In this article we describe an investigation into the rationale of psychotherapist treatment proposals. Over fifty psychotherapists proposed a treatment for four depressed patients. The proposals were divergent, as we had expected. Moreover, they were poorly statistically predicted from the therapist’s arguments. The theoretical backgrounds of the therapists were the better, although weaker, predictor. The best explanations of the treatment proposals seemed to be the therapist’s theory-inspired interpretations of the patient complaints. Structuring the decision task appeared to influence these interpretations. We conclude that a particular theoretical orientation seems to engender a specific interpretation schema of a complaint, which, to therapists, sufficiently explains a treatment decision. We discuss the implications of our findings for patient oriented treatment planning.

Psychotherapists cannot follow standard procedures or rely on textbooks when deciding which treatment is indicated for their patients. There is a lack of comprehensive theory of treatment planning (Beutler, 1991), and a dearth of evidence based rules for proposing certain treatment methods to patients with certain symptoms. This gap between theories about the pathogenesis of disorders and guidelines for their treatment could be imputed to the findings of Luborsky, Crits-Christoph, Mintz, and Auerbach (1988), among others, that there do not seem to be significant differences between most systems of psychotherapy in treatment outcome. Different types of both cognitive and behavioral oriented approaches are effective in the treatment of depression, while drugs have also been found to be beneficial (Albersnagel, Emmelkamp, & van den Hoofdakker, 1989). In reaction to this inability to differentiate between methods by outcome, eclectic approaches have come to stress the unique needs of the patient (Beutler, 1989, 1991; Beutler & Consoli, 1993; Norcross, 1991; Lazarus, Beutler, & Norcross, 1992). The patient needs would determine the optimal treatment strategy. The treatment should fit the patient, not vice versa.

In clinical practice, however, patient characteristics do not seem to be of much influence in treatment planning (De Ridder, 1991). Different therapists were found to propose different treatment methods for the same patient (Witteman, 1992; Witteman & Kunst, 1997). An obvious explanation could be that, contrary to eclectic hopes and the patient best interests, therapist characteristics determine the outcome of the
decision process. Indeed, in our earlier think-aloud study (Witteman & Kunst, 1997), in which we described psychotherapist information processing and treatment decision making processes, we concluded that our subjects seemed to be making a “yes” or “no” decision about the applicability of their favored treatment method based on their own interpretation of the case, instead of arguing for the most suitable treatment method for the given patient. That study involved one patient description only.

We decided to follow up on this idea by checking whether therapists would come to similar conclusions for different cases. In the current study, we investigate the explicit and implicit explanations of psychotherapist treatment proposals for different cases. As before, we use examples of treatment planning for patients with a depressive disorder. The insight gained from such a study would be quite a useful addition to the too meager corpus of knowledge about psychotherapist information processing and decision making (compare Caspar, 1997).

A limitation of our study is that we use paper patients, and that the applicability of our findings to daily clinical practice is uncertain. However, there often are circumstances—such as clinical treatment planning conferences or requested consults—in which therapists do not actually see the patient either. Thus, presenting the patient information on paper may not be the most realistic method for assessing therapist decision processes, but it is not an invalid method either (compare Estrada, Isen, & Young, 1997).

The aim of our study is to find out how psychotherapists perform the cognitively complex task of deciding upon a treatment method. If they cannot fall back on textbooks, their decisions may be informed by their own knowledge, by the specific complaints presented by the patient, or by other sources such as journal articles or colleagues. Will they justify their decisions by referring to their sources of information? There may also be a contextual influence—perhaps the format in which therapists are asked to provide their decisions makes a difference. If this is the case, then interesting avenues for facilitating the task open up (see Witteman, 1997). Acknowledging the fact that treatment decisions are often discussed in a team, we are also interested in whether therapists are able to predict treatment decisions from arguments given by other therapists.

These goals translate into the following four specific questions. The first is, what explains which treatment is proposed to a (depressed) patient? Is it the patient characteristics, such as her or his specific symptoms, social context, and seriousness of the disorder, or is it the theoretical background of the proposing psychotherapist (on the assumption that therapists put their theory into practice)? Our earlier study (cf. above) led us to expect the therapist background to be the better predictor of treatment decisions, possibly via a theory-driven interpretation of the case.

