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CASE FORMULATION AND TREATMENT CONCEPTS AMONG NOVICE, EXPERIENCED, AND EXPERT COGNITIVE–BEHAVIORAL AND PSYCHODYNAMIC THERAPISTS

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The authors examined conceptions among cognitive–behavioral and psychodynamic therapists regarding case conceptualization and treatment. Therapists were classified as novices, experienced, or experts. After constructing formulations in response to 6 vignettes, varying by mental disorder (anxiety, affective, personality) and prototypicality (high, low), therapists completed a questionnaire for each vignette. The investigators then studied differences in the importance of specific formulation factors, conceptualization difficulty, problem severity and expected change, recommended treatment length and session frequency, etiology, and views regarding patient control over problems and solutions. They found that therapy mode, level of experience and expertise, and their interaction predicted differences in case formulation and treatment preconceptions.

It is axiomatic that how a psychotherapist thinks and makes decisions about patients will affect the treatment process and outcome. Surprisingly, however, little research has examined the thinking processes of therapists (Garb, 1998). Witteman and Koele (1999) found that treatment decisions were better predicted by the therapist's theoretical background than by information about patients. In contrast, Zuber's (2000) sample of therapists appeared to base their treatment decisions on how patients presented themselves. Patients complaining primarily of distressing symptoms were more likely to be referred to cognitive or behavioral therapy, whereas those who framed their problems in terms of relationship difficulties or who were verbally facile were referred for psychodynamic therapy. With regard to formulation, a number of studies have shown that therapist adherence to a reliably constructed case formulation predicts treatment processes and outcomes (Crits-Christoph, Cooper, & Luborsky, 1988; Silberschatz & Curtis, 1993; Silberschatz, Curtis, & Nathans, 1989; Silberschatz, Fretter, & Curtis, 1986).

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One reason that thinking processes of therapists have not been studied is that contemporary psychotherapy outcome studies use treatment manuals and typically treat the therapist as a within-group error variable with 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 explore therapist behavior as an independent variable of interest. Even in these studies, however, some therapists consistently perform better than others (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Shaw et al., 1999). In two studies explicitly focused on examining differences between therapists, the researchers found that peer-nominated expert cognitive-behavioral and psychodynamic therapists were more similar than different in exploring emotionally significant events in therapy (Goldfried, Raue, & Castonguay, 1998; Wiser & Goldfried, 1998). Earlier studies support the hypothesis that therapist expertise may be an important therapy outcome variable (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Ricks, 1974). Similar findings have been observed for both cognitive (Kingdon, Tyrer, Seivewright, Ferguson, & Murphy, 1996) and psychodynamic (Barber, Crits-Christoph, & Luborsky, 1996) therapies. However, some studies show that training may not correlate with treatment outcome (e.g., Jacobson, 1995).

As noted, one reason to study therapist thinking processes is that they may influence outcome for better or for worse. Systematic errors in the judgments of clinicians have been reliably documented (Garb, 1998; Meehl, 1973; Turk & Salovey, 1988). Other research shows that therapist expectations can predict treatment events (e.g., Bonner & Everett, 1986; Heppner & Heesacker, 1983; Joyce & Piper, 1990). Hill et al. (1988) found that therapeutic changes were better predicted by therapist intentions than by the actual interventions used to achieve the intentions. In another study, therapist expectations of treatment length predicted actual treatment duration (Jenkins, Fuqua, & Blum, 1986).

Little research has been conducted examining how training in different therapy modalities affects therapists' views of their patients. One would expect training to affect a therapist's basic assumptions about patients because different forms of therapy contain explicit and implicit assumptions about patients, including the causes of their symptoms and problems and what maintains those symptoms and problems. For example, dynamic approaches assume that unconscious events determine symptom production, suggesting less patient control than cognitive approaches, which are based on learning theory and thus should suggest more patient control. One would also expect differences about expectations regarding treatment duration, cause of symptoms, role of past events, and prognosis. It is important to understand these basic assumptions of therapists about patients in light of the research cited previously showing that expectations predict events in therapy.

In addition to treatment modality, level of experience and skill may play a role in how therapists view their patients. Although we know relatively little empirically about the contribution of experience and skill to treatment outcome, some evidence shows that expert therapists can be identified (Goldfried et al., 1998; Skovholt, Ronnestad, & Jennings, 1997; Wiser & Goldfried, 1998) and produce better outcomes (Blatt et al., 1996; Ricks, 1974; Shaw et al., 1999). It is possible that experienced and expert therapists view patients in systematically different ways than do novice therapists. Similarly, expert therapists may view patients in different ways than do experienced therapists.

Two broad classes of therapeutic expertise may be identified: case formulation skills and psychotherapy technique. A case formulation can be defined as a set of "hypotheses about the causes, precipitants, and maintaining influences of a person's

psychological, interpersonal, and behavioral problems" (Eells, 2002). It is a succinct, yet comprehensive statement that describes the nature of a patient's psychological problems. In addition, a case formulation provides guidelines for treatment, may be revised as new information about a patient is gained, and serves as a marker for progress (Strupp & Binder, 1984). Most case formulation methods distinguish between a patient's overt problems and underlying psychological mechanisms that are presumed to organize and maintain the problems (Persons, 1989). Although perhaps more emphasized in psychodynamic therapies (Luborsky et al., 1993), case formulation is increasingly emphasized among cognitive therapists (e.g., Persons) and those practicing integrationist approaches to psychotherapy (e.g., Caspar, 1995; Ryle, 1990). Psychotherapy technique, as opposed to case formulation, refers to the therapist's interventions and tactics during treatment that are directed at helping the patient.

These threads of research suggest that meaningful differences, based on level of experience and expertise and on treatment orientation, may exist among therapists with respect to how patients are conceptualized and how treatment predictions are made. In the current study, we examine concepts of case formulation and treatment held by practitioners of two of the most widely used treatment modalities: psychodynamic and cognitive-behavioral. For each of these treatment modes, we compared the views of novices, experienced therapists, and carefully selected experts. As an exploratory study, we did not generate any specific hypotheses, except that we expected to find differences based on treatment approach and level of experience and expertise.

