is different and it also it might impact the dissemination of cognitively oriented interventions. Schumacher et al. (2018) found that less frequent application of exposure was predicted by therapist's older age. Even though we had no information about the participants' actual age, the findings can be considered similar to ours.

In sum, the results indicated that the beliefs about exposure within Finnish psychologists are somewhat positive, and that cognitively oriented psychotherapists are displaying the most positive beliefs. Considering the increasing demand of mental health services and prevalence of anxiety disorders this is positive news. Cost effective treatments are always welcome, especially in the current economic climate in which measurements focusing on time and resources spent on one client are increasingly common (Nurmi, 2016).

Positive beliefs were associated with an increased use of exposure. A cognitively oriented psychotherapy training predicted an increased use of exposure, whereas work experience in the field predicted a slight decrease. One potential explanation for these results is that exposure as an intervention is derived from the cognitive behavioral therapy (Barlow, 2002). The terms “exposure”, “imaginal exposure” or “in vivo exposure” and their practical applicability might be unclear for some of the participants. Another explanation could be, as Hudson (2009) stated, that some mental health professionals choose to follow existing workplace protocols, and apply only one popular theoretical framework or embrace a thinking that whatever treatment works is fine, instead of an evidence-based intervention. In addition, even if the psychologists would know what treatment, according to the latest research, is the most effective, there are other factors, unrelated to the psychologist that might explain the decision-making. Dunn et al. (1998) listed the working environment, the presentation and distribution of the research results, and the research itself as such factors. It is likely that the working environment plays an important part in any professional’s way of working. If new ideas, enhancing ways of working, and experimenting are not encouraged, it is unlikely that the mental health professional will try anything new. Especially those psychologists who are not familiar with exposure will most likely not study and test the method if there are no time and other resources provided by the employer to do so.

There are also critical voices regarding exposure itself, stating that prolonged exposure (PE) and cognitive therapy do not work for all PTSD patients (Horesh, Qian, Freedman, & Shalev, 2017), and that there is no differential efficacy between cognitive therapy and exposure when treating panic disorder, PTSD and obsessive-compulsive disorder (Ougrin, 2011). In addition, the mechanism through which exposure is supposed to work has been challenged (Rupp, Doebler, Ehring, & Vossbeck-Elsebusch, 2016). Rupp et al. (2016) confirmed that habituation, whether it is within-session or between-session, is positively

related to the treatment outcome. However, the association between initial fear activation and treatment outcome was not confirmed. Even if there is strong evidence that speak for exposure, there are mechanisms that are not fully understood. There are prejudices against exposure (Deacon, & Farrell, 2013), and therefore contradicting results on who benefits from it and how it works might have an impact on its dissemination.

Another aspect is the discussion about evidence-based practice. The aim of designing interventions to meet the needs of the client has existed for a long time. The objective of psychotherapy research is to determine “what treatment, by whom, is most effective for this individual, with that specific problem, under which set of circumstances” (Paul, 1969, p. 44). Paul’s statement is very much aligned with the three-legged-stool of EBP, and therefore interesting in the light of the finding that the use of exposure decreases the more one has work experience as psychologist. If the aim is to apply the most effective treatment, and if the more experienced psychologists are using exposure less frequently, what measures are they employing instead? It is likely that they have some other idea of what is effective, and therefore it would of high priority to understand what we could learn from them. This should, however, be assessed by future research.

One more aspect concerns the view on mental health. For the purpose of this study, a categorical approach to mental disorders was chosen. The entire question as to whether mental disorders are categories or dimensions has been debated (Widiger & Samuel, 2005). One could ask, whether anxiety is a separate clinical condition that is clearly different from “non-anxiety”, or is anxiety a condition somewhere on the dimensions of human functioning in which we make subjective distinctions between different conditions? There is a reason to believe that Finnish psychologists are divided in the question whether mental disorders are seen as categories, dimensions, or perhaps something else. As the current study shows that there are differences in beliefs on exposure, it is likely that there also are differences on the

