Planning the Treatment of a Depressed Patient

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In this paper we present a study of psychotherapeutic treatment planning. By using a process-tracing approach, we were able to gain insight into the nature and the sequence of the considerations that psychotherapists have when they are asked to propose an intervention method for a depressed patient. The results of our study suggest formal similarities: the therapists all gave an interpretation of the patient and his complaints and they all focused on one treatment option, for which they found support in the case description. But the aspects emphasized in the therapists' interpretations were quite dissimilar as were the eventual decisions. We were unable to find a satisfactory explanation for these dissimilarities in our data, but we discuss some possibilities.

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DECIDING UPON A TREATMENT PLAN

Psychotherapists responsible for planning the treatment for their patients face Paul’s classical question ‘What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?’ (Paul, 1967, p. 111). Even when the specific problem has been diagnosed, e.g. as a depression, answers to this question are hardly more definitive now than they were almost 30 years ago (Norcross, 1991). Psychotherapy is said to be in a ‘state of theoretical clutter and disorder’ (Hanna, 1994, p. 124), and ‘the psychotherapy venture has to be viewed partly as an adventure’ (Luborsky et al., 1988, p. 310). The psychotherapist’s task of deciding how best to treat their depressed patients, is rife with uncertainty. No one approach has as yet been shown to be consistently more effective than another (Albersnagel et al., 1989). Yet clinicians perform this task, and we are interested in finding out how they do this. We think that because of the recognized difficulty of therapists’ tasks, and the extra burden of emergent treatment guidelines and other external constraints in practice, the assessment of the process of therapeutic decision making should be a focus of study.

The cognitive processes of clinicians planning the treatment of mental health patients have as yet not been extensively analysed. One notable exception is a study by Leuzinger (1981), who showed 85 subjects (psychiatrists and clinical psychologists) the same videotape of a borderline patient and asked them to say out loud whatever they considered relevant for their therapy decision. Leuzinger found remarkable diversity in his subjects’ remarks. He ascribed this to the complexity of the cognitive process involved, which, he suggested, different therapists handle with different problem-solving styles. Diversity was also found by Persons (1991; Persons et al., 1991, 1995), who studied formulations of a single case by psychodynamic and cognitive-behavioural psychotherapists. She found that the different judges showed moderate agreement in their identifications of the patient’s overt problems, but significant differences in the emphasis put on different aspects of those problems. Persons does not refer to underlying cognitive processes.

To our knowledge, no formal models of the process of treatment decision making have been
developed. Beutler (1991) advocates close inspection of the decisional processes as a way to discover what differential effects there are among treatments, and he warns researchers who follow this course that they may need to provide the common language clinicians lack in order to find the (dis)similarities. The terms we use in this study are derived from logic and methodology. These syntactic labels can hardly be taken to refer to different concepts, even by therapists from widely diverging orientations. We propose a formal, optimal model for making treatment decisions, derived from general decision theory. And we try to establish, in an empirical study, whether psychotherapists’ treatment decisions are made according to the steps of this model.

A Model of the Ideal Treatment Decision Making Process

A rational task-analysis (cf. Breuker et al., 1986) revealed that experienced psychotherapists were in agreement about decision procedures for treatment plans (Witteman, 1992). They believed that their reasoning should be logical. On the basis of information about the client and her or his complaint, different hypothetical treatment options should be proposed. Each of these should be weighed by making an inventory of its pros and cons. Eventually, the option that has the best foundation in justifying arguments should be chosen.

This model of treatment decision making should hold true for all theoretical orientations and all complaints (cf. Clark et al., 1990). It may be regarded as a measure of adequate treatment decision making performance. The draft of this prescriptive model was supplied by practicing clinicians themselves, who also endorsed the eventual version. Yet it is strikingly similar to models derived from decision theory and introduced into clinical decision making from ‘outside’, which advocate an empirical or diagnostic cycle of generating and testing hypotheses (cf. De Groot, 1961; De Bruyn et al., 1995).

Psychotherapeutic Reality

Clinical psychologists have repeatedly been observed to show poor decision performance (Arnoult and Anderson, 1988; Elstein, 1988; Garb, 1989; Shanteau, 1992; Witteman, 1992). This may of course be due to the nature of their decision tasks. There are no robust outcome predictors for the different forms of psychotherapy and there is low consensus about what the best options are. Also, psychotherapists are not in a position to systematically vary treatments with similar patients or complaints and observe the results, which means that they get no reliable feedback about their therapy decisions. And since learning from feedback is one important prerequisite for improving judgmental skills (Brehmer, 1980; Krol, 1992), therapists are at a great disadvantage (Dawes, 1994).