Method

Therapists

Sixty-six psychotherapists served as participants. Of these, 10 did not complete the required questionnaire, leaving a sample of 56. Of these, 20 were "novices," defined as clinical psychology graduate students with less than 1,500 hr of supervised psychotherapy experience. Nine of the novices identified themselves as psychodynamically oriented (PD) and 11 as cognitive-behaviorally (CB) oriented. Eighteen were "expert" psychotherapists, defined as experienced psychiatrists or clinical psychologists meeting one or more of four criteria: (a) developed a method of psychotherapy case formulation, (b) led one or more workshops for professionals on how to construct case formulations, (c) produced several publications on the topic of psychotherapy case formulation, and (d) is nationally recognized as an authority on case formulation. Nine experts were cognitively oriented and 9 were psychodynamically oriented. Among the cognitive experts, 2 had medical degrees and 7 earned doctoral degrees. Among the psychodynamic experts, 5 had medical degrees and 4 had doctoral degrees. The "experienced" therapists had 10 or more years of experience practicing either as a CB therapist ($n = 7$) or a PD therapist ($n = 11$). All 7 experienced CB therapists earned doctoral degrees. Four of the experienced PD therapists earned doctorates and 7 had medical degrees.

Table 1 shows descriptive information about the therapists. The PD novices were significantly older than their CB counterparts, $t(18) = 2.37, p < .05$, and somewhat more experienced but not to the point of statistical significance, $t(18) = 1.49, ns$. The novices, on average, were in their third year of graduate school and were younger and less experienced than the other therapists. The experienced PD therapists were older, $t(16) = 2.25, p < .05$, and had practiced therapy longer, $t(16) = 2.11, p < .05$,

TABLE 1. Mean/Frequency Characteristics of Therapists

Characteristic	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
<i>N</i>	11	7	9	9	11	9
Gender (male/female)	7/4	6/1	6/3	3/6	9/2	8/1
Age (years)	27.3	47.7	45.7	34.9	57.8	56.5
Year in school	3.0	NA	NA	3.9	NA	NA
Years of experience as						
Therapist	1.5	20.0	20.9	2.5	29.4	28.9
Supervisor	0.0	12.6	15.0	0.1	23.7	25.6
No. therapists supervised	0.0	34.0	91.3	0.3	55.7	145.6
No. CF publications	0.0	0.0	5.7	0.0	1.4	14.4
No. CF work- shops taught	0.0	0.3	26.1	0.0	2.5	23.7

Note. CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts; NA = not applicable; CF = case formulation.

than their CB counterparts. The PD experts were also older, $t(15) = 2.60$, $p < .05$, and more experienced with therapy, $t(16) = 2.15$, $p < .05$, than their CB counterparts. Finally, as required for the study, the experts of both treatment modalities had given more workshops and had published more on the topic of case formulation than their experienced and novice counterparts.

Vignettes

Six vignettes were constructed to describe patients with one of three common psychiatric disorders: generalized anxiety disorder, major depressive disorder, and borderline personality disorder. The patients described were either highly prototypical of the condition or had a relatively low number of prototypic features. We included a variety of vignettes because previous research has shown that experts' performance varies depending on specifics of problems presented in vignettes (Elstein, Shuyman, & Sprafka, 1978). The mean length of the vignettes was 405 words (range = 368–424). Each vignette contained information in the following categories: identifying information, presenting condition, history of presenting condition, history of mental health care, developmental history, social history, and mental status.

After completing the Postinterview Questionnaire (PIQ; described later), we asked each therapist to rate how prototypical each vignette patient was of the target disorder. Our purpose was to conduct a manipulation check of the vignettes. As shown in Table 2, for each of the three disorders the high prototypical vignette was rated as significantly more prototypical than its low prototypical counterpart.

Postinterview Questionnaire

The data analyzed in this study derive from a 55-item PIQ completed after the therapists provided an extemporaneous formulation of the patients described in the vignettes. Included in the PIQ were copies of each vignette and questions relating to (a) the im-

TABLE 2. Mean Prototypicality Ratings

Disorder	Vignette prototypicality		<i>t</i> (55)
	High	Low	
Generalized anxiety	7.57	4.64	8.79*
Major depressive	8.04	4.43	12.89*
Borderline personality	8.38	4.09	15.06*

Note. A 9-point scale was used (1 = *minimally prototypical*; 9 = *extremely prototypical*).

* $p < .001$.

portance of each of 11 factors presented in the vignette in developing the formulation for the patient; (b) how difficult the patient was to conceptualize; (c) the severity of the patient's principal problems at the outset of treatment and the severity expected at the end of treatment; (d) the recommended length of treatment and session frequency; (e) the importance of each of six etiological factors in the development of the patient's presentation; (f) the degree of control the patient has over the development of problems and therapeutic change; and (g) the patient's prognosis at the end of treatment.

Procedures

The experienced and expert therapists were recruited through direct contacts by Tracy D. Eells either over the telephone or at professional conferences. Some were contacted after word-of-mouth referrals from professional associates. The students were recruited through the cooperation of two American Psychological Association accredited graduate programs in clinical psychology. All therapists were offered \$40 for their participation. Interviews were conducted in person or over the telephone by either Tracy D. Eells or a clinical psychology graduate assistant.

After obtaining informed consent, the interviewer read a set of instructions to the therapist explaining the purpose of the study, time required for participation, and procedure to be followed. We provided each therapist with a written copy of the vignettes and gave permission to take notes while listening to the vignettes. We then presented the vignettes in a fixed randomized order with the constraint that vignettes describing the same disorder or presenting a disorder at the same level of prototypicality were not presented consecutively. The audiorecording was in the voice of Tracy D. Eells and was about 2 min in length per vignette. After listening to each vignette, the therapist was given 5 min to "think aloud about your conceptualization of the patient . . . [to] construct a case formulation . . . as best you can, addressing whatever you feel is important." After 5 min, the participant was interrupted and given 2 min to "think aloud about how you would treat the patient in psychotherapy." After the therapist completed the "think aloud" formulations and treatment plans for all six vignettes, they were given the set of six PIQs, one for each vignette. A self-addressed stamped envelope was included for return to Tracy D. Eells.

Results

Of the 56 therapists included in the analyses, several left at least one item unanswered on the 55-item PIQ. To maximize the use of the information collected, we

decided to handle missing data by dropping participants only from those analyses in which data were missing but including them in analyses in which their data were present. Thus, the sample size for analyses varies depending on the analysis. A review of missing data indicated that it was spread primarily across the novice and experienced groups and appeared to be the result of overlooking the item in a long questionnaire rather than a systematic omission or rejection of the question. In some cases, the therapist felt that insufficient information was provided in the vignette to answer the specific question asked. An alpha level of 0.05 was used for all statistical tests.