view on mental health, which can be considered a more complex issue than an intervention technique. As our sample was heterogeneous in terms of participants' psychotherapy orientation, additional training and work experience, it is possible that the findings reflect the development of psychology training in Finland throughout the past decades. Simplified, one could theorize, that the current university curriculums in Finland have emerged between two extremes. The other end has focused on analyzing the unconscious motives and conflicts and the other end on behavior that one can observe and measure. The training of psychologists has most certainly been influenced by both ends of the spectrum, gradually forming into the discipline that currently embraces the idea of evidence-based practice and decision-making. While it can be difficult to list all factors that have influenced the training of psychologists, the only thing that can be said with a high level of certainty is that psychology training in universities is different today than what it was 40 years ago. Some of the spontaneous feedback sent by the participants showed that there are strong opinions about the best approach when dealing with anxiety disorders. A few of the participants expressed that the intervention alternatives were insufficient or biased. This again shows that psychologists in Finland do not have a unified approach of treating mental disorders.

4.1 Limitations of the study

Several limitations in this study warrant discussion. The most important limitations concern the vignette method and the intervention alternatives. Typically, the internal validity of vignette studies is good, whereas the external validity is lower (Aguinis and Bradley, 2014). We aimed at presenting clear and typical cases of the selected disorders in the vignettes. Nevertheless, they were simplified in many ways, when compared to actual clinical encounters. Firstly, the client cases were presented only in text. Second, the client-related information was limited only to symptoms, lacking any contextual and other client specific

information. Information about clients' age, gender, background, co-occurring symptoms and possible personal preferences on treatment were not presented. Therefore, elements that might have impacted the decision making in real life were not available. Third, the participants were allowed to select only one, the most important, intervention in each vignette. In reality, pinpointing one intervention might be unrealistic. A design in which the participants would have given a priority order on the selected interventions was discussed. However, our main interest was to study exposure, the beliefs and the possible predictors related to it. Therefore we chose a dichotomous approach of exposure vs. other interventions. Our goal was to include intervention alternatives that would be suitable for all participants, regardless of orientation or personal preferences. To some extent, the presentation of the alternatives may have been incomplete. For example, the word "exposure" was not explained anywhere in the survey. The rationale was that we did not want to reveal the fact that we were interested in beliefs regarding exposure. Another factor is that some interventions that may have been preferred by the participants, such as for example EMDR, were not listed among the alternatives. Relating to EMDR, we chose to exclude this intervention since much previous evidence has indicated that the most effective component of this intervention is exposure (Cahill, Carrigan, & Frueh, 1999). Since we wanted the response alternatives to clearly differentiate between exposure and interventions of other kind, we chose to exclude EMDR. It is possible that the vignettes could have benefitted from an even more thorough procedure of validating the vignettes and the intervention alternatives before launching the survey. Clinical decision making and beliefs can be seen as sensitive and personal topics, which can make the research about them challenging. However, according to Aguinis and Bradley (2014), vignette studies makes it possible to address these sensitive topics, which justifies the selected method.

The TBES which was used in the study has not been validated in Finland, which can be seen both as a limitation. One suggestion for further research is to validate the scale in Finland.

The web survey itself had several limitations. We exerted low control over who responded the survey. The link to the web survey was sent to a large number of recipients within the Finnish Psychology Association in order to gain a sufficient amount of responses. The survey was targeted to psychologist who had already earned their master's degree and license. Technically it was possible for anyone to reply, since no login credentials were required to access the web survey. This made it possible for a participant to reply multiple times or to forward the web survey to someone else who was not in the original target group.

The current study focused only on psychologists in Finland, which makes both the generalization and the comparison of the results challenging to other mental health professionals. There are mental health professionals with other educational backgrounds who are providing treatment for anxiety disorders or other mental health problems. In Finland, there are 5256 psychotherapists listed in Terhikki, which is the register of social welfare and healthcare professionals (Valkonen Henriksson, Tuulio-Henriksson & Autti-Rämö, 2011). According to Valkonen et al. (2011) approximately one third of them are psychologists, thus two thirds of Finnish psychotherapists have some other educational background. Although the present study focused on Finnish psychologists, not psychotherapists, it can be assumed that a significant amount of mental health professionals were not in the target group of this study. Some of the international studies on beliefs on exposure has focused on a specific group, such as cognitive behavioral therapists (Sars & van Minnen, 2015; Schumacher et al., 2018). The sample of the present study focused on a group of professionals who had similar university training and the sample was national.

