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The Plan Formulation Method for Couples

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This article proposes an adaptation to couple therapy of the Plan Formulation Method, an empirically validated and clinically useful assessment procedure for planning case-specific psychotherapy interventions. According to Control-Mastery Theory (CMT), individuals who seek psychotherapy have an unconscious plan, which comprises goals, obstructions, tests, traumas, and insights. The Plan Formulation Method was developed to reliably formulate individual psychotherapy cases. To apply this method to couples therapy, we have added two components: dysfunctional relationship patterns (vicious relational circles) and resources (virtuous relational circles). Each component will be explained with the help of a clinical case. We discuss the implication of the use of the Plan Formulation Method for couples and compare some of the tenets of CMT applied to couples with the main approaches to couple therapy.

Keywords: control-mastery theory, couple therapy, couple's plan, plan formulation method for couples

A recent survey (Norcross, Pfund, & Prochaska, 2013) of psychotherapists indicated that couple therapy is a therapeutic format that will likely reach maximum growth in the coming decades, surpassing individual, family, and group therapy (Gurman, Lebow, & Snyder, 2015). Several research studies attest to the efficacy of couple therapy (e.g., Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003; Snyder, Castellani, & Whisman, 2006; Snyder & Halford, 2012; Sprenkle, 2003) and show that this efficacy does not depend on the therapist's theoretical orientation (e.g., Davidson & Horvath, 1997; Gurman & Fraenkel, 2002; Pinsof & Wynne, 1995; Snyder et al., 2012; Wesley & Waring, 1996).

Despite the substantial equivalence of the efficacy of the main approaches to couple therapy, we think it useful to introduce an innovative model to the landscape of couple therapy: Control-

Mastery Theory (CMT; Gazzillo, 2016; Weiss, 1986, 1993), an integrative, cognitive-dynamic relational theory developed by Joseph Weiss (1986, 1993) and empirically validated by the San Francisco Psychotherapy Research Group over the last 40 years. Given its integrative nature, CMT could help to overcome the theoretical and clinical fragmentation of the field of couple therapy, promoting a model that integrates aspects of different approaches. Moreover, CMT has generated a corpus of empirical research studies that support its therapeutic indications (e.g., Bloomberg-Fretter, 2005; Fretter, 1995; Gassner, Sampson, Weiss, & Brumer, 1982; Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Silberschatz, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Fretter, & Curtis, 1986; Silberschatz, Sampson, & Weiss, 1986; Weiss et al., 1986). However, the only applications of CMT to couple therapy are those of Dennis Zeitlin (1991), who has discussed the application of CMT to couple dynamics, and those of Steven Foreman (1996), who wrote a clinical paper on couple treatment based on CMT. However, these papers do not provide a tool for the clinical assessment of couples or for guiding interventions with couples.

The aim of this paper is to fill this gap by adapting the Plan Formulation Method (PFM; Curtis & Silberschatz, 1991, 2005; Curtis, Silberschatz, Sampson, & Weiss, 1994) to couple therapy. The PFM was developed to reliably formulate individual psychotherapy cases and has been applied to children (Foreman, 1989; Foreman, Gibbins, Grienberger, & Berry, 2000; Gibbins, 1989), adolescents, and adults of all ages, including geriatric cases (Curtis & Silberschatz, 1991), and to families (Bigalke, 2004) but never to couples.

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CMT: A Brief Introduction

CMT assumes that the human mind is driven by an imperative to adapt (Sampson, 1990; Weiss, 1986, 1990), and that a key to adaptation is the construction of reliable relationships with relevant others and of a reliable set of beliefs about reality and morality.

Weiss (1986, 1993) suggested that psychopathology stems from pathogenic beliefs developed in response to two kinds of traumatic developmental experiences: shock trauma (discrete catastrophic events such as a severe illness or death of a family member) and stress trauma (recurrent and persistent traumatic experiences from which the child cannot escape and that may lead to the renunciation of crucial developmental goals). Pathogenic beliefs, which usually are implicit/unconscious, are extremely frightening and constricting because they suggest that the pursuit of healthy, pleasurable goals is dangerous. These beliefs are associated with manifestations of compliance, rebellion, identification, and counteridentification with traumatic others' behaviors, attitudes, and communications. *Pathogenic schemas* are complex structures that comprise pathogenic beliefs and the related affects and strategies associated with them.

