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Case conceptualisations used by psychodynamic psychotherapists seeking insurance reimbursement in Germany

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Abstract

Aims: This study investigated which working models psychodynamic psychotherapists use to conceptualise their approach to working with individual patients.

Methods: We randomly selected 1000 samples from a larger pool of reimbursement applications clinicians submitted to health insurance providers. From these, we extracted whether one or more of the following theories were used: drive theory, object relations theory, Winnicott's, Bion's and attachment theory. We also tracked whether the concepts of the unconscious, the super-ego and regression appeared.

Results: The most frequently used theory was object relations theory, followed by drive theory. The concepts developed by Bion and Winnicott were rarely used. The following concepts did not appear in any of the reports: reverie, alpha-function, beta-elements and pathological organisation. A fifth of the reports did not mention any of the concepts investigated. Therapists trained in psychoanalysis used drive theory, object relations theory, Bion's theory and regression more often than those trained in low-frequency psychodynamic psychotherapy.

Conclusions: We conclude that case conceptualisations for psychodynamic therapies with adult patients nowadays most frequently cite the use of object relations theory and drive theory, whereas Bion's and Winnicott's concepts are rarely explicitly mentioned. On average, therapists trained in psychoanalysis use more theories than those with psychodynamic training.

KEYWORDS
behaviour and behaviour mechanisms, mental health services, psychoanalytic theory, psychological phenomena, psychotherapy

1 | BACKGROUND

'How a problem is understood dictates how it is responded to' (Saunders & Houghton, 1996, p. 843). The ability to apply concepts to individual patients, a skill sometimes referred to as conceptual competence, helps psychotherapists better understand and work with their clients (Storck, 2022). Having strong conceptual skills is considered an important marker of successful psychotherapists (Anderson & Hill, 2017). It means that the therapist is able not only to empathically recognise their patients' concerns but also to understand those issues in a way that allows them to comprehend the dynamic relation between a person's symptoms, their current living situation and their history. Such skills enable the therapist to conceptualise the case in a theoretical and practical way and,

based on that, to metabolise the patient's emotional expressions and meaningfully (re)act in the sessions. Psychoanalytical theory and techniques are therefore highly connected with each other; the therapeutic process is shaped by the practitioner's understanding of psychopathology and the theories they are using (Tuckett, 2011). Another term used for 'case concept' therefore is 'working model' (Spurling, 2018).

Opinions are divided on this, however, as some perceive the application of theories and concepts as an obstacle to meaningful clinical work (Spurling, 2018). One possible risk, for example, is that it might create unwanted distance in the therapeutic relationship (Storck, 2022). Other authors claim that there is widespread conceptual inconsistency among psychotherapists (Collard, 2019) and that the different understandings and uses of one and the same theory or concept may create Babylonian confusion (Basile, 2010; Lhulier, 2005). Hence, it has been argued that the real-world application of psychotherapy may differ considerably from its theoretical background, a potential divide that calls for closer examination (Sandler, 1983).

This study therefore set out to investigate which concepts psychodynamic psychotherapists use in their daily work. We were able to do this because there is a special system established in Germany whereby statutory and private health insurances provide reimbursement for outpatient psychotherapy (BMG, 2017; G-BA, 2016, 2018; Singer, Engesser, et al., 2022). In association with this, a plethora of documents are produced that can be used for such research. Insurance providers cover the costs of psychotherapy if it is deemed: (1) necessary, (2) economic, (3) sufficient and (4) appropriate. To determine whether these criteria are met, the providers pay experienced psychotherapists ('reviewers') to evaluate patients' applications. These applications always include a pseudonymised report written by the psychotherapist planning to provide the treatment in which they describe the patient's symptoms and explain why psychotherapy is indicated. In other words, these reports provide a record of the therapists' working models, their case conceptualisations (while it is not unheard of for patients to see these reports, this is the exception to the rule). The report has to follow a form prescribed by the law, although the rules have slightly changed over the years. The overarching rules are as follows:

1. The report should not be longer than three pages (though the font size and line spacing is not specified and the application is usually not declined only because the report was too long).
2. The first paragraph must describe the patient's symptoms and complaints, preferably using quotes from the patient.
3. A (usually longer) paragraph describes the patient's development during life, that is, the clinical and biographical history.
4. A (albeit preliminary) diagnosis must be provided, together with a detailed description of the patient's mental state.
5. Coexisting somatic diseases and all relevant treatment received in the past must be described.
6. A core part of the report is the description of the psychodynamics of the psycho-pathologic development. Here, current symptoms, unresolved inner conflicts and structural deficits must be explained by the patient's history, at least in the form of hypotheses.
7. The report concludes with an outline for the projected therapy and a prognosis of the patient's further development.

