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The importance of the theoretical framework in the formulation of clinical inferences in psychotherapy

ANDRES JORGE ROUSSOS¹, LUCILA BOFFI LISSIN¹, & ADELA LEIBOVICH DE DUARTE²

¹Department of Investigation, University of Belgrano, Buenos Aires and ²University of Buenos Aires, Buenos Aires

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Abstract

This study explores the importance of psychotherapists' theoretical framework as it pertains to the development of their clinical inferences and construction of working inferences. Therapists in this study came from two different theoretical groups: those with cognitive training and those with psychoanalytic training. After presenting inferences in relation to an initial session of a psychotherapeutic treatment, psychotherapists' inferences were analyzed by a group of judges using Q-sort items (Jones, 1985). The analysis of the inferences indicates that when both the content and style of the therapists' inferences are classified using the Q items criteria two distinctive groups of inferences appear. Each theoretical group produced a different and specific type of inferences.

Clinical inference is one of the central activities of a psychotherapist in the context of a therapeutic treatment. However, few systematic studies deal with the ways in which psychotherapists work with and produce their inferences from the material offered by their patients (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Leibovich de Duarte, 1996). According to Eells and Lombart (2003), this is the product of a bias of the methods used in the studies. Thinking processes of therapists have not been deeply evaluated because, generally, contemporary psychotherapy outcome studies use treatment manuals and typically treat the therapist as a within-group error variable while focusing on treatment approach as the independent variable of interest. With regard to the role of therapists, these studies attempt to minimize therapist variability by measuring and ensuring adherence to a treatment manual rather than exploring therapist behavior as an independent variable of interest. Following this reasoning, it is necessary to generate studies that take into account the therapist variability across the theoretical framework.

The production of clinical inferences, with their different levels of complexity and accuracy, is an important parameter of therapists' activity. It guides and shapes therapists' actions, such as the elaboration of clinical judgments, the formulation of a

differential diagnosis, the establishment of long- and short-term therapeutic goals, and the development of therapeutic strategies. As Caspar (1997) points out, it is possible to consider that the quality of clinical judgments contributes greatly to therapy outcomes.

An inference can be defined as a "cognitive operation (and its resulting content) by which one concludes, by indirect means, the truth of a preposition or state of affairs: by virtue of its association with another fact (inductive reasoning) or from principle (deductive reasoning)" (Bouchard, Lecomte, Carbonneau, & Lalonde, 1987). Holt (1988) considers a clinical inference as a set of cognitive operations associated with the attribution and information-processing systems performed by the therapist. It also can be considered, following Peirce's notion, that clinical inference involves abductive reasoning (Leibovich de Duarte, 2000/2006). It is the process of transforming what the therapist considers relevant in the patient's material to make it meaningful. The present research studies the process of clinical inferences of therapists with different theoretical frameworks (cognitive therapists and psychoanalysts).

In the clinical situation, with the help of the theoretical and technical resources at their disposal, psychotherapists attempt to understand and account

for (or discover) the reasons behind another person's conduct. In the end, therapists attempt to substantiate their hypotheses through the reiteration of significant data that reinforces them or the convergence of data that makes them meaningful. By the same token, therapists record everything that appears relevant, serving either to confirm their conjectures or to send them off on a new track (Leibovich de Duarte, 1996). For Caspar (1997), clinical hypothesis generation is a combination of intuitive and rational-analytic processing.

Several studies, some empirical and others theoretical-clinical, have approached the problem of therapists' theoretical framework incidence in their clinical work. Several strategies were used to analyze the therapist variable (Beutler et al., 2004), which was specially oriented to study the incidence of gender, experience, and personal style in therapists' activities. Some of the studies generated comparative approaches from different theoretical frames to test the therapist variability factor in connection with therapeutic framework aspects (Ablon & Jones, 1998, 2002, 2005; Eells & Lombart, 2003; Eells et al., 2005; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldfried, Raue, & Castonguay, 1998; Roussos & Leibovich de Duarte, 2002).

