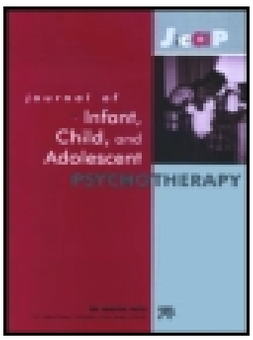

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The Plan Formulation Method for Adolescents (PFM A): Personalizing Psychotherapy for Adolescents

Emma De Luca, PhD, Giorgia Abate, PsyD, Francesco Gazzillo, PhD, and John Curtis, PhD

ABSTRACT

The aim of this paper is to show how the Plan Formulation Method, an empirically validated and clinically useful assessment procedure, can be adapted to the therapy of adolescents.

According to Control-Mastery Theory, patients come to therapy with an *unconscious plan* to achieve their goals, disconfirm their pathogenic beliefs, and master their traumas. PFM is a procedure aimed at formulating the unconscious plan of a patient with high levels of reliability and it articulates this plan in five components: the *goals* that the patient wants to achieve, the *obstructions* to these goals, the *traumas* which have given rise to these obstructions, the way the patient will try to overcome these obstructions during the therapy (*tests*), and the *insights* that the patient needs to achieve in order to get better. To apply this method to adolescent therapy, we added two components: the *vicious relational circles* between adolescents and their relevant others which support the patient's problems and that the patient wants to break, and the *experience the adolescent needs* in order to get better. Each component will be explained with the help of a clinical case. The possible applications of the PFM to adolescents both in clinical and research contexts will be discussed.

Introduction

Adolescence can be defined as the phase of transition from childhood to adulthood, and is placed roughly between the ages of twelve and twenty-four (Siegel, 2013).

Adolescence has long been regarded as a problematic phase in people's lives. Currently, however, adolescence is considered to be prevalently a phase of identity reorganization, in which some people might experience difficulties that are personal and unique (Steinberg & Morris, 2001), but that is not, per se, a particularly conflictual or painful phase (Offer & Schonert-Reichl, 1992; Ostrov et al., 1989; Steinberg, 1999). Simpler models have given way to more complex hormone/environment/behavior interaction models that take the context into account (Susman, 1997).

While classical psychoanalysis has paid relatively little attention to adolescent development and its context, discussing it mostly in terms of psychosexual development (S. Freud, 1905; A. Freud, 1958), Blos (1967) defined adolescence as a second individuation process in which the teenager loosens their

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childhood dependencies in order to become an individuated member of society. Erikson (1968) described adolescence as a period of searching for an identity, in which the peer group plays an important role.

More contemporary psychodynamic perspectives differ in several ways from the earlier psychodynamic views (Atzil-Slonim, 2019). First of all, they take into account the multiple forces that interact to create the singularity of each development. Each adolescent has their own way and time to deal with the evolutionary tasks of adolescence (i.e., separation from the family, building significant relationships with peers and with romantic and sexual partners, defining one's rank position in the groups one belongs to), their development being the product of the interaction between biological, psychic, social and cultural factors (Siegel, 2013). It has been stressed that, during adolescence, the importance of tolerating the experience of multiple versions of oneself, and maintaining a sense of continuity and integrity of the self (Briggs, 2002; Mitchell, 1993), is important. But above all, the centrality of real relationships in the development of the adolescent has been emphasized (Levy-Warren, 2000).

During adolescence, the relationship between oneself and the surrounding world often undergoes very relevant changes, which are then susceptible to further evolutions. The need to reorganize and rework the internal representations of oneself and others, and one's relationships, according to pubertal changes and new social demands is typical of adolescence (Ammaniti, 2002; Maggiolini & Pietropolli Charmet, 2004; Paikoff & Brooks-Gunn, 1991). Talking about adolescence, therefore, means talking about transformations that often undermine the beliefs that had, in the past, regulated the relationship with one's body, family, social institutions, peers and the world. The subject, however, rarely completely renounces what has been learned in the past and, generally, tends to rework those beliefs in support of new developmental tasks and new experiences (Havighurst, 1972).

One of the central and most complex tasks of this phase is the progressive *separation from the family* of origin associated with *the building of meaningful bonds with peers and with romantic and sexual partners*. Research on this topic has found a general increase in squabbling between parents and teenagers, accompanied by a decline in closeness between them (Steinberg & Morris, 2001). However, despite this transition, teenagers still need the continuing relationship with their parents, but less and less frequently (Atzil-Slonim, 2019). Moreover, research indicates that adolescents' relationships with their peers is mostly influenced by the relationship they had with their parents (Brown et al., 1993). Indeed, adolescents with warm and supporting families are more socially and competent in the peer group (Lieberman et al., 1999).

Attachment theory (Bowlby, 1969/1982, 1973, 1980) has stressed the importance of a secure attachment bond for healthy personality development. For example, it has been highlighted how a *secure attachment* in adolescence is associated with a greater capacity for *emotional regulation* and *management of new and stressful situations* (Kobak & Sceery, 1988), as it represents a protective factor for the onset of anxiety, depression, feelings of inadequacy, and antisocial behaviors (Cooper et al., 1998; Kobak & Sceery, 1988).

Although parents and peers are arguably the most important influences on adolescents, recent research has documented the importance of *supportive non-parental adults* for adolescents' psychosocial functioning across ethnic groups (DuBois & Karcher, 2005; Greenberger et al., 1998; Haddad et al., 2011). Non-parental adults differ from peers and parents in different ways. For example, adolescents have reported that, unlike their peers, they are able to provide advice based on experience. Adolescents are also able to talk to them about situations they would not tell their parents for fear of embarrassment (Beam et al., 2002). Moreover, the "role model" behavior of non-parental adults is particularly influential in the lives of at-risk adolescents, regardless of the behavior of their peers and parents (Greenberger et al., 1998).

Therapy for adolescents should therefore take into account the specific phase of life as well as the personal history of the individual asking for help. Moreover, despite the fact that adolescence could be considered a peer-oriented stage, as has been observed, parents are still very influential in the lives of their teens (Svetaz et al., 2014). Thus, family assessment and the inclusion of family in the therapy may sometimes be useful when formulating the plan of an adolescent patient (Winters et al., 2007). Lastly,

it must be remembered that, as therapists, we take the role of important, non-parental adults for the adolescent.

Despite the deep individual differences between adolescents, instead of a patient-based-approach (Norcross & Wampold, 2011; Sales & Alves, 2012), the large majority of treatments for adolescents tend to follow a diagnosis-based-approach (David et al., 2018; Lee et al., 2013), which matches treatment models to diagnoses in order to answer the following question: *what kind of treatment/ specific techniques does this diagnosis need?* Despite this, current evidence does not indicate that following this approach will lead to improved mental health services (Timimi, 2015; Timimi et al., 2013).[1] Moreover, it is well known that when using traditional diagnostic categories, the same diagnosis can be attributed to people who have very different problems and personality features.[2] In addition, these traditional diagnostic categories have extremely limited applications for age-related developmental manifestations in both child and adolescent populations because of the biological and psychological immaturity of these patients, and of the rapid developmental changes that characterize them and make it difficult to label adolescents' clinical conditions with a single category (Timimi, 2015).