While every report must include each of these elements, the requirements for initial applications and follow-up reports vary. The number of sessions that can be requested in the application is restricted, and the number of applications/reports necessary per year is limited to one.

In the 1960s, German health authorities introduced two types of psychodynamic psychotherapies (Vangermain & Brauchle, 2010) that are qualified for reimbursement within this system. These are analytic psychotherapy and 'Tiefenpsychologisch fundierte Psychotherapie' (literal translation: 'psychotherapy based on depth psychology'), which is basically an analytically informed focal psychotherapy conducted at lower frequency (usually once a week), for which patients remain seated instead of lying on a couch. From here on out, we call the first type 'high-frequency analytic psychotherapy (AP)' and the latter 'low-frequency psychodynamic psychotherapy (LP)'. When AP is conducted with less than three sessions per week, it is called 'modified AP'.

The training requirements for both types of psychodynamic psychotherapy are, in principle, very similar. In reality, however, AP trainees complete more sessions of training analysis than LP trainees (on average 319 vs. 134 sessions), more sessions of individual supervision (148 vs. 105), and more treatment hours before graduation (842 vs. 698; Janke, 2020). Because of the de facto differences in training, it is possible that the two groups of psychotherapists use different working models.

Hence, our research questions were as follows:

1. How often are specific working models of patient symptoms and psychodynamics used in real-life outpatient psychotherapy?
2. How often are none of the investigated concepts used?
3. Are there differences in the usage of certain concepts:

Implications for Practice and Policy

- Clinicians are encouraged to reflect on their own use of theories and concepts in case conceptualisations, as well as how they describe and justify the approach they intend on taking.
- Teaching institutes are encouraged to broaden the scope of the theories they teach and to help candidates apply different theories or concepts to a case.
- Institutes need to find faculty who have both a broad and deep understanding of various psychodynamic theories. Although this can be challenging, especially for smaller institutes, our results show that it is well worth the effort.

a. Between different types of therapy (LP vs. modified AP vs. regular AP)?
b. When patients participate in the sessions lying down?
c. Depending on the therapist's training?

2 | METHODS

2.1 | Psychotherapy reports

Via a long-standing reviewer, we had access to about 40,000 applications for psychotherapy reimbursement submitted to various health insurance providers by adult patients. Out of these, we randomly sampled 1000 copies, stratified by year. The applications were already pseudonymised because this is required by law, but we additionally blacked out all identifying personal information about the therapist too. After that, we extracted the concepts used to work with the patient from the report texts.

2.2 | Definition of concepts

According to Luborsky and Barrett (2006), the fundamental concepts of analytic theory are as follows: the unconscious, drives, defences, object relations and the Oedipus complex. Based on that, we documented for each report whether one of the following concepts or words were used at least once: unconscious/preconscious, oral/anal/genital/oedipal/phallic, drives, libido/libidinous/libidinal, cathexis, emotional investment, regression/regressed, super-ego, object/object relations and representation. We had come up with this list of concepts based on our knowledge from teaching psychotherapy in Germany and after reading many reports, as well as intensive discussions among our group of researchers of whom three are fully trained psychoanalysts and one is a medical doctor. After a pilot test with 20 reports, we expanded this list to include the following: false self, holding, containing/contained, rêverie, alpha-function, beta-elements, psychic retreat, pathological organisation and attachment.

It was not always very clear whether a specific formal concept was in fact being used or named. This was especially true for 'psychic retreat', which has a German vernacular equivalent that refers to social withdrawal in general as opposed to the psychoanalytical concept (Steiner, 2011). Therefore, in all such cases, a further person fully trained in psychoanalysis (the first author) reviewed the reports a second time. The concept was then only coded as having been used if both researchers independently determined that to be the case.