Goldfried et al. (1997) conducted a comparative study about therapeutic focus on cognitive-behavioral (CB) and psychodynamic (PD)-interpersonal sessions. The study reported that PD-interpersonal interventions were focused more on emotions, intrapersonal patterns, and discrepancies or incongruities with clients' functioning, whereas the cognitive therapists focused their interventions on external circumstances in clients' lives and their ability to choose and make decisions. Another important difference mentioned by these researchers (Goldfried et al., 1997, 1998), was the temporal dimension of the interventions. The PD-interpersonal therapists focused their sessions on what has not worked in the past, whereas cognitive therapists concentrated on what clients could do to deal with events more effectively in the future.

In a study about the theoretical bias at the moment of selecting information from a clinical session, Leibovich de Duarte et al. (2002) mentioned that adherence to a particular theoretical school of thought was not reflected by the nature of the clues therapists selected, but the theoretical differences did appear in the way those clues were organized and explained. This means that their clinical inferences were different, basically based on their different theoretical frameworks (Leibovich de Duarte et al., 2002).

Eells and Lombart (2003) compared therapists' actions based on their treatment orientation (PD or

CB) and level of experience and expertise. They found differences in the relative importance attributed to several different components of cases formulation, predictions of problem severity and prognosis, expectations about treatment length and session frequency, etiology, and views about patients' control over the genesis, course, and outcome of their disorder. The PD therapists placed significantly more emphasis on coping and defenses, childhood history, strengths, and treatment obstacles than did the CB therapists, who placed more emphasis on symptoms and problems. Also prediction, prognosis, length of treatment, and etiology vary according to the theoretical framework. CB therapists predicted greater improvement from therapy than PD therapists.

Method

The study analyzed how psychotherapists from different theoretical frameworks (cognitive and psychoanalytic) decode patients' discourses. The patient variable was controlled by using one common clinical material (the first interview of a therapeutic treatment) as a stimulus. This stimulus session was used to study (a) intratheoretical group similarities and (b) distinctions between theoretical groups in the way they deal with clinical material and produce clinical inferences.

Sample

Participants were 26 psychotherapists from Buenos Aires, Argentina (Table I). They represented two theoretical orientations: cognitive ($n = 13$) and psychoanalytic ($n = 13$). This group was divided into two subgroups: one with 10 therapists (five cognitive therapists and five psychoanalysts) and the other with 16 therapists (eight cognitive therapists and eight psychoanalysts). Each subgroup evaluated the stimulus clinical material following different strategies described in the Procedures section.

Materials

Stimulus session. The stimulus session presented to the participant-therapists met two criteria. First, it is a first session of a psychotherapeutic treatment. The participants have the same information about the patient as the treating therapist had, except for not seeing and interchanging with the patient. Second, during the session, the treating therapist produced few interventions without theoretical jargon.

The material was previously presented to four independent expert clinicians (two psychoanalysts and two cognitive therapists). The expertise of the

Table I. Frequency/Mean Characteristics of the Participant Therapists.

Variable	Cognitives		Psychoanalysts	
	TESS	TFI	TESS	TFI
<i>n</i>	5	8	5	8
Gender (female/male)	3/2	6/2	3/2	3/5
Age	33	33.5	35	41
Psychologist/physician	4/1	7/1	3/2	6/2
Experience (junior/senior ^a)	2/3	6/2	3/2	4/4

Note. TESS = therapists who evaluated the stimulus session; TFI = therapists that formulated inferences.

^aJunior: fewer than 10 years of experience; senior: more than 20 years of experience.

clinicians (psychiatrists or clinical psychologists) was defined according the following criteria: (a) to be a supervisor in clinical centers; (b) to have led one or more workshops for professionals on psychotherapy research; (c) to have published one or more scientific articles, books, or book chapters on the topic of psychotherapy clinical research; and (d) to have more than 30 years of clinical experience. These criteria are similar to the expertise criteria used by Eells et al. (Eells & Lombart, 2003; Eells et al., 2005) in their studies about experience, expertise, and case formulations.

