Finnish Psychotherapists' Beliefs and Experiences Regarding Trauma, Memory, and Dissociation: A 9-year Follow-up

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Abstract: Research has exposed a scientist-practitioner gap in the trauma field, where some clinicians seem to believe in scientifically unfounded or controversial phenomena. Studies in other countries have, however, suggested that scientifically supported beliefs are increasing. Here, we examined trauma-related beliefs and experiences of Finnish psychotherapists, comparing two data samples, gathered through the same survey in 2011 (N_1 = 166) and 2020 (N_2 = 219). As expected, we found that most psychotherapists in the 2020 sample reported more evidence-based beliefs regarding trauma, memory, and dissociation than those in 2011. In the 2020 sample, we also investigated whether the therapist's therapeutic approach was associated with differing beliefs. We did not find any approach to be associated with more evidence-based beliefs. Trauma therapy or EMDR were found to be associated with stronger agreement with some scientifically controversial topics. There was, however, no consistent association between scientifically supported beliefs and therapeutic approach. Our study shows a positive change during the past decade among Finnish psychotherapists. A scientist-practitioner gap remains and continued efforts to further educate therapists on the risks incorrect beliefs and suggestive methods pose for clients are warranted. As therapeutic approach seems to explain only some of the variance in beliefs and experiences, future studies should investigate other explanatory factors for the differing views among psychotherapists.
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Swedish abstract

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Titel: Finländska psykoterapeuters föreställningar om och erfarenheter av trauma, minne och dissociation: en uppföljningsstudie efter 9 år.

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Abstrakt: Forskning tyder på att en diskrepans mellan forskare och kliniker (eng. *scientist-practitioner gap*) existerar inom fältet för behandling av psykiskt trauma, vilket innebär att en del kliniker verkar tro på icke-evidensbaserade och/eller kontroversiella fenomen. I den nuvarande studien utforskades finska psykoterapeuters föreställningar och erfarenheter angående behandling av psykiskt trauma med data som samlats in via samma enkät, av sampel år 2011 (N_1 = 166) och 2020 (N_2 = 219). I enlighet med våra förväntningar fann vi att de flesta föreställningar som undersökts hade förändrats mellan datainsamlingarna, så att deltagare i det nyare samplet rapporterade föreställningar som är mer i enlighet med vetenskaplig evidens, jämfört med deltagare år 2011. Vi undersökte även huruvida terapiinriktning var associerat med psykoterapeuters föreställningar om trauma, minne och dissociation i det nyare samplet. Vi fann inte att någon terapiinriktning signifikant korrelerade med mer evidensbaserade föreställningar. Däremot fann vi att deltagare som angav sig ha en utbildning i traumaterapi eller EMDR uppvisade signifikant starkare tro på en del vetenskapligt ifrågasättbara fenomen, men dessa inriktningar var inte heller fullkomligt konsistent associerade med icke-evidensbaserade föreställningar. Terapiinriktning verkar därmed förklara en del av variansen i traumarelaterade föreställningar och erfarenheter mellan psykoterapeuter, men vidare forskning krävs för att förstå vilka andra faktorer som kunde förklara de väldokumenterade skillnaderna i föreställningar som olika professionella inom mentalhälsovården uppvisar. Våra resultat tyder på att det fortfarande finns en diskrepans mellan forskare och psykoterapeuter i Finland då det handlar om ämnen relaterade till behandling av psykiskt trauma, men en avsevärd förändring i psykoterapeuters föreställningar i en mer evidensbaserad riktning har skett under det senaste decenniet. Det är likväl nödvändigt att fortsätta undervisa psykoterapeuter om riskerna som felaktiga föreställningar och suggestiva metoder kan medföra för deras klienter.

Nyckelord: psykoterapi, trauma, minne, dissociation, föreställningar

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Over the past 20 years, the scientist-practitioner gap in the trauma field has received considerable attention, as there are concerns that clinicians do not always base their decisions on scientific evidence (Lilienfeld et al., 2015). Recent studies suggest that the gap remains, as many clinicians continuously report strong beliefs in phenomena that have little or no evidence-base, such as unconscious repression of trauma memories (Otgaar et al., 2019; Otgaar et al., 2021). On the other hand, many clinicians also reject these phenomena, suggesting a disparity within the clinical field as well. It is, therefore, important to better understand the reasons for this disparity. Psychotherapy is a recommended and empirically supported treatment for trauma-related psychopathology, such as post-traumatic stress disorder (PTSD; American Psychological Association, 2017; Bradley et al., 2005; Cusack et al., 2016), meaning that psychotherapists hold a central role in treating trauma. In the current study, we examined Finnish psychotherapists' beliefs and experiences concerning trauma-related work, investigating the associations between different therapeutic approaches and therapists' beliefs and experiences within the realm of psychological trauma. We also investigated how these beliefs and experiences have changed during the past decade.

Controversies Regarding Dissociation

Dissociation is characterized by a disruption or discontinuity in the normal integration of psychological functions such as consciousness, identity, memory, emotion, perception, and behavior (Diagnostic and Statistical Manual of Mental Disorders, 5th ed. [DSM-5]; American Psychiatric Association [APA], 2013). Dissociative symptoms range from non-pathological experiences (e.g., daydreaming or lapses in attention) common in the general population (Ross et al., 1991) to more pathological dissociation, characteristic to dissociative disorders (DDs; Giesbrecht et al., 2008; Holmes et al., 2005). Elevated dissociative symptoms are often comorbid with other psychiatric disorders and symptoms, such as PTSD, borderline personality disorder, and schizophrenia (Lyssenko et al., 2018), as well as depression, alexithymia, and suicidality (Maaranen et al., 2005, 2008). Pathological dissociation undeniably causes a lot of distress to those who suffer from it, but despite active research within the field, the underlying mechanisms of dissociative symptoms and disorders remain somewhat unclear and controversial. The trauma model of dissociation assumes a causal link between traumatic experiences anterior to dissociative symptoms (originally Janet, 1889/1973; see also Dalenberg et al., 2012). Meanwhile, the sociocognitive model emphasizes a broader set of explanatory factors for dissociation, such as fantasy-proneness,

suggestibility, media influences, malingering, and cognitive errors (originally Spanos, 1994; see also Lynn et al., 2012; 2019). Despite this ongoing theoretical debate, most researchers agree that dissociative symptoms cannot automatically be explained by past trauma if the patient has no recollection of it and there is no other proof to suggest a history of trauma (e.g., Brand et al., 2018; Dalenberg et al., 2014). This does not mean that trauma cannot play an etiological role in dissociation, but rather that there can be other explanatory factors as well, which should be considered instead of routinely assigning a traumatic explanation for all cases of dissociation (Kihlstrom, 2005; Lynn et al., 2008; Lynn et al., 2014).

Considered the most serious form of DDs, dissociative identity disorder (DID), is described in the DSM-5 as a severe disruption of identity, marked by discontinuity in the sense of self and the sense of agency, characterized by two or more distinct personality states as well as recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events (APA, 2013). The diagnosis has, however, been considered one of the most controversial of all psychiatric diagnoses (Lilienfeld & Lynn, 2015). There has been criticism based on the shortage of evidence for the diagnosis itself, deficient reliability in the diagnostic process, and iatrogenic practices relating to both diagnostic and treatment methods of DID (e.g., Paris, 2012; Piper & Merskey, 2004a, 2004b). Another highly debated diagnosis among the DDs is that of dissociative amnesia (DA), which entails "an inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting" (p. 298, DSM-5; APA, 2013). Many researchers denounce DA and view it simply as a different name for the old, highly debated, and widely debunked phenomenon of repressed memories (e.g., Otgaar et al., 2021; Patihis et al., 2019; but see Brand et al., 2018 for an opposing view). This, in turn, would imply that the empirical and clinical issues pertaining to the concept of memory repression also apply to DA.

Controversies Regarding Memory

Human memory is by no means perfect, static, or immune to changes, as memories are dependent on proper encoding in the first place and are also continuously reconstructed upon later recollection (Hyman & Loftus, 1998; Schacter, 1999). Decades of research have shown that some memories that a person believes to be true can be partially or completely inaccurate (e.g., Brainerd & Reyna, 2008; Johnson, 2001; Loftus, 1997a). Such memory distortions and false memories are easily formed and influenced by both simple and complex processes, including, but not limited to: conversations with others (French et al., 2006; Rechdan et al., 2016); exposure to suggestion (Geraerts et al., 2008; Patihis & Loftus, 2016) or misinformation (Loftus, 2005; Zhu et al., 2010); hypnosis (Patihis & Younes Burton, 2015); social influence (Peterson et al., 2009; Porter et al., 2000); and guided imagery (Herndon et al., 2014). False memories can be created for non-

traumatic, neutral, or positive events (Ceci et al., 1994; Hyman et al., 1995; Wade et al., 2002), as well as for upsetting or traumatic events (Porter et al., 1999; Shaw & Porter, 2015). Research has also shown that distinguishing between true and false memories without additional corroboration (i.e., beyond a person's own recollection) is very difficult (Bernstein & Loftus, 2009; Laney & Loftus, 2013). A person's confidence in their memory is, therefore, not a reliable measurement of its accuracy (e.g., Bernstein et al., 2005; Garry et al., 1996); neither is the extent of emotional content or salience of a recollection (Drivdahl et al., 2009; Kaplan et al., 2016; McNally, 2005).

There are some studies suggesting that memories of childhood trauma can be forgotten, yet still be accurately retrieved years later (e.g., Geraerts et al., 2007). Some interpret this as evidence for memory repression, that is, as the mind's way of protecting itself from overwhelmingly distressing memories by blocking them from the consciousness until it is safe to recall them again. These so-called repressed memories are assumed to resurface after periods of traumatic or dissociative amnesia, and to often reveal alleged experiences of childhood abuse. Nevertheless, the current body of evidence speaks against this conclusion (McNally, 2012). There is a lack of empirical support for the phenomenon of memory repression, and as other scholars underline, what is interpreted by some as memory repression could more parsimoniously be explained as ordinary forgetfulness, reluctance to disclose, or inability to perceive a distressing childhood event (such as sexual abuse) as traumatic, until fully comprehending the nature of the event as an adult (e.g., Engelhard et al., 2019; McNally, 2012). Furthermore, actively aiming to forget an experience or avoiding to think about it can render the experience less memorable (Geraerts & McNally, 2008; McNally & Geraerts, 2009). Moreover, the theory of memory repression lies on the assumption that traumatic memories to their nature are fundamentally distinct from other memories; a notion which has been criticized (Porter & Birt, 2001; Shobe & Kihlstrom, 1997). It is also important to note that while much of the research has focused on remembering childhood sexual abuse (CSA), such experiences are not directly generalizable to other traumatic experiences, since all experiences of CSA are not traumatic at the time they occur, whereas a later realization of the experiences constituting sexual abuse may be chocking (McNally, 2012).

All in all, research indicates that if not all, at least parts of traumatic events are often well-remembered and even intrusive to the memory (e.g., Krans et al., 2009; McNally, 2012; Schacter, 1999) and traumatic memories are generally no more fragmented than other memories (Berntsen et al., 2003, 2008; Rubin et al., 2008, 2011). In sum, there is a myriad of reasons why traumatic memories can be perceived as forgotten, but the notion that traumatic events could be repressed from the consciousness in their entirety, be unavailable to recollection for a long time, and years

later be accurately restored, is scientifically questionable (Engelhard et al., 2019; Patihis, Lilienfeld, et al., 2014).

