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THE PLAN FORMULATION METHOD

John T. Curtis and George Silberschatz
Mount Zion Medical Center of the University of California, San Francisco and
San Francisco Psychotherapy Research Group

Harold Sampson and Joseph Weiss
Mount Zion Medical Center of the University of California, San Franciso,
San Francisco Psychoanalytic Institute,
and San Francisco Psychotherapy Research Group

The Plan Formulation Method, a procedure for developing comprehensive clinical case formulations, is illustrated using the case of Ms. Smithfield. The theory out of which the Method developed and the steps involved in developing a Plan Formulation are described. The Plan Formulation Method has been employed with excellent reliability to a wide variety of cases by different researchers. The validity of the Method has been tested in both process and outcome studies. Applications of the Method to the empirical validation and comparison of different theories of psychotherapy are discussed.

BACKGROUND AND ASSUMPTIONS OF THE METHOD

In order to conduct clinically relevant empirical studies of the process and outcome of psychotherapy, the Mount Zion Psychotherapy Research Group has developed a method for creating case formulations that not only identify a patient's manifest and latent problems, but also the patient's stated and unstated goals for therapy, possible obstacles and resistances to achieving these goals, and how the patient is likely to work in therapy to solve the problems. This method for developing comprehensive case formulations, the Plan Formulation Method (Curtis & Silberschatz, 1991), has proven to be reliable, easily teachable, and applicable to different forms of psychoanalytic and nonpsychoanalytic psychotherapies. Moreover, it can be used in clinically relevant comparisons of different theories of the psychotherapeutic process.

The Plan Formulation Method evolved out of the Plan Diagnosis Method developed by Caston (1977, 1986). The Plan Diagnosis Method was developed as part of a larger research project studying the process of psychoanalysis (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986) and was subsequently modified to streamline its procedures and facilitate its application to brief dynamic psychotherapies (Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986). These modifications were extensive enough to warrant a new name for the method, Plan Formulation.

Address correspondence to John T. Curtis, Ph.D., 3368 Sacramento Street, San Francisco, CA 94118–1912.

THEORETICAL ASSUMPTIONS

Both the Plan Diagnosis Method and the Plan Formulation Method were developed in order to study a cognitive psychoanalytic theory of therapy developed by Weiss (1986). The theory holds that psychopathology stems largely from pathogenic beliefs. These beliefs are frightening and constricting and suggest that the pursuit of certain goals will endanger oneself and/or someone else. Consequently, a patient is highly motivated to change or disconfirm these beliefs in order to pursue his/her goals. Irrational beliefs in one's power to hurt others, excessive fears of retaliation, and exaggerated expectations of being overwhelmed by feelings such as anger and fear are all examples of beliefs that can act as obstructions to the pursuit or attainment of goals (for examples of pathogenic beliefs as applied to the Ms. Smithfield case, see Table 1). One of the primary means by which a patient will attempt to disconfirm pathogenic beliefs is in the relationship with the therapist. The therapist's function is to help the patient understand the nature and ramifications of the pathogenic beliefs by interpretating these beliefs and by allowing the patient to test them in the therapeutic relationship. The manner in which an individual will work in psychotherapy to disconfirm pathogenic beliefs, overcome problems, and achieve goals is called the patient's "plan." The plan is not a rigid itinerary that the patient will invariably follow; rather, it describes general areas on which the patient will want to work and how the patient is likely to carry out this work (see Weiss, 1986, for a thorough description of the theory; also see Curtis & Silberschatz, 1986, and Silberschatz & Curtis, 1986, for further discussion of the applications of the theory to clinical phenomena). Formulations developed according to this theory have four component parts: the patient *goals* for therapy; the *obstructions* (pathogenic beliefs) that inhibit the patient from pursuing or achieving these goals; the *insights* that will help the patient achieve therapy goals; and the manner in which the patient will work in therapy to overcome the obstacles and achieve the goals *(tests)*.

PROCEDURE

Plan Formulations developed for research purposes are based solely on transcripts of early therapy hours, with no additional information (e.g., concerning the subsequent treatment or outcome) included. By restricting the data from which the Plan Formulations are developed, these formulations can then be used, for example, to predict a patient's response to a therapist's intervention in the later hours of the therapy (e.g., Silberschatz & Curtis, 1993; Silberschatz, Fretter, & Curtis, 1986). For a brief therapy, we ordinarily use an intake interview and the first 2 therapy hours of the case; for a psychoanalysis, we usually employ the intake and first 10 hours of treatment. However, as reflected in the case of Ms. Smithfield presented below, we have reliably formulated cases based on as little as one interview.