The four experts were asked to identify the treating therapist's theoretical framework and to judge whether the session gave them enough information to enable them to formulate inferences about the patient. They could not determine the theoretical framework of the treating therapist and considered that the material had enough information with which to work.

Psychotherapy Q Sort (PQS). The PQS was the standard procedure used to evaluate the stimulus session. The Q-sort technique was first developed by Stephenson (1953) and then by Block (1961). A Q set consists of a group of statements (items), each of which is printed on a separate card that is arranged and rearranged to represent a situation. Generally, the statements express different opinions on a certain issue. The distribution of the items is fixed so that the observer is obliged to assign a certain number of statements to each numerical value, ranking the cards into nine piles on a continuum, ranging from those that are least applicable or descriptive (Category 1) to those that are most applicable or descriptive (Category 9). The middle pile (Category 5) is used for items deemed either neutral or irrelevant to the stimulus material.

This way of ranking each item is oriented to generate a statistically normal (bell-shaped) distribution of the information, giving the Q methodology a statistical advantage at the moment of analyzing the obtained data. This sorting generates a model of the

evaluator's subjective point of view of the situation. There are several versions of Q sets with different amount of items and numbers of piles.

The PQS is a multidimensional tool for the description and quantification of therapeutic sessions based on the Q-sort strategy. Developed by Jones (1985, 2000), it was designed specifically to provide a basic language for the description and classification of the psychotherapeutic material in a suitable form for quantitative analysis (Jones, 2000). The method was developed to be applied on an audio- or videotape or, as in the present study, a verbatim transcript of treatment sessions.

The battery of PQS items describes various aspects of the analytical process: attitudes, behaviors, and experiences of the patient; actions and attitudes of the therapist; and the nature of its relation (Jones, 2000). It is possible to differentiate three groups of items: one group oriented to describe the therapist's activities (type of interventions or attitudes, e.g., Item 45: Therapist adopts supportive stance); a second describing the patient's affective states (mood or conflicts) and behaviors (e.g., Item 44: Patient feels wary or suspicious); and a third describing process-oriented dimensions (e.g., Item 19: There is an erotic quality to the therapy relationship).

Several studies have used the PQS for comparative studies between psychotherapeutic theoretical models. Ablon and Jones (1998, 1999) performed a series of studies in which panels of experts developed prototypes of PD and CB therapy using the psychotherapy process Q set. The prototypes were used to assess the extent to which treatments conformed to the prototypes in three treatment samples. The degree to which the treatments adhered to the prototypes was measured quantitatively and correlated with outcome. Jones and Pulos (1993) used archival records to compare therapy process in 30 brief PD and 32 CB therapies. Analyses of verbatim transcripts showed that, although some features were common to both treatments, there were important differences. Sirigatti (2004) used the PQS to identify differences

and similarities between three psychotherapeutic approaches: systemic-relational therapy, CB therapy, and brief strategic therapy. In their preliminary study of therapists' approach to patients' trauma using the psychotherapy process Q sort, Schottenbauer, Arnkoff, Glass, and Hafter Gray (2005) suggest that psychoanalysts and PD clinicians do not differ from each other in their psychotherapeutic approach to patients who have experienced trauma, but as a group they differ from CB therapists in their preference for specific technical interventions. PD clinicians endorsed a preference for empathic and nonjudgmental approaches, whereas CB therapists gave their highest ranks to setting treatment goals and asking for information. The results of these studies and other using the PQS are discussed in several articles (Ablon, 2005; Ablon & Jones, 2005; Blatt, 2005; Fonagy, 2005; Jones, 2000).