Many researchers also warn against the pursuit of recovered memories due to the high risk of creating false memories in the process (e.g., Hyman & Loftus, 1998; Otgaar et al., 2019), as such false trauma memories can cause severe distress for both the client and their relatives (Loftus, 1997b). Regardless, many clinicians continue to trust the accuracy of recovered memories, some even actively suggesting to their clients that they might have repressed traumatic memories (Patihis & Pendergrast, 2019). The active pursuit of allegedly repressed memories does not appear to be limited to specific therapy modalities. Indeed, this can happen within any approach to therapy if the therapist chooses to do so. In other words, even empirically supported therapies may be harmful if administered improperly or if incorporating techniques without evidence base (Hipol & Deacon, 2013; Lilienfeld, 2007). A recent study by Patihis and Pendergrast (2019) on a large age-representative nonclinical US sample found that recovered memories of abuse occurred in most approaches to therapy. Furthermore, participants who reported their therapists had discussed the possibility of repressed memories of abuse were 20 times more likely to report recovered abuse memories than those who did not. In a similar study conducted in France, Dodier, Patihis and Payoux (2019) found that 6% of those who reported having been to therapy at some point reported recovering memories of abuse during therapy—abuse of which they were previously unaware. These results emphasize the need to examine the extent to which therapists themselves report actively pursuing repressed memories that they suspect their client might have, as well as their belief in the notion itself.

Clinicians' Beliefs About Trauma

In a study published in 2014, Patihis and colleagues compared clinicians' beliefs in 2011-2012 to those reported in studies from the 1990s. The research group found that psychotherapists in the US showed greater skepticism regarding repressed memory in 2011–2012 than they did in the 1990s, indicating a change of beliefs towards a more empirically supported view. Nevertheless, almost two thirds of the clinical psychologist practitioners still believed that traumatic memories often are repressed and not far from half that repressed memories can be accurately retrieved in therapy. This indicates that scientifically unsupported beliefs persevere despite the observed general improvement in knowledge over time. In their sample of 183 clinical psychologists in the UK, Ost and colleagues (2013) found that most participants considered memories recalled after a period of total amnesia to be sometimes (41%) or usually (16%) essentially accurate. Most chartered clinical psychologists also considered reports of DID to be sometimes (36%), usually (20%), or always (2%) essentially accurate, and participants who reported seeing a case of DID were more likely to

consider DID reports accurate (Ost et al., 2013). The authors also examined correlations between different beliefs. They found a negative correlation between the belief that false memories of CSA are possible and believing reports of DID to be essentially accurate. The researchers also found a positive correlation between the belief in the essential accuracy of CSA-reports following a period of amnesia, DID-reports, and CSA history being important in causing symptoms.

Other earlier studies have also documented disagreement amongst clinicians on which techniques are appropriate in treatment of trauma. In an early study Poole, Lindsay, Memon, and Bull (1995) found that around three quarters of the US and UK-based psychotherapists in their study reported using at least one memory recovery technique (e.g., hypnosis or dream interpretation). Remarkably, there was a considerable lack of agreement between the participants as to which techniques they considered appropriate. For instance, over a quarter of the US respondents reported using hypnosis to help clients remember being sexually abused as children, whereas an almost equal proportion of respondents indicated that hypnosis should not be used for this (Poole et al., 1995). Compared to psychodynamic and eclectic therapists, cognitive-behavioral therapists seem more skeptical of the concepts of repressed memories and memory recovery in these early studies (Dammeyer et al., 1997; Poole et al., 1995). Taken together, these findings suggest the existence of a scientist-practitioner gap, as well as a gap between groups within the clinical field. Here, we compared the beliefs and experiences of psychotherapists over the past decade and investigated differences between approaches to therapy in a Finnish sample of psychotherapists.

The Current Study

The aim with the present study was to increase the understanding of beliefs and experiences that psychotherapists in Finland have regarding psychological trauma, memory, and dissociation. We compared previously unpublished data gathered in 2011 and 2020 using the same questionnaire. This allowed us to directly observe possible changes in Finnish psychotherapists' self-reported beliefs and experiences regarding trauma-related matters. Moreover, we investigated if the psychotherapy approach used might be associated with more scientifically supported beliefs and experiences in a Finnish sample.

Similar studies on varying groups of clinicians and experts have been conducted in other countries, such as the US (Patihis, Ho, et al., 2014; Poole et al., 1995), the UK (Ost et al., 2013; Poole et al., 1995), France (Dodier & Payoux, 2017), and Norway (Magnussen & Melinder, 2012; Melinder & Magnussen, 2015). To our best knowledge, we are the first to study these beliefs and experiences of trauma, memory, and dissociation among mental health care professionals in Finland. We chose to only include licensed psychotherapists in the current study, as rehabilitative psychotherapy is financially supported by the Social Insurance Institution of Finland when

conducted by a psychotherapist who has been granted the protected occupational title of 'psychotherapist' (i.e., a clinical license to practice psychotherapy in Finland) by the National Supervisory Authority of Welfare and Health.

Our hypotheses were as following:

1. Due to the observed improvements in clinicians' beliefs over time in a similar study by Patihis et al. (2014), we expected an overall decrease in the reporting of beliefs not supported by scientific evidence between 2011 and 2020 by the participants.
2. In accordance with Hypothesis 1, we also expected a decrease in reported experiences or practices that are not empirically supported. We expected a) an overall decrease in the reported proportion of clients who during therapy recover memories of trauma, of which they were previously unaware of; b) a decrease in psychotherapists reporting that they actively try to help clients recover alleged repressed trauma memories. We expected, however, c) that some still actively aim to recover allegedly repressed trauma memories. We also expected d) less participants in 2020 to report having met a patient with DID, and e) those having done so to report smaller numbers of patients with DID.
3. Based on previous findings by Poole and colleagues (1995) and Dammeyer and colleagues (1997), we expected participants with a cognitive or cognitive-behavioural approach to report more empirically supported beliefs and experiences than therapists with other approaches.

Method

Ethical Permission

The Board of Research Ethics at Åbo Akademi University gave their permission before the data collections commenced.

Sampling Procedure

We recruited participants to both data collections by an email invitation containing a link to the electronic questionnaire. We distributed the invitation through an email mailing list for the Finnish Psychological Association as well as email mailing lists for several psychotherapeutic associations in Finland. Members of the target group were identified through an enclosed letter, asking mental health care professionals with experience of working with treatment of trauma to participate in the study. We sent out a reminder halfway through both data collection periods.

Participants

A broader sample of mental health care professionals was collected both years (N = 420 and 466, respectively), but we only included participants reporting themselves to be psychotherapists or

currently in training to become psychotherapists in the current study. The final sample consisted of a total of 385 participants, of which 43.1% participated in the first data collection in 2011 (N_1 = 166) and 56.9% in the second data collection in 2020 (N_2 = 219). The participants' therapy approaches and specializations can be found in Table 1, and further descriptive participant information in Tables 3 and 4.

Materials and Procedures

The survey was constructed by two of the authors and was used in both data collections to ensure comparability of the results. We gathered the data using online survey tools. Participants were able to choose between responding in Finnish or Swedish. For the entire survey, respondents were able to leave questions unanswered. The questionnaire included background information of the respondent, such as age, gender, profession, academic degree, type of workplace, years of clinical experience, and psychotherapeutic approach(es).

Table 1

Percentages and Chi-squared Tests of Reported Therapy Approaches and Specializations

	Percentage (*n*)		χ^2 (1)	*n*
Approaches	2011	2020		
Cognitive or CBT	26.5% (44)	42.5% (93)	9.81**	137
Psychodynamic or -analytic	39.2% (65)	19.6% (43)	16.88***	108
EMDR	28.9% (48)	30.6% (67)	0.06	115
Other therapy approach [a]	22.9% (38)	26.9% (59)	0.62	97
Trauma therapy	24.7% (41)	23.3% (51)	0.04	92
Family therapy	16.9% (28)	18.3% (40)	0.05	68
Eclectic	2.4% (4)	11.4% (25)	9.74**	29
CAT	9.0% (15)	6.4% (14)	0.61	29
Hypnotherapy	6.0% (10)	7.8% (17)	0.21	27
Solution focused	5.4% (9)	6.9% (15)	0.13	26
NLP	7.2% (12)	5.0% (11)	0.47	23
Group therapy	5.4% (9)	4.1% (9)	0.13	18
Sexual therapy	2.4% (4)	3.2% (7)	0.02	11
Art therapy	1.2% (2)	2.7% (6)	0.47	8
Specialized in trauma treatment	36.1% (60)	32.4% (71)	0.43	131
Specialized in children and adolescents	7.8% (13)	26.9% (59)	21.44***	72

Note. The total percentages add to over one hundred because participants could report multiple approaches. CBT = cognitive behavioral therapy; EMDR = eye movement desensitization and reprocessing; CAT = cognitive analytic therapy; NLP = neuro-linguistic programming. [a] Any therapy approach not listed in this table, not including the specializations. * $p < .05$. ** $p < .01$. *** $p < .001$.

Participants were then asked to report the proportion of their clients who have recovered traumatic memories (after no recollection of said memories before therapy) on a range of 0 ("Nobody, all of my clients have always remembered their traumatic experiences") to 4 ("Almost all of my clients have experienced total amnesia before therapy"). To measure the proportion of participants who perform memory work, we asked the participants to respond "Yes" or "No" on the following question: "If you suspect that a client's symptoms are caused by a traumatic experience that they do not remember, do you actively try to help the client restore the event in their memory?". We also asked the following questions concerning experiences of false memories: "If you suspect that the traumatic events that the client remembers are not real, do you actively try to bring up the subject or correct the client's perceptions?" ("Yes" or "No"); and "How often do you suspect traumatic memories recovered after a period of complete amnesia to be false?" on a scale of "Never" (0) to "Always" (4).

To measure participants' experiences of patients with DID, we asked them whether they had encountered at least one patient with DID, and if so, to estimate the number of such patients. For the analyses, the number of reported patients with DID were categorized as following: 1-5; 6-10; 11-20; 21-29; and 30 or more. We also asked the participants "In your experience, how often are experiences of sexual abuse in the background of dissociative symptoms?" with response options ranging from "Very seldom if ever" (0) to "Always" (4).

Finally, to investigate beliefs, the participants were presented with 25 statements about memory, trauma, and dissociation; see Table 2 for all statements. The participants were then asked to report the extent to which they agreed with each statement, on a scale of 1 ("I strongly disagree") to 4 ("I strongly agree"). An additional statement "Psychological trauma is stored as bodily memories and these memories can be released by processing the physical symptoms, e.g., through massage" was added to the second data collection. Many of these statements, as well as the questions regarding experiences, were inspired by a previous study by Ost and colleagues (2013).

Data Analyses

We used the packages *psych* (Revelle, 2021), *dplyr* (Wickham et al., 2021), *car* (Fox & Weisberg, 2019), and *emmeans* (Lenth, 2021) in the software *R* (R Core Team, 2021) for analyses. First, we inspected the distribution of participant characteristics in the total sample, after which we used Welch two sample t-tests and Pearson's chi-squared tests to compare the distribution of participant characteristics between the two data collections, testing whether the groups significantly differed in other aspects than the time point of the data collection.