2.3 | Information about the therapist

We used the application forms to determine whether the treating psychotherapist was a physician, a psychologist, or both, and what type of qualifications they had (AP, LP, cognitive behavioural therapy or a combination of these). We also coded their gender based on their surname before the forms were pseudonymised for further data extraction.

Based on the reports, we documented whether the therapist was still in training or already licensed. This fact is clearly evidenced in the reports as therapists in training are required to declare that they will be performing the planned therapy under supervision and their supervisors must undersign this statement.

2.4 | Information about the therapy

The forms also provided us the data on whether the planned therapy was AP or LP and whether it was individual or group psychotherapy. If it was described in the reports, the frequency of the planned sessions and the setting (couch or chair) was collected as well. The latter information is not required by the law.

2.5 | Data analysis

First, the concepts were assigned to specific theories: *drive theory* (oral, anal, genital, oedipal, phallic, drives, libido, libidinous, libidinal, cathexis and emotional investment), *object relations theory* (object, object relation and representation), *Winnicott's theory* (false self and holding), *Bion's and post-Bion's theory* (containing, contained, reverie, dreaming awareness, alpha-function, beta-elements, psychic retreat and pathological organisation) and *attachment theory* (attachment). This was done in such a way that each concept was absorbed into one single theory. Concepts that are used in different theories, such as super-ego, unconscious or regression, were not assigned to a specific theory. In carrying this out, we were clear about the fact that the theories explored represent different conceptual 'levels' (some broader and encompassing a wide range of different theorists and others narrower with more similar theoretical aspects) and that they are not truly mutually exclusive. However, our system reflects the way theories are usually ordered in German psychoanalytic training institutes and was therefore deemed to be a useful way of categorising the multiple concepts mentioned in the reports.

Potential differences between treatments or therapists in the use of theories and concepts were explored using chi-squared tests. Among the patients diagnosed with depression, we explored differences in the use of concepts based on the severity of the cases as classified in the ICD code (mild, moderate and severe).

Subsequently, we performed multivariate binary logistic regression analyses to identify the independent effects of the therapists' training (LP vs. AP) and the therapy setting (chair vs. couch) while simultaneously adjusting for gender. We deliberately did not put the type of therapy into the models because this is too strongly correlated with the therapists' training, resulting in multicollinearity, which in turn would create invalid effect estimates.

TABLE 1 Characteristics of the therapies for which reimbursement was requested ($n = 998$).

		Number	Percentage
Type of therapy	Low-frequency psychodynamic psychotherapy (LP)	759	76%
	High-frequency analytic psychotherapy (AP)	239	24%
Type of application	First-time application	628	63%
	Follow-up application	370	37%
Frequency	Less often than once a week	53	5%
	Once a week	696	70%
	1–2 times a week	23	2%
	Twice a week	95	10%
	2–3 times a week	57	6%
	3 times a week	46	5%
	3–4 times a week	1	0.1%
	Unknown/not reported	27	3%
Setting	Couch	45	5%
	Chair	780	78%
	Changing between couch and chair	5	1%
	Unknown/not reported	168	17%

All analyses were performed using the statistical software STATA version 15.1 (StataCorp, Texas).

3 | RESULTS

3.1 | Sample

Of the 1000 applications, two had no reports and were therefore excluded. The remaining 998 applications (Table 1) came from 983 different patients (Table 2). The reports within the applications ranged from one to six pages in length and were an average of three pages long. Altogether, they comprised more than 3000 pages of text.

The applications were for LP in 759 (76%) cases and for AP in 239 (24%) cases and had been submitted to the health insurance providers between the years 2003 and 2018. Of them, 37 (4%) were for group psychotherapy. The intended setting for the therapy was chair in 79% of the cases, couch in 4% and changing between the two in 0.5%. The remaining reports made no mention of the setting.

The patients ranged in age from 17 to 76 years ($M = 41$ years), and most of them were female (77%). More details on the patient sample can be found in Table 2.