The observed poor decision performance may also be the consequence of the fact that of course psychotherapists are as limited in their cognitive capacity as everyone else. Making a therapy decision in the thorough manner described above is just not feasible. People have been found to overcome their cognitive limitations by ‘satisficing’: by considering only one option at a time and deciding for the first option, provided they can satisfactorily substantiate it. Alternatives are only considered if the first option is unsatisfactory (Simon, 1955; Payne et al., 1993; van den Brink, 1993). Furthermore, the first option is formulated on the basis of a specific interpretation of the problem. This interpretation facilitates the problem-solving process, because it constrains the search of cues to only information that is relevant to that interpretation (Kahneman et al., 1982; van Schie, 1991).

With increasing experience, decision makers extend and refine their library of interpretations (Lawrence, 1988; Voss and Post, 1988; Turk et al., 1988). For psychotherapists, this would mean that their initial interpretations, derived from textbooks about psychopathology and intervention methods, become more and more adapted to what they encounter in their professional practice. Their ultimate interpretations will thus, to a large extent, be based upon a vivid but unrepresentative sample of all possible clinical cases. Empirical data, which are more abstract and comparatively dull, will most probably be ignored (cf. Nisbett and Ross, 1980). In general, it has been recognized that basing decisions upon interpretations instead of the whole problem is an efficient way to control the complexity of a decision task, although it does make the decision maker vulnerable to biases, such as a tendency to confirm and conserve their own notions (Jordan et al., 1988; Sutherland, 1992; Witteman, 1992). For psychotherapists this could mean that, once they have come to an interpretation of a particular case, they may too easily judge all information about the patient and her or his complaint to accord with it; and with this judgement, they will, in turn, have found confirmation of the appropriateness of the interpretation.
Research Question and Hypotheses

We cannot expect therapists’ treatment decision making to take place in accordance with the optimal procedure (cf. above). Our question is whether the findings from decision research in other areas, presented above, apply to psychotherapists’ treatment decisions. Our hypothesis is that they do, and, consequently, that therapists reach their treatment decisions by interpreting the case, by associating a therapy option with this interpretation and by substantiating this option to their satisfaction through a focus on confirming information. And if indeed therapists decide according to their own interpretations, we expect different therapists to reach different treatment decisions for one and the same case.

METHODS

Decision Task

The subjects were asked to propose a treatment plan for a depressed patient.

Subjects

Eleven subjects were selected by the director of a psychotherapy institute. He was asked to include clinical psychologists (with a completed academic study), not psychiatrists, with different orientations and with varying experience. There were five psychotherapists-in-training, four male and one female, with a mean age of 34.5 years (SD = 3.62). Three of them had a behavioural therapy orientation, one a cognitive-behavioural and one a directive orientation. Their years of work experience ranged from 6 months to over 10 years, with a mean of 5.33 years. Also, six fully certified, independently practising therapists were included, four male and two female, with a mean age of 47.2 (SD = 4.21). One of them had a client-centred approach, one a cognitive-behavioural and four an eclectic orientation. Of these four eclectics, one had a predominantly cognitive approach, one a behavioural and two integrated a cognitive with a behavioural approach. The mean years of work experience of these certified psychotherapists was 15.6 years, ranging from 7 to over 20 years.

Procedure

The subjects participated in the experiment individually. They all followed the same procedure. After a brief training in thinking-aloud, they were presented with the task. They were first asked to study, but not learn by heart, the case of Mr Johnson, who had been diagnosed as suffering from a major depression (see Appendix 1). They were then asked to read the following instruction aloud, from paper:

Imagine that Mr. Johnson comes to you for treatment. You are now asked to decide how you would plan his therapy and why you would do so. You may, but need not, give all possible details, such as number of sessions a week. Please be more specific than, for example, proposing ‘psychoanalysis’. Thus, we ask you to tell which intervention method or methods you would use to start therapy and, moreover, how you come to your treatment decision.

The subjects were asked to think aloud all the time while solving the task, and told that they could take as long as they needed. The subjects’ verbalizations were tape-recorded.

Coding the Protocols

The audiotapes were typed up, resulting in a hard copy protocol for each subject. Then each protocol was segmented into independent thoughts—sentences or groups of closely associated sentences. These segments were encoded by two independent judges, with a highly satisfactory inter-rater agreement ($k = 0.91$), into one of the encoding categories shown in Table 1.

We developed these encoding categories in an iterative process of designing and testing. They should enable us to test our research hypotheses mentioned above, i.e. that the contents of the psychotherapists’ treatment decision processes would show them to come to a treatment plan via an interpretation of the case with its associated treatment option and a subsequent confirming information search (for more details about this technique of gathering and analysing verbal protocols and its validity see e.g. Ericsson and Simon, 1980, 1984, 1993; Breuker et al., 1986; Svenson, 1989). Because of the descriptive and exploratory nature of our investigation and because the technique of analysing verbal protocols is very time consuming, we conducted this experiment with only a relatively small number of subjects.