To test Hypotheses 1 and 2, we performed a series of t-tests and chi-squared tests comparing the mean scores of continuous variables and the frequencies of categorical variables across the two

data collections. To test for correlations between participants' reported therapy approach and beliefs (Hypothesis 3), we computed multiple linear regression models to explore whether reporting a therapy approach predicted stronger or lesser agreement with the measured beliefs, compared to those not reporting the approach. Therapy approaches reported by over 20% of either sample were included in the models (i.e., psychodynamic, cognitive/CBT, trauma therapy, EMDR, and 'Other' [i.e., any of the other approaches listed in Table 1, including "Other approach", but excluding the specializations]). The correlational analyses were only computed for the newer sample (2020), as the main interest with these analyses was to investigate the current state of possible associations. Depending on the outcome, we computed either multiple linear regression models or multiple binary regression models to test for associations between approach to therapy and reporting various experiences.

Table 2

Statements and Corresponding Abbreviations Used to Measure Beliefs

Statement	Abbreviation
"When a person experiences a highly traumatic situation, they unconsciously shut it out from their consciousness, leaving no memory of the event."	belamnesia
"Complete amnesia is more common among those, who have experienced repeated, serious traumatic events, than among those, who have experienced a single traumatic event."	beltraumaamnesia
"Repressed traumatic events can be restored in the conscious memory, even several years after the events."	belmemreturn
"Very traumatic events, which a person could not otherwise remember, can be remembered through hypnosis."	belhypnorecall
"EMDR has been proven to be the best treatment method for patients who suffer from traumatic symptoms."	belemdr
"It is possible to create realistic, but inaccurate mental images, which are thought to be memories, of traumatic events."	belfalsememtr
"It is possible to create false memories (i.e., mental images that one believes to be true, that are in fact inaccurate) of neutral experiences."	belfalsememne
"Very vivid and detailed memories of trauma are more likely to be real than vague memories are."	belmemvivid
"Vague and indefinite memories of childhood events are a sign of a traumatic childhood."	belmemvague

Table 2 Continued

Statement	Abbreviation
"If a person shows greater certainty when speaking of the memory, there is an increased likelihood that the memory reflects true events."	belmemsure
"If a small child experiences a traumatic event, memories can be stored already during their first year of life. These memories can later be restored either spontaneously or through therapeutic work."	belmemearly
"A person can accurately estimate whether a trauma-related memory of theirs is false or if it is based on true events."	belselfassess
"In treatment of trauma, it is crucial that the traumatic memories are restored in the consciousness in detail and processed."	beltherdetail
"An experienced therapist can accurately estimate whether a trauma-related memory is incorrect or if it is based on true events."	beltherassess
"In therapeutic work it is secondary to assess whether a memory of trauma is objectively true or not."	belfactsirrelev
"It is not possible to create detailed false memories of serious traumatic experiences."	belnofalsemem
"Traumatic events are stored in the memory through different processes than neutral events."	belmemdiff
"Trauma-related memories are stored in a different part of the brain than neutral memories."	belbraindiff
"A greater amount of emotional content tied to a traumatic memory, increases the likelihood that the memory is based on true events."	belmememot
"Trauma-related memories do not change over time."	belmemstatic
"Repeated, serious trauma experienced in the childhood can lead to the formation of several separate states of self or personalities, which are not aware of each other."	beldid
"Dissociative disorders are always a sign of traumatic experiences."	beltraumadiss
"Physical symptoms can be the body's way of remembering traumatic experiences and restoring the events in the conscious memory can make the symptoms disappear."	belbodymem
"Psychological trauma is stored as bodily memories and these memories can be released by processing the physical symptoms, e.g., through massage."	belmassage
"There is a scientifically proven link between eating disorders and psychological trauma."	beleatdis
"Trauma-related symptoms cannot be treated with verbal methods alone; other types of processing are also necessary, such as EMDR."	beltherdiff

Results

Descriptive Results

Participant characteristics. See Tables 3 and 4 for descriptive participant characteristics.

Table 3

Means and Standard Deviations of Participant Characteristics Measured in Number of Years

	Total sample			2011			2020			t-Test		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*t*	*df*	*p*
Age	51.93	9.13	383	51.47	9.13	165	52.28	9.14	218	-0.86	353	.389
Time since degree	21.12	10.78	374	21.94	10.35	160	20.5	11.07	214	1.29	354	.198
Work experience in mental health	23.04	9.23	274	22.02	8.84	58	23.31	9.34	216	-0.98	94	.331

Comparisons of participants in the data collections. Respondents in the two data collections did not differ significantly on most of the measured background factors. The only difference was the group of clients with whom they reported primarily working. Also, the frequencies of some therapeutic approaches differed; see Tables 1, 3, and 4 for statistics on the comparisons of the data collections.

Table 4

Distribution and Chi-squared Tests of Categorical Participant Characteristics

	Total Sample	2011	2020	χ^2	*df*	*n*
Sample	100% (385)	43.1% (166)	56.9% (219)			
Gender						
Woman	85.4% (328)	85.5% (142)	85.3% (186)	0.09	2	384
Man	13.5% (52)	13.3% (22)	13.8% (30)			
Other/do not wish to specify	1.0% (4)	1.2% (2)	0.9% (2)			
Profession						
Psychologist	69.6% (254)	69.3% (115)	69.9% (139)	7.43	5	365
Nurse	14.8% (54)	15.7% (26)	14.1% (28)			
Psychiatrist/MD	6.9% (25)	4.2% (7)	9.1% (18)			
Social worker	2.2% (8)	3.0% (5)	1.5% (3)			
Other academic profession	4.1% (15)	6.0% (10)	2.5% (5)			
Other non-academic profession	2.5% (9)	1.8% (3)	3.0% (6)			

Table 4 Continued

	Total Sample	2011	2020	χ^2	*df*	*n*
Level of education						
Bachelor	16.8% (61)	18.3% (30)	15.5% (31)	1.52	3	364
Master	65.7% (239)	66.5% (109)	65.0% (130)			
Licentiate	15.1% (55)	13.4% (22)	16.5% (33)			
PhD	2.5% (9)	1.8% (3)	3.0% (6)			
Primary current work environment						
Primary health care	5.9% (16)	5.2% (3)	6.1% (13)	5.94	6	273
Specialized health care	16.5% (45)	15.5% (9)	16.7% (36)			
Private health care	4.4% (12)	1.7% (1)	5.1% (11)			
Private reception	66.3% (181)	72.4% (42)	64.7% (139)			
Rehabilitation	2.9% (8)	5.2% (3)	2.3% (5)			
School or teaching	1.5% (4)	0.0% (0)	1.9% (4)			
Social service	2.6% (7)	0.0% (0)	3.3% (7)			
Primary age group of clients						
Children	8.3% (23)	8.6% (5)	8.2% (18)	9.94	3	277
Adolescents	10.5% (29)	15.5% (9)	9.1% (20)	*		
Adults	80.5% (223)	72.4% (42)	82.7% (181)			
Elderly	0.7% (2)	3.5% (2)	0.0% (0)			

Note. * $p < .05$.

Comparisons of Respondents' Beliefs

We found significant differences between the two samples on most of the measured beliefs; see Table 5 for all beliefs and corresponding statistics and Figure 1 for response distributions and effect sizes for differences between 2011 and 2020. Some beliefs had not changed significantly in either way. These included belief in being able to remember very traumatic events, which one could not otherwise remember, through hypnosis; belief in EMDR having been proven to be the best trauma treatment; belief in assessment of the objective veracity of a trauma memory being secondary in therapeutic work; belief in there being a scientifically proven link between eating disorders and trauma; and finally, belief in that trauma-related symptoms cannot be processed through verbal methods alone, but need other types of processing as well, such as EMDR.

Table 5

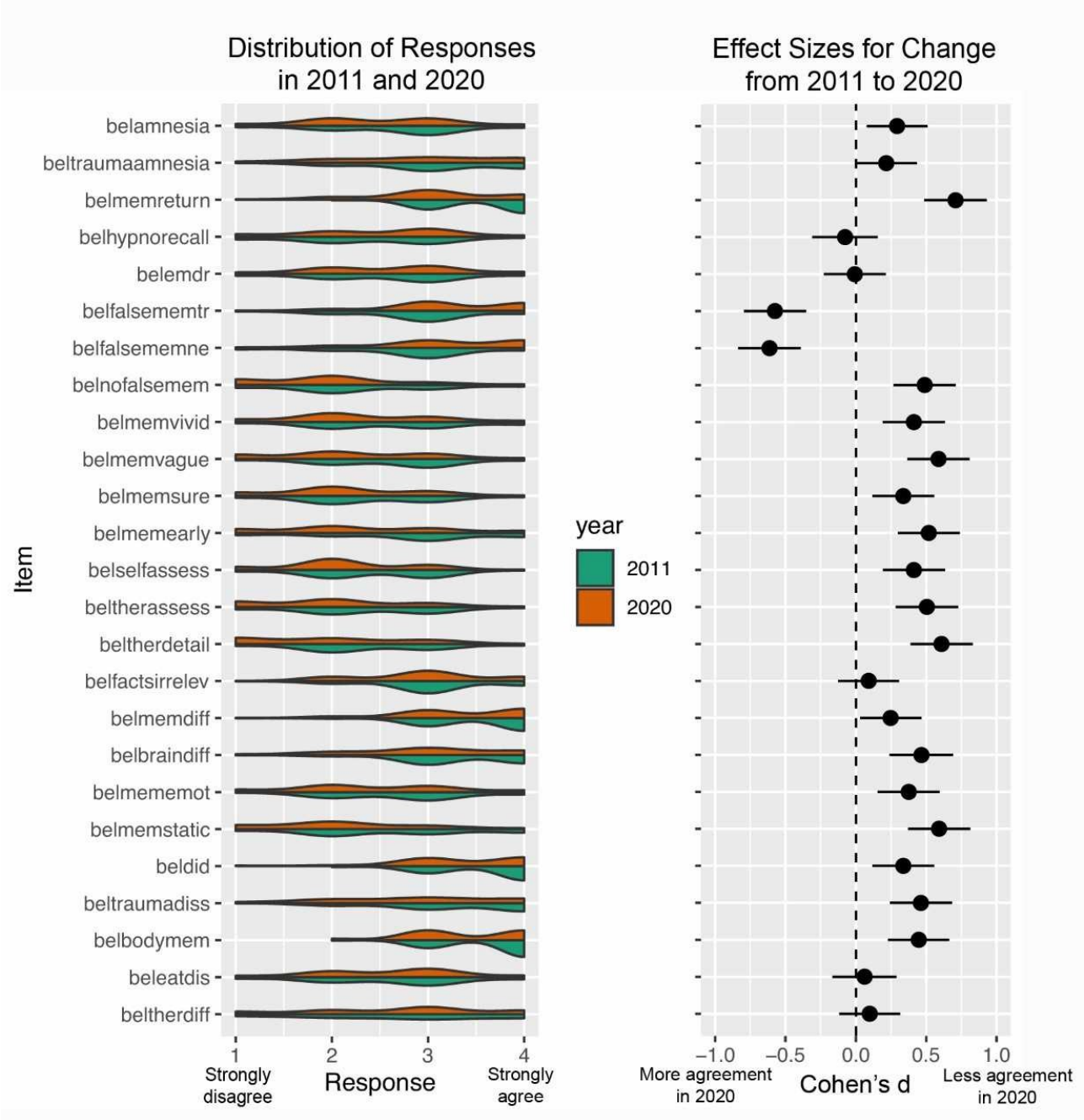
Comparing Psychotherapists' Self-Reported Beliefs in 2011 and 2020