CMT proposes human beings share innate prosocial attitudes that, together with specific features of childhood thinking, may shape the pathogenic beliefs developed during childhood. These pathogenic beliefs may transform guilt, which is normally an adaptive moral emotion (Davidov, Zahn, Waxler, Roth-Hanania, & Knafo, 2013; Zahn-Waxler & Radke-Yarrow, 1990) into a pathogenic factor. CMT identifies five interpersonal types of guilt (Gazzillo, Fimiani et al., 2019; O'Connor, Berry, Weiss, Bush, & Sampson, 1997): *Survivor guilt* refers to a painful emotion that people may experience when they are surpassing important others, believing that they are hurting them by being more successful, happy, fortunate. *Separation/disloyalty guilt* stems from the fear of harming others by becoming independent and separate, having different values, or supporting different political or religious ideas. *Omnipotent responsibility guilt* involves an exaggerated sense of responsibility and concern for the happiness and well-being of other people and the fear of being selfish if one is not caring toward other people. *Burdening guilt* is based on the pathogenic belief that expressing own needs means burdening other people. *Self-hate* describes the feeling of being inherently wrong, bad, inadequate, and undeserving of protection, love and happiness.

In psychotherapy, patients attempt to disconfirm their pathogenic beliefs because they are constricting, painful, and hinder the achievement of healthy goals (Silberschatz, 1986, 2008; Silberschatz, Fretter, & Curtis, 1986; Weiss, 1986, 1993). These attempts often involve *tests*, actions initiated by the patient intended to disconfirm pathogenic beliefs. CMT identifies two kinds of tests (Gazzillo, 2016; Gazzillo, Genova, et al., 2019; Silberschatz, 2005; Silberschatz, Sampson, & Weiss, 1986, 1993; Weiss, 1986, 1993): *transference tests*, by which the patient attempts to assess whether the therapist will traumatize him/her in the same ways he or she was previously traumatized in his or her family of origin; and *passive-into-active tests*, by which the patient tries (unconsciously) to traumatize the therapist the same way the patient has been traumatized earlier in life, to see if the therapist can deal with those traumas more effectively than the patient could, or tries to give to the therapist what he would have liked to receive during his

childhood, hoping that the therapist will benefit from this. Both transference and passive-into-active tests may be mediated by behaviors that show the *compliance* or the *noncompliance* of the patient with the pathogenic belief tested. For example, a patient who holds the pathogenic belief that if s/he express her/his needs, other people will feel burdened may test this belief in four different ways.

1. S/he may hide and conceal her/his need in therapy, hoping that the therapist will encourage her/him to ask for what s/he needs (transference test by compliance).
2. S/he may become extremely demanding, hoping that the therapist will legitimate her/his requests (transference test by noncompliance).
3. S/he may make the therapist feel guilty for any kind of request the therapist may make, hoping that the therapist will not be upset by this behavior and will not renounce to the satisfaction of her/his needs (passive-into-active test by compliance).
4. S/he may be very supportive toward therapist's needs hoping that the therapist will feel relieved and benefit from this behavior (passive-into-active test by noncompliance).

The way in which an individual will work in psychotherapy to disconfirm pathogenic beliefs, master traumas, and achieve goals is called the patient's *plan* (Curtis & Silberschatz, 1991; Curtis et al., 1994). The plan describes general areas on which the patient will consciously or unconsciously want to work and the way in which the patient is likely to carry out this work. The PFM is a procedure for formulating the patient's plan. It has been used by clinicians and researchers and has proven to be reliable, simple to learn, and applicable to different types of psychotherapies (Curtis et al., 1994). PFM has five components: patient goals, obstructions (pathogenic beliefs), traumas (stress and shock), tests, and insights.