The majority of the psychotherapists ($n = 891$, 91%) were trained in LP, 283 (29%) in AP and 178 of them (18%) had both qualifications. Slightly more than half of the therapists were psychologists ($n = 568$, 58%), 406 (41%) were medical doctors, and seven (0.7%) were both, and in two cases, the clinician's profession was not named in the applications. There were 656 (67%) female psychotherapists, 309 (32%) male, and in 18 cases (2%), the therapists' gender could not be ascertained. All 16 of Germany's federal states were represented, with the majority of applications coming from North Rhine-Westphalia ($n = 189$) and Berlin ($n = 151$), and the fewest from Mecklenburg-West Pomerania ($n = 4$) and Saarland ($n = 1$), numbers that are consistent with the population size of those states. A total of 36 reports (4%) came from therapists in training.

3.2 | Frequency of theories used

The most frequently used theory was *object relations theory*, with 59% of all reports using it as the working model in the case described. The second-most frequently used was *drive theory* (34%), followed by *attachment theory* (17%). The concepts developed by *Bion and post-Bionian theorists* as well as *Winnicott* appeared only rarely (5% and 3%, respectively). The more overarching concepts of the *unconscious*, the *super-ego* and *regression* were mentioned in 14%, 21% and 34% of the reports, respectively. The following concepts did not appear in any of the reports: reverie, alpha-function, beta-elements and pathological organisation.

On average, the therapists used 1.9 theories ($SD = 1.4$, $Mdn = 2$), and the maximum number of theories named in a single report was 7. A total of 163 reports (16%) made no mention of any of the concepts under investigation.

On average, therapists in training used the same number of theories as the licensed therapists ($Mdn = 2$, range 0–4).

3.3 | Differences in usage of certain theories

3.3.1 | By type of therapy

Reports for regular high-frequency AP named nearly all of the investigated theories more often as a working model than reports for modified AP did, and the latter mentioned theories more often than

TABLE 2 Patient characteristics ($n = 983$).

		Number	Percentage
Gender	Male	222	23%
	Female	759	77%
	Unknown/not reported	2	0.2%
Age	<20 years	4	0.4%
	20–29	178	18%
	30–39	258	26%
	40–49	303	31%
	50–59	200	20%
	60–69	32	3%
	70–79	8	1%
School education	College	386	39%
	Post-compulsory	211	21%
	Compulsory or below	104	11%
	Unknown/not reported	282	29%
Vocational training	None (yet)	80	8%
	Apprenticeship	469	48%
	Advanced vocational	24	2%
	University or higher vocational education	272	28%
	Unknown/not reported	138	14%
Employment	Full-time or at least half-time	474	48%
	Less than half-time	40	4%
	Homemaker	37	4%
	In training	97	10%
	Unemployed	114	12%
	Early retirement	51	5%
	Age pension	15	2%
	Unknown/not reported	155	16%
Partner	Without partner	303	31%
	Stable partner	548	56%
	Changing partners	70	7%
	Unknown/not reported	62	6%
F0	Organic, including symptomatic, mental disorders	0	0%
F1	Mental and behavioural disorders due to psychoactive substance use	30	3%
F2	Schizophrenia, schizotypal and delusional disorders	12	1%
F3	Mood [affective] disorders	641	64%
F4	Neurotic, stress-related and somatoform disorders	536	54%
F5	Behavioural syndromes associated with physiological disturbances and physical factors	87	9%
F6	Disorders of adult personality and behaviour	172	17%
F7	Mental retardation	2	0.2%
F8	Disorders of psychological development	2	0.2%
F9	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	7	1%

LP (Table 3). An exception to this pattern was *attachment theory*, which was used with nearly equal frequency in LP and modified AP, but less frequently in regular AP (Figure 1).

The concept of the *unconscious* was used with nearly equal frequency in all three types of therapy. *Regression* was used more often in modified AP than in regular AP and LP.

TABLE 3 Frequency of certain theories or concepts used, by type of therapy, therapist's training and setting of the sessions.