Belief	2011			2020			t-Test	
	M	SD	*n*	M	SD	*n*	*t*	*df*
belamnesia	2.67	0.78	164	2.44	0.76	169	2.68**	330
beltraumaamnesia	3.11	0.76	162	2.93	0.92	167	1.97*	318
belmemreturn	3.54	0.55	163	3.08	0.73	169	6.49***	312
belhypnorecall	2.39	0.81	140	2.45	0.83	147	-0.65	285
belemdr	2.58	0.82	156	2.58	0.78	163	-0.07	315
belfalsememtr	2.89	0.72	159	3.29	0.68	169	-5.19***	322
belfalsememne	2.79	0.81	159	3.27	0.76	169	-5.54***	321
belnofalsemem	2.28	0.85	158	1.89	0.75	166	4.39***	313
belmemvivid	2.61	0.84	160	2.28	0.80	163	3.70***	319
belmemvague	2.61	0.76	162	2.14	0.83	167	5.33***	326
belmemsure	2.38	0.76	161	2.13	0.73	165	3.04**	323
belmemearly	2.79	0.94	161	2.30	0.95	170	4.72***	328
belselfassess	2.41	0.70	159	2.13	0.67	166	3.72***	321
beltherassess	2.36	0.79	162	1.96	0.79	163	4.56***	323
beltherdetail	2.39	0.78	162	1.90	0.82	168	5.54***	328
belfactsirrelev	3.05	0.66	162	2.99	0.69	168	0.82	328
belmemdiff	3.54	0.59	159	3.38	0.69	168	2.25*	322
belbraindiff	3.33	0.66	154	2.98	0.84	157	4.11***	295
belmememot	2.72	0.75	159	2.41	0.86	164	3.38***	317
belmemstatic	2.60	0.92	162	2.08	0.84	167	5.36***	322
beldid	3.59	0.58	159	3.37	0.72	167	3.06**	315
beltraumadiss	3.29	0.77	160	2.90	0.91	167	4.20***	320
belbodymem	3.65	0.52	164	3.39	0.62	171	4.10***	327
belmassage		-		2.57	0.77	168	-	-
beleatdis	2.64	0.80	145	2.59	0.76	155	0.53	294
beltherdiff	2.78	0.99	160	2.68	0.97	171	0.90	326

Note. The complete statements corresponding with the abbreviations can be found in Table 2. Participants' beliefs in the statements were measured by answer options 1) I strongly disagree, 2) I partially disagree, 3) I partially agree, and 4) I strongly agree. Since participants were able to leave questions unanswered, the number of participants who answered each statement varies. * $p \leq .05$. ** $p < .01$. *** $p < .001$.

Figure 1

Comparisons of Response Distributions and Effect Sizes for Changes in Beliefs from 2011 to 2020



Note. The statements corresponding with each abbreviation can be found in Table 2. The figure on the right shows Cohen's d-values within a 95 % confidence interval.

Comparisons of Respondents' Experiences

Respondents in 2020 reported significantly fewer clients with traumatic amnesia. We found a large and significant decrease in participants reporting actively trying to help their clients restore allegedly forgotten traumatic memories. We also found a significant decrease in participants reporting that upon suspecting a client's memories to be false, they actively try to bring up the subject or correct the client's perceptions. No significant difference was found in the reported

Table 6

Participants' Experiences of Traumatic Memories and Dissociation

Question	% Yes (*n*)		Chi-Squared Test		
	2011	2020	χ^2	*df*	*n*
"If you suspect that a client's symptoms are caused by a traumatic experience that they do not remember, do you actively try to help the client restore the event in their memory?"	54.0% (88)	18.8 % (36)	46.19***	1	354
"If you suspect the traumatic events that a client remembers to be false, do you actively try to bring up the subject or to correct the client's perceptions?"	49.7% (72)	32.6% (58)	8.99**	1	323
"Have you encountered a patient with DID?"	50.9% (83)	54.4% (105)	0.30	1	356

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

frequency of suspecting traumatic memories recovered after complete amnesia to be false. We found no significant difference in the proportion of participants reporting having encountered patients with DID (Table 6). However, a significant difference was found when examining the number of patients with DID reported by participants in 2011 and 2020, χ^2 (4, N = 167) = 9.80, p = .04. As can be seen in Table 7, both the proportion of therapists who had met five or less DID-patients and those who had met large amounts (21 or more) had increased in 2020, whereas the proportion of therapists reporting having met between six and twenty patients had decreased. Finally, participants in 2020 reported a significantly lower estimate of sexual abuse as a background factor for developing dissociative symptoms (Table 8).

Table 7

Reported Number of Patients with DID.

Year	"How many patients with DID have you encountered?"				
	One to five	Six to ten	11–20	21–29	30 or more
2011	61.8% (47)	25.0% (19)	9.2% (7)	2.6% (2)	1.3% (1)
2020	74.7% (68)	9.9% (9)	5.5% (5)	4.4% (4)	5.5% (5)

Note. This follow-up question was only presented to participants responding affirmatively to the question "Have you encountered a patient with DID?". Subsequently, the percentages reported here represent proportions of those subsamples (n_1 = 76; n_2 = 91).

Table 8

Comparing Mean Responses to Questions Listed in 2011 and 2020

	2011			2020			t-Test	
Question	*M*	*SD*	*n*	*M*	*SD*	*n*	*t*	*df*
"What proportion of your clients, who have experienced a traumatic event, have remembered traumatic experiences after previous amnesia (i.e., no memories of the event before therapy)?"	1.32	0.78	165	0.82	0.78	191	6.03***	346
"How often do you suspect traumatic memories recovered after a period of complete amnesia to be false?"	1.11	0.73	151	1.14	0.78	168	-0.44	316
"In your experience, how often are experiences of sexual abuse in the background of dissociative symptoms?"	2.09	1.03	125	1.71	1.01	163	3.10**	264

Note. The answer option range of each question listed, respectively, was as following: 0 ("Nobody, all of my clients have always remembered their traumatic experiences") to 4 ("Almost all of my clients have experienced total amnesia before therapy"); 0 ("Never") to 4 ("Always"); 0 ("Very seldom if ever") to 4 ("Always"). * $p < .05$. ** $p < .01$. *** $p < .001$.

Correlations of Beliefs and Experiences with Therapy Approach

Associations between therapy approaches. As participants were able to report multiple therapy approaches, we computed Pearson's Phi-correlation tests to examine possible associations between reporting different approaches. Most approaches correlated negatively, but training in trauma therapy, EMDR, and 'Other approach' were all positively correlated; see Table 9.

Table 9

Phi Correlation Coefficients for Psychotherapy Approaches

	Cognitive	Dynamic	Trauma	EMDR	Other
Cognitive	-				
Dynamic	-0.31	-			
Trauma	-0.23	-0.08	-		
EMDR	-0.13	-0.15	0.57	-	
Other	-0.38	-0.19	0.16	0.31	-

Cognitive approach. Reporting a cognitive or cognitive-behavioural approach was significantly associated with lesser belief in that memory repression is more common for clients who have experienced multiple traumatic events ($F = 5.43$, $df = 1$, $p = .021$), so that those with a cognitive or cognitive-behavioural approach reported less agreement with the statement ($M = 2.79$

[2.46, 3.12]) than those without (M = 3.19 [2.99, 3.40]). Reporting a cognitive approach was also associated with stronger belief in memory vividness increasing the likelihood of a memory's veracity (F = 4.90, df = 1, p = .028), meaning that therapists with a cognitive approach reported more agreement with the statement (M = 2.50 [2.20, 2.79]) than therapists without a cognitive approach (M = 2.15 [1.96, 2.33]). Reporting a cognitive therapy approach was furthermore associated with trying to correct a client's suspected false memories or educate them on the matter (χ^2 [1, N = 177] = 7.23, p = .007), as cognitive therapists were more likely to agree with the question "If you suspect the traumatic events that a client remembers to be false, do you actively try to bring up the subject or to correct the client's perceptions?" (logOdds = -0.20 [-0.96, 0.56]) than those not reporting a cognitive approach (logOdds = -1.30 [-1.87, -0.73]).

Dynamic approach. We found a significant negative association between reporting a dynamic approach and belief in the statement "Psychological trauma is stored as bodily memories and these memories can be released by processing the physical symptoms, e.g., through massage" (F = 6.25, df = 1, p = .013), as those with a dynamic approach reported less agreement (M = 2.31 [2.00, 2.62]) than those without (M = 2.73 [2.58, 2.88]). Furthermore, reporting a dynamic approach was associated with lesser belief that non-verbal elements are necessary in trauma treatment (F = 5.98, df = 1, p = .016), as dynamic therapists reported less agreement (M = 2.57 [2.22, 2.93]) than therapists not reporting a dynamic approach (M = 3.03 [2.86, 3.20]).

Trauma approach. We found a significant positive association between reporting a trauma therapy approach and belief in the possibility of recovery of repressed memories years later (F = 4.88, df = 1, p = .029), as those with a trauma approach reported more agreement (M = 3.46 [3.18, 3.73]) compared to those without a trauma approach (M = 3.11 [2.93, 3.28]). Likewise, reporting training in trauma therapy was associated with belief in that vague childhood memories are a sign of a traumatic childhood (F = 5.99, df = 1, p = .015), so that those with a trauma approach reported more agreement (M = 2.52 [2.21, 2.83]) than those without (M = 2.08 [1.87, 2.28]). On the other hand, having training in trauma therapy was negatively associated with the belief that detailed restoring and processing of trauma memories is a crucial aspect of the treatment (F = 4.81, df = 1, p = .030), meaning that trauma therapists reported less agreement (M = 1.70 [1.38, 2.01]) than other therapists (M = 2.10 [1.89, 2.30]). We also found an association between reporting training in trauma therapy and stronger belief in trauma memories being stored in the memory through different processes than neutral memories (F = 4.96, df = 1, p = .027), with trauma therapists reporting more agreement (M = 3.61 [3.34, 3.87]) than others (M = 3.27 [3.09, 3.44]). Stronger belief in that traumatic memories are stored in a different part of the brain than neutral memories was also associated with reporting a trauma therapy approach (F = 6.25, df = 1, p = .013), as trauma

therapists reported more agreement (M = 3.36 [3.05, 3.67]) than others (M = 2.90 [2.69, 3.12]). Furthermore, having training in trauma therapy was associated with stronger belief in that "Physical symptoms can be the body's way of remembering traumatic experiences and restoring the events in the conscious memory can make the symptoms disappear" (F = 5.47, df = 1, p = .021), in so that trauma therapists reported more agreement (M = 3.67 [3.44, 3.90]) than other therapists (M = 3.35 [3.20, 3.50]). Participants with training in trauma therapy further reported stronger belief in that trauma-related memories do not change over time (F = 11.92, df = 1, p < .001), with trauma therapists reporting more agreement (M = 2.68 [2.37, 2.99]) than others (M = 2.06 [1.86, 2.26]). Likewise, participants reporting having training in trauma therapy agreed significantly more with the statement "There is a scientifically proven link between eating disorders and psychological trauma" (F = 22.51, df = 1, p < .001), with trauma therapists reporting more agreement (M = 3.13 [2.85, 3.41]) than therapists not reporting a trauma approach (M = 2.36 [2.17, 2.54]). Finally, we found reporting training in trauma therapy to be significantly associated with stronger belief in non-verbal elements being necessary in treatment of trauma (F = 17.81, df = 1, p < .001), meaning that those with trauma therapy training reported more agreement (M = 3.21 [2.87, 3.54]) compared to those without (M = 2.40 [2.19, 2.61]).