The fact that the web survey was based on self-evaluation can also be seen as a limitation. Self-evaluation can't be seen as an objective truth about what type of decisions one makes in a real-life clinical context. Participants had the possibility to present an ideal picture of themselves as evidence-based clinicians. In psychological measurement this is called socially desirable responding, which refers to the tendency of giving a positive self-descriptions in self-evaluations (Paulhus, 2015).

The participation rate was low, only 4.7 %, which can be considered as a limitation. The invitation to the survey was sent to 4951 Finnish psychologists. The survey tool statistics showed that the survey was viewed 610 times during the survey period. In total the survey was started 474 times and completed 235 times. The completion rate was 49.6 %. Theorizing that all of the 610 views were done by different persons, and that all viewers would have completed the survey, the best possible participation rate could have been 12.3 %. The fact that at least 88 % of the psychologists never even viewed the survey is certainly a result of number different factors. One was, according to the Finnish Psychology Association (A. Ahtola, personal communication, April 3, 2019) that this study concurred with several other studies or surveys targeted to the same group. Possibly lack of time and the burden of various administrative tasks might also have impacted the willingness to reply. Further, there is reason to believe that not all psychologists were excited to participate in a survey titled "clinical decision making". The title alone might have sounded technical, whereas a survey titled differently might have tempted more psychologist to reply. In addition, there are psychologists who work with very specific client groups or who do not work in a clinical context at all. For them the somewhat generic vignettes with specific intervention alternatives could have been perceived as strange or uninteresting, which could explain the drop-out rate being almost 50 %.

4.2 Conclusions

Exposure interventions have been shown to be effective in the treatment of various anxiety disorders, yet they tend to remain underused in clinical practice. In this study, comprising of a national sample of Finnish psychologists, we found that the beliefs regarding exposure in the treatment of anxiety disorders are generally rather positive. Further, the positive attitudes were associated with the use of exposure. Cognitively oriented psychotherapy training predicted an increased use of exposure, whereas work experience predicted a decreased use of exposure. Based on this study we can assume that cognitively oriented training impacts the beliefs about exposure positively, and increases its use in a clinical context. Due to the low response rate the generalization of results to other psychologists or mental health professionals should be done with caution. To our knowledge, no similar study has been conducted among the Finnish psychologists.

Various anxiety disorders will most likely continue to be common phenomenon in the clinical context and therefore effective treatment of anxiety is important. The results can be used for planning and developing training initiatives and targeting communication among the Finnish psychologists. Addressing the variation in the beliefs among Finnish psychologists requires a deep understanding of the differences between them in order to be able to offer tailored training for different target groups.

Based on this study, suggestion on further research include studying how do client characteristics and symptoms impact the decision making when treating anxiety disorders? Since exposure, as portrayed in this study, seems to be a cognitively oriented method, and a majority of clinicians in Finland are not cognitively oriented (Valkonen et al., 2011), one recommendation we give is to explore how anxiety disorders are treated by clinicians who are not using exposure or who have negative beliefs on exposure. Also we suggest that the TBES

scale should be validated in Finland. Finally, the impact of work experience on clinical decision-making needs to be understood on a deeper level.

Swedish Summary

Introduktion

Ångeststörningar har den högsta uppskattade livstidsprevalensen (28,8 %) av alla psykiatriska störningar som är listade i diagnosmanualen *Diagnos Manual of Mental Disorders, Fourth Edition (DSM-IV)* (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). Vilka störningar som räknas som ångeststörning varierar från källa till källa (American Psychiatric Association, 2013; U.S. Department of Health & Human Services (HHS), 2014; Mind, 2013). I denna studie var posttraumatiskt stressyndrom (PTSD), obsessivt-kompulsivt syndrom (OCD) och generaliserat ångestsyndrom (GAD) i fokus.

Den höga prevalensen av ångeststörningar ställer krav på att behandla dem effektivt. Enligt Clark, Hanstock och Clark (2016) använder psykologer interventioner ur kognitiva beteendeterapimanualer vid behandling av enstaka eller upprepade ångeststörningar, men inte specifika evidensbaserade protokoll eller interventioner. Parker et al. (2018) gjorde en meta-analys som handlade om olika psykoterapiers effekt vid behandling av ångeststörningar. Enligt denna analys var exponering den viktigaste medierande variabeln av behandlingseffektivitet.