Adequacy of Vignette Information

Because the vignettes were relatively brief, a key initial question is whether the therapists found the information contained in them adequate to develop a formulation. We addressed this question by asking the therapists to rate the adequacy of each formulation on a 9-point scale ranging from 1 (*completely inadequate*) to 9 (*perfectly adequate*). The mean response in the sample was 5.42 ($SD = 1.91$), indicating that the vignettes on average could be considered as moderately adequate. We observed statistically significant main effects for experience level, $F(2, 300) = 12.27, p < .001$, therapy mode, $F(1, 300) = 24.81, p < .001$, and vignette, $F(5, 300) = 13.71, p < .001$.

Table 3 shows descriptive information for each of the vignettes by therapy mode and experience level. CB therapists ($M = 5.86, SD = 1.89$) found the information in the vignettes to be more adequate for developing a formulation than did PD therapists ($M = 5.00, SD = 1.84$). Experts ($M = 4.81, SD = 2.19$) found the information less adequate than did either the novices ($M = 5.61, SD = 1.87$) or experienced therapists ($M = 5.81, SD = 1.47$). When each vignette was compared with the mean of all six, Vignettes 2, 3, and 5 were significantly different. Vignette 2 is the low prototypical personality disordered patient, which was rated as lowest in adequacy and was commented on by many of the therapists as the most difficult to formulate. Its mean rating of 4.25 ($SD = 1.70$) may still be considered in the moderately adequate range. Vignettes 3 ($M = 6.14, SD = 1.73$) and 5 ($M = 6.46, SD = 1.79$) were rated relatively high in adequacy. These are both high prototypical vignettes, the first for anxiety and the second for a personality disorder. In sum, the vignettes may be considered at least moderately adequate as a basis for developing a formulation.

TABLE 3. Mean Adequacy Ratings By Vignette

Vignette	Disorder	Prototypicality	CBT			PDT		
			NOV	EXP	EXT	NOV	EXP	EXT
1	Anxiety	High	6.4	6.6	5.2	6.0	6.0	4.0
2	Personality	Low	4.1	5.1	4.1	4.2	4.6	3.4
3	Depression	High	6.8	6.7	6.4	5.9	6.1	4.9
4	Anxiety	Low	5.6	5.9	5.0	4.2	5.4	4.2
5	Personality	High	7.8	7.0	6.8	5.9	6.2	5.0
6	Depression	Low	5.5	6.4	4.3	4.2	4.8	4.2

Note. A 9-point scale was used (1 = *completely inadequate*, 9 = *perfectly adequate*). CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts.

Importance of Case Formulation Components

A second set of questions concerned the importance of several case formulation components in developing the formulation. For each of the six vignettes, the therapists were asked to rate the importance of 11 components, on a scale ranging from 1 (*not important*) to 9 (*extremely important*), developing each of their case formulations (Table 4). We first looked at the overall importance ratings and found that symptoms/problems were rated highest ($M = 7.59$, $SD = 1.46$), followed by precipitating stressors ($M = 6.57$, $SD = 2.02$), coping style or defenses ($M = 6.27$, $SD = 1.96$), and childhood history ($M = 5.88$, $SD = 2.28$). Demographics were rated lowest ($M = 3.22$, $SD = 2.09$).

Next, we conducted a multivariate analysis of variance to determine whether the importance ratings varied according to experience level and therapy mode. We found a multivariate interaction between experience level and therapy mode, $F(22, 618) = 2.44$, $p < .001$, as well as main effects for experience level, $F(22, 618) = 4.25$, $p < .001$, and therapy mode, $F(11, 308) = 4.95$, $p = .001$. At the univariate level we found multiple interactions and main effects, which we discuss next in the order of their rated overall level of importance among the entire sample. Means and univariate statistical test results are presented in Table 4. We did not examine the effects for vignette because our primary purpose for varying the vignettes was to obtain a good sample of the therapists' case formulation skills. Thus, all future analyses use mean ratings across the six vignettes.

CB therapists ($M = 7.7$) rated symptoms/problems as more important than the PD therapists ($M = 7.4$). In contrast, PD therapists ($M = 6.7$) rated coping or defense style as significantly more important than did CB therapists ($M = 5.9$). The differ-

TABLE 4. Mean Importance Ratings of Case Formulation Factors

Case formulation factor	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
Demographics ^a	2.7	3.7	3.6	3.5	3.2	2.8
Symptoms/problems ^b	7.8	7.6	7.8	7.4	7.5	7.4
Precipitating factors	6.5	6.7	6.5	6.4	6.6	6.8
History of mental health care	4.5	5.7	4.8	4.8	5.0	4.2
Childhood ^c	4.9	5.9	5.8	6.3	6.1	6.5
Adolescence	4.4	5.3	4.7	4.9	5.0	5.1
Past adult stressors ^d	4.9	5.9	4.5	5.1	4.6	5.5
Coping/defense style/behaviors ^e	5.5	6.5	5.8	6.9	6.1	7.0
Mental status ^f	4.1	6.5	5.1	4.6	6.3	6.0
Treatment obstacles ^g	2.8	4.9	3.7	4.5	4.6	4.8
Strengths ^h	3.0	6.0	4.3	4.9	5.4	4.7

Note. A 9-point scale was used (1 = *minimally important*, 9 = *extremely important*). CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = expert.

^aInteraction, $F(2, 318) = 4.23$, $p < .01$. ^bTherapy mode, $F(1, 318) = 3.84$, $p < .05$. ^cTherapy mode, $F(1, 318) = 9.45$, $p < .01$. ^dInteraction, $F(2, 318) = 5.36$, $p < .01$. ^eTherapy mode, $F(1, 318) = 14.27$, $p < .001$; interaction, $F(2, 318) = 7.19$, $p < .01$. ^fExperience level, $F(2, 318) = 23.58$, $p < .001$. ^gTherapy mode, $F(1, 318) = 9.57$, $p < .01$; experience level, $F(2, 318) = 5.03$, $p < .01$; interaction, $F(2, 318) = 4.20$, $p < .05$. ^hTherapy mode, $F(1, 318) = 6.38$, $p < .05$; experience level, $F(2, 318) = 17.02$, $p < .001$; interaction, $F(2, 318) = 9.65$, $p < .001$.

ences are seen primarily in the ratings of the novices and experts rather than the experienced therapists, as reflected in a significant interaction. Specifically, the ratings of the novices within each therapy mode for coping/defense style were much more similar to those of the experts than to the experienced therapists. The PD therapists ($M = 6.2$) also rated childhood history as more important than the CB therapists ($M = 5.5$).