Numerous research studies (e.g., Curtis & Silberschatz, 2007; Curtis et al., 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Foreman et al., 2000; Horowitz et al., 1975; Silberschatz, 1986, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Curtis, & Nathans, 1989) have shown that when the therapist's behavior, communications, and interpretations support the patient's plan (are *proplan*), the patient improves and the therapy progresses.

CMT and Couples Therapy

CMT, applied to the understanding of couple dynamics, claims that there is a circular causality between each partner's beliefs, emotional experiences, and behaviors and the overall organization of the couple and family system. Dennis Zeitlin (1991), for example, has shown how intimate relationships, by virtue of their stability and the emotional involvement that they imply, represent an ideal context for each member of the couple to attempt to disconfirm his or her pathogenic beliefs by testing the partner in everyday life and in the therapeutic process. In a couple's relationship, a partner can pass the other's tests in two ways: In a transference test, the partner can give different responses/have a different attitude from that of the traumatic caregivers and so

provide a corrective emotional experience. In a passive-into-active test, the partner can give different responses/have a different attitude from that displayed by the other partner during infancy in the relationship with their traumatic caregivers, thus providing an alternative and more functional model to react to those adverse experiences. These tests are considered “passed” if the partner responds in a manner that disconfirms the other’s pathogenic belief; they are “failed” if one partner’s response confirms the other partner’s pathogenic belief. When this occurs, the partners experience, in their current intimate relationship, the same painful dynamics that have characterized the relationships with their caregivers. The resulting negative emotions can trigger dysfunctional relationship dynamics that may encourage the partners to request couple therapy.

We hypothesize that couple impasses are often generated and fuelled by partners’ failing their reciprocal tests. We define *vicious relational circles*¹ as the rigid and repetitive maladaptive patterns derived from this reciprocal failure to pass partners’ tests, confirming their pathogenic beliefs, increasing individual suffering and decreasing dyadic satisfaction.

In addition, each couple has resources that have supported continuity of the relationship over time. We propose that within any intimate relationship there exists a second class of circular dynamics, that are functional and adaptive, namely virtuous relational circles that reflect a sense of safety that develops as a result of the partners’ reciprocally passing each other’s tests and disconfirming pathogenic beliefs.

Finally, in line with CMT assumptions, we believe that couples seek psychotherapy in order to improve their relational and individual well-being and that they enter therapy with an unconscious plan, that comprises goals, pathogenic beliefs, traumas, vicious, and virtuous relational circles and insights. The first step, for a therapist working with a couple, is to develop an adequate formulation of this plan to have a map that can guide the treatment. In this article, we will describe how to develop such a formulation.

The PFM for Couples

A therapist, to gather all the information necessary for the formulation of the couple’s plan, must meet each partner both in a joint and in an individual setting.

One or two dyadic sessions may allow the therapist to observe the partners as a couple, their interactions and their emotional reactions, and to investigate the couple’s history and the reasons the couple have sought treatment.

One or two individual sessions may allow the therapist to collect the history of each partner within the family of origin, the relationships within that family, and the possible traumatic events of her/his earlier years. This will serve as a basis for formulating the plan of each partner, necessary for the drafting of the couple’s plan after having met the partners together for one or two sessions.

In the last step, the therapist meets the partners in a joint session and presents a specific formulation of their issues and a plan for treatment.

We will briefly describe the components of the couple’s plan and then illustrate each of them with the help of a clinical case. The therapist first identifies the couple’s goal(s); then s/he infers the obstructions that have prevented their achievement and identifies the traumas that have created these obstructions. The therapist can

also identify the couple’s vicious and virtuous relational circles. Finally, he identifies the insights that the couple may need to obtain.

For brevity, in the example of the couple’s plan that follows we identify only the couple’s main goal, the obstructions that hinder it, the traumas from which these obstructions derive, the vicious relational circle that originated from them, the virtuous relational circles of the couple and the insights related to all these elements. However, the reader should keep in mind that each section of the couple’s plan is generally more complex because typically a couple has more than one goal and these goals may also be hindered by multiple obstructions originating from different traumas. This is also true for the vicious and virtuous relational circles and for the insights.