	Total		Type of therapy				Training of therapist			Setting		
	N	%	LP, 1x/w or less	AP, <3x/w	AP, ≥3x/w	*p*	LP only	AP ± LP	*p*	Couch	Chair	*p*
Total number	998		759	192	47		707	291		40	791	
Drive theory	344	34%	29%	53%	53%	<.001	28%	51%	<.001	63%	29%	<.001
Object relations theory	589	59%	55%	69%	77%	<.001	55%	69%	<.001	71%	56%	.073
Winnicott	31	3%	2%	6%	9%	.001	2%	6%	.007	9%	2%	.012
Bion/Post-Bion	54	5%	4%	9%	15%	<.001	4%	9%	.001	9%	4%	.253
Attachment theory	174	17%	17%	22%	6%	.024	17%	19%	.486	17%	17%	.976
Unconscious	141	14%	13%	16%	21%	.188	13%	16%	.176	29%	13%	.012
Regression	336	34%	31%	44%	36%	.004	31%	42%	.001	57%	32%	.002
Super-ego	205	21%	19%	21%	40%	.002	20%	23%	.260	26%	19%	.366

Abbreviations: *N*, number; %, percentage; LP, low-frequency psychodynamic psychotherapy; AP, analytic psychotherapy; w, week; *p*, *p*-value based on chi-squared tests.

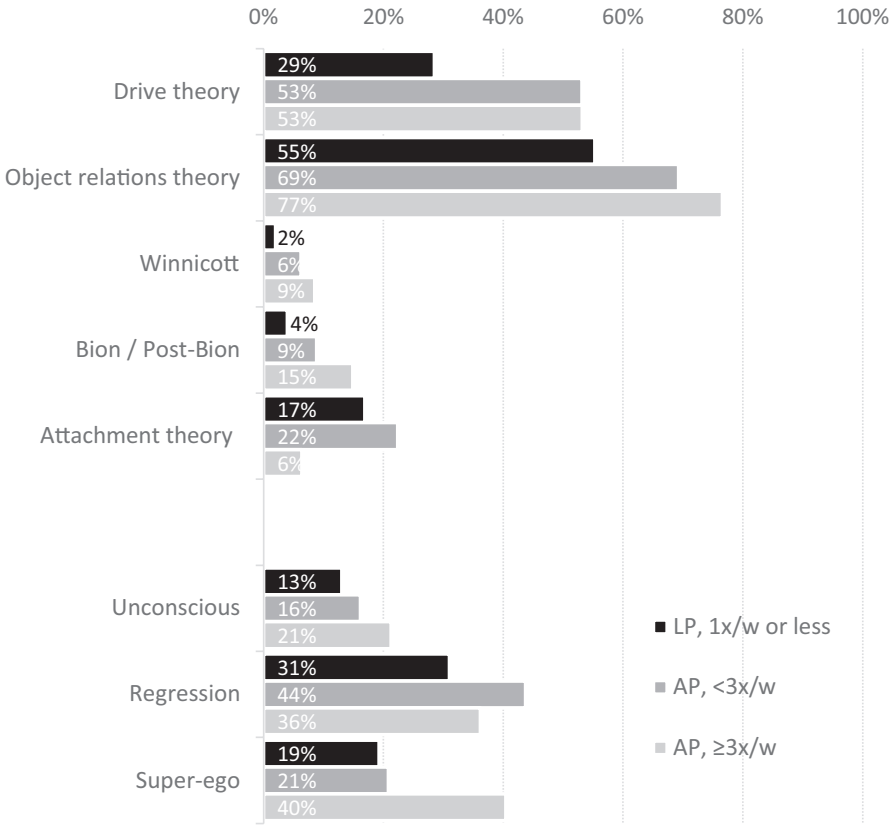

FIGURE 1 Proportion of psychotherapy reports using certain theories and concepts, by therapy type. AP, analytic psychotherapy; LP, low-frequency psychodynamic psychotherapy; w, week.

3.3.2 | By setting (couch vs. chair)

The concept of *regression* was used more often when patients conducted their sessions lying down (57% vs. 32% when seated). When looking simultaneously at the factors *setting* and *therapists' training* (Table 4), the odds for mentioning regression in the reports were 1.7 higher for the couch setting, though the data are also compatible with the assumption that this was due to chance.