As mentioned by Caston (2004), "What permits the overarching of theories is that [Jones's] research instruments, principally the Psychotherapy Process Q-sort (PQS), carry no language of diagnosis or technique specific to the different paradigms" (p. 74). This lack of theoretical terminology in the language used to describe concrete situations allows researchers to perform studies comparing information from different theoretical frames.

In the present study, the items of the PQS (Jones, 1985) were used in two different ways: (a) in its standard form, asking the participant to organize 100 items into nine piles with a fixed number of items following the Q technique (Stephenson, 1953) and (b) taking into account only the content of the 100 psychotherapy Q-sort items.

The standard procedure (identified in the study as PQS) was used to characterize the stimulus therapeutic session. The alternative procedure (identified in the study as Q items) was used to evaluate the content of the inferences formulated by the therapists about that stimulus session. Examples regarding the use of the PQS items in its alternative form are presented in the Data Analysis section.

Procedures

Two different criteria were used to determine the theoretical framework of the participant-psychotherapists. First, they identified themselves as psychoanalysts or cognitive-oriented therapists. Second, they should have performed a training period (more than 1 year) in an acknowledged training institution. All the psychoanalysts were members or candidates of component societies of the International Psychoanalytic Association. In the case of the cognitive therapists, they were trained

members or in training at a clinic with systematic formal training in cognitive psychotherapy.

Each subgroup was asked to perform one of two tasks. Members of the first subgroup (labeled "therapists who evaluated the stimulus session," or TESS), with 10 participant-therapists, were to evaluate the session according to the standard procedure version of the PQS (Jones, 1985, 2000) previously described. The second subgroup (labeled "therapists who formulated inferences," or TFI), with 16 participant-therapists, were presented with the same clinical material and had to formulate the clinical inferences they considered relevant to the case. The following steps were followed for the TFI subgroup's task in order to formulate their inferences¹:

1. Instructions were presented.
2. The participant-therapist listened to the recorded session.
3. The participant-therapist simultaneously read the verbatim transcription.
4. The participant-therapist underlined what he or she considered relevant.
5. The recording was stopped every time the participant-therapist had to offer an inference, a commentary, or a possible intervention in relation to the material. The participant-therapist's production was recorded.
6. The participant-therapist continued listening to the recorded session, and Step 5 was repeated whenever the participant-therapist considered it necessary.

Data Analysis

The data were analyzed using the following procedures: evaluation of the clinical material using the standard PQS and evaluation of the inferences using the topics of the PQS items.

Evaluation of the clinical material using the standard PQS (TESS subgroup). After studying the stimulus session, each participant-therapist of the TESS subgroup organized the 100 items of the Q sort according to the PQS procedures (Jones, 1985), previously described.

Jones (2001), in his Spanish translation of the technique, suggests that to obtain reliable results it is necessary for participants to receive three training sessions. However, it must be emphasized that, in this study, because the aim was not to force consensus but to test spontaneous individual responses, the participant-therapist received only general indications on how to proceed with the PQS.

To compare the data obtained from both groups, a Pearson correlation test was run. A significant correlation was obtained ($r = .742$, $p < .01$). These

results showed an aspect of the similarities of the clinical evaluation performed by therapists of different theoretical stances: psychoanalysts and cognitive therapists. This analysis was performed to determine whether the session offered similar contents to each participant-therapist of both theoretical frameworks participating in this study.

Evaluation of the inferences using the topics of the PQS items. The TFI subgroup produced inferences about the stimulus session. Their inferences were analyzed using Q items. Four judges (psychology graduate students) were asked to evaluate the inferences offered by the therapists using the contents of the 100 items of the PQS set for each inference. The judges, who had not participated before in any of the steps of this study, had no formal training in psychotherapy or a manifest allegiance to any school of psychotherapy.

The original PQS scale was simplified from the nine classification possibilities to just three: (a) as characteristic when the items reflect the content of the inference, (b) as uncharacteristic when the item reflects the opposite of the content of the inference, and (c) as neutral when the topic is not reflected in the inference.