When examining participants' experiences, we found a significant association between having training in trauma therapy and the proportion of one's clients recovering traumatic memories after no recollection of said memories before therapy (F = 7.83, df = 1, p = .006). Those with training in trauma therapy reported a larger proportion of patients with recovered trauma memories (M = 1.24 [0.97, 1.52]) than those without (M = 0.80 [0.61, 0.98]). We also found a significant association between having training in trauma therapy and having encountered at least one patient with DID (χ^2 [1, N = 192] = 11.44, p = .001), as those with training in trauma therapy were more likely to report having met a patient with DID (logOdds = 1.49 [0.51, 2.48]) than those without (logOdds = -0.19 [-0.71, 0.32]). Finally, we found a significant association between having training in trauma therapy and reporting having encountered larger numbers of patients with DID (F = 7.83, df = 1, p = .006). In other words, participants with training in trauma therapy reported having met more patients with DID (M = 1.24 [0.97, 1.52]) than those without trauma therapy training (M = 0.80 [0.61, 0.98]).

EMDR approach. Unsurprisingly, reporting training within EMDR was significantly associated with a stronger belief in EMDR having been proven to be the best treatment method for trauma (F = 16.51, df = 1, p < .001), with EMDR therapists reporting more agreement (M = 2.97 [2.73, 3.21]) than others (M = 2.35 [2.13, 2.58]). Reporting training in EMDR was also associated with a stronger belief in that a person's certainty in their memory is an indicator of its accuracy (F =

5.93, *df* = 1, *p* = .016), as those with training in EMDR reported more agreement (*M* = 2.40 [2.16, 2.64]) than those without (*M* = 2.04 [1.81, 2.26]). We also found an association between having training in EMDR and stronger belief in the statement "If a small child experiences a traumatic event, memories can be stored already during their first year of life. These memories can later be restored either spontaneously or through therapeutic work" (*F* = 5.42, *df* = 1, *p* = .021). In other words, therapists with training in EMDR reported more agreement with the statement (*M* = 2.68 [2.38, 2.98]) than other therapists (*M* = 2.24 [1.96, 2.52]). Training in EMDR was further associated with stronger belief in that an experienced therapist can accurately assess whether a memory is true or false (*F* = 3.96, *df* = 1, *p* = .048), with EMDR therapists reporting more agreement (*M* = 2.22 [1.97, 2.47]) than other therapists (*M* = 1.90 [1.67, 2.13]). Finally, a stronger belief in the statement "Repeated, serious trauma experienced in the childhood can lead to the formation of several separate states of self or personalities, which are not aware of each other" was also associated with reporting training in EMDR (*F* = 4.00, *df* = 1, *p* = .047), as those with EMDR training reported more agreement (*M* = 3.57 [3.35, 3.79]) than those without (*M* = 3.29 [3.09, 3.49]).

Other therapy approaches. Reporting another therapy approach than those mentioned above was only significantly associated with belief in that an experienced therapist can correctly estimate a memory's veracity (*F* = 5.87, *df* = 1, *p* = .017), as those with some other therapy approach reported more agreement (*M* = 2.23 [1.98, 2.48]) than those without (*M* = 1.89 [1.67, 2.10]). Reporting having training in some other therapy approach was also associated with having met a patient with DID (χ^2 [1, *N* = 192] = 4.66, *p* = .031), as those with some other therapy approach were more likely to have met a patient with DID (logOdds = 1.07 [0.31, 1.83]) than those without (logOdds = 0.23 [-0.41, 0.86]).

Non-significant results. Some beliefs were not significantly associated with any therapeutic approach. This included repressing memories of traumatic experiences, being able to restore repressed memories through hypnosis, the possibility of false trauma memories, the possibility of false neutral memories, a person being able to reliably assess the accuracy of their own memories, a trauma memory's objective veracity being secondary to assess in therapeutic work, false memories not being possible, emotional content indicating a memory's veracity, and dissociative disorders always being a sign of traumatic experiences. Also, the psychotherapist reporting to having suspected false memories or actively trying to help clients remember allegedly forgotten trauma memories was not significantly associated with any therapeutic approach, neither were the answer estimates on the question "In your experience, how often are experiences of sexual abuse in the background of dissociative symptoms?".

Discussion

The aim with this study was to investigate Finnish psychotherapists' beliefs and experiences regarding treatment of psychological trauma and traumatic memories, and to investigate whether different psychotherapy approaches were associated with varying beliefs and experiences. We found general support for our first hypothesis, that therapists' beliefs would have changed over time in a more evidence-based direction. We also found partial support for our second hypothesis, that reported experiences would change in a more evidence-based direction. To our surprise, we did not find support for our third hypothesis, that cognitive therapists would report more evidence-based beliefs and experiences than therapists reporting other approaches. Instead, we found psychotherapists reporting to have approaches in trauma therapy or EMDR to be associated with some less evidence-based beliefs and experiences, but these results were not fully consistent.

General Discussion

The present study was the first to investigate Finnish psychotherapists' self-reported trauma-related beliefs and experiences and comparing these between the years 2011 and 2020. We were pleased to observe a notable change over the past decade, with therapists' beliefs and experiences in many ways becoming more in line with current research evidence and indicating an increased caution in using suggestive methods. Our results on the time-wise comparisons are largely consistent with those of Patihis et al. (2014), reflecting a general change and representing a more empirically supported view in the more recent sample. This was expected, as there have been efforts to disseminate information about controversial and at times even erroneous beliefs relating to traumatic memories and dissociation. Despite this improvement, however, our results indicate that a scientist-practitioner gap is still somewhat present among psychotherapists in Finland. Some beliefs had not changed between the data collections, such as belief in hypnosis aiding in remembering very traumatic memories, which could not otherwise be recalled, whereas some other beliefs, while showing improvement over time, still entailed scientifically questionable concepts. This is not all too surprising, as research has shown that incorrect beliefs can be quite persistent and challenging to change (Lewandowsky et al., 2012). However, advancements in research and education can be expected to have influenced the observed changes, meaning that efforts of dissemination have not been in vain. Promising results on long-lasting belief-corrections, specifically on memory repression, have also been observed by Sauerland and Otgaar (2021), further encouraging educational endeavors to correct non-evidence-based beliefs.

Our second hypothesis, that therapists in 2020 would report more empirically supported experiences, was partially supported. A remarkable difference that we found was that over half of the participants in 2011 reported doing active memory work with their clients, whereas under a fifth

of the participants in 2020 reported doing so. Interestingly, a large decrease was also found in the percentage of participants (around half versus around a third, respectively) reporting that, upon suspecting a traumatic memory of the client to be false, they try to bring this up or correct the client's allegedly false perception. The opposite might have been expected, considering the overall changes in both the beliefs and experiences reflecting a more skeptical viewpoint regarding memory repression and a more widespread knowledge of possible false memories. However, this may be at least partially due to the question referring to correcting a client's memories, which might invoke carefulness in agreeing with it. Considering the increased disagreement that participants in 2020 reported with the belief that a therapist can reliably assess whether a memory is true or false, it is not, after all, surprising that they would refrain from "correcting" a client's memories. This result may not, therefore, primarily reflect a stance on educating clients about the possibility of false memories but might instead be more indicative of psychotherapists acknowledging that they cannot reliably assess whether a client's memory is true or false and therefore being careful in influencing a client's memories in any way. On the other hand, these results could also reflect the observed perseverance of strong belief in that assessing a trauma memory's objective veracity is secondary in therapeutic work. Future studies including similar questions should aim to explore the question of psychotherapists' opinions and experiences about trying to alert their clients to the possibility of false memories occurring, to better be able to assess this prevalence.

Our hypothesis that cognitive therapists would have more evidence-based beliefs was not supported, as reporting a cognitive training was only significantly associated with lesser belief in memory repression being more common for clients who have experienced multiple traumatic events, as well as stronger belief in vivid and detailed memories being more likely to be true than vague memories are. Instead, we found that reporting a trauma therapy or EMDR approach were both significantly associated with several scientifically questionable or controversial beliefs, such as belief in being able to restore repressed memories into the consciousness years after a traumatic event (trauma therapy) and belief that an experienced therapist can accurately assess the veracity of a memory (EMDR). It is important to note that reporting trauma therapy and EMDR approaches were also strongly and positively correlated, which is perhaps not that surprising, as EMDR is widely used as a trauma treatment method. However, most beliefs and experiences where a statistically significant correlation was found were only associated with one of the psychotherapy approaches included in the models, meaning that no single approach consistently correlated with neither more nor less evidence-based beliefs. As with the beliefs, our third hypothesis was not generally supported when examining correlations between reported therapy approaches and experiences. Reporting a cognitive approach was only associated with an increased likelihood of,

upon suspecting a client's memories to be false, bringing the subject up or trying to correct them. To our surprise, we did not find therapists within any approach to be neither more nor less likely to report actively helping their client remember allegedly forgotten trauma experiences. However, our results showed that reporting a trauma therapy approach correlated with an increased proportion of one's clients recovering traumatic memories in therapy, after no recollection of the experiences beforehand. Trauma therapists were also more likely to have encountered at least one patient with DID, and to further report having encountered larger numbers of patients with DID, than those without training in trauma therapy. These results may partially be explained by the assumption that therapists who are specialized in trauma treatment are more likely to encounter clients with more severe symptoms. However, taking into consideration that reporting having training in trauma therapy and/or EMDR was also significantly associated with some empirically questionable beliefs and that clinicians' own beliefs, expectations and biases may influence the treatment (Ruscio, 2006), it is imperative that professionals specialized in treatment of trauma ensure that they practice evidence-based therapies and do not expose their clients to suggestive practices based on controversial beliefs. It is also of great importance that the information provided regarding memory functions in therapy training programs, regardless of approach, is based on scientific evidence.

Our results suggest, in line with those of Poole et al. (1995) and Dammeyer et al. (1997), that although differing therapy approaches correlate to some degree with varying types of beliefs, they do not alone provide a strong explanation for the diverging beliefs observed in both the current and previous studies on beliefs held by psychotherapists and other clinicians. During the recent years, research on clinical practice has put an increased emphasis on the integration of common factors, such as therapeutic alliance, and specific factors, such as appropriate application of specific techniques suited for a particular problem, as these have been found to be more indicative of therapy effectiveness, rather than strict adherence to a specific therapy modality (e.g., Owen & Hilsenroth, 2014). The lack of support for our expectation that the different therapy approaches would explain the variance in beliefs and experiences could therefore be due to an increase in eclectic approaches - an increase which was also observed in our latter sample, with 11.4 % of participants in 2020 reporting an eclectic approach, compared to 2.4 % in 2011. These results indicate that other possibly associated psychotherapist characteristics should also be examined. For instance, in Finland, most psychotherapists are psychologists, nurses, or medical doctors (Valkonen et al., 2011). Considering the differences between these professional educations with regards to teaching about cognitive processes and memory functions, it would be of interest to investigate whether the base education of the psychotherapists could explain part of the variance in reported beliefs.