3.3.3 | By therapists' training

Therapists trained in AP used *drive theory* (51% vs. 28%, adjusted odds ratio [OR_{adj}] 1.9, $p < .001$), *object relations theory* (69% vs. 55%, OR_{adj} 1.5, $p < .07$), *Bion's theory* (9% vs. 4%, OR_{adj} 2.4, $p = .03$) and *regression* (42% vs. 31%, OR_{adj} 1.7, $p = .02$) more often than those trained in LP (Table 3). The concepts based on *Winnicott* were used a bit more often by AP than by LP therapists (6% vs. 2%),

TABLE 4 Likelihood of using a certain theory or concept based on the therapist's training and the setting of the sessions.

	Training AP vs. LP			Setting couch vs. chair		
	OR	95% CI	*p-value*	OR	95% CI	*p-value*
Drive theory	1.9	(1.2–3.0)	*<.001*	1.9	(0.9–4.1)	*.08*
Object relations theory	1.5	(1.0–2.4)	*.07*	1.7	(0.7–3.8)	*.22*
Winnicott	0.8	(0.2–3.6)	*.75*	4.2	(0.7–26.9)	*.13*
Bion / Post-Bion	2.4	(1.1–5.5)	*.03*	1.7	(0.6–5.2)	*.35*
Attachment theory	1.3	(0.8–2.2)	*.34*	1.3	(0.5–3.0)	*.61*
Unconscious	1.2	(0.6–2.2)	*.61*	1.9	(0.8–4.8)	*.16*
Regression	1.7	(1.1–2.6)	*.02*	1.7	(0.8–3.5)	*.18*
Super-ego	1.0	(0.6–1.7)	*.94*	1.5	(0.6–3.5)	*.36*

Note: Multivariate logistic regression analyses.

Abbreviations: AP, analytic psychotherapy; CI, confidence interval; LP, low-frequency psychodynamic psychotherapy; OR, odds ratio, mutually adjusted for the other variables in the model; *p*, *p*-value based on Wald tests.

but the multivariate analysis shows that this effect was largely due to confounding effects of setting and gender. That means, when we looked at the therapists' training and gender while simultaneously also taking the therapy setting into account in the statistical analysis, there was no evidence that the use of Winnicott's theory differed by training type. This difference between the univariate and the multivariate analysis is due to the fact that both the therapists' training and the theory usage differed by gender: while 40% of the male therapists were trained in AP, only 27% of the women were; and 5% of the men versus 2% of the women used Winnicott's theory.

There was also no evidence for differences in AP versus LP in usage of *attachment theory*, the *super-ego* and the *unconscious*.

3.3.4 | By severity of depression

Among the patients with a depression diagnosis, 63 had mild depression, 352 were coded as moderate and 54 as severe. The remaining were in remission ($n = 1$), other ($n = 2$) or unspecified ($n = 178$).

We found no evidence for differences in usage of theories between the three severity groups. The only potential difference was for Bion's theory, which was used less frequently in patients with mild depression (3%) than in those with moderate or severe depression (both 7%), though this difference could also be due to chance ($p = .49$).

4 | DISCUSSION

With this study, we wanted to find out what theories and concepts are used by psychodynamic psychotherapists in real life. In contrast to what is often assumed (Peskin, 1997), drive theory has not died out—it was used in about a third of all the cases we investigated, 'topped' only by object relations theory, which was used in more than half of all reports. By contrast, Bion's and Winnicott's theories are only very rarely applied, a finding that surprised us as these are commonly taught theories in psychoanalytic training and supervision (Fritsch & Winer, 2020; Spurling, 2003) and are frequently used in research and clinical settings (Ehrensaft, 2023; Ehrlich, 2021; Kriss, 2016; Yudilevich & BenEliahu, 2022). A study based on published psychoanalytic case reports from the Single Case Archive (Meganck et al., 2022) also found that object relations theory and Freudian psychoanalysis were most often used for case conceptualisation (Willemsen et al., 2015). However, Winnicottian ideas were used in 23% of their cases, whereas we identified them in only 3% overall. One explanation for this striking difference is that all therapies in the Willemsen study were AP, 44% of which even had a frequency of 4 or more sessions per week, whereas we also included LP cases and we found that Winnicottian ideas were used significantly more often in AP than in LP. Another explanation is the different methods that were used—while we relied on the written reports, they approached the original authors and asked them to explicitly state which theories they felt attached to when writing the case study.