The instructions given to the judges were a variation of the original PQS instructions. This variation was due to the fact that the original instruction in the PQS—presence or absence of a certain attribute corresponding of the session—was not adequate for this particular part of the study. Instead, the instruction given to the judges was to look for the presence or absence of the content of the Q items in the therapists' inferences.

The judges, who did not know the stimulus session, scored one common set of inferences to establish the degree of agreement among them. To prepare the common set, a group of 10 inferences from therapists of both theoretical frameworks were mixed without any sequencing order. The judges did not have any information about the original framework of the author of each inference, and they analyzed the set of inferences in different order.

This interrater agreement was evaluated using the kappa test, and the score obtained was .45. This was considered, accordance to Landis and Koch's criteria (1977), as a fair agreement among judges. Three cases were given to each judge for evaluation. The judges analyzed the 266 inferences (116 from cognitive therapists and 150 from psychoanalysts). An example of a psychoanalyst's inferences in relation to the stimulus session follows.

I believe this brings another feature about this young woman, besides that I am now realizing that

she is absolutely monotonous. She offers a chronicle, as if she were reading someone else's clinical record, because there is nothing emotional in her. She has a serious difficulty to connect with her emotions, it looks as if in this accident she is about to talk about what she achieved and what she wanted; the important thing is that everything is in order, tidy and properly, if your hair is well combed: I love you; she talks about differences but what she is looking for is the repetition of the same, something that probably keeps her calm. But she is not able to connect with her emotions, and consequently unable to express them, on another time she does something equivalent of a "paralyzed kiss"; these are signs of how picky she is and how much affection she can give, she assimilates things of different kinds, and I go back again, 19 years old and we haven't talked about sexuality.

Examples of the judge's analysis are as follows:

Item 56: "The patient discusses experiences as if they were distant from his/her feelings." Evaluated as characteristic because of the following part of the inference: "She offers a chronicle, as if she were reading someone else's clinical record, because there is nothing emotional in her. She has a serious difficulty to connect with her emotions."

Item 97: "The patient is introspective, readily explores inner thoughts and feelings." Evaluated as uncharacteristic because of the following part of the inference: "She is not able to connect with her emotions, and consequently unable to express them."

Item 81: "The therapist emphasizes patient's feelings in order to help him or her experience them more deeply." Evaluated as neutral in the inference.

An example of a cognitive therapist's inferences in relation to the stimulus session follows.

I think there is a discrepancy between two beliefs: On the one hand she believes that she needs therapy and wants to begin, and on the other, she believes she doesn't need it, and so she doesn't want to go into therapy. In other words, there are two belief systems present in what she feels, in what she thinks and in what she does, the three things linked to needing and not needing. This ambivalence repeats itself further on in what she says about her mother, exactly the same "I couldn't live without her" and later on "I want to have my own life." She says, "With my mother sometimes I feel I want to be alone, do my own

thing, not depend on her,” and at another point she says, “I couldn’t live without her.” Exactly the same as the need for therapy: great ambivalence. Also from the cognitive point of view, one could see a very dichotomous way of thinking, very extremist let’s say, there’s “I couldn’t live without her” and “my own life,” “total autonomy.”

Examples of the judge’s analysis are as follows:

Item 100: “The therapist draws connections between the therapeutic relationship and other relationships.” Evaluated as characteristic because of the following part of the inference: “exactly the same as the need for therapy: great ambivalence.”

Item 32: “Patient achieves a new understanding or insight.” Evaluated as uncharacteristic considering the following part of the inference: “Also from the cognitive point of view, one could see a very dichotomous way of thinking, very extremist let’s say, there’s ‘I couldn’t live without her’ and ‘my own life,’ ‘total autonomy.’”

Item 73: “The patient is committed to the work of therapy.” Evaluated as neutral in the inference.

Statistical Analysis of the Data

A stepwise logistic regression was run with the data obtained from the evaluation of the inferences produced by the TFI group. This was performed to discover whether the topics described in the 100

Q items could differentiate between inferences formulated by participant-therapists of different theoretical frameworks.