Exponering innebär att klienten konfronteras med stimuli som hen är rädd för eller traumatiserad av. Detta stimulus kan till exempel vara ett objekt, en situation, ett minne och/eller en tanke. Exponering görs kontrollerat och gradvis tills ångesten har minskat eller försvunnit (Marks, 1973). De två huvudtyperna av exponering är *in vivo*-exponering och imaginär exponering. *In vivo*-exponering innebär att klienten exponeras för det ångestfyllda stimuluset i verkliga livet. Till exempel, en klient som är rädd för hissar besöker en byggnad med hissar tillsammans med sin terapeut. Klientens uppgift är att öva på att reglera sin ångest, medan klienten observerar och möjligen åker med en hiss. Imaginär exponering betyder att klienten exponeras för ett stimulus genom att terapeuten beskriver det i tal (Foa, 2011). Till

exempel, en klient som är rädd för bakterier, och som därför tvättar sina händer hela tiden, kunde exponeras för sin bakterieskräck genom att terapeuten beskriver en situation i tal där klienten besöker en offentlig toalett utan att tvätta händerna efteråt. Imaginär exponering kan också göras genom att terapeuten bandar in beskrivningen. Exponering kan också göras med hjälp av virtuell verklighet (Virtual Reality Exposure, VRE). VRE är en form av in vivo-exponering där man använder virtuell teknologi som hjälpmedel. Teknologin kan vara till hjälp vid till exempel rädslor för farliga djur eller ställen som inte är lätt tillgängliga (American Psychological Association, 2019).

Becker, Zayfert och Anderson (2004) kom fram i en studie, vars sampel bestod av 852 psykologer, att över 52 % av dem var bekanta med exponering vid behandling av PTSD, medan enbart 17 % av dem tillämpade exponering. En annan studie av van Minnen, Hendriks och Olff (2010) bekräftade Becker et al.'s (2004) forskningsresultat. Van Minnen et al. (2010) hävdade att ju mera exponeringsutbildning experterna som arbetade med psykologiska trauman hade fått, desto mera sannolikt var det att de skulle föreslå exponering till sina klienter. Ruzek et al. (2014) rapporterade att yrkesmänniskor inom mental hälsa var oroliga över att exponering kan skapa mera ångest hos klienter.

Praxis som baserar sig på vetenskapliga bevis kallas för evidensbaserad praxis (EBP). EBP innebär att man fattar medvetna beslut angående klientens behandling med hjälp av den bästa befintliga vetenskapliga evidensen (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). De tre väsentliga områden inom EBP är den bästa vetenskapliga evidensen, klinisk expertis och klientens värderingar, egenskaper, preferenser och omständigheter (Spring, 2007). Deacon och Farrell (2013) hävdade att orsaken till att yrkesmänniskor inte tillämpar evidensbaserade psykologiska behandlingar är att behandlingar som inte är evidensbaserade är överrepresenterade under deras respektive utbildning. Enligt dem borde man betona mera kognitiva beteendetekniker under utbildningen. En studie (Dunn, Crichton, Roe, Seers, &

Williams, 1998) kom fram till att det finns fyra faktorer som förklarar varför den vetenskapliga evidensen inte syns i det dagliga arbetet. Dessa är att omgivningen inte tillåter att implementera nya arbetssätt, brist på samarbete, arbetstagarens egen motivation och kunskap, distribuering och presentation av forskningsresultat samt forskningens kvalitet.

Faktorer som ökar sannolikheten att psykologen eller terapeuten använder sig av exponering är positiva uppfattningar om exponering, utbildning om exponering och yngre ålder (Sars, & van Minnen, 2015; Scumacher, Weiss, & Knaevelsrud, 2018). Deacon et al. (2013) fann resultat som tydde på att uppfattningar om exponering hade ett samband med hur försiktigt terapeuten gjorde exponering med klienten. Vidare drog Deacon et al. (2013) slutsatsen att negativa uppfattningar om exponering hindrar användning av exponering. Området angående klientens värderingar, egenskaper, preferenser och omständigheter var inte i fokus i denna studie.

Studiens syfte

Syftet med denna studie var att undersöka finska psykologers uppfattningar om exponeringsinterventioner och vilka faktorer som är relaterade till sannolikheten att psykologen använder sig av exponering vid behandling av ångeststörningar.