The second question examines the informational value of the therapist arguments for each decision. Are these arguments understandable from the therapists’ theoretical backgrounds, and do they allow a correct prediction of the decisions actually made? We expected this to be the case, in line with the results of studies by Persons (1991; Persons, Mooney, & Padesky, 1995), who found significant disagreement between theoreticians of different schools in their interpretations of patient symptoms. A therapist with a psychodynamic background would, for example, interpret symptoms as evidence of an internal conflict and propose psychodynamic treatment, while a client-centered therapist would interpret the same symptoms as betraying a feeling of helplessness, and propose client-centered treatment.

Thirdly, does the degree of structuring of information presentation and response mode influence the treatment decision? The expectation was that when therapists
were offered lists of decision elements to choose from, they would consider more aspects and possible decisions, and they would then use arguments for, and propose different treatment plans, than when they stated a treatment proposal for the same patient in answer to open, unstructured questions. Making all elements possibly of use for a decision available in a clear and ordered format is a well-known “debiasing” method to increase the probability that no possibly relevant information is overlooked (compare among others Keren, 1992; Williams, 1992; Vermande, 1995). Therapists would then also be more likely to “see” the same patient, which would be an aid to more patient centered treatment planning.

Fourth, do therapists recognize each other’s arguments? We expected that therapists would be able to recognize the interpretation schema used by the authors of the argumentations. This would become clear when they correctly predicted the relevant decisions. Trained psychotherapists would be able to distinguish the frames of reference of the different theories, and accept these as explanations of the treatment indications. That would mean that not patient data itself but rather the interpretations thereof would explain the (different) treatment decisions.

METHOD

DESIGN

In order to answer the first three research questions, we asked a group of psychotherapists (the decision group) to read four case descriptions of depressed patients, and then to answer a number of questions about these patients that dealt with the treatments they would propose for the patients, and the arguments for these proposals. We asked them to do this twice, with an interval of four weeks.

On the first occasion, the questionnaire consisted of four open answer questions. On the second occasion, the questionnaire was a structured one, and the psychotherapists had to mark symptoms and treatment proposals they considered to apply to the case descriptions.

From the arguments given by the psychotherapists of the decision group on the first (unstructured) questionnaire, we selected six arguments. We then asked a second group of psychotherapists (the prediction group) to predict the treatment proposal belonging to the argument. In this way, we hoped to be able to answer the fourth research question.

All material was sent by mail together with a return envelope.

MATERIAL

Case Descriptions. From the archives of the Dutch Institute for Mental Health Care, four cases of depressed patients were selected, dissimilar in seriousness and duration of the symptom, area of dysfunction, and social circumstances. The case descriptions had been drawn up by a multidisciplinary intake team and had a length of between four and six pages. They were arranged as follows: biographical data, complaints, impression, elaboration of the complaints, family situation, possible therapy expectations, and concluding remarks. Summaries of the cases are presented in Appendix A.

All four descriptions were sent to the decision group twice. One of these four descriptions, case 32, was sent to the prediction group, with six of the arguments of
the decision group. These six arguments had an average length of five lines. The following criteria were used in selecting the arguments: the proposing therapist had to have a distinct background in one method only; the arguments had to be four lines or longer, and be connected to one proposal and not a combination of two or more; the four treatment methods that had been proposed most often by the decision group (psychodynamic treatment, cognitive behavior therapy, client-centered therapy, and group therapy) had to be represented (see Appendix B for the six arguments).

Questionnaires. Three questionnaires were constructed. The first questionnaire, sent to the decision group in the first communication, instructed the therapists to read carefully the case descriptions and then to answer in their own words. After each case description, four open questions were asked.

1. Would you treat the described patient yourself? (with the response options “yes” and “no: to be referred to .. ”)
2. Which treatment do you propose for the described patient?
3. Which considerations underlie your proposal?
4. How would you classify your proposal? (to be answered by marking one or more options on a list of 19 treatment methods)

The second, structured questionnaire, sent to the decision group in the second communication, contained 80 symptom and factor descriptions taken from an earlier survey.

On this second questionnaire, the therapists were instructed to read a case description and then to mark each of these 80 elements as either applying or not applying to the case under consideration, with the option to check the box “don’t know.” Then the therapist was to give her or his treatment proposal by marking one or more of the 19 options also used in the first questionnaire. Finally, questions were included about place(s) of work (institute, private practice, hospital), received training, number of active years, sex, and year of birth. The therapists were to repeat this reading and marking for all four cases.