The Q items were considered as the independent variables assuming the following values: characteristic=1, uncharacteristic=2, and neutral=3. Logistic regression can be used whenever an individual is to be classified into one of two populations (Afifi & Clark, 1996). The theoretical framework was the classifying dependent variable: psychoanalytic = 1 and cognitive therapy = 2.

The stepwise logistic regression analysis showed that the utilization of the Q-set criteria can be useful in detecting significant differences ($p < .05$) in content and style of the inferences produced by participant-therapists of the two theoretical frameworks included in this study: cognitive and psychoanalytic. Figure 1 shows a plot of the classification function of the theoretical framework for this analysis. The symbols identify the classified inferences coming from both groups of participant-therapists. The plot shows an overlapping among the inferences between groups: 89.3% (134 of 150) of psychoanalytic and 51.7% (60 of 116) of cognitive inferences were classified in the correspondent group of origin, whereas 27.1% (72 of the 266 inferences) were classified in the wrong group by the stepwise logistic regression analysis (Table II).

The inferences of the psychoanalytic group were homogeneous in terms of its representative items. The inferences presented by the cognitive therapists present a higher variety of items; they were not so

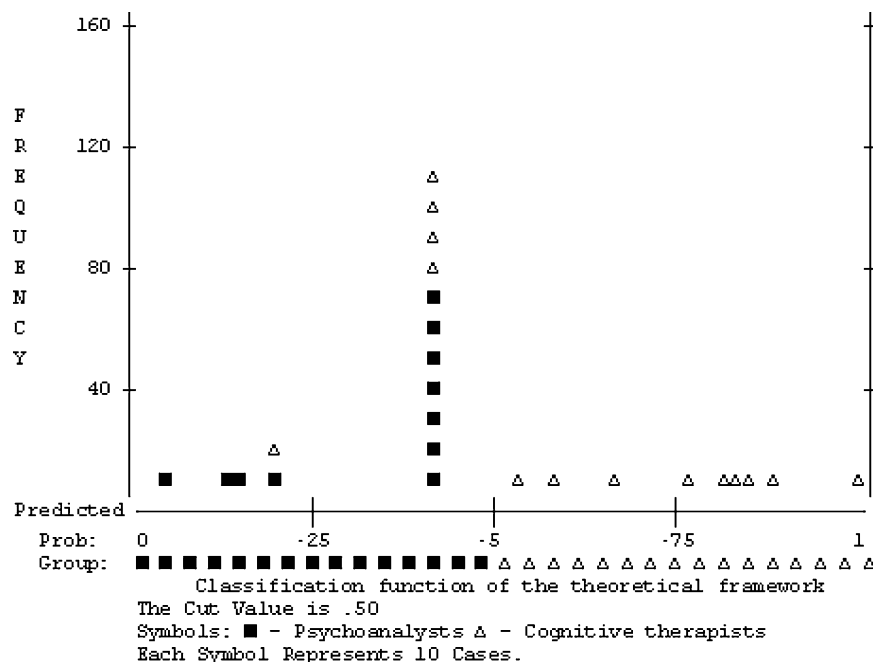


Figure 1. Observed groups and predicted probabilities. (Squares indicate inferences of the psychoanalysts and triangles indicate inferences of the cognitive therapists. Some items are associated only with the cognitive inferences, represented on the right side.)

Table II. Classification of the Inferences by the Stepwise Logistic Regression Using the PQS Items.

Group of origin	Predicted group		Total TFI inferences
	Psychoanalysts	Cognitive	
Psychoanalysts	134 (89.3%)	16 (10.7%)	150
Cognitive	56 (48.3%)	60 (51.7%)	116
Total			266 ^a

Note. 72.9% of original grouped cases were correctly classified. PQS = psychotherapy Q sort; TFI = therapists who formulated inferences.