Another aspect to be considered is that, although the empirical literature on adolescent-focused therapies suggests that a treatment in general is more effective than no intervention, no systematic difference in outcomes has been found between therapies from different theoretical models (Fristad & MacPherson, 2014; Miller et al., 2008; Spielmans et al., 2007; Weisz et al., 2006), supporting the assumption of the so-called Dodo verdict: "Everyone has won, so all must have prizes" (Luborsky et al., 2002). Thus, as in adult treatments, evidence supports the conclusion that common factors are more powerful than specific therapy ingredients (Chorpita et al., 2011; Messer & Wampold, 2002), and that diagnostic-based approaches deriving from different specific theories tend to be equivalent in their efficacy.

In conclusion, what can a therapist do when working with adolescents? Perhaps instead of just focusing on *the kind of treatment/specific techniques a diagnosis needs*, they should evaluate *the kind of treatment that is better tailored to a specific patient's need*s. In other words, a treatment that is beneficial for one patient might not be beneficial for another, considering the wide differences that exist among patients who have similar diagnoses, but different individual specific needs. For these reasons, it may be helpful to introduce the reader to the Control-Mastery Theory (CMT; Gazzillo, 2021; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986), a theoretical model that, because of its integrative nature and case-specific approach, provides a mean to overcome the limitations of evidence-based therapies for adolescents. CMT is a psychodynamic relational theory[3] of mental functioning, psychopathology, and psychotherapy processes, developed by Joseph Weiss and empirically validated by Weiss, Harold Sampson and the San Francisco Psychotherapy Research Group over the last fifty years.

CMT is a case-specific approach in which the focus of treatment is shifted from the disorder toward the patient. Instead of a top-down process based on the therapist's well-established theory and constructs, in a bottom-up process, the patient, with their history, goals and obstructions, may implicitly suggest to the therapist how to proceed (Gazzillo, Di Maggio et. al., 2019). Moreover, CMT allows the therapist to use any kind of technique, as long as it is useful for that patient in that moment of the therapy. It is clear that all models of psychotherapy use a theoretical framework of reference and, inevitably, have some top-down components. What is thought to differentiate CMT from other models is the fact that the categories used in the assessment are at a low level of abstraction. A Control-Mastery therapist, for example, does not try to understand the level of organization of the personality of the patient or their deficits in functions that are a-priori considered important, but the healthy and adaptive goals that patients are trying to pursue without being able to reach them, and the fears or difficulties that have obstructed them from achieving those goals. This allows the level of inference and abstraction to be reduced and the therapy to be adapted to each patient. Since this is a case-specific approach, there are no patients to whom it cannot be adapted. It is also believed that CMT may organize, in a unified meaningful framework specific to each patient, multidisciplinary

interventions, where several different practitioners need to be involved in the therapy of the patient (psychologists, psychiatrists, social workers, nutritionists and so on).

In order to conduct empirical studies on the processes and outcomes of psychotherapy, the San Francisco Psychotherapy Research Group has developed a method for creating a comprehensive case formulation of the patient—the plan formulation method (PFM; J. T. Curtis & Silberschatz, 1991, 2007; J. Curtis et al., 1994). The PFM is a procedure for the formulation of the patient's unconscious plan, which has been standardized for adult patients, and which has proved to be reliable, and applicable to different forms of psychoanalytic and non-psychoanalytic psychotherapies (J. Curtis et al., 1994). CMT has thus generated a corpus of empirical research studies on the processes and outcomes of psychotherapy, aimed at furthering the understanding of psychotherapy change mechanisms and at optimizing therapeutic effectiveness (e.g., Bloomberg-Fretter, 2005; Fretter, 1995; Gassner et al., 1982; Horowitz et al., 1975; Silberschatz, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Fretter et al., 1986; Silberschatz, Sampson et al., 1986; Weiss et al., 1986). Although the PFM has been applied to adolescents, CMT has not, so far, provided a specific tool for the clinical assessment of adolescents.

The aim of this study was to introduce a PFM for adolescents, a case formulation procedure for adolescent psychotherapy.

CMT: A case-specific approach

According to CMT, the human mind is driven by an *adaptation imperative* (Sampson, 1990; Weiss, 1990; Weiss et al., 1986) and by the search for *safety* in one's interpersonal environment. In line with contemporary infant research (Stern, 1985), CMT stresses how children are, since very early on, intrinsically interested in their interpersonal world. We know that the first reality for a child is their family. Thus, a child is deeply interested in their parents' moods and behaviors because seeing them self-absorbed, detached, sad or angry can be felt as danger by the child. Indeed, given that children need their caregivers' love, depending on them for survival and growth, their only possible adaptation strategy is to establish and maintain a *secure relationship* with the caregiver (attachment), and make them as happy as possible (*care*). Contemporary hypotheses and the findings of affective neuroscience, and developmental and dynamic psychology (see, e.g., Lichtenberg et al., 2011; Liotti, 2005; Liotti et al., 2017; Panksepp & Biven, 2012) share the idea of the existence of a series of affective-motivational systems, evolutionarily founded, but environmentally labile, that humans have in common with other mammals. These regulate sequences of behavior and emotions with an adaptive value, which are shaped by the specific adaptation's environment, learning and higher-order cognitive processes. Among these basic social emotional-motivational systems, all primary, there is the care system. The central role given by CMT to prosocial motivations, such as attachment and care, is coherent with a paradigmatic change in the conceptualization of human motivations, in which group selection (Sober & Wilson, 1998; D. S. Wilson, 2015; E. O. Wilson, 2012) is thought to have encouraged a series of prosocial emotions, abilities and behaviors that favor group survival via reciprocal care and mutual support. These prosocial emotions and abilities include a sense of responsibility and guilt that favor prosocial behaviors (Davidov et al., 2016; Tomasello, 2009, 2016; Tomasello et al., 2007).

In an attempt to adapt to their reality, a crucial role is played not only by the construction of reliable relationships with relevant others, but also by the construction of a reliable set of *beliefs* about "reality" and "morality". These beliefs orient one's attention, shape one's perceptions and feelings, indicate how to behave in any situation, outline what to expect from others, and demonstrate which feelings and behaviors can be adopted and which should be avoided, inhibited, or changed. These beliefs can be conscious or unconscious, explicit or implicit, and can be encoded in language or as implicit emotional and procedural knowledge.