The third questionnaire, sent to the prediction group, contained the six arguments, each followed by four check boxes labeled psychodynamic treatment, client-centered therapy, cognitive behavioral therapy, and group psychotherapy, respectively. The therapists were instructed to read the case description and then to check, after each argument, only one of these four boxes. The second page of this form

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1This list of 19 treatment methods had been drawn up from the reactions of 75 psychotherapists out of the 166 we had randomly selected from the list of registered psychotherapists (excluding psychiatrists and those working in an intramural setting; a response of 45.2%, which is highly satisfactory, given that a questionnaire distributed by mail may normally be expected to yield a response of between 30% and 50%). We had asked these therapists which treatment methods they in general considered beneficial for depressed patients.

2In this survey, we had made an inventory of arguments that are, according to psychotherapists, relevant to their decision about the most suitable treatment method for a depressed patient. We drew up a list of 126 possibly relevant variables, derived from the literature. Subjects were asked to score this list for one particular treatment method, by marking each item as an argument either in favor, against, or neutral with respect to that treatment method. This list was sent to 588 therapists, randomly selected from the list of registered psychotherapists, again excluding psychiatrists and those working in an intramural setting. The list was returned by 184 therapists (a response of 31.3%). Factor analyses had resulted in a summary of the 126 variables in a list of 80 symptom and factor descriptions, categorized under 14 headings.
contained two open questions to be answered in their own words: Would you like to comment on one or more of the arguments? What would be your proposal for this patient and on what grounds? Finally, the same questions were included as on the second questionnaire about place(s) of work, number of active years, sex, and date of birth.

Responses on questionnaires 1 and 2 were compared to answer the first, second, and third research question (about explanation, arguments, and response mode, respectively). Responses on questionnaire 3 were analyzed to answer the fourth question (about recognizability), as well as to substantiate the answer to the first research question.

SUBJECTS

For the first questionnaire, every twentieth name to a total of 85 was taken from the list of registered psychotherapists, excluding psychiatrists and those working in an intramural setting, and also excluding those who had been subjects in one of our earlier studies. The decision group consisted of the 56 psychotherapists who returned the first questionnaire (a satisfactory response of 66%). We found no geographic, gender, or affiliation differences between responders and nonresponders. The decision group was representative of the population of Dutch psychotherapists with respect to the characteristics most relevant to this study, that is, theoretical background, years of experience, and place(s) of work. These 56 therapists then received the second questionnaire, which was returned by 50 therapists (four of them only answering the questionnaire for case 32).

The 56 therapists in the decision group had a mean of 14.1 (SD = 6.6) active years. Their mean age was 47.5 (SD = 7). They were 17 women and 39 men. Most of them worked in an institute for mental health care (n = 32) or they (also) had their own practice (n = 21). The majority had a (cognitive) behavioral training (n = 20). A training in client-centered therapy was also relatively frequent (n = 9). Otherwise, they had a psychodynamic training (n = 7), or a combination of (cognitive) behavioral and psychodynamic training (n = 6). The combination (cognitive) behavioral training with client-centered training also occurred often (n = 8). Finally, there was a group of four family therapists and two therapists without a specific training. Apart from the correlation between age and number of active years (r = .46), which is hardly surprising, there were no relations between subject characteristics.

The prediction group was recruited by consulting lists of members of professional associations of psychotherapists. Thirty names were selected at random from each of the lists of the four major associations (psychoanalytic psychotherapy, client-centered therapy, behavior therapy, and group psychotherapy). Restrictions were that they were not members of more than one association and that they had not been in the decision group. Again, psychiatrists and those working in an intramural setting were excluded. These 120 therapists were sent letters in which we explained the purpose and design of our study and asked for their participation. Some forty therapists asked to be excused for various reasons not correlated to their affiliation. The (third) questionnaire was then sent to the other 80 therapists and returned by 38 (seven psychodynamic therapists, twelve client-centered, nine behavioral therapists, and ten group psychotherapists)—a response of almost 50%.

The mean number of active years of these 38 members of the prediction group was high (16.3; SD = 10.18); highest for the psychodynamic therapists (24.29; SD = 8.22) and lowest for the behavioral therapists (11.25; SD = 10). Their mean age was
also rather high (50.61; SD = 8.54), again highest with the psychodynamic therapists (57.14; SD = 10.79). There were 18 women and 20 men. Most had their own practice (n = 24) or worked in an institute (n = 17).