^aTotal number of inferences formulated by the 16 TFI therapists.

identifiable by grouping. It is possible to observe in Figure 1 some items associated only with the cognitive inferences.

These results show a distinction between the inferences drawn by cognitive therapists and by psychoanalysts. The content analysis carried out according to the Q items enabled the detection of the items that distinguish the formulations produced by both theoretical frameworks.

The stepwise logistic regression allows us to detect which Q items were characteristic of each theoretical framework and their grade of importance (Tables III and IV). Some of the Q items that allowed the differentiation of the inferences produced by the participant-therapists were consistent with the basic assumptions of both theoretical frameworks involved in the present study: cognitive psychotherapy and psychoanalysis (see Tables III and IV). As an illustration, we point out that among the most representative items for the psychoanalysts' inferences were Item 67 ("Therapist interprets warded-off or unconscious wishes, feelings, and ideas") and Item 68 ("Real vs. fantasized meanings of experience are actively differentiated"). For the cognitive therapists, among the representative items were Item 17 ("Therapist actively exerts control over the interaction, e.g., structuring, and/or introducing new to-

pics") and Item 30 ("Discussion centers on cognitive themes, i.e., about ideas or belief systems").

It is important to keep in mind that the judges who evaluated the inferences produced by the participant-therapists were not acquainted with the original framework of the author of each inference, and they analyzed the set of inferences in different order.

Discussion

This exploratory study analyzed the influence of the theoretical framework held by therapists in two different conditions: (a) at the moment of describing a clinical session with a standard procedure and (b) when formulating inferences about that clinical session.

The first procedure involved participant-therapists, cognitive and psychoanalysts, who evaluated the stimulus session (TESS) with the PQS. It was oriented to explore the therapists' perception and selection of information in that clinical material. According to the results obtained in this part of the study, the description of clinical material did not seem to be influenced or biased by the theoretical framework of the participant-therapists. That is, decoding clinical material and grasping consistencies imply diverse methods to select and organize clues. There is no doubt that applying rules mechanically is not the way to handle and understand clinical material; what is required, above all, is a psychotherapist able to find, discern, and integrate indicators considered relevant. Based on the absence of significant differences between therapists from different theoretical frameworks when the standard Q sort was used, it appears that, at the moment of the description of a clinical situation, the theoretical framework does not have primacy over other possible factors, as could be the cognitive bias or the therapists' general belief system (factors not controlled but obviously present in the study).

Table III. Most Representative PQS Items for the Psychotherapists' Inferences.

Item no.	Psychoanalysts	Item no.	Cognitives
80	Therapist presents an experience or event in a different perspective.	17	Therapist actively exerts control over the interaction (e.g., structuring and/or introducing new topics).
67	Therapist interprets warded-off or unconscious wishes, feelings, or ideas.	22	Therapist focuses on patient's feelings of guilt.
68	Real vs. fantasized meanings of experience are actively differentiated.	29	Patient talks of wanting to be separate or distant.
92	Patient's feelings or perceptions are linked to situations or behavior of the past.	30	Discussion centers on cognitive themes (i.e., about ideas or belief systems).
28	Therapist accurately perceives the therapeutic process.	53	Patient is concerned about what therapist thinks of him or her.
44	Patient feels wary or suspicious (vs. trusting and secure).	89	Therapist acts to strengthen defenses.

Table IV. Summary of Stepwise Logistic Regression Analysis Predicting Theoretical Framework, Last Step (12).

Item	B^a	Exp b	SE	Wald
17	-1.567	0.209	0.449	12.211**
22	-1.793	0.167	0.867	4.278*
28	1.558	4.751	0.499	9.749**
29	-2.077	0.125	0.550	14.285**
30	-2.281	0.102	0.701	10.579**
44	1.927	6.868	0.695	7.677**
53	-3.831	0.22	1.435	7.129**
67	1.044	2.840	0.546	3.652*
68	1.405	4.075	0.709	3.926*
80	1.043	2.839	0.486	4.607*
89	-7.439	0.001	14.409	0.267
92	1.525	4.593	0.773	3.885*

^aItems with positive values suppose a psychoanalytic theoretical framework. Items with negative values suppose a cognitive theoretical framework.