Several peculiarities of a child's psychic functioning influence the formation of their beliefs. First, as previously stated, a child needs to see their family members as wise and good, and to establish a secure enough relationship with them (attachment). At the same time, they are deeply interested in their

parents' moods and behaviors because they need to feel that they are fine, happy, and that they have a satisfying relationship with them (care). Whatever parents say and everything they do becomes a moral imperative to be respected (Gazzillo et al., 2020). Moreover, the cognitive immaturity, the lack of experience, and the egocentric quality of children's thoughts make them establish incorrect causal links among events, over-generalize the rules they infer from the experiences with their relatives, and feel responsible for everything that happens around them (Davidov et al., 2013; Hoffman, 1982; O'Connor et al., 2012; Weiss, 1993; Zahn-Waxler et al., 1992).

In an attempt to adapt to traumatic situations (*stress trauma or shock trauma)*, a person may develop beliefs that inhibit the pursuit of healthy and adaptive life goals, linking their achievement to the occurrence of an internal (guilt, fear, shame, etc.) or external (suffering of loved ones, separation or estrangement from them) danger; these are termed *pathogenic beliefs*. Indeed, when traumas arise, children are highly motivated to understand why these traumas occurred to prevent any future recurrence. Given children's tendencies to feel that what happens is their fault, and to preserve positive relationships with their caregivers—maintaining their image as good and wise—adverse and traumatic experiences tend to encourage the development of pathogenic beliefs and the notion that, by pursuing normal goals, they will cause themselves and others to suffer.

These pathogenic beliefs can also transform guilt, which in itself is an adaptive moral emotion (Davidov et al., 2013; Zahn-Waxler & Radke-Yarrow, 1990), into a pathogenic factor. In fact, children feel deeply guilty when their behaviors, emotions and motivations seem to cause loved ones to suffer or threaten their relationship with them. Toddlers show a greater propensity to empathize with and help other people who show signs of emotional distress and suffering, even when they are not directly responsible for this distress (Drummond et al., 2017; Zahn-Waxler et al., 1979, 1992). This suggests that it is not empathy, per se, that motivates prosocial behavior, but the propensity to feel responsible for the well-being of others (Chapman et al., 1987). Pathogenic guilt derives from pathogenic beliefs, and acts as a powerful factor giving rise to, and supporting, the maintenance of inhibitions, symptoms, dysfunctional behaviors and affects.

CMT, in line with the hypotheses of other American analysts (Asch, 1976; Loewald, 1979; Modell, 1965, 1971; Niederland, 1981), and anticipating recent developments in moral and evolutionary psychology (Haidt, 2012), involves the in-depth analysis of five types of interpersonal guilt.

(1) *Survivor guilt* experienced by people who think that being or feeling better off than important others, or having more good things or a better destiny than them, makes them suffer.
(2) *Separation/disloyalty guilt* based on the belief that separating physically or psychologically from loved ones, or becoming independent from them, can cause them harm.
(3) *Omnipotent responsibility guilt* based on the belief that one must and has the power to make loved people happy, so that putting the satisfaction of one's own needs in the foreground means being selfish.
(4) *Burdening guilt* derives from the pathogenic belief that one's emotions and needs are a burden to loved people, and that one's own problems and fragility cannot be expressed because this would hurt them.
(5) *Self-hate* based on the strong conviction of being bad, degraded, inadequate and worthless.

Unlike the other kinds of guilt, self-hate is a self-accusation for what one is, not for what one has done or could potentially do, and its interpersonal origin derives from the fact that, in the presence of ill-treating, neglecting or abusive parents, it is safer for a child to think that they deserve the mistreatment they suffer rather than feeling dependent on parents who are actually bad (Fairbairn, 1943). Because of traumatic experiences with abusive or neglectful parents, children may end up blaming themselves and think they deserve the mistreatment.

In conclusion, according to CMT, psychopathology can be understood as the expression of: (1) the pathogenic beliefs developed in an attempt to adapt to a traumatic environment; (2) the emotions

connected to them; and (3) the strategies adopted to deal with these beliefs; that is, psychopathology can be read as the expression of different *pathogenic schemas*.

In line with several studies on social cognition (Bargh, 2014), CMT also stresses humans' ability to unconsciously perform many of the same complex mental functions that are performed consciously (*higher mental functioning hypothesis*). According to CMT, people are consciously and unconsciously able to *control* their mental functioning through the perception of safety and danger, and are motivated to *master* their traumas and strive, both consciously and unconsciously, and to pursue healthy and adaptive developmental goals[4] (Gazzillo, 2021; Weiss, 1993). Given the fundamental motivation to pursue adaptive and pleasurable goals, people are intrinsically motivated to become conscious of, and disprove, the pathogenic beliefs that obstruct them (Weiss, 1993). In psychotherapy, patients try, both consciously and unconsciously, to disconfirm their pathogenic beliefs because they cause pain, symptoms, and anxiety for the individual, preventing them from achieving healthy and pleasurable goals (Silberschatz, 2008; Silberschatz, Fretter et al., 1986; Weiss, 1993; Weiss et al., 1986). These attempts are known as tests.

It is known that in Freud's early works he assumed that the therapist's task was to help the patient make the unconscious conscious, and that he could effect this by being neutral to the patient's conflict, avoiding using authority and reassurance, and primarily utilizing interpretations. However, in his later works, Freud suggested that unconscious motivation included not only primary impulses seeking gratification, but also motives stemming from the unconscious parts of the ego and the superego serving a variety of purposes and functions. These new concepts change the analyst's position relative to the patient's unconscious, altering the early concept of neutrality, which several later authors have considered impossible to respect with, or even harmful to, some patients (see, e.g., Gill, 1994; Wolf and Leider, 1984). According to CMT, the therapist should not be neutral, but should be the patient's ally in their effort to disprove their pathogenic beliefs and pursue their goals. For this reason, CMT minimizes the difference between insight therapy and supportive therapy. Within this context, in fact, interpretation is not the sine qua non of therapy, just as insight is not the only factor of change in psychotherapy. Already by 1986, Wallerstein (2000) had determined that patients who received so-called supportive therapy demonstrated as much structural change in follow-up as patients who received insight-oriented therapy. It is now commonly accepted that change in psychotherapy takes place thanks to "something more than interpretation" (Stern et al., 1998). Empirical evidence (Wampold & Imel, 2015) supports the conclusion that the common factors, rather than the specific technicques, are important for producing benefits from psychotherapy. For example, on the basis of a series of empirical studies, Waldron and collaborators (Gazzillo et al., 2018; Waldron et al., 2015) identified the overall quality of therapists' interventions, and of the relationship between patient and therapist, as the most important factors in good outcomes. Regardless of the type of intervention – interpretation, clarification, transference, conflict interpretation and so forth – it seems that the therapist's ability to "say [and do] the right thing at the right time" (Waldron et al., 2004, p. 1106) is what allows the patient to improve. But what does this right thing consist of? According to the Boston Change Process Study Group (2010), Lyons-Ruth et al. (1998) and Stern et al. (1998), this "something more than interpretation" relies on the intersubjective patient – therapist exchanges that modify the implicit relational knowledge of the patient (and of the therapist). CMT considers the therapist's ability to help the patient carry out their plan the most important change factor because, through the relationship with the therapist, the patient can disprove their pathogenic beliefs and modify their explicit and implicit relational knowledge; empirical studies support this view (e.g., Bloomberg-Fretter, 2005; Fretter, 1995; Gassner et al., 1982; Horowitz et al., 1975; Silberschatz, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Fretter et al., 1986; Silberschatz, Sampson et al., 1986; Weiss et al., 1986).