A therapy mode main effect emerged for mental status information; experienced therapists ($M = 6.4$) tended to rate this factor as more important than either the novices ($M = 4.3$) or experts ($M = 5.5$) within both therapy modalities. For past adult stressors, we found a Therapy Mode \times Experience Level interaction. As with coping or defense style, this interaction is explained by the similarity between novices and experts within each modality and the dissimilarity with their experienced counterparts. For strengths, we found main effects for therapy mode and experience level as well as an interaction. The PD therapists ($M = 5.5$) rated this factor as more important than the CB therapists ($M = 5.5$). Experienced therapists ($M = 5.7$) rated strengths as a more important factor than did novices ($M = 4.0$) or experts ($M = 4.5$). As with past adult stressors and coping/defense style, however, novices and experts within each therapy mode were more similar in their ratings of strengths than either was to the ratings of the respective experienced therapists. The same main effect and interaction pattern emerged with treatment obstacles. Overall, the PD therapists ($M = 4.6$) rated treatment obstacles as more important than the CB therapists ($M = 3.8$), but the ratings of the CB novices were more similar to those of the CB experts than they were to those of the CB experienced therapists. The PD therapists rated this factor similarly across experience and expertise levels.

The pattern for demographic factors was different than for any other formulation component. The more experienced ($M = 3.7$) and expert ($M = 3.6$) CB therapists rated demographics as more important than the novice CB therapists ($M = 2.7$). Conversely, the more experienced ($M = 3.2$) and expert ($M = 2.8$) PD therapists rated demographics as less important than the PD novices ($M = 3.5$).

Conceptualization and Treatment Difficulty

There were no differences in experience level, therapy mode, or their interaction in the ratings of how difficult the cases, considered as a group, were to conceptualize. Neither did we find any differences in the therapists' ratings of the difficulty in treating the patients depicted in the vignettes.

Problem Severity and Prognosis

For each vignette, we asked three questions related to problem severity and prognosis. First, the therapists rated the severity of what they viewed as the patient's primary problem. Next, they estimated severity of that problem in 1 year assuming the patient received the recommended treatment (or after 12 months, whichever came first). Finally, the therapists provided an overall rating of prognosis at the earlier of completion of the recommend treatment or 12 months. Ratings were made on the 9-point scales indicated in Table 5.

We found no differences in ratings of initial problem severity. However, CB therapists ($M = 3.5$) predicted less problem severity after treatment than did the PD therapists ($M = 3.9$). We also found that the CB therapists ($M = 6.5$) predicted a somewhat better prognosis than did PD therapists ($M = 6.0$).

TABLE 5. Mean Views of Primary Problem Severity and Prognosis

Problem severity, prognosis, treatment difficulty	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
Primary problem initial severity	7.0	7.0	6.8	6.7	7.0	6.8
Severity of primary problem at end of recommended treatment (or after 12 months, whichever comes first) ^a	3.4	3.8	3.3	3.7	4.1	3.9
Prognosis at completion of recommended treatment (or after 12 months, whichever comes first) ^b	6.5	6.3	6.6	6.2	5.9	6.0

Note. For each question, a 9-point scale was used (primary problem severity: 1 = *minimally severe*, 9 = *extremely severe*; prognosis: 1 = *poor prognosis*, 9 = *excellent prognosis*). CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts.

^aTherapy mode, $F(1, 330) = 5.00, p < .05$. ^bTherapy mode, $F(1, 329) = 4.54, p < .05$.

Treatment Length and Session Frequency Expectations

For each vignette, the therapists were asked to estimate how long the patient needs to be in therapy using three specific measures: overall length of treatment, number of sessions, and frequency of sessions. Mean ratings are shown in Table 6. With regard to overall length of treatment, we found main effects for experience level and therapy mode. PD therapists estimated that treatment would be longer than CB therapists. Experts and experienced therapists also estimated treatment would be longer than did novices.

For number and frequency of sessions, we again observed main effects for both experience level and therapy mode and an interaction. Experts predicted more sessions and more frequent sessions compared with the novices and experienced therapists. The PD therapists also predicted more sessions and more frequent meetings than did the CB therapists. In addition, experienced PD therapists anticipated the need for more sessions and more frequent meetings than experienced CB therapists.

TABLE 6. Treatment Length and Session Frequency Expectations

Treatment expectations	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
Overall treatment length (weeks) ^a	33.8	36.8	65.1	55.5	89.1	96.7
No. sessions ^b	35.5	26.6	69.1	57.4	156.2	196.9
No. sessions/week ^c	1	0.8	1	1	1.5	1.6

Note. CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts.

^aExperience level, $F(2, 321) = 6.77, p < .001$; therapy mode, $F(1, 321) = 18.40, p < .001$. ^bExperience level, $F(2, 321) = 7.60, p < .001$; therapy mode, $F(1, 321) = 26.22, p < .001$; interaction, $F(2, 321) = 4.37, p < .01$. ^cExperience level, $F(2, 321) = 7.18, p < .001$; therapy mode, $F(1, 321) = 48.64, p < .001$; interaction, $F(2, 321) = 18.22, p < .001$.

Etiology

Next, we considered whether views of etiology varied according to therapy mode or experience level. For each vignette, we asked therapists to rate the extent to which they attributed the cause of the patient's presenting condition to each of six factors: biological/chemical, constitutional, early childhood events or stressors, past adult events or stressors, recent and/or ongoing stressors, and social learning history. Therapists used a 9-point Likert scale ranging from 1 (*not causal at all*) to 9 (*extremely causal*). Mean ratings are shown in Table 7. We found a multivariate Experience Level \times Therapy Mode interaction, $F(12, 650) = 3.21, p < .001$, as well as main effects for both experience level, $F(12, 650) = 2.26, p < .01$, and therapy mode, $F(6, 324) = 7.26, p < .001$. Univariate effects were observed for each of the six factors. These are presented next in descending order of their overall ratings.