Typically, three or four clinical judges, trained in the Mount Zion cognitive psychoanalytic theoretical orientation, are used to formulate a case. We have used judges with widely varying degrees of clinical experience and of experience applying the theory to therapy (Curtis & Silberschatz, 1991). Ms. Smithfield's case was formulated as a training exercise for a research seminar conducted by the authors. An unusually large number of judges (N = 8) were employed to allow for comparisons between the seminar attendees (five psychology graduate students or

recent graduates who had received training in the aforementioned theory but had no experience developing Plan Formulations) and several more experienced clinicians (three psychologists with at least 5 years experience formulating cases).

The Plan Formulation Method involves five steps:

1. Clinical judges independently review the transcripts of the early therapy hours, and each develops a formulation for the case. Each judge then creates lists of "real" and "alternative" goals, obstructions, tests, and insights for the case. The judges are instructed to include in their lists items they believe are relevant to the case as well as any items they think reasonable for the case, but of lesser relevance (e.g., items of which they are unsure or items that they at one point thought were highly relevant but ultimately decided were of lesser relevance). These alternative items are not "straw men" that can be readily discounted. Indeed, these items are sometimes given high ratings by other judges.

2. The judges' lists are combined into master lists of goals, obstructions, tests, and insights. In the master lists, the authors of the items are not identified, and the items developed by any given judge are randomly distributed within the appropriate list.

3. The master lists of goals, obstructions, tests, and insights are returned to the clinical judges who independently rate the items on a 5-point Likert scale for their relevance to the case (0 = "not relevant"; 1 = "slightly relevant"; 2 = "moderately relevant"; 3 = "highly relevant"; 4 = "very highly relevant").

4. Because different formulations are developed for each case, there tends to be relatively little overlap of items across cases. Consequently, reliability is measured for each of the four plan components (goals, obstructions, tests, insights) for each case by calculating an intraclass correlation for pooled judges' ratings (Shrout & Fleiss, 1979). Two figures are calculated, the estimated reliability of the average judge ($r_{(1)}$—referred to by Shrout & Fleiss as ICC 3,1) and coefficient *alpha*, the estimated reliability of κ judges' ratings ($r_{(\kappa)}$—referred to by Shrout & Fleiss as ICC 3,κ).

5. After determining reliability, the development of the final formulation involves a two-step process. First, items rated as being of lesser relevance to the case are dropped from the list. This step is done by taking the mean of judges' ratings per item, determining the median of the mean item ratings per category (goals, obstructions, etc.), and then dropping all items within each category that fall below the median rating for that category. This selection process represents a rather conservative criterion in that final items usually have received mean ratings falling at or above the "highly relevant" range. The second step entails a separate team of judges individually reviewing the final items to identify redundancies. The judges then meet and decide by consensus which items are redundant and should be eliminated. The remaining items are included in the final formulation.

The Plan Formulation is cast in the following format: There is a description of the patient and of the patient's current life circumstance followed by a narrative of the patient's presenting complaints. Then the goals, obstructions, tests, and insights are listed for the patient. Depending upon the nature of the formulation and how it is to be used, a paragraph summarizing the main features of the individual items may be included under each of the rubrics. (A complete manual of the Plan Formulation Method is available from the authors.)

The Plan Formulation Method has been applied to children (Foreman, 1989; Gibbins, 1989), adolescents, and adults of all ages, including geriatric cases (Curtis & Silberschatz, 1991). The majority of cases we have formulated receive DSM-III-R

Axis I diagnoses of dysthymia or generalized anxiety disorder, frequently accompanied by DSM-III-R Axis II Cluster C personality disorder (American Psychiatric Association, 1987). The cases have displayed mild to severe symptomatology, with moderate to catastrophic psychosocial stresses.

The Plan Formulation Method can be easily modified to incorporate new elements. For instance, our research group has recently added a new component, early traumata, in an effort to reliably identify experiences that contribute to the development of pathogenic beliefs (Curtis & Silberschatz, 1991). Other researchers have found that the basic methodology of the Plan Formulation Method can be adapted to formulate cases from different theoretical orientations (Collins & Messer, 1988). The ease with which the components of the Method can be modified or changed leads us to believe that the basic method can be applied to any form of therapy (Curtis & Silberschatz, 1991). Its application requires a core group of investigators who share a common theoretical orientation and who have been able to identify and operationalize its basic tenets. The Plan Formulation Method was not designed to enable clinicians of different theoretical orientations to agree upon a case formulation (see Horowitz, 1985, and this volume, for a method employing clinicians of different psychodynamic orientations). Rather, the Plan Formulation Method was developed to create reliable views of a particular case from a particular theoretical orientation.