RESULTS

Decision Processes

Figure 1 shows 12 graphical representations, one for the sequences of steps in each of the 11 subjects’
protocols separately and one of all subjects together. On the vertical axis are the codes referring to the different content categories (cf. Table 1 above), the sequence of the verbalizations is shown on the horizontal axis as the number of the step in the protocol. The mean length in time of the decision processes was almost 11 min (SD 8), ranging from 2 to 30 min. The mean number of steps in the protocols, that is, of sentences that could be encoded into one of the content categories, was 16 (SD 4), ranging from 7 to 22 (see below: Considerations). There was no correlation between number of years of work experience and length of the protocols.

The mean number of times that a code was given to a sentence was 21 (SD 15), ranging from seven times for codes 0 and 4.2 to 45 times for code 4.1 (see Figure 2). There were over seven times more confirming sentences than disconfirming verbalizations.

Six subjects mentioned their orientation (code 0). The clearest example was ‘behaviour therapy—but then of course that is my orientation and I cannot do something I don’t know anything about’. All but one subject mentioned the diagnosis in one way or another (code 1). Some questioned the diagnosis in the course of their deliberations, but they did not reject it or come to an alternative diagnosis. Most subjects agreed with the diagnosis, explicitly or implicitly, e.g. ‘the first thing to do is to clarify the source of his depression to him’. All subjects offered an interpretation (code 2) of the patient and/or his complaints (cf. Interpretations below for examples and discussion) before verbalizing a therapy option (code 3). Usually this option was mentioned only once.

Most of the subjects’ considerations were found in sentences that confirmed the suitability of the therapy options (code 4.1). An instance taken from the report of a subject who decides, among other methods, upon assertiveness training, is ‘aspects of his assertiveness have been tried’. Only very few considerations were disconfirming (code 4.2) and only with three subjects. In all instances disconfirmation took the form of mentioning risks associated with the chosen treatment plan. For example, a subject who opted for ‘a behaviour analysis followed by cognitive restructuring and assertiveness training’, mentioned the risk that ‘he wants to have a helping hand, but I don’t think we should let it get to the point that the therapist is the saving angel, I think we need to make clear, from the very beginning, that he has to do it himself’. None of these three subjects who mentioned risks rejected their earlier option. All but one subject reflected upon an alternative (code 4.3), for instance: ‘by concentrating on sexuality too soon it could become threatening and provoke fears I’d rather avoid’. Whenever an alternative was mentioned, it was rejected in the same sentence.

All subjects specified their treatment plan (code 5), both in the course of their decision process and in concluding sentences. An example is: ‘so to sum up, I think of a cognitive therapy, with medication to provide a basis for treatment, a counselling therapy concentrating on main points, indirect interventions and homework assignments aimed at self-insight’.

Apart from the above-mentioned exceptions, remarks about all five content areas were found in all reports. As can be seen from the graph containing all subjects’ sequences of considerations in Figure 1, the more global remarks (e.g. giving an interpretation or a therapy option) were generally found before the more specific remarks (i.e. specifications of the treatment plan). The latter remarks

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**Table 1. Encoding categories for the protocol segments**

<table>
<thead>
<tr>
<th>Code</th>
<th>For sentences containing a reference to</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Theoretical orientation</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… behaviour therapy I think, since that is my approach…’</td>
</tr>
<tr>
<td></td>
<td>‘… because I am a client-centred therapist…’</td>
</tr>
<tr>
<td>1</td>
<td>The diagnosis</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… and I see a depressed person…’</td>
</tr>
<tr>
<td></td>
<td>‘… ok it clearly is a depression…’</td>
</tr>
<tr>
<td>2</td>
<td>An interpretation</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… there’s a discrepancy, he’s strong and at the same time surrendering…’</td>
</tr>
<tr>
<td></td>
<td>‘… I see an inhibited person…’</td>
</tr>
<tr>
<td>3</td>
<td>A treatment option</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… I think we should focus on establishing an accepting relationship…’</td>
</tr>
<tr>
<td></td>
<td>‘… I would propose a cognitive approach…’</td>
</tr>
<tr>
<td>4</td>
<td>A consideration:</td>
</tr>
<tr>
<td></td>
<td>4.1 Supporting the treatment option,</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… he has sufficient insight’ (with a cognitive approach)</td>
</tr>
<tr>
<td></td>
<td>4.2 Disconfirming the treatment option,</td>
</tr>
<tr>
<td></td>
<td>e.g. ‘… he seems addicted’ (with a client centred approach)</td>
</tr>
<tr>
<td></td>
<td>4.3 Giving an alternative option</td>
</tr>
<tr>
<td></td>
<td>e.g. (client-centred therapy) ‘or possibly an assertiveness training’</td>
</tr>
<tr>
<td>5</td>
<td>A treatment plan</td>
</tr>
</tbody>
</table>
|      | e.g. ‘in a cognitive treatment I would try to give him self-insight, with indirect interventions, by giving homework assignments, …’

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were given more towards the end of the report. This cycle from more global to more specific generally recurred.