The novice and expert therapists judged recent and/or ongoing stressors as more causal than did the experienced therapists, although the finding among the experts appears to be due primarily to the ratings of the PD therapists rather than their CB counterparts. As one might expect, the PD therapists rated childhood events or stressors as more causal than CB therapists. Conversely, the CB therapists rated social learning as more causal than the PD therapists. The novices across both treatment modalities tended to agree in their ratings of social learning. Whereas the PD experienced and expert therapists rated social learning as less causal than did the PD novices, the CB experienced and expert therapists gave ratings similar to those of the CB novices. Like social learning, the pattern observed for past adult events/stressors shows greater similarity among the novices than among the experienced and expert therapists. CB therapists rated constitutional factors as more causal than did the PD therapists, although the differences are seen more among the experts and experienced therapists than among the novices. Finally, we found two main effects and a significant interaction for biology as an etiological factor. CB therapists tended to rate biology as more causal as experience and expertise increased, whereas the opposite was the case for the PD therapists.

TABLE 7. Mean Importance Ratings of Etiological Factors

Etiological factor	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
Biological/chemical ^a	2.8	3.4	3.6	3.4	3.3	3.0
Constitutional ^b	4.6	5.2	4.9	4.6	4.8	3.9
Early childhood events/stressors ^c	5.9	6.6	6.2	6.5	6.8	7.2
Past adult events/stressors ^d	5.3	6.0	5.2	5.4	5.1	6.6
Recent and/or ongoing stressors ^e	7.2	6.8	6.8	6.7	6.4	7.5
Social learning history ^f	6.5	6.6	6.8	6.4	5.0	5.5

Note. A 9-point scale was used (1 = *minimally causal*, 9 = *extremely causal*). CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts.

^aInteraction, $F(2, 329) = 3.18, p < .05$. ^bTherapy mode, $F(1, 329) = 5.71, p < .01$; interaction, $F(1, 329) = 5.71, p < .10$. ^cTherapy mode, $F(1, 329) = 7.62, p < .01$. ^dInteraction, $F(2, 329) = 7.81, p < .001$.

^eExperience level, $F(2, 329) = 2.95, p < .05$; interaction, $F(2, 329) = 3.49, p < .05$. ^fTherapy mode, $F(1, 329) = 20.09, p < .001$; experience level, $F(2, 329) = 3.17, p < .05$; interaction, $F(2, 329) = 5.17, p < .01$.

Patient Control Over the Disorder

We examined differences in views of how much control patients have over their problems and the solutions. First, we were interested in the extent to which the therapists believed the patients had control over the pathogenesis of their problems. As might be expected (Table 8), PD therapists ($M = 4.8$) rated the patients as having less control in producing their disorder than did the CB therapists ($M = 4.1$). In addition, experienced ($M = 4.6$) and expert therapists ($M = 4.9$) across both treatment modalities tended to view the patient as having more control than did the novices ($M = 3.9$).

Second, we examined the extent to which the therapists believed that the patient could achieve significant change independent of therapy. Expert therapists ($M = 6.2$) tended to endorse this statement more than experienced therapists ($M = 4.9$). We also observed an interaction, which is explained by the similarly high ratings of the PD novices and all experts and the relatively low ratings of the PD experienced therapists.

Third, we asked the therapists to rate the extent to which they agreed that each patient requires therapeutic intervention to achieve significant change. We observed no significant differences. However, the therapists of all groups tended to agree that the patients needed therapeutic intervention, as shown by the overall mean rating of 6.78 ($SD = 1.80$) on a 9-point scale (1 = *strongly disagree*, 9 = *strongly agree*).

Effect Sizes

We examined effect sizes of each variable for which statistically significant differences were observed, as shown in Table 9. Following Cohen (1988), we chose the product-moment correlation coefficient as the measure of effect size, correlating each dependent variable with index values of the independent variables. Cohen suggested that a correlation of .10 be considered small, .30 medium, and .50 large. On the basis of these criteria, the observed effect sizes range from small to me-

TABLE 8. Mean Views of Patient Control

Patient control question	CBT			PDT		
	NOV	EXP	EXT	NOV	EXP	EXT
Patient's problems are determined by factors over which the patient has had no control ^a	3.6	4.0	4.8	4.2	5.2	4.9
Actions taken by this patient, independent of those taken by a therapist, can lead to significant therapeutic change ^b	5.1	5.3	6.4	6.1	4.4	6.0
Patient requires therapeutic intervention to achieve significant change	6.8	6.4	6.8	6.5	6.9	7.1

Note. A 9-point scale was used (1 = *strongly disagree*, 9 = *strongly agree*). CBT = cognitive-behavioral therapists; PDT = psychodynamic therapists; NOV = novices; EXP = experienced; EXT = experts.

^aTherapy mode, $F(1, 330) = 7.81$, $p < .01$; experience level, $F(2, 330) = 7.27$, $p < .001$. ^bExperience level, $F(2, 330) = 11.13$, $p < .001$; interaction, $F(2, 330) = 5.69$, $p < .01$.

TABLE 9. Effect Sizes Expressed as Pearson Product–Moment Correlation Coefficients

Variable	CBT ¹ vs. PDT ²	Expertise level		
		NOV ¹ vs. EXP ²	NOV ¹ vs. EXT ³	EXP ² vs. EXT ³
Case formulation factor				
Demographics	-.02	.07	.06	-.01
Symptoms/problems	-.10	—	—	—
Childhood	.19	—	—	—
Past adult stressors	.00	.03	.03	.00
Coping/defense style	.19	.02	.05	.04
Mental status	—	.43	.25	-.20
Treatment obstacles	.19	.24	.14	-.09
Strengths	.16	.36	.12	-.27
Problem severity and prognosis				
Severity at treatment end	.14	—	—	—
Prognosis	-.13	—	—	—
Treatment expectations				
Overall treatment length	.23	.16	.30	.06
No. sessions	.27	.20	.29	.06
Frequency of sessions	.35	.22	.25	.05
Etiology				
Biological/chemical	.01	.07	.07	.00
Constitutional	.12	—	—	—
Childhood	.16	—	—	—
Past adult events	.05	.01	.11	.11
Recent stressors	-.04	-.11	.04	.17
Social learning history	.25	-.21	-.08	.12
Patient control				
Over problem cause	.17	.21	.24	.03
Independent change ability	.03	.17	.14	.32

Note. Superscript numbers show index values used for the independent variables. Empty cells signify lack of statistical significance in analysis of variance. CBT = cognitive–behavioral therapy; PDT = psychodynamic therapy; NOV = novice; EXP = experienced; EXT = expert.

dium, with most falling in the small range. The largest effect sizes were found with regard to treatment expectations and beliefs about patient control over their problems.