DATA ANALYSIS

Some reduction was necessary before we could analyze the large diversity and quantity of data from the first two questionnaires (filled in by the decision group). The nineteen approaches, both of proposed treatments and of training, had to be grouped. We asked four experts (professors in clinical psychology with more than twenty years of clinical experience and active in courses for therapists-in-training) to first make their own categorization and then reach consensus among them. This resulted in the following five categories of orientation: A. psychodynamic (containing psychoanalytic psychotherapy, short psychodynamic therapy, therapy on analytic lines, psychoanalysis, transactional analysis, and psycho/symbol drama); B. biological (containing drug therapy, running therapy, and sleep deprivation); C. (cognitive) behavioral (containing both behavior therapy and cognitive therapy and their combination, as well as rational emotive therapy); D. client-centered (including interactional therapy and gestalt therapy); and E. group/family/system therapy. With the data categorized in these five orientations, intrarater reliabilities were determined with multiple Kappas, calculated according to the model of Kupper and Hafner (1989). A further clustering was often needed, because many therapists proposed methods and/or had training in more than one of these five categories. To be able to assign each proposition and each training to one cluster only, we then used the following six categories: 1. psychodynamic (category A); 2. (cognitive) behavioral (category C); 3. client-centered (category D); 4. a combination of psychodynamic and cognitive behavioural; 5. a combination of cognitive behavioral and client-centered; and 6. a cluster containing approaches focusing on biology or the family or a group (categories B and D). Except when multiple Kappas were calculated over the five categories (cf. above), these six clusters were used in all analyses discussed below, both for treatments and for training.

Agreement in the decision group about the selection of items from the list of 80 possibly relevant symptoms and factors on the second questionnaire was assessed with Loevinger’s H-coefficient (Loevinger, 1948). It resembles Cohen’s Kappa—the degree of agreement found is compared to the maximum possible agreement and expressed on a scale from 0 to 1.

The members of the decision group used a large diversity of terms to formulate their considerations (question 3 on the first questionnaire), even when referring to the same aspect of the complaint. They would, for example, mention a patient’s divorce, call this her separation, or write about the husband leaving. To allow comparison between the considerations, the terms were coded by two independent judges as one of the 80 elements from the second questionnaire with a satisfactory intrarater reliability (Cohen’s Kappa = .71, SD = .14). Subsequently, the 80 symptoms and factors in their 14 categories were grouped in the following five clusters: 1. symptoms;
RESULTS

Over the four cases, 60% of the therapists in the decision group said they would take on the treatment of the described patients themselves. Forty percent of them would refer one or more patients. The pattern was the same with all groups of therapists: they would treat a patient themselves when they proposed the method belonging to their own training, and they would refer when proposing another method. No differences were found in any of the analyses described below for therapists who would take on the treatment themselves versus those who would refer. Here the analyses were performed over the whole group.

FIRST RESEARCH QUESTION

The theoretical background of the members of the decision group (that is, the training they had received) did appear to be related to the treatment method they proposed, but only slightly. For all four cases the associations between background and propositions were weak to moderate, both on the first questionnaire (where they ranged from $\lambda = .03$ to .26) and on the second (where they ranged from $\lambda = .04$ to .19). To give an example, the client-centered therapists proposed for case 31 client-centered therapy, but also family therapy and psychoanalytic treatment. And the multiple Kappas over the unclustered treatment propositions did not show a strong relation between background and proposal in any of the cases (values between .15 and .27).

Members of the prediction group showed a much more distinct tendency to propose their own treatment method. This is most visible for the client-centered therapists, 57% of whom proposed client-centered therapy, and the cognitive behavioral therapists, 64% of whom proposed cognitive behavioral therapy. The group psychotherapists were less consistent. Thirty-six percent of them proposed group psychotherapy. The psychodynamic therapists proposed psychodynamic therapy as often as group psychotherapy (and no other methods). Since group psychotherapy makes use of psychodynamic conceptions, their choice would be more a matter of setting than of orientation.

SECOND RESEARCH QUESTION

The questions of whether the therapist arguments for their decisions are understandable from their background and whether the arguments are related to the decisions made could not be answered in the affirmative. The associations between the arguments given on the first questionnaire and the theoretical background were slight ($\lambda$s between .07 and .01), and between the arguments and the treatment decision even slighter. We found no associations between the symptoms and factors selected on the second questionnaire and theoretical background, or between these selections and the treatment decisions. We regularly found different aspects selected with the same treatment decision, or the same aspects selected with different treatment decisions.