**Interpretations**

We then checked whether the interpretations (code 2) in fact led to the therapy options. Two judges independently examined the reports for the subjects' interpretations, i.e. remarks about the patient and/or his complaint that did not appear in the case description. The judges came to a 95% similar selection of segments, with agreement over the remaining 5% reached in discussion. We found interpretations in the protocols of all 11 subjects (cf. Figure 1). In Table 2 we give four examples: subjects 6, 7, 9 and 11. Subjects 6 and 7 emphasized quite different aspects of the client's complaints in

![Figure 1. Subjects 1–6](image-url)
their interpretations. For subject 6, the patient was primarily someone who might have inhibitory thoughts and who hid his real thoughts and feelings. Subject 7 saw an insecure person, with a lot of obligations. Despite these differences, the proposed treatment plans were more or less similar. Subject 7 proposed assertiveness training, which is understandable given her interpretation of insecurity. And both subjects suggested RET. For subject 6, this follows from the interpretation of inhibitions.
for subject 7, from the interpretation of compulsion. Subject 9 made the same suggestions as subject 7, that is: both assertiveness training and RET. He also mentioned insecurity, but otherwise gave an extensive interpretation in which an underdeveloped identity, difficulty in expressing feelings, problems in sexual relationships and refusal to take responsibility are prominent. Subject 11 mentioned several of the themes stressed by subject 9, especially the lack of responsibility, but suggested psychodynamic therapy.

The picture emerging from these examples applies to all interpretations. With individual subjects, links may be found between (parts of) their interpretation and (parts of) their treatment plan. There is, for instance, the obvious relation between uncertainty and assertiveness training. But similar treatment plans may be decided upon on the basis of different interpretations, and similar interpretations may lead to different decisions. We therefore cannot conclude that for an outside observer, interpretations and treatment decisions appear closely associated.

Decisions

In Table 3 we present each subject’s proposed treatment plan for Mr. Johnson. Probably because of the formulation of the task (cf. above) only one subject (number 3) considered medication, in combination with psychotherapy, and none of the subjects proposed referral. We then looked at the treatment decisions in more detail: at the methods, themes and (sub)goals the subjects mentioned (see Table 4). A qualitative analysis, statistics not being appropriate for this small sample, shows that five out of the 11 subjects said they would start with a further inventory of the patient’s actual situation and complaint. One specific method and one technique were often decided upon: Rational Emotive Therapy (RET) and assertiveness training. It might be expected that the latter would occur in conjunction with one of two most common themes, mentioned by subjects of different orientations, that is, social contacts or relationships. And again, a focus on this theme would explain the frequent occurrence of the goal to improve contacts or relationships. But these three elements did not always occur together in a decision: they did with subject 2 but not, for example, with subject 6 (see Table 3). The latter did focus on problems in social intercourse, but she did not mention assertiveness training and her aim was insight rather than improved contacts.

Just as parts of the interpretations were given by more than one subject, so common elements may be found in the 11 decisions. But the same conclusion that was drawn about the relation between interpretations and decisions, holds for the relation between theme, method and goal within a decision: beyond the individual level there do not seem to be straightforward, identifiable links or generally accepted associations.

Considerations

While the conclusions of the 11 subjects diverged, they might still have considered similar aspects of the case. The 11 subjects together made 171 remarks about the case, either repeating parts of the description or making an inference from the description (means = 16, SD = 4; cf. above: Considerations), ranging from seven from subject 2 to 22 from subject 6.

Subjects seldom used precisely the same terms, but often they could be taken to refer to the same phenomenon, as for example with ‘capable of reflection’ and ‘has introspective abilities’. To be able to compare the subjects’ considerations, we had to reduce the total number of 171. A content analysis was done (cf. Hutsemaekers, 1990), and we achieved condensation into 29 categories, shown in Table 5 below. Category 9 for example, concerning problems with intimate contacts, includes ‘has trouble getting involved with others’, ‘cannot bind himself’, ‘doesn’t dare form real intimate relationships’ and ‘unable to experience intimate contact’.

Figure 2. Frequencies of assignment of codes to subjects’ remarks
Table 2. Interpreting remarks of subjects 6, 7, 9 and 11