Goals

The goals that the couple wants to achieve must be healthy, enjoyable, achievable, and must take into account the needs of both partners. Such goals, which may be conscious or unconscious, concrete or abstract, and short- or long-term, must be the couple’s goals. However, it is possible that the partners do not share some important goals; in this case, unique goals should be created that take into account the positions of both partners.

Luca and Eleonora have been married for about 20 years and have two children. They sought couple therapy because of continuous family conflicts that have created opposing “teams”: the children allied with the mother versus the father who was excluded from everything that relates to their lives. The partners were not able to cooperate as parents: Eleonora was the “Lady Yes,” because she tended to satisfy all the requests, wishes, and needs of their children; and Luca was the “Mister No”, who opposed any proposal presented to him by Eleonora and their children, blocking every project and giving rise to very intense family conflicts. After two couple sessions and one session with each partner, we hypothesized that the main couple’s goal was to improve their coparenting relationship.

Obstructions

These include the pathogenic beliefs of individual partners which, when combined with those of the other partner, give rise to the vicious relational circles that prevent the couple from reaching its goal(s). Although each partner typically has multiple pathogenic beliefs, only the obstructions that feed the dyadic dysfunctional dynamics are considered, excluding from the couple’s plan those that characterize exclusively the individual functioning of each partner.

Luca had the tendency to remain on the side in important relationships and to worry about others. In the relationship with Eleonora and with their children, however, Luca imposed himself and asserted his position without considering their wishes and needs. We hypothesized that these behaviors, only apparently incompatible, were supported by the same pathogenic belief: Luca believed that he burdened others if he

¹ The concept of “vicious relational cycles” is similar to the concept of “cyclical psychodynamics” proposed by Wachtel (1977). The main difference between these two concepts is that vicious relational cycles, according to CMT, serve an adaptive purpose (i.e., disproving the reciprocal pathogenic beliefs, rather than merely being a repetition of dysfunctional relationships).

communicated his needs, ideas and wishes; and he believed that if he did not take care of the people he loves, these people would be deeply hurt. Because of these beliefs, Luca experienced burdening and omnipotent responsibility guilt. Generally, Luca complied with these beliefs, but in his relationship with Eleonora and their children he tended to noncomply with them.

Eleonora was a good woman, smart and pleased with her work. However, it emerged that she did not recognize her merits and value, tending instead to diminish and underestimate herself. Moreover, she was very sensitive with their sons and tried to do everything she could to be a good mother. We hypothesized that these behaviors derived from the fact that Eleonora believed that she was not worthy of being loved and did not deserve affection and attention. Consequently, she suffered from self-hate, and her attitudes and behaviors toward her children represented her efforts to disconfirm these beliefs by noncompliance with it: she tried to be a very good mother.

Individual and Couple's Traumas

We identify the individual traumas that each member of the couple has experienced and then identify those joint traumatic events that the partners have experienced in the history of their relationship that have fed their vicious relational circles, that is, the couple's traumas.

From a very early age, Luca put aside his needs to take care of his sick father, his depressed sister, his nephews and his mother. He grew up burdened by the duty of managing the problems of the whole family. These experiences led Luca to perceive his own wishes and needs as a burden for others and to believe that he had to take care of loved ones first, before himself.

Eleonora grew up with a dictatorial and sexist father who showed a critical and devaluing attitude toward her. In her family there was no affection and no sharing of ideas, wishes or concerns. The parents inflicted emotional abuses on Eleonora. This experience led Eleonora to believe that she was not worthy of being loved and that she did not deserve affection and attention.

Couple's trauma: their eldest daughter manifested an anxiety disorder, which greatly alarmed the parents. Eleonora experienced the presence of this disorder as "evidence" of her inability to be a good mother, fueling her self-hate. Luca interpreted his daughter's disorder as confirmation of the belief that he must take care of others unconditionally in order not to hurt them severely.