On the first questionnaire, the therapists considered different aspects—as may be concluded from the significantly different frequency distributions of argument
categories used—in all four cases ($\chi^2 = 98.12$, $df = 12$, $p < .001$). On the second questionnaire, the agreement between therapists about whether the different elements did or did not apply was far from perfect (Loevinger’s $H$-coefficients between .34 and .47). Often, for the same case, the same item was judged by one therapist to apply and by another not to apply.

We did find a remarkable difference between the argument categories the therapists had used on the first questionnaire and those marked as applying on the second questionnaire, in all four cases ($\chi^2 = 71.09$; $\chi^2 = 68.98$; $\chi^2 = 66.53$; $\chi^2 = 84.14$; respectively, all with $p < .001$ and $df = 4$). In all cases but case 67, the difference was most marked for category 5. The “weak personality aspects” were stressed in the therapists’ own considerations, and much less frequently judged to apply. In case 67, the “social problems then and now” were stressed in the therapist considerations. In all four cases, elements in the category “social strength then and now” were judged to apply, but were hardly mentioned in the considerations. And the “strong personality aspects” were hardly mentioned in the considerations with three of the four cases. Only in case 31, where the indication psychodynamic therapy was predominant, did this category also appear in the considerations. The “symptoms” were often both given as arguments and judged to apply, which is understandable given the question put to the therapists.

THIRD RESEARCH QUESTION

The third question was whether the presentation of information in a structured format, as in the second questionnaire, would influence the treatment decisions. As can be seen in Table 1, we did indeed find differences between the proposals argued in the therapist’s own words (first questionnaire, $Q_1$) and the proposals formulated in the more structured approach (second questionnaire, $Q_2$). Agreement between the indications on the two questionnaires, expressed in Cohen’s Kappa, was between .40 and .69. Comparison of the unclustered proposals showed a somewhat lower agreement, with multiple Kappas between .37 and .56. Only four therapists proposed the same treatment method twice for the four cases.

<table>
<thead>
<tr>
<th>Therapy cluster</th>
<th>case 31</th>
<th>case 32</th>
<th>case 36</th>
<th>case 67</th>
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<tr>
<td></td>
<td>$Q_1$</td>
<td>$Q_2$</td>
<td>$Q_1$</td>
<td>$Q_2$</td>
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<td>9</td>
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<td>21</td>
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<td>4</td>
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<td>2</td>
</tr>
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<td>$n = $</td>
<td>56</td>
<td>46</td>
<td>56</td>
<td>50</td>
</tr>
</tbody>
</table>

*For each of the four cases, on the first questionnaire ($Q_1$) and the second questionnaire ($Q_2$).
Inspection of Table 1 also shows that the therapists came to significantly different decisions for each case on each of the questionnaires ($\chi^2 = 44.55$, $df = 15$, $p < .001$ on Q1 and $\chi^2 = 34.82$, $df = 15$, $p < .01$ on Q2). Also, the multiple Kappas (agreement between judgments of different cases) were very low on both questionnaires. They ranged from .09 to .20.

FOURTH RESEARCH QUESTION

The fourth research question, which addressed the recognizability of arguments for colleagues, was answered by the 38 psychotherapists of the prediction group. These therapists saw marked differences between the six arguments, as could be deduced from the different proposals they predicted from them ($\chi^2 = 234.86$, $df = 15$, $p < .001$; see Table 2).

As can be read from Table 2, the therapists were predominantly correct in their predictions of what their colleagues had proposed. The first argument, which had led to a proposal of cognitive behavioral therapy, was correctly linked to that proposition by 79% of the therapists. And the second argument, which had resulted in a proposal of psychodynamic therapy, was correctly coupled with that proposal by 87% of the therapists. With the third argument, which had led to client-centered therapy, correct predictions were made by 55% of the therapists. The fifth argument had led to group therapy, and was recognized by 59% of the therapists. The fourth and sixth arguments seemed to be more difficult to recognize. The fourth argument had led to cognitive behavioral therapy, as had the first, but that was now correctly predicted by only 5% of the therapists. And the sixth argument was correctly seen as having led to client-centered therapy by only 26% of the therapists.

Only the psychodynamically oriented therapists correctly predicted their own treatment method to have been proposed significantly more often than the other methods.