<table>
<thead>
<tr>
<th>Subject</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>There are all sorts of things in his social contacts, I wonder what kind of thoughts such a man has been taught, that he doesn’t dare form intimate relationships, those social contacts draw my attention, and suddenly it comes to me that I think a lot of his problems have to do with that, doesn’t show himself to others, doesn’t show what he really thinks and feels, is angry with others really but doesn’t show that either, thinks others inane, but shows something completely different, and I think that that must take a lot of energy to keep all that inside and to pretend to be different, family background not very strong, and it seems as if he tries to find something in relations that he himself lacks, and that he wants to see something in others that maybe he wants badly to reach, he is the little one and the other stable and healthy</td>
</tr>
<tr>
<td>7</td>
<td>This man repeatedly has problems in the social sphere, seems sensitive to authority, to have some social fear, a somewhat pathological family background, in general also lacks affect, everything gives the impression that the man has a lot of obligations, but he never mentions enjoying what he does, he seems apart from socially fearful and sensitive to authority also somewhat subservient, possibly dependent, indeed insecure, doesn’t trust his own insights and feelings, because he has never learned to do so, obviously assesses situations and then decides, but the question is whether his assessments are correct, and the whole sexual background is confused, big sexual insecurity, whole identity there insecure, anyway he’s afraid to form equivalent attachments, uses work to suppress the complaints, can’t stand conflicts, is part of course of the social fear, obviously may not feel, may not experience</td>
</tr>
<tr>
<td>9</td>
<td>If you look closely he has from his early years been unable to develop his own identity, that way you may get punished for expressing aggression, and at the same time rewarded for not expressing it, so that gives a complex problem, a second problem concerning identity of course who you are, what interests you have, what shields you from others, that of course has to do with your own identity, but also important is the sexual development the idea you have of yourself and what you want with sexuality, that was taboo as well, hasn’t had the opportunity to test his sexual ideas and feelings, has a sort of mixup of the more psychic identity and the sexual identity, looks for women who are really his father, dominant, who control him, and lets himself be led and seduced by those women, but also lets himself be made a puppet, so he has trouble here also to express his sexual ideas and feelings, has partly hidden it, a third thing that surprises me is that he’s rather contradictory (he feels dominant and insecure towards his friends), thinks he is worth more than his friends, or imagines so, but cannot express that in any way, (working in developing countries) is also something that I see as betraying his inner emptiness, what you also see is that he hasn’t really learned in his identity to take responsibility to be behind it completely, to undertake things for which he takes full responsibility, which shows up especially in his relationships, looks for relations that are doomed to fail, because he takes no responsibility for it whatsoever, afraid to express his aggression, even his opinion even with fiends, is very controlled, so has to take all sorts of pains to suppress his feelings of fear and aggression, great ambivalence in the management of aggression and sexuality, because he hardly expresses himself he is more a follower, a spectator, also isolated, which he blames not on himself but on the circumstances, because of his self-pity</td>
</tr>
<tr>
<td>11</td>
<td>He’s not only dependent on father, I think with father he gets into an everything-or-nothing situation, and that process continues later in contacts with colleagues and of course women, he not only rationalizes, but he especially also splits, with words like always and never, he is often very absolute in his thinking, runs away from his feelings, and that is typically something I read as not taking responsibility, and it seems he is able to instruct his surroundings so they don’t hold him responsible, (opinion of father) typically goes towards those splittings, so with this man I strongly think of distance nearness, unable now, I think, to allow or experience intimate contact</td>
</tr>
</tbody>
</table>

Not all categories were used by all subjects and some categories were used more than once by the same subject. The frequencies with which each of the 11 subjects named each of the 29 categories were subjected to a correspondence analysis (subject by category) using the SPSS-program ANACOR. With so little data relative to the large number of values on the two categorical variables, we could only infer that subjects considered the same categories if we could account for most of the inertia with few dimensions. As it was, the first dimension accounted for only 21% of the total inertia, the second dimension for an additional 16% (see Figure 3).

On the first dimension we found ‘aetiology other than family, insight and talks about emotions but is unable to handle’ opposite ‘social fear, lack of assertiveness and feels powerless with other people’. This dimension might tentatively be interpreted as distinguishing between a focus on
Table 3. Treatment plans proposed by the 11 subjects