Tests, according to CMT (Gazzillo, 2021; Gazzillo, Genova et al., 2019; Silberschatz, 2005; Silberschatz, Sampson et al., 1986; Weiss et al., 1986; Weiss, 1993), are unconscious attempts to disconfirm pathogenic beliefs and explore how safe it is to pursue healthy goals. CMT delineates two broad testing strategies—transference tests and passive-into-active tests. Each strategy may be pursued

by either compliance or noncompliance with the pathogenic beliefs being tested (Gazzillo, Genova et al., 2019; Silberschatz & Curtis, 1993). In a *transference test*, the patient observes whether the therapist responds to them or treats them in the same way the patient's parents or significant others previously traumatized them. This type of testing may be done *by compliance*, the path consistent with the pathogenic belief, to see whether the therapist encourages a more adaptive response, or in opposition *by noncompliance*, the path inconsistent with the pathogenic belief, to see whether the therapist is critical of, or upset by, this behavior. On the contrary, *passive-into-active tests*, in general, are based on role reversal. The patient acts as a parent, giving the therapist the role of themselves as a child. In passive-into-active tests *by compliance*, patients treat, or behave toward, the therapist in the same way that they were treated (and traumatized) by others in relationships or circumstances that gave rise to their pathogenic beliefs, in the hope that the therapist will not be traumatized as they were. By contrast, when patients pose a passive-into-active test *by noncompliance* (Gazzillo, Genova et al., 2019), they typically behave in an antithetical way to the traumatizing parent or loved one to see whether the therapist feels recognized and appreciates it.

To infer the testing dimension of patient communication, it is vital to identify the patient's goals, pathogenic beliefs, traumas and preferred testing strategies (i.e., a formulation of the patient's plan; see Curtis & Silberschatz, 2007). However, sometimes the meaning of a test can only be understood after having observed the patient's reaction to the therapist's response to their test. Therapists can verify whether they passed or failed tests by observing the patient's behavior soon after their response or in the following weeks. If the test has been passed, the patient will tend to feel safer, and may become less anxious and depressed and more relaxed. They may produce new memories, develop new insights, become bolder and more collaborative, make progress or pose bolder tests. When a test is failed, the patient will tend to feel in danger, potentially becoming more anxious, silent and depressed. They will also be unlikely to recover new memories or gain new insights, may change the topic and may temporarily retreat from their goals.

CMT considers that patients enter psychotherapy with an *unconscious plan* (Curtis & Silberschatz, 2007; Weiss, 1998) to disconfirm their pathogenic beliefs, master their traumas and achieve their goals (J. T. Curtis & Silberschatz, 1991; J. Curtis et al., 1994). The PFM (J. T. Curtis & Silberschatz, 2007; J. Curtis et al., 1994) is a procedure for the formulation of a patient's unconscious plan, standardized for adult patients, which has proved to be highly reliable (J. Curtis et al., 1994). Empirical research, conducted using the PFM, has indicated that it is possible to reliably formulate the plan of a patient on the basis of the first three or four sessions, and that a plan formulated in this way can serve as a useful guide for the therapist. In fact, several studies have shown that, when therapist interventions support patients in carrying out their plan (i.e., are pro-plan), patients get better (e.g., J. T. Curtis et al., 1988; J. T. Curtis & Silberschatz, 2007; J. Curtis et al., 1994; Foreman et al., 2000; Horowitz et al., 1975; Silberschatz, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz et al., 1989). The PFM has five components: (1) the patient's *goals* for therapy; (2) the *obstructions* (pathogenic beliefs and guilt) that prevent the patient from achieving their therapy goals; (3) the *traumas* (stress and shock) that have generated these obstructions; (4) the way in which the patient will work in therapy to overcome the obstruction (*tests*); and (5) the *insights* that the patient may want to achieve to get better.

PFM for adolescents

As already discussed, according to CMT inhibitions and symptoms are expressions of pathogenic beliefs, developed in an attempt to adapt to traumas and adverse experiences, which almost always involve family members. The traumatizing parents generally carry on being part of the everyday life of the adolescent. Thus, in order to formulate a plan for an adolescent, it may be very useful for the therapist to examine the family history of the young patient (*the traumas giving rise to pathogenic beliefs)* and their current relationships within their family (*the factors which may support their pathogenic beliefs).*

As per these criteria, we have adapted the PFM (J. T. Curtis & Silberschatz, 2007), developed and validated for adult patients, to adolescent psychotherapy. To formulate the adolescent plan, the therapist should have a couple of sessions with the patient's parental figures in order to collect data about their individual histories, explore their experiences, as well as understand their traumas and how they have shaped their own pathogenic beliefs. At the same time, it is important to conduct a couple of interviews with the adolescent, with the aim of understanding the healthy and adaptive goals they would like to achieve, the pathogenic beliefs that hinder these achievements, and the traumas from which the pathogenic beliefs derive. At the end of these four meetings, two with the parental figures and two with the adolescent, the clinician should have a clear picture of the plan for the adolescent, articulated in seven components.

The therapist first identifies the patient's *goal(s)*. Then they infer the *obstructions* (pathogenic beliefs) that prevent their achievement, and the parents' possible *pathogenic beliefs and attitudes* that feed the adolescent's obstructions. The therapist has to also identify the *traumas* that have created these obstructions—the patient's *tests* and the *vicious relational circles* between the patient and their parents. Finally, they identify the *experience* that the adolescent needs to get better and the *insights* that the patient may need to obtain.

The development of the PFM for adolescents has been influenced not only by the PFM for adults, but also by the PFM for the developmental age (PFM-DA; Crisafulli, 2016) and the PFM for couples (Rodomonti et al., 2020).