Another noteworthy finding of our study is that the concept (or at least words related to this concept) of the unconscious was used in only 14% of the reports, meaning that it did not appear in the other 86%. This is a high percentage given that this concept is often seen as the common ground for psychoanalytic approaches (Smith, 2003) and as a basic concept in psychodynamic curricula and treatment (Fritsch & Winer, 2020; Park & Auchincloss, 2006; Wilson, 2019). As the clinician's theoretical orientation has a clear impact on diagnostic and therapeutic procedures (Gordon et al., 2016), one must wonder whether unconscious processes are, in part, neglected by a substantial number of psychodynamic therapists, both with AP and LP training. It is, of course, also possible that the concept is in fact used more often than is explicitly mentioned in the reports, though we can only speculate on the matter. It is conceivable that clinicians only report using concepts they believe are necessary to describe cases concretely in order to

get reimbursed. At the same time, because psychodynamic therapy and psychoanalysis use the concept of the unconscious as a basic principle, it is possible therapists consider it self-evident and thus not worth mentioning. Whether or not this is true is impossible to know, but it is a plausible assumption. Similarly, a therapist mentioning a certain concept or theory in their paperwork does not necessarily mean that they apply it in their daily clinical practice. However, the chances of it actually getting used do seem higher if it is at least mentioned in the report.

We also found that about 16% of all conceptualisations for treatments for which reimbursement was being sought did not include any (or none of the major) theories. This is in line with the assumptions of some (Bohleber, 2007b) that clinical work sometimes uses few or no theories, and if they are used, they are often amalgamated with more implicit private theories (Bohleber, 2007a). This finding could also represent a tendency among some clinicians to devalue theories, both in teaching candidates and in their own clinical practice (Storck, 2022; Target, 2003). It may also be a sign that they feel confused and overwhelmed by the different usages of concepts (Lhulier, 2005) and consequently avoid theory-based approaches in general. This stands in contrast with the published literature about analytic psychotherapy in which theories play an important role, unlike in other schools of thought (Collard, 2019; Singer, 2023).

However, these interpretations must be handled with care as we did not investigate every single concept that exists in the literature, a decision that was influenced both by the need to restrict the search to clearly identifiable words that cannot be confused with daily language, and by resource limitations. For example, we did not extract the following concepts: projective identification, paranoid-schizoid or depressive position, pleasure and reality principle, castration, Lacanian concepts, inferiority complex, attacks on linking, core-self, introjection, self-object, transitional object or good enough mother. Moreover, we did not use information about defence mechanisms to classify a certain theory though this would have been an interesting possibility (Perry & Cooper, 1989). Our choice not to do so was informed by the fact that in many cases, the therapists simply listed the defence processes as a number of terms instead of describing them. Furthermore, in order to be able to use them for the classification of theories, we would have had to conduct extensive in-depth qualitative work, which was only possible to do for a small fraction of the reports (Maier, Blanck, et al., 2023; Sievers & Singer, 2021; Singer, Blanck, et al., 2022; Singer et al., 2021).

Another limitation is that we identified the theories used based on the words that appeared in the paperwork. This could potentially be misleading as some therapists may use the theories while employing idiosyncratic vocabulary for them, or alternately, use the jargon without really relying on the theory. At the same time, one must assume that they chose the language they used to communicate with another psychotherapist, the reviewer, about their patients deliberately, and, as such, there must be at least some truth in it. Readers should also keep in mind that most of the reports were coded by a single person; hence, we cannot quantify the chance of erroneous coding or calculate any inter-rater concordance.

Another aim of this study was to compare differences in usage of theories and concepts between different types of therapy and therapist training. We found that, overall, therapists trained in analytic therapy mention more theories in their reports than therapists trained in low-frequency psychodynamic therapy. One of the explanations for this fact could be that, in Germany, only analysts with AP training are eligible for insurers' approval to offer the more expensive, high-frequency, long-term analytic psychotherapy, and, as such, they thought they had to offer more 'justification' as to why such a treatment is necessary. Another possible explanation is that because AP therapists have received more extensive theoretical training, they are consequently more likely to apply those theories in their work. However, both explanations are speculative as we have no further data to support this finding. It is simply in line with the observation that theories also create identity (Bohleber, 2007a).