Discussion

In this exploratory study, systematic differences about concepts of case formulation and treatment emerged based on therapist treatment orientation and level of experience and expertise. We observed differences with regard to the relative importance attributed to several different components of a case formulation, to predictions of problem severity and prognosis, to expectations about treatment length and session frequency, to etiology, and to views about patient control over the genesis, course, and outcome of their disorder. We discuss the key findings in turn.

Information Adequacy

On average, the therapists found that the information presented in the six vignettes was at least moderately adequate for developing their formulations. We were not surprised that the experts viewed the available information as less adequate than did the experienced and novice therapists. Glaser and Chi (1988) identified one robust characteristic of experts as having stronger self-monitoring skills than nonexperts. Thus, we would expect them to be more aware of the need for additional information to develop the formulation more completely.

Relative Importance of Case Formulation Components

The PD therapists placed significantly more emphasis on coping/defenses, childhood history, strengths, and treatment obstacles than did the CB therapists, who placed more emphasis on symptoms and problems. These differences are largely consistent with the respective theoretical approaches of these groups. It is somewhat surprising that these therapists also rated strengths and treatment obstacles as more important.

Experienced therapists placed more emphasis on mental status information than did either the novices or experts. The difference observed regarding mental status, a concept deriving from medicine (Eells, 1997), could be an artifact of the relatively greater number of physicians among the experienced PD group.

The interaction effects were the most striking and unexpected findings regarding case formulation components because they were largely explained by the greater similarity in ratings among the experts and novices within therapy mode compared with those of the experienced therapists. This pattern was observed, either for CB or PD therapists individually or both modes together, for past adult stressors, coping or defense style, obstacles to treatment success, and strengths. One explanation for these interactions is that the learning of the novices, compared with that of the experienced therapists, more closely matches the teaching of the experts. If so, one would expect greater similarity between the views of the experts and the novices. Although the experienced therapists may also have had training in case formulation methods like those of the experts, it likely occurred after their initial and more formative training in case formulation. Henry, Strupp, Butler, Schacht, and Binder (1993) documented that psychotherapy training effects are not straightforward and can have unintended consequences, even when the new training falls generally within the theoretical domain of the method already learned.

Predictions About Problem Severity and Prognosis

CB therapists predicted greater improvement from therapy. A possible explanation for this finding is that the CB therapists identified different and more easily resolved problems than did the PD therapists. They may have identified symptom distress as the primary problem, whereas the PD therapists may have identified problems related to maladaptive relationship patterns or the patient's self-concept, both of which tend to be more resistant to change than are symptoms (Kopta, Howard, Lowry, & Beutler, 1994). Messer (1986) commented that behavioral therapists are much more likely to accept a problem at face value as what the client states it is, whereas psychodynamic therapists tend to be more skeptical, looking for unconscious conflicts and distinguishing between symptoms and underlying psychopathology. We are currently preparing a more extensive analysis of the problems identified by thera-

pists of different orientations and at different levels of experience and expertise, which will permit us to understand this finding better.

Expectations About Treatment Length and Session Frequency

Expert and PD therapists predicted longer treatment, more sessions, and more frequent sessions than did their novice and CB counterparts. Within the group of experienced therapists, those with a PD orientation expected more sessions and more frequent sessions than those with a CB orientation. The effect for therapy mode is consistent with the theoretical approach of the two groups. It was surprising, however, that the experts of both orientations recommended longer treatments than the respective novice and experienced therapists. These findings are consistent with those of Blatt et al. (1996), who found that more effective therapists estimated a longer period of time to successful treatment compared with those who were less effective. The explanation could lie with another robust characteristic of experts identified by Glaser and Chi (1988): Experts see and represent problems in more abstract and meaningful conceptual categories than do novices, who tend to categorize problems according to more superficial properties. It is possible that the experts understand these patients and their problems better and make their treatment recommendations accordingly.

Etiology

PD therapists rated early childhood events and stressors as more causal than did the CB therapists, whereas the CB therapists rated social learning, constitutional factors, and biology as more causal. These differences are consistent with the theoretical underpinnings of each therapy modality.

The most striking finding among the etiological factors is the interaction effects, which suggest that novices of both orientations shared similar views on etiology, but their experienced and expert counterparts differed from each other and from the novices. This pattern was observed with the etiological roles of social learning, adult events or stressors, and constitutional factors. It is possible that the learning environment shared by the novices of both orientations accounts for their similar ratings, and that subsequent experiences in their chosen treatment modality mold them toward somewhat different views.

Views About Patient Control Over the Disorder

CB therapists were more likely to view the patients as having control over their disorder than did the PD therapists. This finding is consistent with the respective theoretical underpinnings of the two orientations, specifically the greater role psychodynamic theory attributes to unconscious mental processes. We also found that experts were more likely than other therapists to believe that the patient was able to achieve therapeutic change independent of actions taken by the therapist. It is possible that belief in patient autonomy, and thus ability to change outside of therapy, is one component of therapeutic expertise. However, all therapists tended to agree that the vignette patients needed therapeutic intervention to achieve significant change.

The findings of this study should be viewed in light of its limitations. It is an exploratory study, the sample is small, and the effect sizes are relatively small despite numerous statistically significant differences and some effect sizes in the medium range.

Future research with a larger, more representative sample should be conducted. With regard to effect sizes, it is possible that relatively small-magnitude differences in basic assumptions about patients could lead to significantly different outcomes in therapy. For example, attributing slightly greater causality to childhood events than to biological factors could dramatically alter the treatment and its outcome. An additional limitation is that this study addresses only concepts about case formulation and treatment. It does not examine actual differences in case formulation or treatment. We are currently analyzing the actual formulations of the therapists, which will provide information about performance that the current study does not.

Another limitation of the study is that the sample differed in ways other than theoretical orientation and degree of experience/expertise, introducing possible confounds. On average the PD therapists were older and had greater therapy and supervision experience than the CB therapists. Conceivably, observed therapy mode differences could be due to the greater level of experience in the PD sample.

One could object that we collapsed the therapists into two groups, PD and CBT, when each of these groups has many diverse theoretical variations within it. We were able to explore this possibility because we asked the therapists to identify a more narrow orientation within the broader one. Almost without exception, the CB therapists identified with the Beck tradition, whereas the PD therapists identified themselves within an interpersonal/relational tradition.