The theoretical assumption is that it is often very useful to understand why parents are not able to disconfirm their children's pathogenic beliefs and how they feed into them. This approach is similar to that suggested by CMT for working with children; it is important to consider the pathogenic beliefs and attitudes of each parent, and how these pathogenic beliefs and attitudes have affected the child (Crisafulli, 2016). Thus, as in the PFM-DA (Crisafulli, 2016), it may be useful for the plan formulation for the adolescent to consider the parents' possible *pathogenic beliefs and attitudes* from which the adolescent's obstructions and traumas originated. Moreover, as in the PFM for the developmental age (Crisafulli, 2016), *experience* is included in the adolescent's plan. This includes those experiences that the patient needs to have in order for their pathogenic beliefs to be disproved. These experiences can be viewed as "passed tests" or "corrective emotional experiences" (Alexander & French, 1946).[5]

Furthermore, as in the work with couples (Rodomonti et al., 2020), when formulating the plan for an adolescent, it is useful to identify the *vicious relational circles*[6] that have arisen from the failure of their parents to disconfirm their pathogenic beliefs, in order to help the parents understand the meaning of their children's behaviors and thus pass their tests, reassuring them and favoring the disconfirmation of their pathogenic beliefs. *Vicious relational circles* as those circular relational processes that trigger positive feedbacks that feed negative experiences and expectations among family members. They arise from the intersection between the pathogenic beliefs of a member who, in a circular and systemic perspective, feeds and is fed by the pathogenic beliefs of the other members. The identification of these vicious relational circles should start with the following questions: "What are the parents' pathogenic beliefs, and how have they shaped the adolescent's pathogenic beliefs?". Vicious relational circles are examples of patient–parent interactions that do not constitute the origins of the patient's pathogenic beliefs, but do end up supporting them. These are recurring relational patterns, characterized by the patient trying to disconfirm their pathogenic beliefs by testing the parents, that end up confirming the parents' pathogenic beliefs. The parent, in turn, with their answer to the test, ends up confirming the pathogenic belief that the adolescent was trying to disconfirm.

Understanding these vicious relational circles requires the clinician to carry out sessions with the parents in order to investigate their history, employing a tri-generational perspective (Andolfi, 2015) that facilitates the identification of the expectations, roles and beliefs that characterize that specific family system and its members.

Understanding and overcoming these vicious relational circles requires sharing and reading these circles within the family system in order to transform these negative relational dynamics into positive experiences, characterized by the parents' ability to pass the tests set by their child. In order to build

a basic sense of safety within the family relationship, it may be important to help the patient become aware of these dysfunctional relational dynamics, highlighting the underlying pathogenic beliefs, their origins in the individual histories of the family members, and the ways in which they are tested.

Parental involvement in the therapy of the adolescent, on the other hand, may be useful in helping the parents feel part of the therapeutic process, reducing their potential fear of being replaced by the therapist in their parental role, and restoring the sense of dignity and competence they have lost. However, in stressing the need to involve parents in an intervention with an adolescent from a CMT perspective, the case-specific approach of our model must not be forgotten. For example, parental involvement may be useful for an adolescent with burdening guilt, but damaging for a patient with separation/disloyalty guilt. In the first case, seeing their parents involved in their psychotherapy may disconfirm the adolescent's pathogenic belief that their needs and wishes are a burden on their parents. In the second case, the adolescent may think that their parents need to be involved in their psychotherapy because, in order not to hurt them, they have to renounce any private space that is free of, and at a distance from, the family. So, according to CMT, work with an adolescent and their family is always case-specific. It is possible that, unlike therapy with a child, where the therapist works with both the child and their parents, in the case of an adolescent, the therapist who deals with the parents may be a different person and, in some cases, the adolescent's therapist may even decide not to have contact with the parents.

Below, we briefly introduce the components of an adolescent plan, illustrating each of these with the help of a clinical case.

Clinical case

Marco was a 15-year-old teenager with black hair and almond-shaped eyes. His smile hid his embarrassment. He had been in therapy for two years at the ASL (Local Health Authority), but he talked about it as a negative experience because, as he reported, *"they didn't let me talk"*. He required individual therapy due to a *social anxiety disorder*, as diagnosed by the ASL, based on the Diagnostic and Statistical Manual of Mental Disorders (DSM 5; American Psychiatric Association (APA), 2013). Marco stated that, from primary school through the first year of high school, he had been the teacher's favorite because he was always quiet and got good grades. But now, he expressed his discomfort in going to school because of a deep anxiety, manifested by chest pains, a choking feeling, and palpitations. Marco was the eldest child and had a sister who was three years younger.

During the first two assessment sessions with Marco, it emerged that the incident that triggered his school withdrawal was an episode in which his Italian teacher gave him a bad grade, and Marco's parents reacted to that grade with displeasure and disappointment. Marco stopped going to school and failed twice, in the first and third year of high school. In his relationship with his peers, Marco was shy and introverted, he was often afraid of making mistakes and being judged for what he said or how he behaved. Even when some friends asked him to go out with them, Marco pulled back and always stayed home.

Marco struggled to speak with his therapist, seemed to belittle his problems and appeared to be deeply ashamed. Talking about his relationship with his mother, he described her as someone who was always tired. Every request from Marco was greeted with an accusation of "being flawed", regardless of Marco's need and the request's cost. When the therapist asked Marco what he thought about their sessions together, Marco said that he was worried about his parents' reactions, belittling his emotions and saying: "Worse things happen to people at sea. I'm sorry I always have to cause trouble and they have to spend money on these things". The therapist told him that the situation was quite serious, and that she was sure that his parents cared about his wellbeing and not about the money. Marco smiled and appeared more relaxed.

As already stated, the involvement of the parents in an intervention with an adolescent, from a CMT perspective, is a case-specific choice, as it depends on how much this involvement may be useful in disconfirming the adolescent's pathogenic beliefs. In this specific case, it was the adolescent

himself who asked the therapist to see his parents: "*I would like mum and dad to be able to attend a session once a month. Because, okay, I know what to do, I know what's best for me, but if they don't understand or don't know what I need, I go alone*".

The sessions with the parents took place once a month, for two months, and were aimed at exploring the parents' experiences, and at understanding the origins of their pathogenic beliefs and how they fed into, and fit with, Marco's own pathogenic beliefs.

During the sessions with them, it emerged that his mother had a family history in which she always had to be "a good and diligent daughter" to avoid creating problems for her parents. Moreover, following a betrayal by her father figure, it was she who had to take care of her mother. Marco's father, on the other hand, told a story of rejection, characterized by a cold and hostile mother. When he was 12 years old, he moved into an annex because his mother was disturbed by the sound of his music. During his childhood, Marco's father learned to hide his vulnerability and to show outward autonomy and independence.

For the sake of brevity, in the example of Marco's plan that followed, we identified only his main goals, the obstructions that hindered them, the parents' pathogenic beliefs that influenced his own beliefs, the traumas from which these obstructions derived, the vicious relational circle that originated from them, the experiences that Marco needed, and the insights related to these elements.

Goals

A teenager's goals are based on what they want to achieve in the short, medium or long term, and can be conscious or unconscious, concrete or abstract. By definition, they must be healthy and adaptive.

In Marco's case, it emerged that he wanted to:

(1) be able to go to school without feeling distressed, and to not feel distressed when he was not quiet and even if did not always get good grades;
(2) feel entitled to express his needs and his discomfort, and ask for support;
(3) overcome his fear of judgment, to improve his self-esteem and to express himself and appreciate himself as he is; and
(4) have a good relationship with his peers.