The use of theories and the impact on therapeutic technique has also changed over time (Bohleber, 2007b). Whereas the focus was initially on intra-psychic processes, inter-subjective ones are now considered to be more relevant. We could, however, not investigate this change because the timespan for which reports were available was too short for this. Nevertheless, it has been argued that not all new theories are actually all that new after all (McWilliams, 2022).

There are a few more limitations that we would like to mention. First, the reports all concerned adults seeking psychotherapy; thus, no information about conceptualisations for child or adolescent psychotherapies was available. It is possible that some theories, for example Winnicott's, are used more often in child psychotherapy.

Second, because of the anonymisation, we do not know whether all of the reports came from different therapists. It is possible that some individuals appear twice or even more often in the sample. Their working models may or may not differ from patient to patient.

Due to the fact that the reports were written before the patients underwent the planned psychotherapy, we also have no information about the outcome of the treatment. Therefore, it was not possible to explore how the use of different theories and concepts might affect the results of a therapy or psychoanalysis.

Another limitation is that we have no clear indication as to how severely the patients were limited in their functioning. It is possible that psychotherapists adjust their theoretical considerations to the severity of psychopathology. We found that Bion's theory was used about twice as often in patients with moderate or severe depression compared to those with milder cases. We cannot be sure that this was not due to chance but the result would be in line with the fact that Bion used to work with more severely disturbed people. While our data clearly do not allow for drawing further conclusions on this, they do underline that it would be worth doing further research regarding this question.

Finally, one has to keep in mind that the reports were written for a certain purpose, namely, to seek reimbursement for psychotherapeutic treatments. In doing so, therapists are legally required to describe the hypothesised psychodynamic origins of their patients'

current problems and their working model for the intended treatments. It is not very likely that the therapists 'hid' the use of a certain theory in order to influence reviewers, as it is unusual for them to know who they are addressing and thus be in a position to tailor their requests to a specific person's (assumed) theoretical preferences. It is possible though that they described the use of a certain concept for the sole purpose of securing reimbursement, even if they do not actually apply it in their clinical work with that patient (Maier, Engesser, et al., 2023). As such, the reports (being requests for service reimbursement approval) represent only proxies of a case formulation.

A strength of this study is that we used real-life data sets rather than artificially produced ones, resulting in a high probability of clinical validity. The data are from 'field clinicians' who usually do not present at conferences or publish papers. The reports represent what they indeed do in daily life. It is highly unlikely that the results are distorted by selection or information biases.

In view of these strengths and limitations, we conclude that case conceptualisations in daily psychodynamic therapies with adult patients in Germany nowadays most frequently use object relations theory and drive theory, whereas concepts by Bion and Winnicott are rarely explicitly mentioned. On average, therapists trained in analytic psychotherapy use more theories for their case conceptualisations than those with low-frequency psychodynamic psychotherapy training.

The practical implication of our results for clinicians is that they be encouraged to reflect on their own use of theories and concepts in case conceptualisations, as well as how they describe and justify the approach they intend on taking. For teaching institutes, it may be an encouragement to broaden the scope of the theories they teach and to help candidates apply different theories or concepts to a case. This means that institutes need to find lecturers with both a broad and in-depth understanding of various psychodynamic theories. Although this can be challenging, especially for smaller institutes, our results show that it is well worth the effort. The use of certain didactic methods, for example the use of standardised vignettes and their analysis using the 'operators model' (Polipo, Willemsen, & Kallai, 2024), has been shown to improve case conceptualisation skills in students (Polipo, Willemsen, Hustinx, & Bazan, 2024) and should be applied more often.

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CONFLICT OF INTEREST STATEMENT

The authors have no relevant financial or non-financial interests to disclose.

DATA AVAILABILITY STATEMENT

The quantitative data that support the findings of this study are available from the corresponding author upon reasonable request in an aggregated form. The qualitative data are not publicly available to protect the privacy of the patients.

ETHICAL STATEMENT

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2000. Approval was obtained from the responsible ethics board of the state of Rhineland-Palatinate (# 2018–13321).

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