* $p < .05$. ** $p < .01$.

The second procedure was oriented to evaluate not the description of the clinical material but rather the inferences formulated by cognitive and psychoanalytic therapists about the same stimulus session used in the previous procedure. This step involved the work of judges, without therapeutic training, who evaluated the clinical inferences using the contents of the Q items. In this particular analysis, the judges evaluated those contents of the Q items in the clinical stimulus material as characteristic, uncharacteristic, or neutral, considering whether the items of the PQS did or did not reflect the content of the elicited inferences. The judges evaluated the therapists' inferences elicited by the clinical material, and data analysis resulted in the differentiation of specific content characteristics of each theoretical framework, showing how each different theory comes into play as an organizer of the clinical inferences formulated by the participant-therapists.

During the inferential process, the theoretical framework has an important incidence. In this part of the study, the inferences produced by each of the two groups of therapists were consistently different between groups and with different levels of consistency within groups (see Table II).

While listening, the clinician tries to apprehend from the patient's speech what he or she recognizes as an indicator or clue and organizes those registries in meaningful units. Sometimes greater attention could be paid to certain aspects that are rescued from margins of the story that, in a previous descriptive analysis of the clinical material, may have seemed irrelevant. In this way, psychotherapists track indicators, sometimes small, almost imperceptible, and occasionally barely registered in the general description of a clinical case, mixing this information with their own theoretical background.

Theoretical frameworks, as explanatory theories, supply new information for the shaping of inferences, as Schwaber (1990) expressed it with the concept of theoretical scaffolding. The theoretical framework colors the way in which the clinical material is interpreted, contributing to a confirmation or rejection of indicators, guiding the presentation of ideas, and allowing the configuration of the data attributing sense to them.

A stimulus triggers an inference (perhaps a future clinical hypothesis), which becomes a primary categorization that is confirmed, reformulated, or discarded. The underlying inferences guide our observation and our data processing.

The adherence to a particular theoretical framework in this study was reflected on the distinctiveness of the inferences presented by the therapists. Theoretical variations between therapist from cognitive and psychoanalytic groups did appear in the way those inferences were organized and formulated. These variations were reflected on the content analysis of the Q items—belonging to Jones's psychotherapy Q sort—which allowed that differentiation. The content of the characteristic items that represent and differentiate each theoretical group shows that the therapists' theoretical stance permeates the formulation of their inferences. It is important to remark that, even though the Q set was designed to analyze sessions as a whole and not for the analysis of distinctive elements intrasession, its items were sensitive and effective for the individual analysis of the therapeutic inferences. The findings of this exploratory study with a small sample are being replicated with a larger sample and a new clinical stimulus material.

In the present study, we tried to address the way in which different therapists from diverse theoretical frameworks deal with the same stimulus material. For that purpose, our provision was to work as closely as possible to a real clinical setting. Unfortunately, to achieve this purpose, it is not possible to compare different therapists working with their own clinical material. That is, even though working with treating therapists and their own clinical materials could be an ideal situation, working without a common stimulus session would not allow the comparison among the therapists' inferences elicited by the same material. The present study was oriented to test similarities and differences in the way therapists with different theoretical framework analyzed the same clinical data. It would be useful to develop new studies in which different comparisons were drawn (e.g., including other theoretical frameworks to observe whether the differences and similarities are maintained or a different grouping can be detected).

As can be observed from the results presented in this study, the PQS is a useful tool for analyzing the importance of the theoretical framework in the formulation of clinical inferences.

Note

- ¹ The clinical stimulus and the procedures followed by this group of therapists are the same as those used by Leibovich de Duarte et al. (2002), research which was funded by Grant UBACyT, TP 30.

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