Obstructions

These include an adolescent's pathogenic beliefs. A pathogenic belief can be described following an "If (I reach my healthy goal) . . ., then (there is a danger for me or my loved ones)" format. As for the PFM for the developmental age (Crisafulli, 2016), for every pathogenic belief an adolescent shows, it is useful to specify the parents' possible pathogenic beliefs that gave rise to or feed into the adolescent's pathogenic beliefs. Marco's beliefs originated from dysfunctional relationships (*stress traumas* developed within the family environment) and were fed by misattuned responses from the parental figures with respect to Marco's needs.

In Marco's case, the pathogenic beliefs were:

(1) if I express myself as who I am and show my weaknesses, instead of trying to perform and be perfect, I will be ignored and criticized (self-hate); and
(2) if I express my needs, desires and disagreement, instead of setting them aside to make my loved ones happy, I will weigh them down and hurt them (burdening guilt).

Marco had also developed other possible pathogenic beliefs (e.g., "I am not smart" or "Success in school is not possible for me"), based on his experience in school. We won't focus on that here for two reasons. First of all, it is not possible to fully describe the complexity of Marco's story in this paper. But, secondly, and most importantly, we thought that these kinds of pathogenic beliefs could be considered to be secondary, connected to the core pathogenic belief "*If I express myself for who I am, and show my*

weaknesses, instead of trying to perform and be perfect, I will be ignored and criticized", which developed in the family context.

Parents' pathogenic beliefs

We considered the parents' possible pathogenic beliefs that fed Marco's obstructions.

The mother's belief that influenced Marco's belief was:

(1) "I am responsible for the sickness and well-being of people I love, if I do not to take care of them, they will be deeply hurt" (omnipotent responsibility guilt).

The father's belief that influenced Marco's belief was:

(2) "If I show my fragility and am demanding, others will not love me. I don't deserve love, care and protection" (self-hate).

Traumas

After having described the goals and pathogenic beliefs that are obstructing an adolescent's achievements, it is important to describe the traumas at the basis of these pathogenic beliefs, distinguishing between shock traumas and chronic family situations that have given rise to the adolescent's pathogenic beliefs (stress trauma). Weiss (1993) proposed defining a traumatic situation as one in which the person felt overwhelmed by negative feelings of anxiety, fear, tension, pain, or helplessness. It could also be a situation in which the desire and attempt to pursue a healthy goal, and the expectation of succeeding and obtaining the support of caregivers, followed a dangerous situation for the adolescent or their significant relationships (Gazzillo, 2021). Thus, according to CMT, we consider traumas to be those experiences adolescents may have with their parents or other caregivers and sibling that are connected to these feelings and that prevent them from pursuing their goals.

The traumas listed in Marco's plan were:

(1) His father, when faced with Marco's fragility, tended to ignore it, devalue it or criticize it. He had long reproached him for his difficulties, considering them to be faults that needed to be quickly eliminated. For a considerable period of time, he'd reacted to the feelings of anxiety and impotence his son was experiencing when he had to wake up and go to school by scolding him. These experiences contributed to Marco's pathogenic belief that "If I express myself for who I am and show my weaknesses, instead of trying to perform and be perfect, I will be ignored and criticized".
(2) On several occasions, when Marco did something "wrong" or simply asked for more attention from his father, his father reacted by being annoyed (for example, he said he wanted to watch television in peace) and locking him in his room, in order to calm him down, quiet him down, and "prevent him from creating problems". These experiences contributed to Marco's pathogenic belief: that "If I express my needs, desires or disagreement, instead of setting them aside to make my loved ones happy, I will weigh them down and hurt them".
(3) His mother tended to react to Marco's discomfort by becoming anxious, screaming, and crying. When Marco, anxious and demoralized, did not get out of bed to go to school, his mother burst into tears, telling him he was exaggerating his feelings and that by doing so he made her tired and angry. These experiences contributed to Marco's pathogenic belief: "If I express my needs, desires or disagreement, instead of setting them aside to make my loved ones happy, I will weigh them down and hurt them".

Tests

This section includes the tests Marco proposed to the therapist and his loved ones. To identify the tests, the clinician used both what emerged during individual interviews (with the parents and with the child) and, where possible, observations of the interactive and relational dynamics the family system exhibited during the joint interview.

Here are the main tests proposed by Marco:

To disconfirm the pathogenic belief (1): "If I express myself as who I am and show my weaknesses, instead of trying to perform and be perfect, I will be ignored and criticized". **Marco could perform the following:**

Transference test by compliance: Avoid expressing his discomfort or minimize it, in the hope that the therapist would encourage him to express it and would listen to him with interest.

Transference test by noncompliance: Exaggerate his difficulties and problems or indulge in complaining about his difficulties and his suffering, in the hope that the therapist would not be distressed, and would continue to accept his problems and try to make him feel understood.

Passive-into-active test by compliance: Blame those who express their discomfort and ask for support, in the hope that the therapist would defend them and value their attachment needs. If he was to criticize the therapist for her "problems", she would remain calm and not let herself be conditioned.

Passive into active test by noncompliance: Be particularly sensitive to the discomfort of others, in the hope that the therapist would value him for doing so, and (if he was diligent with her) she would be happy about that.

To disconfirm the pathogenic belief (2): "If I express my needs, desires and disagreement, instead of setting them aside to please those dear to me, I will weigh them down and hurt them". **Marco could perform the following:**

Transference test by compliance: Avoid expressing his needs or agree to do things he does not like to be compliant with others, in the hope that that the therapist would discourage this behavior and convince him he had the right to take care of himself and to express his needs.

Transference test by noncompliance: Be particularly selfish, putting his needs in the foreground by not caring about those of others (e.g., he could arrive late to or skip the sessions without warning in order to engage in pleasant activities; he could ask to change the meeting time if he wanted to do something interesting for himself), in the hope that the therapist would recognize his rights.

Passive-into-active test by compliance: Require that the therapist or other important people put aside their needs to meet his needs, in the hope of meeting them or the therapist's firm and calm "no". He would look distressed or be critical when others did not put aside their needs to deal with him, or they would have a different perspective to his, in the hope that the therapist would defend them.

Passive-into-active test by noncompliance: Relieve others of their responsibility toward him, encouraging them to take care of themselves. He would express his happiness and approval when others took care of themselves and their needs. The therapist would be pleased to welcome these methods, both promoting them and showing him that he could be happy.

Vicious relational circles

This section includes dealing with the vicious relational circles that generate suffering and misunderstanding in family systems (this section has also been present in the PFM for couples; Rodomonti et al., 2020). Starting with the obstructions identified for each family member, it is possible to delineate the vicious relational circles that form the basis of an adolescent's problems. In particular, this section describes a specific family's dysfunctional relational patterns that stemmed from the parents' failures to pass the adolescent's tests.

To identify the family's dysfunctional dynamics, the therapist used their observations of the family's dynamics and the history of the parents and adolescent that emerged from the individual sessions.