DISCUSSION

The expectation that therapists’ theoretical backgrounds would be the best explanation of their treatment decisions was confirmed by our data, although statistical analyses revealed only weak associations for the decision group. In the prediction group, the relation between background and proposal was prominent. The decision group had

<table>
<thead>
<tr>
<th>Therapy</th>
<th>1</th>
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<th>3</th>
<th>4</th>
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</tbody>
</table>

*Note. One therapist did not make a prediction for arguments 4 and 5.

*Correct predictions in italics.
training in (and presumably experience with) more than one method, and was more eclectic in their proposals. The prediction group, on the other hand, adhered to only one theoretical approach and may overall be said to be believers in the suitability of that approach.

The descriptions had been drawn up by a multidisciplinary intake team, and were therefore written in terminology that did not favor any one therapeutic approach. But since the decision group did use different arguments in the four different cases, for example stressing “strong personality aspects” in one case and “social problems” in another, we may conclude that they did see different patients. And with these differently assessed patients, they did propose different therapies. That means that the patient characteristics did “do” something. It would not be true to conclude that every patient would be treated the same way. The therapists also often proposed referral to colleagues with another specialization, to social work (especially case 67), or to an institute for alcohol and drug addiction (case 36). The therapists then said they would not treat the patient themselves, which suggests that they tend not to treat a patient using a method they have not been trained in. Other factors may, of course, influence a decision to refer, such as, for example, the expectation (formed from the case as described) that one may not be able to establish a propitious working relationship with the patient.

The results suggest to us that psychotherapists acquire, with their training, a schema of the pattern of complaints that may be treated with the acquired methods. When they have had training in more than one method, they will have more schemas at their disposition. Their practical experience will help them fine-tune these schemas. With a given patient, they may then check for a pattern that fits the schema(s) they know. If they find it, they may call upon that schema in justification of the treatment method. If they don’t find it, they may refer. The argumentations given in answer to the open question support this interpretation. One therapist who proposes psychodynamic treatment talks about “narcissistic problems,” another therapist justifies a proposed group psychotherapy by, among other things, “reality testing and adapting self-image.” Cognitive behavioral therapy is proposed to “concretely address practical matters,” and a client-centered therapy to “take account of herself” and with “acceptance and empathy.”

Another finding supports our interpretation of treatment decisions as schema driven and not only explainable by theoretical background or patient characteristics. The considerations offered by the decision group on the first questionnaire, as well as those symptoms and factors these therapists judged to apply on the second questionnaire, were only marginally related, both to theoretical background and to the decision. This is in line with results of De Ridder (1991), who also found a very weak relation between anamnestic information on the one hand and treatment proposals on the other. We suggest it is the therapist’s interpretation, colored by training and experience, that is the mediator. Why these interpretations were not made explicit in the arguments may possibly be explained by the high number of active years of the therapists (over fourteen). It is a well-documented fact (see for example Ericsson & Smith, 1991) that the more experienced one is in a certain task, the less explicit and elaborate one’s decision processes are, and the more self-evidently (and thus more implicitly) one activates a schema to relate facts and decisions.

A third finding in support of schema-driven treatment decisions is the far from complete agreement about which symptoms and factors the therapists judged to apply to the different patients. This means that it is a matter of interpretation, rather than
determination, whether something does or does not apply to a patient. The one therapist seemed to be envisioning a different patient than the other. Comparable disappointing results about the interrater reliability of clinicians is reported by others, for example by Hay, Hay, Angle, and Nelson (1979), who concluded in their studies that the agreement about the presence of the overt problems of a depressed-anxious patient was no higher than 0.55, and by Persons et al. (1995), who found that only 46% of the clinical psychologists in their population recognized all symptoms of a depressed patient.

In sum, our findings suggest that not the patient data and not (only) the theoretical background, but a schema or schemas that go with certain theoretical orientations, refined by practical experience, explain psychotherapist treatment proposals. This would also explain both the correct and the incorrect predictions made by the second group of therapists about the proposals of the first group. A psychodynamic schema would, for example, contain references to self insight and introspection, both well-known conditions for a successful application of that type of treatment. The second argument, which had led to psychodynamic treatment and which was recognized by the majority of the therapists, is most clearly put in this terminology, with “anal fixations” and “defence against the phallic oedipal.” The sixth argument misled many therapists. Only 26% correctly predicted client-centered therapy, while 58% recognized a psychodynamic schema from the “critical, condemning interjections” and “stagnated separation-individuation.”