The perseverance of a scientist-practitioner gap within the trauma field, documented here and elsewhere, is not to be ignored. Disturbingly, Rubin and Boals (2010) discovered that people who expect to enter psychotherapy are also prone to expect to recover repressed memories in therapy. Myers and colleagues (2015), in turn, discovered that while laypersons can recognize suggestive practices, they fail to connect these to the questionable accuracy of memories reported following therapist suggestion, or to question the therapist's competence in light of their degree of suggestiveness. However, when possessing the knowledge that the therapist's suggestiveness had induced false memories, participants rated the therapist less competent and more responsible for the false memories (Myers et al., 2017). Unfortunately, real-life therapy clients can seldomly be assumed to possess knowledge about the risks inherent in suggestive memory work. These findings, in combination with our results and those from other similar studies, further emphasize the need for therapists, as the professionals in a therapy relationship, to stay educated on evidence-based approaches and to conduct their work in a responsible and non-iatrogenic way. This entails, among other aspects, being informed on how memory processes work and how memories can be influenced, and therefore avoiding suggesting to their clients that they might have experienced and forgotten traumatic events in their past.

Limitations

Some limitations should be considered when interpreting the results of this study. As participants remained anonymous in both data collections, we cannot tell how large a percentage, if any, of the respondents may have participated both years. We cannot therefore distinguish to which degree our results reflect repeated measures of the same participants' beliefs and experiences, and to which degree they are independent samples. However, as our two sets of data were highly comparable with regards to participants' background factors, we may attribute the documented differences between 2011 and 2020 to the point in time, rather than to participant characteristics.

Due to the controversial nature of the topics studied, assessing the most correct answer to some of our statements may be challenging. Each question in our survey had varying response rates in both data collections. A neutral option was intentionally left out for research purposes, but it may have led some participants to choose not to respond at all. While this is not uncommon in studies measuring controversial beliefs (see Ost et al., 2013), it might lead participants with greater uncertainty regarding a topic to opt out of answering, leading us to possibly measure more extreme beliefs from participants with stronger opinions on the subject. Furthermore, participants may have embellished their answers to seem more in line with empirical evidence and therefore more appropriate, even if their true beliefs were more questionable. However, since the data was collected at two points in time, the results do show trends in answering.

Finally, as the topics studied here are broad and manyfold, participants will likely have had differing interpretations of at least some of the questions. For instance, participants may have interpreted "actively helping" a client remember suspected previously forgotten traumatic experiences in different ways, in so that some might approach the alleged memories in a general, non-suggestive way of exploring the client's childhood, whereas others may explicitly tell their clients that they are likely to have repressed trauma memories. These approaches are quite distinct with regards to their level of suggestiveness yet could not be differentiated in our current analyses. Exploring the level of suggestiveness used by clinicians when reporting helping a client remember earlier experiences, as well as more general understanding of suggestibility within the context of therapeutic work, would be interesting topics for future research.

Conclusions

The present study offers the first inspection of trauma-related beliefs and experiences reported by Finnish psychotherapists, as well as a comparison of these in the beginning and the end of the past decade. Although our results indicate improving trends, our study also highlights the continued need for psychotherapists in Finland as well as clinicians in general to continuously update their scientific knowledge, in order to diminish the scientist-practitioner gap and to provide the best possible treatment for their clients. This is vital especially for controversial topics. No psychotherapist can rule out the possibility that a client's memories of trauma are partially or entirely false, as false memories can arise spontaneously both in and out of therapy. Yet, by staying informed on the scientific support for one's beliefs and by conducting evidence-based practices and avoiding using suggestive methods, a therapist can minimize the risk of influencing a client's memory or perceptions in a harmful way. As Lindsay and Read (1994) argued already decades ago, both critics and proponents of memory recovery therapy should find shared interest in ensuring that therapy treatment involves as small a risk as possible of inducing or influencing false memories of trauma. Despite the continuous debates related to the field of trauma psychology, we believe most researchers and clinicians would be able to agree on this.

Summary in Swedish – Svensk sammanfattning

Finländska psykoterapeuters föreställningar om och erfarenheter av trauma, minne och dissociation: en uppföljningsstudie efter 9 år

En diskrepans mellan forskare och kliniker (eng. *scientist-practitioner gap*) har redan länge väckt livliga debatter inom fältet för behandling av psykiskt trauma, då många forskare är oroliga över den potentiellt skadliga inverkan som föreställningar med bristfälligt vetenskapligt stöd kan ha i det kliniska arbetet (Lilienfeld et al., 2015). Ett fenomen som anses vara mycket kontroversiellt är bortträngda minnen (Patihis et al., 2014). Flera studier har visat att kliniker fortsättningsvis starkt tror på att traumatiska minnen som är överväldigande smärtsamma ofta omedvetet trängs bort ur medvetandet, tills det är tryggt att framkalla dessa minnen igen antingen spontant eller i terapi (Otgaar et al., 2019; Otgaar et al., 2021). Decennier av forskning har dessvärre gett som resultat bristfälligt stöd för dylik minnesbortträngning (McNally, 2012). Många forskare har i stället lyft fram den avsevärda risken för att det skapas falska minnen (dvs. icke-sanningsenliga mentala bilder, som man tror är äkta minnesbilder; Brainerd & Reyna, 2008) under processen av att söka efter bortträngda minnen (Dodier et al., 2021). Detta är särskilt problematiskt i terapikontext, då falska minnen lätt skapas bland annat i diskussioner med andra (French et al., 2006; Rechdan et al., 2016) samt som följd av suggestion (Geraerts et al., 2008; Patihis & Loftus, 2016), social inverkan (Porter et al., 2000), eller hypnos (Patihis & Yones Burton, 2015). Forskning har även påvisat att man inte kan avgöra om en minnesbild är sann eller förvrängd utgående varken ifrån emotionella innehållet i minnesbilden (Drivdahl et al., 2009; English & Nielson, 2010; Kaplan et al., 2016; McNally, 2005; Phelps & Sharot, 2008) eller säkerheten som personen i fråga känner inför att minnesbilden är sann (Bernstein et al., 2005; Garry et al., 1996; McNally, 2003).

Etiologin för dissociativa störningar är ett ytterligare ämnesområde som utgjort grunden för hektiska debatter bland både kliniker och forskare. Dissociation karaktäriseras av en störning i den normala integrationen av psykologiska funktioner så som medvetande, identitet, minne, emotioner, perception och beteende (Diagnostic and Statistical Manual of Mental Disorders, 5th ed. [DSM-5]; American Psychiatric Association [APA], 2013). Den så kallade traumamodellen för dissociation antar ett kausalförhållande mellan tidigare traumatiska upplevelser och senare dissociativa symptom (ursprungligen Janet 1889/1973; se även Dalenberg et al., 2012), medan den socio-kognitiva modellen lyfter fram flera potentiella förklarande faktorer för dissociation, bland annat suggestibilitet, benägenhet för fantasi, influenser från media, simulering av symptom samt kognitiva brister (ursprungligen Spanos, 1994; se även Lynn et al., 2012; 2019). Trots denna oenighet kring grunden för dissociativa störningar håller de flesta forskare med om att dissociativa symptom inte

per automatik kan förklaras av tidigare traumatiska upplevelser, ifall patienten inte har några minnesbilder av dessa och inga andra bevis påvisar att personen varit med om traumatiska upplevelser (se t.ex. Brand et al., 2018; Dalenberg et al., 2014; Kihlstrom, 2005; Lynn et al., 2008; Lynn et al., 2014). Bland de olika dissociativa störningarna är dissociativ identitetsstörning (DID) och dissociativ amnesi (DA) bland de mest kontroversiella. DID anses vara en allvarlig identitetsstörning, som innebär en bristfällig känsla av kontinuitet i självupplevelsen och karaktäriseras av två eller fler skilda jagupplevelser eller personligheter samt upprepade luckor i återkallelsen av vardagliga händelser, viktig personlig information, och/eller traumatiska upplevelser (DSM-5, APA, 2013). Diagnosen har dock kritiserats i hög grad, bland annat på grund av den bristfälliga evidensen för själva diagnosen samt iatrogena tillvägagångssätt i både diagnostiska processen och själva behandlingen av störningen (se t.ex. Paris, 2012; Piper & Merskey, 2004a, 2004b). DA beskrivs i DSM-5 som en oförmåga att återkalla viktig självbiografisk information, oftast av traumatiskt slag, som skiljer sig från vanligt glömmande (DSM-5; APA, 2013). Många forskare har kritiserat DA starkt, eftersom det anses vara en ny benämning för det starkt ifrågasatta fenomenet av bortträngda minnen (se t.ex. Otgaar et al, 2021; Patihis et al., 2019; men se även Brand et al., 2018 för en motsatt synpunkt), vilket innebär att DA medför samma empiriska och kliniska problem som minnesbortträngning.

Resultaten från studier som genomförts i andra länder, i vilka man undersökt klinikers traumarelaterade föreställningar, tyder på att många kliniker fortsättningsvis tror på vetenskapligt ogrundade eller kontroversiella fenomen (Dodier & Payoux, 2017; Magnussen & Melinder, 2012; Melinder & Magnussen, 2015; Ost et al., 2013; Patihis, Ho, et al., 2014). Dessa resultat väcker frågor kring hurdana föreställningar och erfarenheter kliniker i Finland har, samt vad som kunde förklara skillnaderna mellan olika klinikers föreställningar. Enligt vår vetskap har inga studier dessvärre genomförts med ett sampel bestående av professionella personer inom mentalhälsovården i Finland. Eftersom psykoterapi är en starkt rekommenderad vårdform för traumarelaterad psykopatologi (American Psychological Association, 2017; Bradley et al., 2005; Cusack et al., 2016) och eftersom FPA-stödd psykoterapi i Finland endast får praktiseras av psykoterapeuter som fått sin legitimering av Valvira, undersöktes i denna studie finländska psykoterapeuters föreställningar och erfarenheter angående minne, dissociation och behandling av psykiskt trauma. Vi jämförde även dessa föreställningar och erfarenheter mellan två sampel av psykoterapeuter, som besvarat vår enkät antingen år 2011 eller år 2020, för att undersöka ifall finländska psykoterapeuters föreställningar och erfarenheter förändrats under det senaste decenniet.

Våra hypoteser för denna studie var:

1. Utgående ifrån utvecklingen av klinikers traumarelaterade föreställningar över tid som observerats i en liknande studie av Patihis et al. (2014), förväntades det att deltagarna år 2020 skulle rapportera färre föreställningar som inte grundar sig i vetenskaplig evidens, än deltagarna år 2011.
2. I enlighet med Hypotes 1 förväntades det att psykoterapeuterna i det nyare samplet skulle rapportera suggestiva tekniker i mindre utsträckning än psykoterapeuterna som besvarat enkäten år 2011. Vi förväntade oss även att deltagarna år 2020 skulle rapportera färre yrkesupplevelser av bortträngda minnen och patienter med DID.
3. Baserat på resultaten från tidigare studier av Poole et al. (1995) samt Dammeyer et al. (1997) förväntade vi oss att deltagare med en kognitiv eller kognitiv-behaviorell terapiinriktning skulle rapportera empiriskt stödda föreställningar och upplevelser i högre grad än terapeuter med andra terapiinriktningar.