Marco tended not to express his needs so as not to burden other people, and remained "silent and in a corner" (*transference test by compliance* of the belief connected to his burdening guilt). Marco's unconscious hope was that his parents would dissuade him from being this way and would recognize that he had the right to take care of himself and to express his needs. However, Marco's mother was not able to pass Marco's tests because she was reliving her childhood experiences of having to take care of others, putting aside her own needs. His mother felt burdened by Marco's needs, and acted irritable and tired (*transference test by non compliance* of the belief connected to her omnipotent responsibility guilt). In so doing, she prevented Marco from expressing his needs and his discomfort, and from asking for support.

Moreover, Marco refused to go to school (*transference test by noncompliance* of the belief connected to his self-hate). Marco's unconscious hope was that his parents would not be distressed, and would continue to comfort him when he was distressed and try to make him feel understood by not criticizing him. However, Marco's father did not pass Marco's test. His father displayed the same critical and devaluing attitude that his mother had had with him (*passive into active test by compliance* of his self-hate beliefs). Consequently, he refused or downplayed Marco's requests, often blaming Marco for his inability to deal with his own problems. Marco said that he had never felt understood by him. This prevented Marco from overcoming his fear of judgment, and from being able to express his own discomfort and fragility.

Understanding and working to break these circles during family interviews may increase the sense of safety for Marco because it helps his parents understand the meaning behind his symptoms and be able to pass his tests.

Experiences the adolescent needs

Unlike the PFM for couples (Rodomonti et al., 2020), the "virtuous relational circles" section was not included in the adolescent's plan. In this case study, in fact, it was the parents who had to disconfirm the adolescent's pathogenic beliefs.

Thus, rather than talking about virtuous relational circles, it is better to talk about the experiences that the adolescent needs, as in the PFM in the developmental age (Crisafulli, 2016). This part includes the experiences of a safe relationship, in which the adults (but also the peer group) respond in a pro-plan way to the adolescent's tests, with the aim of reducing his guilt.

The experiences that Marco needs are:

(1) to have a relationship with a person who does not feel burdened by Marco's needs, but who will encourage him to talk about them and make him feel heard and understood; and
(2) to have a relationship with a person who does not criticize and devalue him, but tries to make sense of Marco's difficulties, making him feel loved despite his frailties.

Insight

The last part of the adolescent's plan includes the insights that the patient may want to gain in order to improve. The therapist conveys these insights by identifying the adolescent's healthy goals, the obstructions that hinder their achievement, and the traumas that generated these obstructions.

Marco needs to understand that:

(1) His anxiety problems and his difficulty in calmly going to school express a self-punitive behavior of noncompliance with the idea that, if he shows his needs and weaknesses, he will be criticized.[7] This difficulty derives from his over-demanding, critical and abusive parents, who are prone to distress (mother) and unable to provide him with support (father).
(2) His difficulty in overcoming his fear of judgment, being able to improve his self-esteem, express himself, and appreciate himself for who he is stems from the idea that he deserves to be criticized. This belief comes from his relationship with his father, who is inclined to criticize and devalue him when he expresses his fragility and fails to be self-sufficient.

(3) His difficulty in expressing his fragility and needs stems from the idea that, in doing so, he would burden his loved ones. This belief comes from his relationship with his mother, who, faced with Marco's difficulties, appears tired, burdened, and distressed.
(4) His difficulty in building a good relationship with his peers stems from the idea that he deserves to be criticized and that expressing his needs would burden his loved ones. The first belief comes from his relationship with his father, while the second one comes from his relationship with his mother.

Conclusions and clinical implications

To date, Marco's therapy has lasted for 20 months. Initially, Marco was rather uncommunicative, and described himself as a "quiet boy, with no particular problems". The sessions proceeded slowly, stirring up feelings of boredom in the therapist, which she fought by trying to pay attention to the non-verbal communications of the patient, and asking him, every once in a while, what he was thinking and feeling. Sometimes the boredom was so strong that she found herself thinking of the next, more lively patient–her "best" patient. Sometimes, she felt nervous and unable to work with Marco. Just like Marco, she felt she was not capable enough. After about three months from the beginning of the therapy, Marco began to talk about his difficulties and his insecurities concerning school and his relationships with his peers and parents. The sessions become more emotionally charged for the therapist, but also more lively and authentic for both participants. The therapist interpreted Marco's initial attitude as a transference test by compliance on the first belief: "If I express myself as who I am and show my weaknesses, instead of trying to perform and be perfect, I will be ignored and criticized", but also as a passive-into-active test of the first belief, and the therapist did not feel good enough.

During the first year of the treatment, Marco and his therapist worked mainly to help the patient go out with his classmates without getting anxious. The major difficulties reported by Marco concerned his feeling of being under observation by his friends, and his fear of expressing a need to his parents that he considered to be too much—that he wanted to go out alone. Thus, in parallel, the therapist helped Marco's parents to understand the importance that going out alone with his friends had for Marco, and the importance of supporting Marco in this need as he tried to become more autonomous.

After the first year of therapy, Marco had finished his first year of high school and started attending the second year.

During the last few months, Marco started to skip therapy sessions to hang out with his friends. The therapist was quite upset, and at first interpreted Marco's behavior as an attempt at avoiding sharing his negative emotions, such as shame and fear. Marco became anxious and confused during sessions. The therapist then interpreted Marco's attitude in terms of a transference test by noncompliance on the second belief: "If I express my needs, desires and disagreement, instead of setting them aside to make my loved ones happy, I will weigh them down and hurt them". Just like Marco's parents, the therapist felt irritated and hurt by his needs. So, despite the feeling of annoyance that this behavior initially aroused in the therapist, she decided to satisfy his need and agreed with Marco to have the session twice a month in order to protect their space, but also to give him the opportunity to spend more time with his friends. When the therapist acceded to Marco's wish to come every other week, he became more relaxed and started to speak about his feelings. The therapist recognized when she had passed the test because of the patient's reaction. The fact that the patient reacted this way helped the therapist recognize that this attitude and response were what the patient needed, and were not simply an acting out by the therapist. Only then, feeling safe enough in the therapy, did Marco start to talk about his feelings toward his parents, for example, his anger about certain father's behaviors.

Now, Marco expresses his needs and wishes more freely and he is less self-critical. Moreover, he is able to communicate his needs and his anxiety to his parents more directly. This evolution was facilitated by a more comprehensive, less critical and judgmental parenting attitude, deriving from his parents' understanding the meaning behind Marco's problems and their origins. His parents, after recognizing the beliefs and behaviors that caused their son to suffer and that fueled the family's

dysfunctional dynamic, were able to read Marco's behaviors in a different way, and respond in a pro-plan way to his tests. Passing from *vicious relational circles* to the experiences that an adolescent needs encourages the achievement of a sense of safety that is necessary for an adolescent to be able to pursue healthy and adaptive goals.