<table>
<thead>
<tr>
<th>Subject no. + orientation</th>
<th>Treatment plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Client centred</td>
<td>Interactive therapy: building up a cooperative relationship, theme left open (possibly reason for coming, parents, discrepancy in sexual development) aimed at the removal of inhibitions and more insight</td>
</tr>
<tr>
<td>2 Behaviour</td>
<td>First postponed: talks to map out the depression; in the second instance behaviour therapy, working on contacts with others, assertiveness and depression, possibly with RET and assertiveness training, aimed at decreasing social tensions and daring to be himself in contacts</td>
</tr>
<tr>
<td>3 Directive</td>
<td>Medication to provide a basis; cognitive, counselling therapy concentrating on main points, focusing on relation to family and sexuality and on actual situation, with indirect interventions, homework assignments and replacing cognitions, aimed at self-insight</td>
</tr>
<tr>
<td>4 Behaviour</td>
<td>Talks to come to an inventory, followed by adaptation of the actual cognitions, relations and the depressive complaint, aimed at improving social skills and more insight</td>
</tr>
<tr>
<td>5 Eclectic (cognitive)</td>
<td>First postponed, clarifying spectator-role and sexuality, diagnosis questioned; in the second instance: make an inventory, individual, cognitive behaviour therapy, once a week</td>
</tr>
<tr>
<td>6 Cognitive-behavioural</td>
<td>Individual behaviour therapy, once a week, giving concrete form to cognitions and the depression, with RET and rehearsing different behaviour, working on problems in social intercourse (possibly getting through a traumatic past, also discussing therapy behaviour) and ideas about relations, consequences of behaviour and sexuality, aimed at insight in coping strategies</td>
</tr>
<tr>
<td>7 Behaviour</td>
<td>Assertiveness training to decrease social fears, build up a relationship and work on cognitions and compulsion, with some RET, to learn to feel and experience and trust own insights and feelings and to make correct estimates of what he sees or thinks</td>
</tr>
<tr>
<td>8 Cognitive-behavioural</td>
<td>Analysing the complaint, the actual (social) situation, cognitive labelling of situations and own capacities, followed by cognitive restructuring and assertiveness training to improve actual behaviour and emotional life and for more self-confidence and self-respect</td>
</tr>
<tr>
<td>9 Eclectic (behaviour)</td>
<td>Make an inventory of strong and weak points, activities (who initiates them, when do they lead to depression), thoughts about himself, activities and parents; stimulating pleasant activities and assertiveness training with role-plays to learn to cope with criticism, to express aggression, to make and keep contacts, to take responsibility; rehearse cheerful behaviour; RET with homework to improve self-image; guided fantasy for signification; weekly, possibly with parents</td>
</tr>
<tr>
<td>10 Eclectic (cognitive+behaviour)</td>
<td>Clarify the source of depression, RET with homework to work through the past, especially the idea of never having been singled out; so that he can be himself in behaviour and cognitions, improving ability to make own choices, to accept the past and to gain insight; weekly</td>
</tr>
<tr>
<td>11 Eclectic (cognitive+behaviour)</td>
<td>Short interactive psychodynamic therapy, confronting, to work on actual problems, vision of own life, the family, responsibility, intimacy and actual relations, to learn to take responsibility and to improve relationships with himself and others</td>
</tr>
</tbody>
</table>
### Table 4. Methods themes and goals mentioned more than twice by the 11 subjects

<table>
<thead>
<tr>
<th>Method</th>
<th>Behaviour n=3</th>
<th>Directive n=1</th>
<th>Eclectic n=4</th>
<th>Cognitive Behaviour n=2</th>
<th>Client Centred n=1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventory/analysis</td>
<td>1</td>
<td>—</td>
<td>2</td>
<td>2</td>
<td>—</td>
<td>5</td>
</tr>
<tr>
<td>RET</td>
<td>2</td>
<td>—</td>
<td>2</td>
<td>1</td>
<td>—</td>
<td>5</td>
</tr>
<tr>
<td>Assertiveness training</td>
<td>2</td>
<td>—</td>
<td>1</td>
<td>1</td>
<td>—</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme</th>
<th>Behaviour n=3</th>
<th>Directive n=1</th>
<th>Eclectic n=4</th>
<th>Cognitive Behaviour n=2</th>
<th>Client Centred n=1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts/relations</td>
<td>3</td>
<td>—</td>
<td>2</td>
<td>2</td>
<td>—</td>
<td>7</td>
</tr>
<tr>
<td>Sexuality</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Parents/family</td>
<td>—</td>
<td>1</td>
<td>3</td>
<td>—</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Depressive complaint</td>
<td>2</td>
<td>—</td>
<td>—</td>
<td>1</td>
<td>—</td>
<td>3</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Aimed at</th>
<th>Behaviour n=3</th>
<th>Directive n=1</th>
<th>Eclectic n=4</th>
<th>Cognitive Behaviour n=2</th>
<th>Client Centred n=1</th>
<th>Total</th>
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<tr>
<td>Improving contacts/relations</td>
<td>4</td>
<td>—</td>
<td>3</td>
<td>—</td>
<td>—</td>
<td>7</td>
</tr>
<tr>
<td>Insight</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Improving behaviour</td>
<td>—</td>
<td>—</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Take responsibility</td>
<td>—</td>
<td>—</td>
<td>3</td>
<td>—</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Self-confidence</td>
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<td>—</td>
<td>1</td>
<td>1</td>
<td>—</td>
<td>3</td>
</tr>
</tbody>
</table>