RELIABILITY

We have obtained excellent reliabilities applying this method to long- and short-term therapies from different settings—research programs, private practices, and hospital and university clinics—and involving patients treated under differing theoretical models—including psychodynamic psychotherapy, psychoanalysis, interpersonal psychotherapy, and cognitive–behavioral therapy (Curtis & Silberschatz, 1991; see also, Persons, Curtis, & Silberschatz, 1991; Silberschatz, Curtis, Persons, & Safran, 1989). Across six cases reported elsewhere (Curtis & Silberschatz, 1991), coefficient *alpha* averaged: goals, .90; obstructions, .84; tests, .85; insights, .90.

The Method has also been used by other investigators with good reliability. Collins and Messer (1988, 1991) employed the Plan Formulation Method and obtained good interjudge reliabilities among their judges who were generally less clinically experienced than the typical Mount Zion judges. We have found no significant differences between ratings of judges who have had previous experience with the Method, and those who have not, nor have we found level of clinical experience to be a barrier to learning this method (Curtis & Silberschatz, 1991).

VALIDITY STUDIES

The validity of the Plan Formulation Method has been tested in studies in which formulations have been used to measure the impact of therapist interventions (Fretter, 1984; Norville, 1989; Silberschatz, 1978, 1986; Silberschatz & Curtis, 1993; Silberschatz et al., 1986) and patient progress in psychotherapy (Nathans, 1988; Silberschatz, Curtis, & Nathans, 1989). For instance, in several studies we have demonstrated that the "accuracy" of therapist interventions (defined as the degree

of adherence of the interpretation to the individual patient's Plan Formulation) predicts subsequent patient progress in therapy (Broitman, 1985; Fretter, 1984; Silberschatz, 1986; Silberschatz & Curtis, 1993; Silberschatz, Curtis, Fretter, & Kelly, 1988; Silberschatz et al., 1989; Silberschatz et al., 1986; see also, Bush & Gassner, 1986). In preliminary studies, we have also shown that a case-specific outcome measure, Plan Attainment, that rates the degree to which a patient has achieved the goals and insights and has overcome the obstacles identified in his/her Plan Formula-

Table 1. Mean Relevance Ratings of Sample Plan Formulation Items for Ms. Smithfield

Plan Formulation Items	Mean Ratings
Goals	
To take herself and her needs seriously.	4.00
To be able to see people realistically and not place herself in self-endangering situations.	4.00
To be less compliant and more self-assured.	3.67
To be more separate from her parents and to have better boundaries.	3.33
To feel more comfortable experiencing her envy of other women.	0.00
To pursue her interests without modifying or subjugating them to the interests of others.	4.00
To understand and become conscious of emotional problems that she is repressing in order to improve her memory.	0.83
To find a long-term relationship that would lead to marriage.	1.00
To find a good job that is fulfilling and well-paying.	1.17
Obstructions	
She believes that she is capable of seriously harming others if she does not carefully tend to them.	4.00
She believes that her mother would be weakened and lonely if she could not control her daughter.	3.50
She believes that if she expresses her feelings, needs, and concerns that she will end up alone and isolated.	0.83
She believes both parents would be hurt if she did not comply with them; they would experience her autonomy as disloyal.	4.00
She believes that if she experiences her feelings of victimization she will feel overwhelmed by depression.	0.67
She believes her mother would feel betrayed if she were to allow herself to be different than her mother (i.e., to trust and distrust others as they deserve).	4.00
She believes that her father—and men in general—are weak and want/need to be taken care of/dominated by women.	1.00
Tests	
She will try to deny or rationalize her problems to see if the therapist needs or wants to deny issues.	1.50
She will take control of the session to see if the therapist is bothered by her strength and direction.	3.50
She will brag about sexual contacts to see if the therapist is bothered by her sexuality.	1.25
She will act vulnerable, needy, and/or seductive to see if the therapist will take advantage of her.	0.75
She may do appropriately independent acts, bold moves, to see if therapist can tolerate them.	3.75
She may invite the therapist to exploit her in some way to take charge of her (e.g., tell her what she should or should not do) to see if his intentions are truly in her best interests.	3.75

Table 1. Mean Relevance Ratings of Sample Plan Formulation Items for Ms. Smithfield (*continued*)