At the same time, during sessions, the therapist provided Marco with a relationship with an adult who encouraged him to talk about his needs and made him feel heard and understood, a person who did not criticize or devalue him, but who tried to make sense of his difficulties and make him feel loved despite his frailties, passing his tests and helping him to overcome his pathogenic beliefs in order to achieve his goals.

The therapy with Marco, as with any other therapy, was winding and rocky. Sometimes the therapist was not able to understand why Marco behaved in a certain way, feeling disappointed and powerless and then, immediately after that, enthusiastic and full of energy. However, in the difficult moments of Marco's treatment (e.g., when Marco started to skip his sessions, or when he asked to change from a frequency of one session per week to one session every other week), thanks to her CMT orientation and the formulation of a plan for Marco, the therapist was able to focus the testing dimension of Marco's behavior and to respond to him in a pro-plan way.

In conclusion, in our opinion, CMT allows therapists to overcome the limitations of the categorical approach, and the problems linked to common factors in psychotherapy. The therapist can use all their technical tools, as long as they are useful for that patient at that time; that is, in so far as they are pro-plan, and aware that the main tool they can use to help a patient is their relationship with that patient. Moreover, thanks to the concept of testing, CMT gives the clinician a sophisticated theoretical tool that enables them to understand which kind of relational experiences the patient needs in order to get better. The involvement of parental figures in adolescents' assessments, from a CMT perspective, is aimed at identifying and studying the relational dynamics that support the patient's symptoms. Being aware of these relational dynamics allows clinicians to break the vicious relational circles that support the patient's pathogenic beliefs, facilitating the passing of the adolescent's tests by the parental figures. When treating adults, we are rarely in a position to be able to influence or correct the pathogenic behaviors of their parents, but the possibility of doing so with adolescents, and the potential to undo or diminish the development of pathogenic beliefs, is profound.

It is worth remembering that, from a CMT perspective, every clinical choice is based on the patient's plan. Besides this, it is essential not to forget the roles that the peer group and early romantic relationships play in an adolescent's life, which can both confirm and disconfirm the adolescent's pathogenic beliefs and, in some cases in early adolescence, also create new pathogenic beliefs. Thus, in addition to the family relationship, the therapist should also explore these aspects during the assessment phase.

The formulation of a plan for adolescents may be useful both in the assessment phase, where in just a few sessions it is possible to reliably understand the meaning of the adolescent's symptoms, and during the therapeutic process, where it guides the clinician to work in accordance with the adolescent's goals and needs, and to monitor the therapeutic process and its evolution.

To conclude, a PFM for adolescents provides a useful research tool for the clinical assessment of adolescents, which is needed in order to improve the understanding of change mechanisms in psychotherapy, and to optimize therapeutic effectiveness. Our next step will be to empirically assess the reliability of the application of the PFM for adolescents, and whether interventions and communications that support this plan are predictors of a good outcome of the therapy.

Notes

1. There are many treatments for specific diagnoses in adolescents—both psychodynamic and cognitive behavior therapy—that have been successful. But what the data show and how has been suggested by the American Psychological Association (APA, 2012), is that most valid and structured psychotherapies are roughly equivalent in effectiveness, and in clinical trials, only about 60% of patients reach what is considered the "recovery" range

(Lambert, 2013). Since patient and therapist characteristics, which are not usually captured by a patient's diagnosis or by the therapist's use of a specific protocol of psychotherapy, affect the results, we think that a case-specific approach could help in this direction.

2. For example, the DSM criteria for borderline personality disorder can describe around 256 different combinations of "symptoms" (Trull et al., 2007).
3. The relational approaches of psychoanalysis are certainly indebted to Sullivan's (1953) interpersonal psychoanalysis and Bowlby's (Bowlby, , 1973, 1980) attachment theory.
4. The reader can also find this innate drive toward health and self-actualization in the early contributions of Abraham Maslow (1943, 1954) and Robert White (1959). More recently, Migone and Liotti (1998) have proposed an integration of psychoanalysis and evolution-oriented clinical cognitivism under the umbrella of CMT. In particular, they have connected this idea of an innate drive toward health with the evolutionistic hypothesis of the existence of an innate unconscious mental functioning aimed at pursing evolutionary adaptive goals (cf. Panksepp & Biven, 2012).
5. In accordance with Alexander and French (1946), CMT agrees that therapists help patients by providing them with certain significant corrective emotional experiences. However, Alexander and French (1946) approach did not recognize that the patient unconsciously seeks these experiences with the therapist, that the therapist should offer the patient the particular experiences that they are seeking, and that the therapist may check on the pertinence of their interventions by observing the patient's reactions to them. Alexander and French (1946) did not provide empirical evidence for his hypotheses. In contrast with their theory, CMT underlines the importance of the therapist offering the patient certain corrective experiences in a theoretical context in which these make sense. Indeed, if we consider, as Alexander and French (1946) did, that the unconscious mind contains psychic forces, such as impulses and defenses, that are regulated by pleasure principles, the therapist's attempts to offer the patient corrective experiences run the risk of either strengthening the patient's defenses or satisfying their impulses. Instead, if we consider that the patient is working unconsciously to disprove certain unconscious pathogenic beliefs, by seeking experiences that run counter to these beliefs, that same therapist's attempts would make sense. Similarly, Freud (1920), in his last works, stimulated psychoanalytical thinking through his idea that patients might work unconsciously to master their problems (Freud, 1920, pp. 32–35). Following this, several psychoanalysts have assumed that, in analysis, the patient may unconsciously, but actively, seek corrective experiences from the analyst (see, e.g., Dewald, 1976, 1978; Kohut, 1984; Rangell, 1969). Nowadays, several empirical research studies have confirmed the idea that we unconsciously monitor and control reality, set and pursue goals, and react to environmental changes (Bargh, 2007, 2014; Churchland, 2013; T. D. Wilson, 2002; Glaser & Kihlstrom, 2007). Furthermore, the encouragement of the patient to engage in corrective experiences, with an emphasis on ongoing reality testing in the client's life has been proposed by Goldfried (2019) in a recent article about the future of psychotherapy.
6. For more on vicious circles with adult patients, the reader may want to consult Paul Wachtel (1993), Therapeutic Communication, on "cyclical psychodynamics". For the role of vicious circles in the development of child and adolescent psychopathology, see Barish (2018). Cycles of Understanding and Hope: Toward an Integrative Model of Therapeutic Change in Child Psychotherapy. *Journal of Infant, Child, and Adolescent Psychotherapy, 17*(4), 232–242.
7. The anxiety and his difficulty in calmly going to school arose both from Marco's experience of discouragement and shame in school and from his parents' reactions to his feelings. But it was the impossibility of being able to think of himself as fragile and ashamed that made Marco unable to deal with the anxiety the school caused him, leading to him avoiding school. Feeling anxiety and shame is a common experience in adolescence; feeling that you need to be perfect and cannot show weakness may be a more complex and pervasive experience.

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