Forskningsfrågorna var:

1. Hurdana uppfattningar har finska psykologer om exponeringsinterventioner? Hurdan effekt har en eventuell psykoterapiutbildning på uppfattningar om exponeringsinterventioner?
2. Påverkar positiva uppfattningar användningen av exponering? Hurdan effekt har psykologens arbetserfarenhet och antalet timmar hen arbetar kliniskt under en vecka på användning av exponering?

3. Vilka faktorer är relaterade till sannolikheten att psykologen använder sig av exponering?

Metod

Som metod användes en vinjettstudie. Vi skapade en webenkät som bestod av bakgrundsfrågor, sex vinjetter om fiktiva klienter som led av olika typer av psykologiska symptom och Therapist Beliefs about Exposure Scale (TBES) som bestod av 21 flervalsfrågor. Enkäten med rubriken "Klinisk beslutsfattning" distribuerades av Finlands Psykologförbund till 4951 av dess medlemmar. Totalt 235 utexaminerade psykologer svarade på enkäten vilket ledde till en svarsprocent på 4,7 %. Vinjetterna beskrev kortfattat sex olika klientfall som handlade om olika psykiatriska störningar. Dessa störningar var PTSD i två olika vinjetter samt en vinjett om OCD, GAD, depression och ätstörning. De två sistnämnda störningarna räknas inte till ångeststörningar och de inkluderades med i studien för att maskera studiens syfte. Varje vinjett hade 11 interventionsalternativ, varav exponering var ett. Deltagaren instruerades att välja den mest lämpliga interventionen som i det ideala fallet var central för den fiktiva klientens återhämtning. Svartalternativen var desamma i samtliga vinjetter och presenterades i samma ordning.

TBES är en skala avsedd för att undersöka terapeuternas attityder angående exponering. Varje fråga har fem svartalternativ som ger noll till fyra poäng. Ju lägre poäng man får på skalan som ligger mellan 0 och 84, desto positivare uppfattningar har man om exponering. Skalan har blivit utvecklad av Deacon et al. (2013) och den översattes till finska för denna studie.

Resultat

De finska psykologernas medeltal i TBES skalan var 35,1 ($SD = 9,1$), vilket indikerar att uppfattningarna är någorlunda positiva. Den signifikanta variationen mellan grupperna i TBES-poäng fanns mellan olika psykoterapi-inriktningar, $F(7, 227) = 8.22, p < .001$.

Psykologer som hade en kognitivt orienterad psykoterapiutbildning hade de mest positiva uppfattningarna ($M = 25,9, SD = 9,8$). Skillnaderna fanns mellan de som hade en kognitivt orienterad psykoterapiutbildning och psykoanalytiska- ($MD = 17.8; SEM = 2.7; p < .001; d = 1.85$), psykodynamiska- ($MD = 12.2; SEM = 2.6; p < .001; d = 1.45$) och familjepsykoterapeuter ($MD = 14.3; SEM = 3.1; p < .001; d = 1.61$). Det fanns också en signifikant skillnad mellan kognitivt utbildade psykoterapeuter och dem som inte hade någon psykoterapiutbildning ($MD 9.7; SEM 1.7; p < .001; d = 1.10$).

Vi undersökte sambandet mellan val av exponering i de fyra ångestvinjetterna och TBES-poängen. TBES-poäng innebar att deltagaren fick en poäng varje gång hen valde exponering som intervention i de fyra ”ångestvinjetterna”. Det fanns en moderat negativ korrelation ($r = -.49, p > .001$) mellan användning av exponering och TBES-poäng. Korrelationen innebar att ju lägre poäng man fick i TBES, det vill säga positiva uppfattningar om exponering, desto mera sannolikt var det att man valde exponering som intervention.

Till slut analyserade vi vilka faktorer som predicerar användning av exponering med hjälp av en regressionsanalys. Regressionsmodellen förklarade 20,1 % av variansen i vårt sampel. Kognitivt orienterad psykoterapiutbildning ($\beta = .85; t = 4.42; p < .001$) var den starkaste prediktoren för att psykologen valde exponering som intervention. Arbetserfarenhet ($\beta = -.03; t = -3.99; p < .001$) minskade sannolikheten för att psykologen valde exponering som intervention. Kön eller antalet timmar som psykologen arbetade kliniskt under en vecka varken förklarade skillnaderna mellan grupperna eller predicerade användning av exponering i denna studie.