Vicious Relational Circles

Starting from the obstructions identified for each partner, it is possible to delineate the vicious relational circles that are the basis of the couple's problems and that arise from the mutual failures of the partners to disconfirm their reciprocal pathogenic beliefs. To identify the couple's dysfunctional dynamics the therapist uses his observations of the couple's relational dynamics and the history of the partners and the couple that emerge from the joint and individual sessions. This is the first main difference between the PFM for individuals and the Plan Formulation Method for Couple (PFMC; Crisafulli, & Rodomonti, 2017): Although in PFM this section describes the tests connected to each of her/his pathogenic belief (obstruction) that the patient may propose to the therapists,

in the PFMC this section describes the particular couple's dysfunctional relational patterns that derive from the partners' failures to pass their reciprocal tests.

Eleonora displayed the same critical and devaluing attitude that her father had with her: she devalued Luca in his parental role and did not involve him in decisions about their children (passive-into-active test by compliance of the beliefs connected to her self-hate). Eleonora's unconscious hope was that Luca would not be troubled by her behavior and would defend his right to exercise the paternal role and his desire to be considered. However, Luca did not pass Eleonora's test because he relived the childhood experience of not being acknowledged by other people, which fueled his pathogenic belief of having to give up his wishes and ideas to take care of other people. Instead, Luca's response was to raise a wall of "no" between himself, Eleonora, and their children by imposing his opinion (transference test by noncompliance of the pathogenic belief connected to his omnipotent responsibility). Unconsciously, Luca's hope was that Eleonora would not be troubled by his behavior and that she would recognize his right to express ideas and needs. However, Eleonora did not pass Luca's test and reacted by excluding him even more from the choices relating to their sons while arguing with him. This way, Luca and Eleonora failed their reciprocal tests and nurtured their vicious relational cycle.

Virtuous Relational Cycles

This section includes resources that allow partners to mutually experience a sense of safety within their relationship. These resources may be thought of as the strengths of the couple, meaning the partners' ability to reciprocally disconfirm each other's pathogenic beliefs that have given rise to virtuous relational circles. We identify those attitudes and characteristics of a partner that allow the other partner to experience a more functional way of being in an intimate relationship and to provide a role model which is different from the childhood relational patterns at the origin of the pathogenic beliefs. This section represents the second main difference between PFMC and PFM; in PFM there is not section for describing the "strength" of the patient, whereas this PFMC section aims to point out the main resources that a couple can find in itself for dealing with the difficulties deriving from the reciprocally failed tests. In other words, in this section the therapist has to delineate the reasons why the partner keeps wanting to be a couple.

In the couple's history it emerged that Luca has always been very sensitive with Eleonora, ready to recognize her merits and values, to consider her a valid woman and a loving mother. Eleonora felt safe in this relationship because, thanks to Luca, she could disconfirm her pathogenic belief that she was not worthy of being loved and did not deserve affection.

For his part, Luca could feel relieved of his omnipotent responsibility and his pathogenic belief that he must take care of others before himself because he felt that Eleonora was a smart and independent woman.

Insights

The last part of the couple's plan comprises the insights that may be useful for the partners to improve and achieve their goals. The therapist conveys these insights by identifying the couple's healthy goals, the obstructions that hinder their achievement, and the traumas that have given rise to those obstacles.

To improve the coparenting relationship, Eleonora had to understand that her tendency to devalue Luca in his father's role and to rule him out of the decisions relating to their sons derived from her family model where authoritarian figures mortified others.

To improve the coparenting relationship, Luca had to understand that his rigid "no" to Eleonora's decisions about their children were attempts to avoid repetition of childhood experiences of his own wishes and rights not being considered in and of having to always think first of the needs of others and then of his own

Both Eleonora and Luca needed to appreciate that their partner's behaviors were a consequence of traumatic childhood experiences.