It was remarkable that the therapists often proposed different treatments on the two questionnaires. The question had been the same, in both cases—to propose the most suitable treatment method for the described patient. But on the first questionnaire, the therapists were first asked for their proposal and then to give their considerations in their own words, while on the second questionnaire, the therapists were first asked to describe the patient by marking all symptoms and factors applying to that case, and only then to give their proposal. The shift in decisions suggests that when therapists pay more attention to patient data they may interpret the case differently. This is a tentative explanation, because it is a theoretical possibility that the therapists would have decided differently after some weeks, even with the same presentation. But it does suggest that patient oriented treatment planning may be furthered by supporting the therapist assessment of characteristics of the patient and her or his complaint before proposing a treatment method. This could be done by offering them checklists of possibly relevant symptoms and factors (Witteman, 1997).

One therapist of the prediction group wrote as a comment on the arguments of the decision colleagues, “It is interesting to see how different the approaches of the different practitioners appear to be.” Another therapist remarked that “the language in the considerations sometimes shows the frame of reference, which is not the same as the most obvious treatment plan.” Approach and frame of reference seem to be the key words. The inability of the therapists in the decision group to supply arguments for their proposals, and our finding that their theoretical background did not explain the proposals satisfactorily either, would, we conclude, be accounted for by the intervening, implicit interpretations.

Our study has some limitations and raises some questions. An obvious limitation, apart from the use of paper patients, is that our subjects knew that they did not actually have to treat the patients. They may have been less critical in their decision making than they would have been had actual treatment been in question. This ties
in with another possible limitation. It is uncertain whether a proposal of, for example, psychodynamic treatment, actually translates into treatment along psychodynamic lines. The questions that arise from our results, and which we cannot answer given the limitations of our method, are these. Do psychotherapists in practice actually actively decide upon a specific treatment method after substantive processing, before they start treatment? Or is it maybe more a matter of deciding by recognition, an almost automatic process? And do they subsequently actually practice in line with their decisions? Our next attempt at furthering insight into treatment decision making should take place in the clinic or institute. Based on our results, there are many open questions in need of clarification. These could be investigated in a clinic or institute.

Appendix A: Summaries of the Four Case Descriptions

The first description (case 31) is of a twenty-eight-year-old faculty member, who came to the Institute without immediate causes. He complains about feeling depressed, and of being unable to bear conflicts and to be happy. He often feels like an onlooker. Slight causes sadden him. He shows signs of insight and introspective abilities. He relates his depression to suppressed aggression. In his upbringing aggression and sexuality were taboo. Both parents, as well as both sisters, had serious psychological problems. For a long period he was very dependent on his father. When his first relationship with a girlfriend failed, the process of breaking away from home got underway. He rationalizes his feelings. He wants to learn to be more open.

The second description (case 32) is of a thirty-two-year-old physiotherapist, who came on the advice of a girlfriend because she feels unhappy, a sad feeling she has known regularly since she was fifteen, without distinct causes. Recently she has discovered that she always feels guilty. Contacts with others are problematic. Others find her an immodest and intrusive person. She has felt left out since she was a child. She feels insecure about her relationship with her boyfriend, whom she has known for five months, because he smoothly fits in with her parental class, a conventional Roman Catholic business family. Her motivation for treatment is ambivalent, which relates directly to her problems: strong connections with her parental class, which disapproves of therapy.

The third description (case 36) is of a twenty-eight-year-old freelance worker, who came on his own initiative with complaints about depression and feelings of dissociation. He comes from a working class family. His parents had ideals. This alienated him from the household, from the rest of the family, and from the neighborhood, where they were never really accepted. He was always bullied. Because of the age difference with his brother and sister, there was no companionship at home. At his secondary school he found support from a girl, with whom he played truant and visited pubs. He got more and more involved in homosexual circles. He was very depressed during that period, until he formed a steady relationship with a boyfriend, which broke up last year. Since then there were grief-related problems. He drinks regularly, sometimes also in the afternoons. He sometimes smokes hashish.

The fourth description (case 67) is of a thirty-year-old woman with three small children, recently divorced, who came because of problems with her five year-old
son. She feels helpless and almost desperate in her situation, with financial problems and the care of her children. She blames herself for the failure of her marriage. She has always been withdrawn socially and feels very insecure in social situations. She is preoccupied with her lack of social relations. She feels that now she cannot control her difficult situation any longer, and she seeks help.