Plan Formulation Items	Mean Ratings
Insights	
To become aware that she feels compelled to comply with other people's expectations of her because of her mother's need to be in charge.	3.83
To become aware of her unconscious rage toward men.	0.00
To understand how she is acting in compliance with her mother's need to be in charge by inhibiting expression of her own needs and wants.	4.00
To become aware that she feels deeply responsible for her parents' (and others') happiness and believes she will harm them if she acts on her own wishes.	4.00
To become aware that her self-image of a vulnerable, rejected, victimized woman is based on a defensive need to make others (parents) feel superior and strong.	4.00
To become aware of her need to build her parents up in order to protect their self-esteem.	3.67
To become aware of her envy of other women.	0.00
To become aware that she has allowed others to manipulate and rule her because she feels guilty over leaving her parents (who dictated her behavior and manipulated her).	4.00
To become aware that she is tempted to allow herself to be exploited or victimized as a compliance with mother and an identification with father out of guilt.	3.67

Note. The rating scale: 0 = "not relevant"; 1 = "slightly relevant"; 2 = "moderately relevant"; 3 = "highly relevant"; 4 = "very highly relevant."

tion correlates highly with other standardized outcome measures and is a good predictor of patient functioning at posttherapy follow-up (Nathans, 1988; Silberschatz et al., 1989). These studies support the hypothesis that the Plan Formulation identifies important factors which influence the nature and maintenance of a patient's psychopathology. These findings are clinically relevant because when therapists respond in accord with their patients' plans it leads to improvement both in the process and outcome. We believe that this line of research has important implications for the theory and practice of psychotherapy.

PLAN FORMULATION OF MS. SMITHFIELD

The Plan Formulation developed for Ms. Smithfield was based on the transcript of a single hour-long psychodynamic interview conducted by a clinician (not the therapist) prior to the first treatment session. As noted above, eight clinicians of different levels of experience independently reviewed the clinical material and developed their lists of goals, obstructions, tests, and insights. Their ratings of the master lists of items were also done independently.

Examples of the real and alternative goals, obstructions, tests, and insights developed for the case of Ms. Smithfield, and the judges' mean ratings of these items, are presented in Table 1 (adapted from Perry, Luborsky, Silberschatz, & Popp, 1989).

The interjudge agreement for each of the Plan Formulation components are presented in Table 2 (data for which is taken from Curtis & Silberschatz, 1991; Perry et al., 1989). Reliabilities for the novice judges and for the experienced judges were

Table 2. Interjudge Reliabilities of Experienced and Novice Judges for the Plan Formulation Method

	Reliabilities[a]			
	Experienced Judges $r_{(1)}/r_{(\kappa)}$	Novice Judges $r_{(1)}/r_{(\kappa)}$	All Judges $r_{(1)}/r_{(\kappa)}$	Correlation Between Experienced Judges[b] and Novice Judges
	(n = 3)	(n = 5)	(n = 8)	
Goals	.51/.76	.41/.77	.45/.87	.78*
Obstructions	.47/.73	.43/.79	.45/.87	.79*
Tests	.72/.88	.47/.82	.53/.90	.78*
Insights	.66/.85	.50/.83	.56/.91	.85*

[a] $r_{(1)}$ is the estimated reliability of the average judge; $r_{(\kappa)}$ is the estimated reliability of κ judges' ratings (coefficient alpha). Number of formulating clinicians for each case is in parentheses.
[b] Pearson correlations between mean novice and experienced judges' ratings.
* $p < .01$.

high when calculated separately as well as when combined. In addition, the correlations between the average item ratings of the experienced and novice judges were high.

Items receiving low ratings were discarded, as were redundancies amongst the highly rated items. The remaining goals, obstructions, tests, and insights were included in the final Plan Formulation document. The following summary is drawn from the Mount Zion Plan Formulation for Ms. Smithfield:

> This patient is a very bright, capable woman who hides her intellect and talent out of intense unconscious guilt toward her parents. She developed the idea that her parents, especially her mother, wanted to own her and to run her life. She saw both parents as weak and vulnerable and felt she would hurt them if she successfully managed her own life. She saw her mother as a chronically dissatisfied, fragile woman who needed her daughter to have problems so that mother could correct her, scold her, tell her what to do, and generally feel superior to her. She experienced mother as a manipulative woman who ruled others by guilt. The patient was worried about her father and felt sorry for him; she saw him as henpecked by mother and as abandoned by his first wife. She had a strong need to protect her father and did so by commiserating with him and by building him up.
>
> She feels extremely guilty for not being owned, for having her own ideas, and for running her own life. Her unconscious guilt is manifested in several ways:
>
> 1. She proves her mother right by acting as though she is incapable of running her life.
> 2. She fails to stand up for herself and allows others to dominate her.
> 3. She is very self-destructive.
>
> Although the patient may express dependency longings and act needy and helpless, her primary problem is her unconscious guilt over being separate and independent.