Implications for the Use of PFMC

The formulation of the couple's plan is useful both in the assessment phase, where in few sessions it is possible to understand the heart of the couple's dysfunctional dynamics, and during the therapeutic process, where it guides the clinician to work with the couple's goals and needs and to monitor the therapeutic process and its evolution. The couple's plan enables the clinician to "foresee" what the couple can bring to therapy and to anticipate what functional and dysfunctional relational dynamics are likely to emerge in session with the partner and the therapist. Likewise, a good couple's plan formulation allows the clinician or researcher to understand, based on partner responses and behaviors, whether the therapy is going in the right direction and whether the individual and the couple are benefiting from that psychotherapeutic path and, if not, change the focus of the therapy or the therapist's attitude, adapting it to the specific needs of the couple.

For example, at the beginning of one session Eleonora was furious because Luca had not yet given his agreement for their son to participate in a sailing course during the summer, and the deadline for submitting that request was the following day. In the session, Luca confirmed that he did not want his son to take the sailing course, and Eleonora violently accused him of not being a good father and not wanting the best for their son. Luca, however, had not been involved in the choice of the sailing course, and had received his wife's request for his approval in the form of an application completed by Eleonora with only his signature missing. The therapist, following the couple's plan, interpreted Eleonora's behaviors as a passive-into-active test by compliance (she was devaluing Luca as she had been devaluated by her parents), and Luca's behavior as a transference test by noncompliance of his omnipotent responsibility (i.e., he was trying to assert his own ideas and opinions without worrying excessively about his wife and children). Following this hypothesis, the therapist stayed calm and was not upset by Eleonora's attacks. Moreover, she interpreted Luca's "no" as an attempt to assert his own ideas and opinions, stressing how this behavior had a self-punishing component because it distanced both Eleonora and their children from him. After these interventions, Eleonora calmed down, and the following day Luca signed the request for their son.

A therapist who did not know this couple's plan might have attempted to address Luca's stubborn attitude by focusing his or her interventions on the rights of their children to have their wishes supported by both parents and might have tried to stop Eleonora's attacks. In this way, however, the therapist would have failed both partners' tests by being upset by Eleonora's attacks and by im-

plicitly denying Luca's right to express his ideas and have them respected.

PFMC approaches each couple in a case-specific way, considering the couple's specific goals, needs, and vicious and virtuous relational circles. For this reason, it is possible to use this map both in therapies with marital couples and in working with parental couples, regardless of the request that the couple presents to the therapist. Working in a case-specific way allows the clinician to help patients not only weaken their dysfunctional dyadic dynamics, but also to improve wider family relationships, making available to the individuals more functional patterns of interaction and relationships, thus contributing to the achievement of greater individual, couple and family well-being.

Through the formulation of the couple's plan, the therapist can also plan the interventions that will disconfirm the pathogenic beliefs of partners and break the vicious relational circles of the couple and strengthen the virtuous relational circles of the couple.

CMT in Dialogue With Other Approaches to Couple Therapy

The application of CMT to couple therapy shares several elements with other empirically validated approaches to couple therapy (Gurman et al., 2015). For example, the idea of CMT that it is necessary to make conscious and to break the rigid and repetitive dysfunctional patterns at the base of the couple's suffering is shared by behavioral (Epstein & Baucom, 2002; Karney & Bradbury, 1995), insight-oriented (Snyder, Wills, & Grady-Fletcher, 1991), and integrative approaches (Follette, Naugle, & Linnerooth, 2000). Moreover, like insight-oriented (Snyder et al., 1991), psychodynamic (Siegel, 1992, 2004) and multigenerational approaches (Andolfi, 2002, 2015; Bowen, 1985; Framo, 1976), CMT stresses the importance of the reconstruction of the partners' individual histories and the creation of links between each partner's relational model and the current couple relationship. Furthermore, CMT, like insight-oriented and multigenerational approaches, recognizes that to appreciate the potential for the couple to have a more functional relationship, it is necessary to clarify how and why each partner originally expected that the other partner would be more affectively attuned than previous caregivers, but still ended up experiencing the couple relationship as a repetition of the old traumatic experiences with the caregivers (Andolfi, 1999; Snyder et al., 1991, 2012). Moreover, the application of CMT to couples shares with structural model (Minuchin, 1974) and with multigenerational approaches (Andolfi, 2002, 2015) the belief that within each couple there are individual and dyadic resources that the therapist should identify and strengthen. In both multigenerational approaches and in CMT, the dysfunctional relational patterns should be positively redefined (Andolfi, 2015) or understood in their adaptive values and modified. Finally, CMT, like insight-oriented approaches, uses interpretation as a therapeutic tool, but stresses that it is not always needed for the partners to make progress. In fact, the therapist can help the patients feel safer by passing tests by noninterpretative means. When patients feel safe, they can develop new insights (Gassner et al., 1982) and disprove their pathogenic beliefs on their own (Weiss, 1992).