**Appendix B: Arguments by Six Decision Therapists for Case 32. Theoretical Background of Therapists and Proposals (not included in the material for the prediction group) in Parentheses.**

**Argument 1** *(background and proposal: cognitive behavioral)*

To make her thinking a little less negative and to make her more adept and relaxed in contacts, have her acknowledge her emotions and express these more and more adequately, on the basis of the problems the patient mentions; to counter these more positive and less demanding thinking seems helpful. She acts a little clumsy toward others, could be cleverer.

**Argument 2** *(background and proposal: cognitive behavioral)*

Her history shows a hardly protective mother and a forceful, somewhat sadistic father. Mother depressed? Moved often, always felt left out, special place with father. Strikes me as some neglected affect and depersonalized. In puberty probably strong feelings of rivalry for 14 years younger sister and stepsister. Can bear ambivalence, for example towards father, but also some anal fixations and defence against the phallic oedipal. Introspection may possibly be mobilized, difficulty may be masochistic attitude. Themes in therapy may be first being uprooted as daughter in business family, insecurity at home, then aggression, shame, and identification with mother as oldest daughter and self-image.

**Argument 3** *(background and proposal: client-centered)*

It is quite questionable whether the patient would not be capable of insight. She has always lived on a low level of consciousness. This has broken open only recently; so there is a danger of being flooded by emotions, experiences. Apart from differentiation, integration is very important. Little ego-strength. Maybe there have been traumatizing experiences.

**Argument 4** *(background and proposal: cognitive behavioral)*

Her attitude toward her parents is such that within the relationship with them she cannot experience her own worth. This is, in my view, the result of the fact that she was, as a sensitive child, mangled by her parents, so that she has never been able to develop any autonomy. Would restart this process.

**Argument 5** *(background: client-centered; proposal: group)*

No vital depression, rather neuroticism, but fixed and long-lasting. Limited insight, problems checking impulses, tendency to react regressively. High chance of dependency and unworkable transference. Judges herself irrationally negative. Others have a more positive picture of her.

**Argument 6** *(background and proposal: client-centered)*

Blocked aggression household. Too little holding environment. Self-image contaminated by very critical, condemning interjections. Separation-individuation process stagnated. Important life events in puberty (crisis in family; introduction of stepsister; placements in boarding schools) repressed. Very frightened to allow this suppressed anger, experiences of being left.

Zusammenfassung


REFERENCES


schema der Beschwerden einhergeht, welches - für die Therapeuten - eine Behandlungsentscheidung ausreichend erklärt. Daraus abgeleitet diskutieren wir die Implikationen der Befunde für eine patientenorientierte Behandlungsplanung.

Résumé
Dans cet article, nous décrivons une investigation de la logique sous-jacente aux propositions de traitement des psychothérapeutes. Plus de cinquante psychothérapeutes ont proposé un traitement pour quatre patients déprimés. Comme attendu, les propositions étaient divergentes. Par ailleurs, elles étaient à peine prédictibles statistiquement sur la base des arguments des thérapeutes. La provenance théorique du thérapeute était un prédicteur faible, bien que meilleur. Les meilleures explications des propositions thérapeutiques semblaient être les interprétations, inspirées par l'école thérapeutique, au sujet des plaintes des patients. Une structuration de la tâche décisionnelle semblait influencer ces interprétations. Nous concluons qu'une orientation théorique particulière semble engendrer un schéma spécifique d'interprétation d'une plainte qui explique suffisamment aux thérapeutes leurs décisions de traitement. Nous discutons les implications de nos résultats pour une indication thérapeutique centrée sur le patient.

Resumen
En este artículo describimos una investigación sobre la justificación de las propuestas de tratamiento de los psicoterapeutas. Más de cincuenta psicoterapeutas propusieron un tipo de tratamiento para cuatro pacientes deprimidos. Las propuestas fueron divergentes, como habíamos esperado. Más aún, difícilmente la estadística podía haberlas predicho a partir de los argumentos dados por los terapeutas. El mejor predictor, si bien más débil, fue la formación teórica del terapeuta. Las mejores explicaciones para las propuestas de tratamiento parecieron ser las interpretaciones (basadas en la teoría del terapeuta) de las quejas del paciente. La estructuración de la tarea de elección parece influir sobre estas interpretaciones. Concluimos que la orientación teórica particular parece engendrar un esquema específico de interpretación de la queja que, para los terapeutas, explica suficientemente la elección del tipo de tratamiento. Discutimos las implicaciones de nuestros hallazgos para planear un tratamiento orientado por el paciente.

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