Metod

Etiskt tillstånd

Denna studie har fått Forskningsetiska nämnden vid Åbo Akademis godkännande innan datainsamlingarna påbörjats.

Rekrytering av deltagare

Deltagare rekryterades till båda datainsamlingarna med hjälp av en inbjudan per epost som innehöll länken till elektroniska frågeformuläret. Denna inbjudan skickades ut till medlemmar i Psykologförbundet samt medlemmar i diverse psykoterapiföreningar i Finland.

Deltagare

Ett större sampel av professionella personer inom mentalhälsovårdsbranschen samlades båda åren (N_1 = 420, N_2 = 466) men endast deltagare som angav sig vara psykoterapeuter eller psykoterapeutstuderande inkluderades i den här studien. Vårt sampel bestod därmed av totalt 385 deltagare, varav 43,1 % deltog i första datainsamlingen år 2011 (N_1 = 166) och 56,9 % i den andra datainsamlingen år 2020 (N_2 = 219). Andelen deltagare som rapporterat olika terapiinriktningar år 2011 och 2020 hittas i Tabell 1 och vidare beskrivande statistik på deltagarnas bakgrundsfaktorer hittas i Tabellerna 3 och 4.

Material och tillvägagångssätt

Enkäten skapades av två av författarna och användes i båda datainsamlingarna för att försäkra resultatens jämförbarhet. Enkäten innehöll frågor om deltagarnas bakgrundsinformation, bland annat ålder, kön, yrke, utbildningsnivå, typ av arbetsplats, hur länge de arbetat kliniskt samt vilken eller vilka psykoterapiinriktningar de har. Deltagare ombads därefter besvara frågor om deras arbetserfarenheter relaterade till falska minnen, bortträngda och återhämtade minnen, samt patienter med dissociativa symptom eller DID. Slutligen presenterades 25 påståenden om minne, trauma och dissociation (se Tabell 2) till deltagarna, som ombads rapportera i vilken grad de håller med om varje påstående på en skala från 1 (”Jag är starkt av annan åsikt”) till 4 (”Jag är starkt av samma åsikt”). Ett ytterligare påstående lades till i den senare datainsamlingen, nämligen ”Psykiskt trauma lagras som kroppsliga minnen och dessa minnesbilder kan lösgöras genom att bearbeta fysiska symptomen, t.ex. med hjälp av massage”. De flesta påståenden och frågorna om erfarenheter fick sin inspiration från en studie av Ost et al. (2013).

Analyser

Analyserna genomfördes i programmet *R* (R Core Team, 2021) med hjälp av paketen *psych* (Revelle, 2021), *dplyr* (Wickham et al., 2021), *car* (Fox & Weisberg, 2019), samt *emmeans* (Lenth, 2021). Först undersökte vi distributionen av deltagarnas bakgrundsfaktorer under båda datainsamlingarna och jämförde sedan dem med hjälp av t-test och chi-kvadrat-test. Detta gjordes för att säkerställa att samplen inte signifikant skilde sig åt på andra faktorer än tidpunkten av datainsamlingen.

För att testa hypoteserna 1 och 2 genomförde vi ett antal t-test och chi-kvadrat-test för att jämföra medeltalen av kontinuerliga variabler och frekvensen av kategoriska variabler i datainsamlingarna. För att testa för korrelationer mellan deltagarnas rapporterade psykoterapiinriktning och deras föreställningar (Hypotes 3) genomfördes multipla linjära regressionsmodeller för att undersöka huruvida det att man rapporterat en terapiinriktning predicerade starkare eller svagare enighet med varje påstående, jämfört med dem som inte rapporterat samma inriktning. Terapiinriktningar som rapporterats av över 20 % av deltagarna i någotdera sampel inkluderades i modellerna. Korrelationsanalyserna genomfördes endast på nyare data från år 2020, då huvudsakliga intresset med dessa analyser var att utforska nuvarande läget av möjliga associationer. Beroende på utkomstvariabeln genomförde vi antingen multipla linjära regressionsmodeller eller multipla binära regressionsmodeller för att testa för associationer mellan terapiinriktning och rapporterande av olika erfarenheter.

Resultat

Deskriptiva resultat

Då distributionen av deltagarnas bakgrundsinformation i de två datainsamlingarna jämfördes kunde vi konstatera att deltagarna år 2011 och 2020 inte signifikant avvek från varandra på så vis att det skulle hindra vidare analyser eller tolkningar. Se Tabellerna 1, 3 och 4 för statistiska värden.

Jämförelse av psykoterapeuters föreställningar över tid

Vi fann signifikanta skillnader mellan de två samplen på flesta av de föreställningar som mättes, se Tabell 5 för alla påståenden och respektive statistik samt Figur 1 för svarsdistributioner och effektstorlekar mellan 2011 och 2020.

Jämförelse av psykoterapeuters erfarenheter över tid

Deltagare år 2020 rapporterade en signifikant lägre andel klienter med traumatisk amnesi och vi fann en signifikant minskning i deltagare som angav att de aktivt försöker hjälpa sina klienter att återhämta glömda traumatiska minnen. Därtill fann vi en signifikant minskning i deltagare som angav att de försöker korrigera klienters minnen ifall de misstänker att minnesbilderna är falska. Det fanns ingen signifikant skillnad i den rapporterade frekvensen av att misstänka att traumatiska minnen, som återhämtats efter total amnesi, kunde vara falska. Vi fann ingen signifikant skillnad i proportionen av deltagare som angav att de hade träffat en patient med DID. Däremot fann vi en signifikant skillnad i mängden DID-patienter som deltagarna angav år 2011 och 2020, χ^2 (4, N = 167) = 9,80, p = 0,04. Slutligen fann vi att deltagare år 2020 rapporterade signifikant lägre estimat av sexuellt utnyttjande som bakgrundsfaktor för dissociativa symptom. Se tabellerna 6, 7 och 8 för statistiska värden.

Korrelationer med terapiinriktning

Eftersom deltagare kunde rapportera flera terapiinriktningar genomförde vi Pearsons phi-korrelationstest för att utforska möjliga associationer mellan rapporterande av olika inriktningar, se tabell 9.

Kognitiv inriktning. Att rapportera en kognitiv eller kognitiv-behaviorell inriktning var associerat med mindre stark tro på att minnesbortträngning är vanligare för klienter som har varit med om flera traumatiska händelser (F = 5,43, df = 1, p = 0,021; $M_{kognitiv}$ = 2,79 [2,46, 3,12]; M_{utan} = 3,19 [2,99, 3,40]). Kognitiv inriktning var även associerat med starkare tro på att livliga och detaljerade minnen är mer sannolikt verkliga (F = 4,90, df = 1, p = 0,028; $M_{kognitiv}$ = 2,50 [2,20, 2,79]; M_{utan} = 2,15 [1,96, 2,33]). Rapporterande av en kognitiv inriktning var vidare associerat med högre frekvens av att försöka korrigera klienters misstänkta falska minnen (χ^2 [1, N = 177] = 7,23, p = 0,007), då kognitiva terapeuter var mer sannolika att hålla med frågan (logOdds = -0,20 [-0,96, 0,56]) än deltagare utan kognitiv utbildning (logOdds = -1,30 [-1,87, -0,73]).

Dynamisk inriktning. Dynamisk inriktning var negativt associerat med tro på att psykiskt trauma lagras som kroppsliga minnen, som kan lösgöras med hjälp av massage (F = 6,25, df = 1, p = 0,013; $M_{dynamisk}$ = 2,31 [2,00, 2,62]; M_{utan} = 2,73 [2,58, 2,88]), samt tro på att icke-verbala element är nödvändiga i traumavård (F = 5,98, df = 1, p = 0,016; $M_{dynamisk}$ = 2,57 [2,22, 2,93]; M_{utan} = 3,03 [2,86, 3,20]).

Traumaterapiinriktning. Rapporterande av en traumaterapiinriktning var associerat med starkare tro på möjligheten av minnesbortträngning och -återhämtning (F = 4,88, df = 1, p = 0,029; M_{trauma} = 3,46 [3,18, 3,73]; M_{utan} = 3,11 [2,93, 3,28]), att vaga barndomsminnen är ett tecken på en traumatisk barndom (F = 5,99, df = 1, p = 0,015; M_{trauma} = 2,52 [2,21, 2,83]; M_{utan} = 2,08 [1,87, 2,28]), att traumatiska minnen lagras genom olika minnesprocesser (F = 4,96, df = 1, p = 0,027; M_{trauma} = 3,61 [3,34, 3,87]; M_{utan} = 3,27 [3,09, 3,44]) och i en annan del av hjärnan (F = 6,25, df = 1, p = 0,013; M_{trauma} = 3,36 [3,05, 3,67]; M_{utan} = 2,90 [2,69, 3,12]) jämfört med neutrala minnen, samt att fysiska symptom är kroppens sätt att minnas traumatiska erfarenheter och bearbetning av dessa symptom kan återställa händelserna i det medvetna minnet (F = 5,47, df = 1, p = 0,021; M_{trauma} = 3,67 [3,44, 3,90]; M_{utan} = 3,35 [3,20, 3,50]). Vidare var rapporterande av en traumaterapiinriktning associerat med starkare tro på att traumarelaterade minnesbilder inte förändras med tiden (F = 22,51, df = 1, p <0,001; M_{trauma} = 2,68 [2,37, 2,99]; M_{utan} = 2,06 [1,86, 2,26]), att det finns en koppling mellan ätstörningar och trauma (F = 22,51, df = 1, p <0,001; M_{trauma} = 3,13 [2,85, 3,41; M_{utan} = 2,36 [2,17, 2,54]) samt att icke-verbala element är nödvändiga i traumabehandling (F = 17,81, df = 1, p <0,001; M_{trauma} = 3,21 [2,87, 3,54]; M_{utan} = 2,40 [2,19, 2,61]). Däremot var traumaterapiinriktning negativt associerat med tro på att detaljerad återställning och bearbetning av traumaminnen är avgörande för behandlingen (F = 4,81, df = 1, p = 0,030; M_{trauma} = 1,70 [1,38, 2,01]; M_{utan} = 2,10 [1,89, 2,30]).

Då deltagares erfarenheter utforskades, fann vi ett signifikant samband mellan traumaterapiinriktning och högre proportion av ens klienter som återhämtat traumatiska minnen efter en period av total amnesi innan terapin (F = 7,83, df = 1, p = 0,006, M_{trauma} = 1,24 [0,97, 1,52]; M_{utan} = 0,80 [0,61, 0,98]). Vi fann också en association mellan att ha en traumaterapiinriktning och större sannolikhet att rapportera att man har träffat åtminstone en patient med DID (χ^2 [1, N = 192] = 11.44, p = 0,001; $\text{logOdds}_{\text{trauma}}$ = 1,49 [0,51, 2,48]; $\text{logOdds}_{\text{utan}}$ = -0,19 [-0,71, 0,32]). Slutligen fann vi även en signifikant association mellan att rapportera en traumaterapiinriktning och att rapportera att man har träffat en större mängd patienter med DID (F = 4,48, df = 1, p = 0,006; M_{trauma} = 1,24 [0,97, 1,52]; M_{utan} = 0,80 [0,61, 0,98]).