### Table 5. Categories of considerations

1. Depression, symptoms of —
2. Family/father/mother/siblings, neutral remarks about —
3. Family as source/explanation of complaints
4. Aetiology other than family: endogenous factor, has not built up adequate behaviour repertoire or self-confidence, has not experienced stability
5. Hope/positive factors: is strong, has always been able to get along, no direct avoidance, does everything, perseverance, has been active and successful, seems able to change
6. Insight into complaints, emotions; reflexive abilities
7. Wishes: to be active, energetic, open, free, happy; wants a helping hand
8. Social fear
9. Making/entertaining/keeping/intimate contacts, problems with —, afraid to tie himself
10. Dominant in social relations
11. Powerless, feels — with other people, in relations
12. Social network, lack of —
13. Tension/arousal
14. Assertiveness, lack of —
15. Inability to express himself, afraid to —, inhibited
16. Looks up to others, idealizes —, overestimates —
17. Conflict management inadequate
18. Dissociation/spectator, feels himself to be a —
19. Inferiority, sense of —/lack of self-confidence
20. Hostility, suppressed —/aggression, difficulty coping with —
21. Negative labelling of own activities, others, situations, sexuality
22. Insecurity
23. Sexuality, problems with —/sexual identity
24. Works, but doesn’t enjoy —, used as flight
25. High standards, absolute thinking, self-controlled
26. Emotions, talks about but unable to handle —
27. Psychosomatic complaints: bronchitis
28. Rationalizes
29. Lack of insight
personal problems and a focus on social problems. On the second dimension we saw ‘social fear and lack of assertiveness’ opposite ‘feels powerless with other people and negative labelling’. This could be interpreted as identifying behavioural factors versus cognitive factors, which is supported by the fact that subjects with a (predominantly) behavioural orientation (2, 4, 7 and 9) all scored high on this dimension.

In answer to our question, we have to conclude that, at least at this level of description, each subject seemed largely to be using her or his own personal subset of considerations.

CONCLUSION AND DISCUSSION

In this exploratory study, for which we used a process-tracing approach, we found formal similarity in therapeutic treatment decision making processes. Our research question may be answered in the affirmative: the findings from decision research in other areas indeed apply to psychotherapists’ treatment decisions. Our subjects all gave an interpretation and a treatment option, for which they, selectively, found confirming information. They did not seriously consider alternatives, but were satisfied with their first option. The following
excerpt is illustrative for this link between first option and later specification of an intervention. Subject 6 remarks in one of her first sentences that she would first try to find out why behaviour therapy would be suitable for this man. The therapist betrays her favouritism when she wonders ‘why’ instead of ‘if’ behaviour therapy would be suitable. Towards the end of her protocol, she concludes that she thinks she would indeed opt for behaviour therapy, would focus on (among other themes) contact with others and see the patient once a week.

However, we could not establish the expected causality between the interpretations and the proposed treatments. Both the interpretations and the information used by the different subjects were quite idiosyncratic. It is therefore not surprising that the proposals themselves also varied.

It is naturally an open question how comparable the actual treatment would turn out to be, because therapists may use different terms but in fact refer to similar interventions. Also, therapists may not put into practice what they say they do (cf. van Lieshout, 1990).

The lack of common and clear connections between proposals and interpretations and between interpretations and the case description, is quite astonishing. An explanation could be that the subjects’ starting point was not the case description, but their preferred treatment method. Therapists could have been answering a different question than the one put to them, not ‘what would be the most suitable treatment plan for this patient?’ but ‘could I treat this patient with the methods I usually apply?’ They could have been making a ‘yes’ or ‘no’ decision about the applicability of the treatment method they master and/or favour instead of choosing the most suitable treatment method from among alternatives. In a large-scale study currently underway we follow up on this idea, by checking whether the same therapists would come to a similar conclusion for other cases, with varying similarity of description.

We discussed our findings with the subjects and other practising therapists. They were not as shocked as we had expected them to be. They admitted to a large measure of subjectivity and looseness in their decisions. And they agreed that their decision-making processes cannot really be described as (psychological, because although their decision steps more or less follow a certain order, they do not follow from each other. Time constraints, availability of therapists, preferences for certain types of patients—these and similar extraneous factors seem to account for the difference between actual and adequate treatment decision making.

REFERENCES


**APPENDIX 1: CASE DESCRIPTION**

**Mr Johnson, 28, anthropologist**

‘Feeling rather down-hearted. I’m quite often depressed, gloomy. Don’t really know what I want. Can’t handle conflicts, am passive. Often tired, eating badly at times, then having problems falling asleep, feel like being “dead”; don’t desire anything, not other people or sex either. Never really happy. Fighting to function socially. I want to be active, to participate. After my studies, when I was 23, I worked in Asia for 2 years. After 1 year I had exactly the same feelings that I had had at home; it

had been my motivation to start afresh, but after 1 year I was dissatisfied with my job, had no friends. I did have several girlfriends simultaneously, but no real relationships. It was compromising all round. I often feel like a spectator. I'm labile, little things can make me feel dejected. For myself, I think suppressed aggression. Getting frightened instead of angry. Feeling down and then getting the hump'.

Elaboration
‘I am always a little tense, especially with other people. I work 3 days at a post-doc institute. I function comfortably there. I always overestimate others a little, let myself be overborne sometimes. A grim attitude. A threatened feeling. I don’t dare to let myself go wholeheartedly. It’s amazing that I’ve always been able to stay upright. Even when I felt rotten, I still studied. I always managed. The job does offer support. I am interested in the problems of developing countries’.