Diskussion

Studien ger vid handen att finska psykologer har en positiv uppfattning om exponering, vilket påverkar deras beslutsfattning. Vidare tyder resultatet på att det finns skillnader i uppfattningar om exponering hos finska psykologer. Eftersom ångeststörningar är vanliga krävs det effektiv och evidensbaserad behandling. För att kunna ta itu med de negativa uppfattningarna angående exponering och dess effekt på klinisk beslutsfattning, krävs välplanerad upplysning och utbildning gentemot de olika grupperna inom den finska psykologkåren.

Studiens viktigaste begränsningar var vinjetternas kvalitet och en låg deltagarprocent (4,7 %). Enligt den spontana deltagaråterkopplingen var interventionsalternativen i vinjetterna för ensidiga och saknade, enligt några respondenter, lämpliga alternativ. Den låga svarsprocenten kan vidare förklaras med att temat var något kontroversiellt, eller åtminstone känsligt. Dessutom pågick flera enkätstudier hos psykologförbundet samtidigt (A. Ahtola, personlig kommunikation, 3 april, 2019), vilket sannolikt påverkade deltagandet.

Förslag till fortsatt forskning innefattar studier om klientens påverkan på klinisk beslutsfattning, hur exponering tillämpas i det kliniska arbetet i Finland av dem som inte är kognitivt orienterade och arbetserfarenhetens inverkan på klinisk beslutsfattning. Vidare föreslås att TBES-skalan valideras i Finland.

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Appendix 1

The second part of the web survey included the vignettes that were created for the purpose of this study. The survey language was Finnish, but the vignettes can be found also in English.

The intervention alternatives are displayed only after the first vignette in this appendix. The alternatives were identical and in the same order after each vignette in the actual web survey.

In Finnish, as seen in the web survey:

2. osio: Asiakastapaukset

Alla näet kuusi eri asiakastapausta. Jokaista tapauskuvausta seuraa mahdollisista interventiovaihtoehdoista koostuva valikko. Tyypillisesti psykologisessa hoidossa hyödynnetään useiden eri interventioiden yhdistelmiä.

Tässä osiossa pyydämme sinua valitsemaan kunkin tapauksen kohdalla vain yhden intervention, jonka ideaalitulanteessa arvioit asiakkaan kuntoutumisen kannalta kaikista olennaisimmaksi. Lue jokainen tapaus ja valitse annetuista vaihtoehdoista yksi interventio.

1. Asiakas kertoo olevansa ahdistunut ja näkevänsä painajaisia lähes joka yö. Painajaiset liittyvät kaksi kuukautta sitten tapahtuneeseen onnettomuuteen. Eräänä talvi-iltana asiakas oli ajamassa töistä kotiin, kun vastaan tuleva auto odottamatta ajautui hänen kaistalleen aiheuttaen nokkakolarin. Asiakas selvisi törmäyksestä verrattain pienillä vammoilla, mutta joutui seuraamaan vierestä, kun vastaan tulevan auton kuljettaja menehtyi saamiinsa vammoihin.

Tapahtuman jälkeen asiakas ei ole kyennyt ajamaan autoa voimakkaan pelon ja ahdistuksen vuoksi. Hän kokee, että ahdistus ja unettomuus heikentävät hänen toimintakykyään. Lisäksi hän kokee syyllisyyttä siitä, ettei onnettomuusiltana lähtenyt töistä aikaisemmin.

Tukikeskustelu

Persoonallisuusrakenteiden selvittäminen

Ratkaisuvaihtoehtojen ideointi asiakkaan kanssa

Altistushoito (in vivo, mielikuvat ja/tai virtuaalinen)

Itsetuntemuksen ja -ymmärryksen lisääminen

Hypnoosi

Mindfulness-harjoitukset

Psykoedukaatio

Aktivointi ja arjen jäsentäminen

Itsemyötätuntoharjoitukset

Maalaisjärkeen vetoaminen ja toimintamallien kyseenalaistaminen

2. Asiakas on työskennellyt samassa työpaikassa ja -tehtävissä viimeiset kolme vuotta. Hän kokee, että työ ei tunnu yhtä innostavalta kuin ennen, hänen on vaikea keskittyä ja päivät ovat keskenään ihan samanlaisia. Asiakkaan mielestä kaikilla muilla menee paremmin kuin hänellä. Asiakas mainitsee, että hänellä on ollut useita lyhyitä poissaoloja töistä päänsäryn, flunssan sekä selkäkivun vuoksi viimeisen vuoden aikana.