Some might view our choice to use vignettes as a limitation because the "patients" are not real. On the other hand, the use of vignettes provided several benefits. We were able to better control the information provided to the therapists, for example, by ensuring that similar categories of information are contained in each. Vignettes also permitted us to systematically vary disorder and prototypicality, which made the presentation of three different disorders at two distinct levels of prototypicality. Although not quantitatively measured, we were struck by how engaged the therapists became in producing formulations. Several commented on how realistic the vignettes were and how similar they were to patients they had seen, or they asked whether they were actual patients.

Despite these limitations, we believe that these findings suggest areas for further research. We are currently content analyzing the formulations offered by the therapists. We have developed several reliable measures of case formulation quality, which we are using to determine whether expert, experienced, and novice therapists differ with regard to the quality of their formulations. The quality measures include comprehensiveness, degree of elaboration of formulation components, evidence of a systematic formulation process being followed across multiple formulations, precision of language, complexity of the formulation, coherence, degree of treatment plan elaboration, and the goodness of fit between the formulation and treatment recommendations. We mentioned earlier our in-process study of differences in problems formulation based on therapy orientation and level of expertise. Another area of needed research is longitudinal studies of therapist skill levels to explore the course of skill development and how therapists can best be trained to a level of expertise.

Most of the findings differentiating the CB and the PD therapists are consistent with the theoretical distinctions of these orientations. That they are reflected in this study indicates that these views do not exist merely as inert knowledge of the therapists (Binder, 1993) but were actively applied to the individual "patients" in the study. An appreciation of these different perspectives of reality (Messer & Winokur, 1980) and their effect on the course and outcome therapy may facilitate greater understanding among CB and PD therapists. We are intrigued by the possibility that the experts in

both traditions may have supervened the theoretical strictures of their method and consequently may have understood the patients better.

References

- Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology, 64*, 619–622.
- Binder, J. L. (1993). Is it time to improve psychotherapy training? *Clinical Psychology Review, 13*, 301–318.
- Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analysis of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 1276–1284.
- Bonner, B. L., & Everett, F. L. (1986). Influence of client preparation and problem severity on attitudes and expectations in child psychotherapy. *Professional Psychology: Research and Practice, 17*, 223–229.
- Caspar, F. (1995). *Plan analysis: Toward optimizing psychotherapy*. Seattle, WA: Hogrefe & Huber Publishers.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.
- Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56*, 490–495.
- Eells, T. D. (1997). Psychotherapy case formulation: History and current status. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation*. New York: Guilford Press.
- Eells, T. D. (2002). Formulation. In M. Hersen & W. Sledge (Eds.), *The encyclopedia of psychotherapy* (pp. 815–822). New York: Academic Press.
- Elstein, A. S., Shuylman, L. S., & Sprafka, S. A. (1978). *Medical problem solving: An analysis of clinical reasoning*. Cambridge, MA: Harvard University Press.
- Garb, H. N. (1998). *Studying the clinician: Judgment research and psychological assessment*. Washington, DC: American Psychological Association.
- Glaser, R., & Chi, M. T. H. (1988). Overview. In M. T. H. Chi, R. Glaser, & M. J. Farr (Eds.), *The nature of expertise* (pp. xx–xxvii). Hillsdale, NJ: Erlbaum.
- Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66*, 803–810.
- Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 62*, 434–440.
- Heppner, P. P., & Heesacker, M. (1983). Perceived counselor characteristics, client expectations, and client satisfaction with counseling. *Journal of Counseling Psychology, 30*, 31–39.
- Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 33*, 222–233.
- Jacobson, N. (1995). The overselling of therapy. *Family Therapy Networker, 19*, 41–47.
- Jenkins, S. J., Fuqua, D. R., & Blum, C. R. (1986). Factors related to duration of counseling in a university counseling center. *Psychological Reports, 58*, 467–472.
- Joyce, A. S., & Piper, W. E. (1990). An examination of Mann's model of time-limited individual psychotherapy. *Canadian Journal of Psychiatry, 35*, 41–49.
- Kingdon, D., Tyrer, P., Seivewright, N., Ferguson, B., & Murphy, S. (1996). The Nottingham study of neurotic disorder: Influence of cognitive therapists on outcome. *British Journal of Psychiatry, 69*, 93–97.
- Kopta, S. M., Howard, K. I., Lowry, J. L., & Beutler, L. E. (1994). Patterns of symptomatic recovery in psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 1009–1016.
- Luborsky, L., Barber, J. P., Binder, J., Curtis, J., Dahl, H., Horowitz, L., et al. (1993). Transference-based measures: A new class based on psychotherapy sessions. In N. E. Miller, L. Luborsky, J. P. Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 326–341). New York: Basic Books.
- Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602–611.
- Meehl, P. E. (1973). *Why I do not attend case conferences*. New York: Norton.
- Messer, S. B. (1986). Behavioral and psychoanalytic perspectives at therapeutic choice points. *American Psychologist, 41*, 1261–1272.

- Messer, S. B., & Winokur, M. (1980). Some limits to the integration of psychoanalytic and behavior therapy. *American Psychologist*, 35, 818–827.
- Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: W. W. Norton.
- Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcomes of adolescent patients. In D. F. Ricks, M. Roff, & A. Thomas (Eds.), *Life history research in psychopathology* (pp. 275–297). Minneapolis: University of Minnesota Press.
- Ryle, A. (1990). *Cognitive analytic therapy: Active participation in change*. Chichester, England: Wiley.
- Shaw, B. F., Olmsted, M., Dobson, K. S., Sotsky, S. M., Elkin, I., Yamaguchi, J., et al. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology*, 67, 837–846.
- Silberschatz, G., & Curtis, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology*, 61, 403–411.
- Silberschatz, G., Curtis, J. T., & Nathans, S. (1989). Using the patient's plan to assess progress in psychotherapy. *Psychotherapy*, 26, 40–46.
- Silberschatz, G., Fretter, P. B., & Curtis, J. T. (1986). How do interpretations influence the process of psychotherapy? *Journal of Consulting and Clinical Psychology*, 54, 646–652.
- Skovholt, T. M., Ronnestad, M. H., & Jennings, L. (1997). Searching for expertise in counseling, psychotherapy, and professional psychology. *Educational Psychology Review*, 9, 361–369.
- Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key*. New York: Basic Books.
- Turk, D. C., & Salovey, P. (Eds.). (1988). *Reasoning, inference, and judgment in clinical psychology*. New York: Free Press.
- Wiser, S., & Goldfried, M. R. (1998). Therapist interventions and client emotional experiencing in expert psychodynamic-interpersonal and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, 66, 634–640.
- Wittman, C., & Koele, P. (1999). Explaining treatment decisions. *Psychotherapy Research*, 9, 100–114.
- Zuber, I. (2000). Patients' own problem formulations and recommendations for psychotherapy. *Journal of Psychotherapy Integration*, 10, 403–414.