Life History
Physical development/early youth: ‘there are no peculiarities. There is a memory in the sexual sphere. When I was a toddler I saw, via the mirror, my mother naked. This was a taboo in our home. It made a strange impression on me. I also suffered from some sort of bronchitis, but I can’t remember anything about that. My parents were both overwrought at the time. Both parents are of a nervous disposition. My brother has been in ambulant treatment for a year now. Sister is 30 and is on sick-pay, also in connection with depressions’.

Family Situation
Father, 63 years. Eventually manager of a big firm. Has worked his way up through evening-classes. ‘I used to admire him, until I was around 15. He always knew everything. Popular and a social success. That has turned into rather negative feelings. During my studies, from around 18 to 23 years, we had arguments about politics at the weekend, he always overbore me. Outside home, I disseminated his views. I have come to dislike him thoroughly. He never really used to read. Just work, never went to the pictures or anything. He had commonplace pleasures and opinions. Has conservative prejudices, is a stupid man. The period in Asia led me to see some relativity. I find him somewhat naive. He would have liked to arrange his life differently. My brother and sister resent him for often being away. That he was authoritarian. It hurts me that I can’t talk to him. This feeling is mutual. He is also depressed. When I was 23, I was afraid of resembling him’. Mother, 60 years. Works at home and does a little charity. Clubs and things like that. Mother was the pivot of the family. Mother is energetic, did everything for you, put a stamp on the family. For a long time I was inclined to blame father for everything, but now I think mother was also very domineering. Before marriage she finished secondary school. Mother was afraid, conflicts were shoved under the carpet. Mother is pacifying. Father can fly out terribly. I have never felt much warmth for her’. Sister, 30 years, single. ‘We are alike. We fight to feel good. She read philosophy. Is well-read but rationalizes very much. She had a job at university, but left after 2 months, heavily overwrought. She has been in different kinds of treatment for years. This hardly helps her. She thinks of herself as lesbian. My brother is homosexual. Sexuality is a problem in the whole family’. Brother, 25 years. Broke down while patient was working in Asia. Finished the Arts Academy and there he found out he was a homosexual.

Psychosexual Development
‘When I was 11 a friend told me that his parents slept together. I didn’t want to believe it. I didn’t ever want to do it myself either. I have always felt very attracted to girls. I mixed with girls a lot in primary school. Coition experience from age 17. With varying partners. Always used to feel guilty afterwards’. When patient was 19, a relationship was started with a woman of whom he felt a puppet. Appeal and repulsion in turn. Patient says he has the best relationships in the holidays, because these are casual. When he was 23 he met a woman with whom he had a prolonged relationship. It was sexually satisfying, but fear of a real commitment started to figure importantly. This girlfriend put an end to it, because she thought he was not really involved with her. Patient agreed with the break-up. Since then he evades women. He has a hankering for women he can’t get. He needs to conquer and he needs stable people, who he can look up to. He then enlarges such a person and makes himself small and then it goes wrong. These last years he has girlfriends who remind him of his sister. Patient says about this: ‘There is also something wrong with me sexually’.

Social Contacts
‘I’m very domineering in relations. Often I don’t feel at home with friends. I don’t feel completely at
ease. I soon find them inane and feel that if I were honest with them they wouldn’t stand for it. I would like to be more sincere, to be able to say for example: I don’t agree with you. I beat around the bush, afraid that something cannot be said directly. It also frightens me. I find it difficult when others are different than I am. If for example they don’t like soccer, or don’t want to talk about women like I do. I don’t dare to tell much about myself. When people are self-assured, I envy that, but at the same time they irritate me and I think: they are, I’m not. At work I am anti-authoritarian, but sometimes I would like to say to my students: this is nonsense. I give workshops, but am very careful and this often makes me feel isolated. I keep a low profile. The sad feeling is a sort of self-pity about being isolated.

Therapy Expectations

‘I want to be more open, not relapse in old complaints. The hurried and gloomy part of me is a negative undertone. I want to be the way I am when I feel good, cheerful, free. I can’t do it on my own, I’ve been struggling for so long, I need a helping hand, I think I suppress a lot’.

Impression and Conclusion

Mr Johnson, 28, anthropologist, has the following complaints: depressed, often gloomy, not feeling like work, often not feeling like eating, sex, often tired, dead-tired. Sometimes fantasies about rather being dead, then also has problems falling asleep. Can’t bear conflicts, not able to be happy. Being a spectator for as long as he can remember. He recognizes the other complaints from earlier days but since he got back from Asia—3 years ago—they are constantly there; it goes up and down a little but actually it colours his life. Small incidents cause dejection. He shows insight and introspective powers. Relates his depression to suppressed aggression: ‘getting frightened instead of angry’ or ‘feeling down and then getting the hump’. During his upbringing direct aggression and sexuality were taboo. Both with his parents and with his brother and sister this has caused serious psychical conflicts. For a long time patient was very dependent upon his father. When his first relationship with a girlfriend broke up, the dissociation from home came underway. The patient is now able to criticize his parents in an adequate manner. As for his defence mechanisms: the patient rationalizes his feelings away.