Asiakas kertoo nukkuvansa katkonaisesti ja heräävänsä ennen herätyskellon soittoa. Kuluneen kuukauden aikana ruokahalu on ollut tipotiessään. Hän sanoo, että ihmiset hänen ympärillään vain ärsyttävät häntä koko ajan. Hän viettää vapaa-ajan kotonaan katsoen Netflixia.

3. Asiakas kertoo joutuneensa viimeisen viiden vuoden aikana kolme kertaa pahoinpidellyksi ihonvärinsä vuoksi. Häntä ja hänen perhettään on toistuvasti uhkailtu väkivallalla. Muistot pahoinpitelyistä tulvivat usein mieleen. Asiakkaan isä on pahoinpidellyt häntä lukuisia kertoja asiakkaan asuessa kotona alaikäisenä. Yläasteella asiakasta kiusattiin toistuvasti koulussa.

Asiakas kertoo kärsivänsä päivittäisestä ahdistuksesta. Ahdistus lamauttaa ja tuntuu voimakkaana paineena rintakehässä. Nykyään hän ei lähde pimeällä ulos ollenkaan. Tietetyt paikat kotikaupungissa hän kiertää valoisaankin aikaan kaukaa. Pelkojensa ja ahdistuksensa vuoksi asiakas on kyvytön työskentelemään, minkä seurauksena hänellä on talousvaikeuksia.

4. Asiakas kertoo kärsineensä päänsärystä viime kuussa ja pelänneensä, että hänellä on aivokasvain. Käytyään yksityisen lääkärin vastaanotolla hän rauhoittui hieman, mutta pelko vakavasta sairaudesta palasi pian uudelleen. Hän on epäillyt aivokasvainta useasti aikaisemminkin. Lisäksi häntä huolettavat ilman epäpuhtaudet asuinpaikkakunnalla ja hän tarkistaa useita kertoja päivässä Ilmatieteen laitoksen ilmanlaatuindeksin.

Asiakas kertoo, että häntä hikoiluttaa usein ilman varsinaista syytä, päässä pyörii ja sydän hakkaa. Oireita on viikoittain. Hän kertoo puhuvansa terveydentilastaan ja oireistaan lähes päivittäin ystävänsä kanssa. Asiakas kertoo elävänsä hyvin spontaania elämää, koska pitkän ajan suunnitelmat tuntuvat ahdistavilta ja sitovat liikaa.

5. Asiakas kertoo olevansa jatkuvasti riidoissa vanhempiensa ja sisarustensa kanssa. Riidat saavat alkunsa tavallisista arkipäivän asioista ja päättyvät asiakkaan raivokohtaukseen. Asiakas on vihainen perheelleen ja samalla surullinen jatkuvasta riitelystä. Viime kuukausina riidat ovat usein liittyneet asiakkaan triathlon-harrastukseen sekä runsaaseen syömiseen.

Asiakas kertoo urheilevansa yli kymmenen tuntia viikossa. Viikkoina jolloin hän on syönyt enemmän, harrastaa hän raskasta liikuntaa lähemmäs 20 tuntia. Asiakas kertoo olevansa tunteellinen ja että vastoinkäymiset tai kritiikki saattavat pilata hänen koko päivänsä. Syömisestä tulee usein hyvä mieli jota seuraa useimmiten pakottava tarve tehdä pitkäkestoisia kuntoliikuntaharjoitteita.

6. Asiakas kertoo, että hän ei ole poistunut kotoaan moneen päivään. Asiakkaan kertomuksesta käy ilmi, että aamutoimet vievät varsin paljon aikaa. Asiakas peseytyy suihkussa samaa tarkkaa rutiinia noudattaen, mikä kestää noin puoli tuntia. Poistuminen kotoa on työlästä, koska hänen täytyy pukea vaatteensa ja pakata tavaransa aina samassa järjestyksessä.