> Broadly speaking, this patient's *goals* for therapy are to feel more comfortable having her own ideas, to stand up more for herself, and to see her parents more clearly. The *obstacles* to these goals are her unconscious guilt and her fear of hurting others. In the transference, she is likely to *test* the therapist to see if he would traumatize her as she has been traumatized by her parents. She might, for example, act helpless in order to see if the therapist wishes to run her life as her parents have. The patient would be helped in therapy by developing *insight* into the origin and nature of her unconscious pathogenic beliefs—for example, to become aware that she feels responsible for her parents' happiness and fears harming them. (summarized from Perry et al., 1989, pp. 311–312)

FUTURE DIRECTIONS

A comparison of the formulations developed on Ms. Smithfield reveals dramatic differences of great clinical significance; although all of the formulation methods reported in this journal issue are based on a psychoanalytic view of psychopathology and psychotherapy, they do not share a common psychoanalytic perspective. For example, the Core Conflictual Relationship Theme (CCRT) and the Idiographic Conflict Formulation (ICF) suggest that Ms. Smithfield is motivated by a conflictual wish to be guided by someone else or to yield control to others (Perry et al., 1989). The Mount Zion Plan Formulation is directly opposite these conclusions: It emphasizes that Ms. Smithfield does *not* want to yield control to others and that she does so only because of her conflicts over being in control and dominant. Consequently, the CCRT, ICF, and Plan Formulation have strikingly different clinical implications. The Plan Formulation suggests that Ms. Smithfield's dependency is a defense against her fear of her power to hurt others; accordingly, interventions focusing on the patient's desire to be guided by, or to yield to, another could run counter to her wish to be more independent and less worried about others. Thus, in the transference, therapist interventions that focus on her desire to be dependent could reinforce this defense, implying to the patient that the therapist (like her mother) has a need for her to be dependent. On the other hand, therapist interventions addressing Ms. Smithfield's guilt over independence would allow the patient to address her conflict and learn in the transference that she does not need to take care of others.

These comparisons illustrate that there can be significant differences between formulations even though they share a broad psychoanalytic framework and employ reliable methods. Does this mean that the field has made little progress since 1966 when Seitz, reporting on his work in the area of seeking agreement amongst clinicians on formulations, noted that problems arose not so much because individual judge's formulations were wrong, but rather because each judge's formulation was only partly right? Most emphatically not! Rather, groups of clinicians, sharing a well-defined and operationalized theoretical perspective, can now develop reliable formulations. The advent of such a method enables clinicians to systematically specify different views of a case. This, in turn, enables us to embark on research hitherto impossible, namely, the empirical validation and comparison of psychoanalytic theories of psychotherapy. We are presently in a position to begin to see which theory (or combination of theories) carries the greatest predictive power—that is, which theory identifies therapist interventions that will be significantly helpful and significantly harmful to a given patient.

One strategy for doing such comparative studies entails having one case formulated according to different methods (as has been done with Ms. Smithfield) and, then, employing methodologies such as those used by the Penn (e.g., Crits-Christoph & Luborsky, 1988; Crits-Christoph, Cooper, & Luborsky, 1988) and Mount Zion Groups (e.g., Silberschatz, 1978, 1986; Silberschatz & Curtis, 1993; Silberschatz et al., 1986) in their psychotherapy studies, comparing how well each formulation predicts particular changes in process and outcome. A more powerful approach is for researchers with different views of a case to formulate that case under a common method. The advantage of this strategy is that once reliable formulations based on two or more theoretical perspectives are developed on a given case using a common method, the similarities and differences between these formulations can be easily identified and measured. For example, Collins and Messer (1988, 1991) compared the formulation of a case by their research group at Rutgers with the formulation developed by the Mount Zion Psychotherapy Research Group (both groups used the Plan Formulation Method). Each group rated the relevance of the items in its formulation, as well the items in the formulation of the other group. Using *obstructions* as an example, there was a –.91 correlation between the Mount Zion and Rutgers ratings (i.e., the *obstructions* rated "highly relevant" by the Mount Zion group tended to be rated of lower relevance by the Rutgers group, and vice versa) (Collins & Messer, 1988). This illustrated where and how much these formulations differed. The significance of such similarities and differences can be explored by testing the power of each formulation to predict changes in process and outcome.

Our ability to develop reliable case formulations has moved us into a qualitatively different position enabling us now to rigorously compare theories of psychotherapy in an empirical and clinically meaningful way. Further work in this direction should result in the identification of both unique and common aspects of those theories which account for therapeutic change. The basis for understanding the process and outcome of psychoanalysis, and psychotherapy more broadly, will then be seen to move significantly beyond a reliance upon ex cathedra debate toward more clinically relevant empirical research.

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