Zusammenfassung

Die Autoren haben Auffassungen in bezug auf Fallkonzeptualisierungen und Behandlungen bei kognitiven Verhaltenstherapeuten und dynamischen Therapeuten untersucht. Die Therapeuten wurden in "Neulinge", "Erfahrene" und "Experten" eingeteilt. Nachdem sie Formulierungen abgegeben hatten für sechs Vignetten, die hinsichtlich psychischer Störungen (Angst, Affekt, Persönlichkeit) und prototypischer Qualität (hoch, niedrig) variierten, haben die Therapeuten für jede der Vignetten einen Fragebogen ausgefüllt. Die Autoren haben dann die Unterschiede bezüglich der Wichtigkeit spezifischer Formulierungsfaktoren, der Konzeptualisierungsschwierigkeit, des Ernstes der Störung, und der erwarteten Veränderung, der empfohlenen Länge der Behandlung und der Sitzungsfrequenz, der Ätiologie und der Ansicht in bezug auf die Kontrolle der Patienten über ihre Probleme und Lösungsmöglichkeiten untersucht. Es zeigte sich, dass die Therapieart, der Grad der Erfahrung und des Expertenwissens und ihre Interaktionen Unterschiede in den Fallformulierungen und Behandlungsauffassungen vorhersagten.

Résumé

Les auteurs ont examiné les conceptions au sujet de la formulation du cas et du traitement chez des thérapeutes cognitivo-comportementaux et psychodynamiques. Les thérapeutes étaient classés en débutants, expérimentés et experts. Après avoir conçu une formulation répondant à chacune des 6 vignettes, et variant en fonction du trouble mental (anxiété, affectivité, personnalité) et du degré de prototypicité (haut, bas) les thérapeutes ont complété un questionnaire pour chaque vignette. Les investigateurs ont ensuite étudié des différences concernant l'importance de facteurs spécifiques de formulation, la difficulté de conceptualisation, la gravité du problème et le changement attendu, la durée de traitement suggérée et la fréquence des séances, l'étiologie et l'estimation du contrôle du patient sur les problèmes et les solutions. Ils ont trouvé que le mode thérapeutique, le niveau d'expérience et d'expertise ainsi que leur interaction pouvaient prédire les différences dans la formulation du cas et dans la pré-conception du traitement.

Resumen

Los autores examinaron las concepciones existentes en las terapias cognitivo-comportamental y psicodinámica con respecto a la conceptualización del caso y su tratamiento. Los terapeutas fueron clasificados en novicios, experimentados o expertos. Después de construir formulaciones en respuesta a 6 viñetas que variaron según el desorden mental (ansiedad, trastorno afectivo, personalidad) y su prototipicidad (alta, baja), los terapeutas completaron un cuestionario para cada viñeta. Los investigadores estudiaron entonces las diferencias en la importancia de factores específicos de formulación, dificultad de conceptualización, severidad del problema y cambio esperado, recomendaron duración del tratamiento y frecuencia de las sesiones, etiología y puntos de vista respecto del control ejercido por el paciente en relación a sus problemas y soluciones. Encontraron que la modalidad terapéutica, el nivel de experiencia y su expertez y sus interacciones predijeron diferencias en la formulación del caso y en las preconcepciones acerca del tratamiento.

Resumo

Os autores analisaram a conceptualização de caso e tratamento de terapeutas cognitivo-comportamentais e psicodinâmicos. Os terapeutas foram classificados como iniciados, com experiência ou especialistas. Após a construção de formulações em resposta a 6 vinhetas que variaram em termos de perturbação mental (ansiedade, afetiva ou personalidade) e de prototipicidade (elevada ou reduzida), os terapeutas completaram um questionário para cada vinhetas. Os investigadores estudaram então as diferenças na importância dada a factores específicos de formulação, dificuldade de conceptualização, gravidade do problema e mudança esperada, duração recomendada do tratamento e frequência das sessões, etiologia e perspectivas relativas ao controlo do paciente sobre os problemas e as suas soluções. Encontraram que o tipo de terapia, nível de experiência e perícia, e a sua interacção predisseram diferenças na formulação de caso e pré-conceptualização do tratamento.

Sommario

Gli autori hanno esaminato le differenze tra trapeuti cognitivo comportamentali e psicodinamici nella concettualizzazione di un caso clinico e del suo trattamento. I terapeuti sono stati classificati in tre categorie: poco esperti, abbastanza esperti, molto esperti. Dopo aver elaborato delle formulazioni in risposta a 6 vignette cliniche diverse tra loro per disturbo descritto (disturbo d'ansia, affettivo, di personalità) e per gravità, i terapeuti hanno completato un questionario per ognuna delle vignette presentate. I ricercatori hanno poi studiato il peso di differenti fattori importanti per la formulazione del caso, la difficoltà nell'inquadrare il caso clinico, la gravità del disturbo e le possibilità di cambiamento, le indicazioni per la durata del trattamento e la frequenza delle sedute, l'etiologia e i giudizi circa la capacità del paziente di gestire le proprie problematiche e nel trovare soluzioni. E' stato visto come il modello teorico, il livello di esperienza e la loro interazione erano predittori significativi delle differenze nelle formulazioni dei casi.

摘要

研究者檢視認知行為學派與心理動力學派治療者的個案概念化及處遇情形。治療者分為新手、有經驗與老手。當治療者針對六個分屬不同性質（焦慮、情感性疾患與人格疾患）與不同典型反應的多寡（高、低）的精神疾患案例做完個案形成，治療者針對每個案例填寫一份問卷。研究者接著檢視不同專業程度治療者對於這些案例某些形成原因的重要性、形成概念化的難易度、困擾的嚴重性、預期的改變程度、建議的治療時間與晤談頻率、發生原因，以及對於病患對於困擾是否能掌控及找到解決之道等，是否有所差異。研究發現治療取向、經驗與專業程度以及這些因素的交互作用可預測個案形成及處遇的差異。

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