Hän on väsynyt omiin ajatuksiinsa ja siihen, että hän on yksinäinen. Viime viikolla hän perui useamman kaveritapaamisen, koska ei päässyt lähtemään kotoaan. Kavereita ei voi kutsua kylään, sillä he eivät noudata siisteysääntöjä riittävän tarkasti. Asiakas kertoo siivoavansa kotiaan vähintään tunnin päivässä.

In English, translated

Section 2: Client cases

Below there are six different client cases. Each case description is followed by a set of possible intervention alternatives. Typically, combinations of various interventions are utilized in psychological care.

In this section, we kindly ask you to choose only one intervention for each case, which, in an ideal situation, you would consider as the most relevant considering your client's recovery. Please read each case and choose one of the alternatives.

1. The client is anxious and has nightmares almost every night. The nightmares are related to an accident two months ago. One winter night, the client was driving home from work when the driver of another car unexpectedly lost control of his vehicle causing a head-on collision. The client survived the collision with relatively small injuries, but witnessed when the driver of the other car died of the injuries he had received.

After the event, the client has been unable to drive the car due to intense fear and anxiety. The client thinks that anxiety and insomnia weaken the ability to function. In addition, the client feels guilty of not leaving from work earlier that day.

Supportive counselling

Detecting personality structures

Brainstorming alternative solutions with the patient

Exposure (in vivo, imaginal and/or virtual)

Increasing self-awareness and self-understanding

Hypnosis

Mindfulness

Psychoeducation

Behavioral activation and organizing everyday life

Self-compassion exercises

Appealing to patient's common sense and challenging his/her behavior

2. The client has been working for the same employer and with the same duties for the last three years. The client feels that work does not seem as inspiring as before, finds it hard to concentrate and that the days are all alike. The client believes that everyone else is doing better than the client. The client mentions that s/he has had several short absences from work due to headaches, flu and back pain during the past year.

The client tells s/he is having broken nights and wakes up before the alarm clock rings. Over the past month, there has been no appetite. The client says that people around the client are annoying. After work, the client watches Netflix at home.

3. The client tells that s/he has been beaten three times in the last five years because of the client's skin color. The client's family has been repeatedly threatened with violence. Memories of the assaults often come to mind. The client's father has beaten the client many

times while the client was living at home as a minor. At high school, the client was repeatedly bullied.

The client says s/he is suffering from daily anxiety. Anxiety paralyzes the client and there is a sensation of a strong pressure in the chest. Currently the client is not leaving home after the dark at all. Certain places in the client's hometown feels scary even during the daylight. Because of fears and anxiety, the client is incapable of working, which has resulted in financial difficulties.

4. The client has suffered from headaches for the past month and has been afraid of having a brain tumor. After visiting a private doctor's appointment, the client calmed down a bit, but the fear of a serious illness soon returned. The client has suspected brain tumor several times before. In addition, the client is worried about air pollutants in the in the client's home town, and therefore checks the Meteorological Institute's air quality index several times a day.

The client often sweats without an actual cause, feels dizzy and notices that the heart is racing. The symptoms are present on a weekly basis. The client talks about the symptoms almost daily with close friends. The client describes the everyday life as spontaneous, because long-term plans seem to be distressing and burdening.

5. The client is constantly arguing with her parents and siblings. Disputes originate from ordinary everyday situations and end with an outburst of rage of the client. The client is angry with the family and at the same time sad due to the constant disputes. In recent months, disputes have often been related to the client's triathlon hobby and abundant eating.

The client is exercising for more than ten hours a week. During the weeks when the client has eaten more, s/he will practice heavy exercise closer to 20 hours. The client thinks that s/he is emotional and that criticism of any kind may ruin the whole day. Eating is often followed by feeling of joy, which is often followed by a compelling need to do long-term exercise.

6. The client has not left the house for many days. Client's various morning routines take a lot of time. The client showers following the same exact routine, which takes about half an hour. Leaving home is laborious, because the client has to dress and pack in the same order.

The client is exhausted by constant thoughts of tidiness and feels lonely. Last week, the client canceled several meetings with friends because of the client's inability to leave the house. Friends cannot be invited to visit because they do not follow the rules of cleanliness strictly enough. Cleaning the house takes at least one hour a day.