The CMT approach to couples therapy differs from other models in the following ways: It proposes that people are motivated to

adapt to reality, can unconsciously control their conscious and unconscious mental functioning according to their sense of safety, can unconsciously execute higher mental functions, and are intrinsically motivated to master their traumas, solve their problems, and disconfirm their pathogenic beliefs by testing them in important relationships. The testing concept provides the therapist with the possibility of giving a different meaning to the partners' behaviors, allowing the therapist to understand the problems that lead a couple to seek psychotherapy as a consequence of reciprocal failures in passing partners' tests. Moreover, the concept of testing helps the therapist to choose the best attitude to take with a couple, to understand the answers that the partners hope to receive, and to make explicit the implicit requests that a partner might be presenting through a certain behavior. Above all, CMT provides therapists with a clinically useful tool to guide them both in the assessment phase and during the treatment: the formulation of the couple's plan. PFMC is a map that orients the therapist through the complexities of the clinical work with couples and allows her/him to "tailor" the therapy to the specific needs of that specific couple.

For example, a couple, Anna and Marco, share the pathogenic belief that if they are happier and more satisfied than their families of origin, they would be disloyal to their parents who have had unhappy marriages and whose lives have been characterized by sacrifice and renunciation and entirely focused on work. In one session, Anna and Marco reported that that they had been invited to a wedding in London. They were uncertain whether to go because it would have meant leaving their adolescent children at home alone and spending money on themselves. Then they discussed something else, as if the topic of the wedding was not very important. Following the formulation of their plan, their therapist went back to this topic, expressed enthusiasm about the invitation, and invited the partners to go to London and to feel entitled to enjoy their free time together as a couple. In that same session, Anna for the first time talked about her brother who suffered from a chronic form of leukemia and whose condition was worsening. A few sessions later, the couple reported that they had decided to attend to the wedding.

Future Directions

An empirical research is underway to assess the level of agreement between independent judges who elaborate the couple's plan following the guidelines of the PFMC described in this article. The procedure follows the steps indicated by Curtis et al. (1994) for the formulation of the patient's plan for research purposes. Results of previous research carried out to date on different types of treatments, and never on couple therapy, have shown that clinicians trained at CMT achieve high levels of interrater reliability in the independent formulation of the patient's plan (Curtis & Silberschatz, 2007; Silberschatz, 2017). Future studies will investigate the existence of a significative relationship between the therapist's proplan interventions and the positive outcome of couple therapy.

摘要

本文提出了一种适用于伴侣治疗的计划制定方法,这是一种经实证验证并且临床有益的评估程序,用以制定个案心理治疗干预的计划。根据控制-掌控理论(CMT),寻求心理治疗的人有着一个无意识的计划,

包含着对目标、障碍、检验、创伤和领悟的妥协折衷。发展出计划制订方法是为了可靠地规划个体的心理治疗。将这种方法应用于伴侣治疗。我们加入了两个部分:功能失调的关系模式(恶性的关系循环)和资源(良性的关系循环)。二者都借助一个临床案例来进行了解释。我们讨论了对于伴侣治疗使用计划制订方法的含义,也将应用于伴侣治疗的控制-掌控理论的一些原则与伴侣治疗的主要流派进行了比较。

关键词: 控制-掌控理论, 伴侣治疗, 伴侣计划, 伴侣治疗的计划制定方法

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