EMDR. Som förväntat var utbildning i EMDR associerat med starkare tro på att EMDR har bevisats vara den bästa vårdmetoden för trauma (F = 16,51, df = 1, p <0,001; M_{EMDR} = 2,97 [2,73,

3,21]; M_{utan} = 2,35 [2,13, 2,58]). Deltagare som rapporterade utbildning i EMDR trodde även starkare på påståendet att en persons tilltro till sina minnen indikerar att minnena är mer sanningsenliga (F = 5,93, df = 1, p = 0,016; M_{EMDR} = 2,40 [2,16, 2,64]; M_{utan} = 2,04 [1,81, 2,26]). Deltagare med EMDR-utbildning rapporterade också starkare tro på att minnesbilder från traumatiska händelser kan formas redan under första levnadsåret och senare återhämtas antingen spontant eller i terapeutiskt arbete (F = 5,42, df = 1, p = 0,021; M_{EMDR} = 2,68 [2,38, 2,98]; M_{utan} = 2,24 [1,96, 2,52]), att en erfaren terapeut korrekt kan estimera huruvida ett minne är verkligt eller falskt (F = 3,96, df = 1, p = 0,048; M_{EMDR} = 2,22 [1,97, 2,47]; M_{utan} = 1,90 [1,67, 2,13]) samt att upprepade traumatiska erfarenheter i barndomen kan leda till formationen av flera separata jagtillstånd eller personligheter, som är omedvetna om varandra (F = 4,00, df = 1, p = 0,047; M_{EMDR} = 3,57 [3,35, 3,79]; M_{utan} = 3,29 [3,09, 3,49). Slutligen fann vi en signifikant association mellan att rapportera sig ha träning i EMDR och högre svarsestimat på frågan ”Enligt din erfarenhet, hur ofta är erfarenheter av sexuellt utnyttjande i bakgrunden för dissociativa symptom?” (F = 4,79, df = 1, p = 0,030; M_{EMDR} = 1,79 [1,45, 2,12]; M_{utan} = 1,35 [1,05, 1,66]).

Övrig inriktning. Att rapportera någon terapiinriktning utöver de ovannämnda var endast signifikant associerat med starkare tro på att en erfaren terapeut korrekt kan avgöra huruvida ett minne är verkligt eller falskt (F = 5,87, df = 1, p = 0,017; $M_{övrig}$ = 2,23 [1,98, 2,48]; M_{utan} = 1,89 [1,67, 2,10]) samt med en större sannolikhet att ha träffat åtminstone en patient med DID (χ^2 [1, N = 192] = 4,66, p = 0,031; $\text{logOdds}_{\text{övrig}}$ = 1,07 [0,31, 1,83]; $\text{logOdds}_{\text{utan}}$ = 0,23 [-0,41, 0,86]).

Icke-signifikanta resultat. En del föreställningar var inte signifikant associerade med någon terapiinriktning. Dessa var tro på att kunna återställa bortträngda minnen med hjälp av hypnos, att falska traumaminnen kan framkomma, att falska neutrala minnen kan framkomma, att en person själv kan pålitligt estimera huruvida ens minnen stämmer eller inte, att det är av sekundärt intresse i terapeutiskt arbete att utreda ifall ett traumaminne stämmer eller inte, att falska minnen inte är möjliga, att högre emotionellt innehåll indikerar en verklig minnesbild samt att dissociativa störningar alltid är ett tecken på traumatiska erfarenheter. Vidare var vissa erfarenheter inte heller associerade med någon terapiinriktning, nämligen frekvensen av att misstänka falska minnen samt att rapportera att man aktivt försöker hjälpa sina klienter att minnas misstänkta glömda traumaminnen.

Diskussion

I denna studie jämfördes finska psykoterapeuters föreställningar och erfarenheter relaterade till minne, dissociation och traumabehandling år 2011 och 2020, samt utforskades möjliga associationer mellan psykoterapiinriktning och olika typers föreställningar och erfarenheter.

Resultaten visade en märkbar positiv förändring i finska psykoterapeuters föreställningar och erfarenheter över tid, då de flesta utav dessa hade utvecklats till att återspegla en mer vetenskapligt stödd synpunkt år 2020, jämfört med 2011. Våra resultat för utvecklingen av psykoterapeuters föreställningar i en mer empiriskt stödd riktning över tid var som förväntat i enlighet med tidigare resultat av Patihis et al. (2014). Däremot fann vi mot våra förväntningar inte att någon psykoterapiinriktning skulle predicera mer evidensbaserade föreställningar. Inriktningarna i traumaterapi och EMDR var emellertid kopplade med flera vetenskapligt ifrågasättbara föreställningar, men dessa inriktningar korrelerade inte heller fullständigt konsistent med mindre vetenskapligt stödda synpunkter. Våra resultat, likt resultaten från Poole et al. (1995) och Dammeyer et al. (1997), tyder därmed på att psykoterapiinriktning inte är en stark förklarande faktor för variationen i psykoterapeuters föreställningar. En ökad användning av integrativa tekniker över inriktningsgränser kunde potentiellt förklara varför terapiinriktning inte i hög grad förklarar psykoterapeuters föreställningar och upplevelser. Övriga förklarande faktorer bör därmed utforskas, exempelvis psykoterapeuters grundutbildning. De flesta psykoterapeuter i Finland är psykologer, sjukskötare eller läkare (Valkonen et al., 2011). I och med att dessa basutbildningar kan tänkas skilja sig från varandra en hel del då det handlar om undervisning i minnesfunktioner och suggestibilitet, skulle det kunna vara intressant att utforska i vilken utsträckning psykoterapeuters basutbildning kunde förklara variationen i föreställningar och upplevelser som dessa psykoterapeuter rapporterar.

Även om en märkbar förändring kunde observeras på många föreställningar som rapporterades av deltagarna i våra två sampel, tyder våra resultat även på att psykoterapeuter i Finland fortsättningsvis tror på en del vetenskapligt ifrågasättbara fenomen. Exempelvis verkar många psykoterapeuter i båda våra sampel anse att minnen av traumatiska händelser, som en person annars inte kommer ihåg, kan återställas med hjälp av hypnos, trots att användning av hypnos i terapikontext kritiserats på grund av risken för suggestion av falska minnen (Lynn et al., 1997). Icke-evidensbaserade föreställningar bland kliniker är problematiska, eftersom klinikers egna uppfattningar, förväntningar och kognitiva snedvridningar kan påverka själva terapibehandlingen (Ruscio, 2006). Forskning har visat att personer som förväntar sig påbörja en terapiprocess även är mer benägna att förvänta sig att återuppfinna bortträngda minnen i terapi (Rubin & Boals, 2010). Därtill har studier av Myers et al. (2015; 2017) påvisat att lekmän kan känna igen suggestiva metoder i terapi, men att de oftast inte inser dessa metoders inverkan på pålitligheten av minnesbilderna som framkommit under inverkan av suggestion och ifrågasätter inte heller terapeutens kompetens utgående ifrån hens användning av suggestiva metoder (Myers et al., 2015).

Endast då lekmännen i dessa studier fått veta att terapeutens suggestion hade framkallat falska minnen hos klienten bedömde de terapeutens kompetens som lägre och ansåg hen vara mer ansvarig för falska minnena (Myers et al., 2017). Tyvärr kan klienter i verkligheten däremot sällan antas ha kunskap om riskerna som suggestiva tekniker medför i terapi. Dessa fynd, i samband med våra resultat, framhäver vikten av att terapeuter känner till den verkliga vetenskapliga grunden för olika tekniker och fenomen och att de avstår från att använda suggestiva metoder i terapiprocesser.

Vissa begränsningar bör tas i beaktande i tolkandet av denna studies resultat. Eftersom de teman som studerats här är både mångfaldiga och kontroversiella kan deltagarna som haft mindre starka åsikter ha valt att inte besvara frågor de varit osäkra på, vilket kan ha påverkat våra resultat. Deltagarna kan ha tolkat frågorna på olika sätt och kan även avsiktligt ha besvarat frågorna på socialt önskvärt eller acceptabelt sätt, även om deras verkliga föreställningar inte motsvarat dessa svar. Eftersom data samlades med hjälp av samma enkät vid två tidpunkter och våra två sampel var mycket kompatibla kan våra resultat dock anses visa utvecklingen i svarstrender.

Sammanfattningsvis understryker våra resultat behovet för psykoterapeuter – och även övriga kliniker – att se till att de har kunskap om det tillgängliga vetenskapliga stödet för olika fenomen och metoder. Detta är absolut nödvändigt särskilt då det handlar om kontroversiella teman, för att minska på diskrepansen i föreställningar mellan forskare och kliniker och för att kunna ge den bästa möjliga behandlingen för terapiklienter, vilket torde vara i allas intresse.

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FINNISH PSYCHOTHERAPISTS' BELIEFS ABOUT TRAUMA

PRESSMEDDELANDE

Finländska psykoterapeuters traumarelaterade föreställningar har utvecklats i en mer vetenskapligt stödd riktning under det senaste decenniet

Pro gradu-avhandling i psykologi

Fakulteten för humaniora, psykologi och teologi vid Åbo Akademi

Resultaten av en pro gradu-avhandling vid Åbo Akademi tyder på att finländska psykoterapeuters föreställningar och erfarenheter relaterade till behandling av psykiskt trauma har utvecklats i en mer vetenskapligt stödd riktning under det senaste decenniet. I studien jämförde forskarna finländska psykoterapeuters självrapporterade föreställningar och erfarenheter relaterade till minnesfunktioner, dissociation och behandling av psykiskt trauma, med hjälp av data som insamlats år 2011 och 2020. Samplet bestod av 166 psykoterapeuter som deltagit år 2011 och 219 psykoterapeuter som deltagit år 2020. Resultaten tyder på att psykoterapeuters föreställningar generellt sett har utvecklats i önskvärd riktning, i och med att deltagare år 2020 rapporterade mindre stark tro på flera kontroversiella och vetenskapligt ifrågasättbara fenomen, än deltagare år 2011. Dock visar resultaten även att många psykoterapeuter fortsättningsvis rapporterar relativt stark tro på fenomen som är empiriskt ifrågasättbara. Forskarna undersökte även associationer mellan psykoterapiinriktning och olika föreställningar och erfarenheter. Då associationer mellan psykoterapiinriktning undersöktes visade sig ingen psykoterapiinriktning vara associerad med mer vetenskapligt stödda föreställningar eller erfarenheter. Utbildning i traumaterapi samt EMDR visade sig vara associerade med en del icke-evidensbaserade föreställningar, men dessa resultat var inte konsistenta. Studiens resultat tyder därmed på att psykoterapiinriktning inte till en hög grad förklarar variationen i traumarelaterade föreställningar mellan finländska psykoterapeuter. Det kunde vara av intresse för framtida studier att undersöka övriga faktorer som potentiellt är associerade med klinikers föreställningar och erfarenheter relaterade till traumavård. Huvudsakliga implikationen av denna studie är att psykoterapeuter och andra kliniker inom mentalhälsovården bör undervisas mer om bristen på vetenskapligt stöd för kontroversiella fenomen relaterade till behandling av psykiskt trauma, för att undvika att klinikers icke-evidensbaserade föreställningar leder till potentiellt skadlig vård för deras klienter.

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