The Structure of Psychotherapy: Control-Mastery Theory's Diagnostic Plan Formulation

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©*Psychotherapy*, *1996,* **33(1)**

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The view that psychotherapy patients unconsciously organize their therapy process in the service of their treatment goals has been advanced and empirically supported by Control-Mastery theory proponents. This article discusses the patient's plan *according to Control-Mastery theory and shows how it is made explicit in the Diagnostic Plan Formulation. It describes how the plan formulation can be used to guide the therapist's interventions, and shows how it creates a structure which organizes the whole therapeutic enterprise. A case example is given to illustrate the therapeutic clarity and power which can result from the use of this approach.*

The Structure of Psychotherapy

Many therapists wish they had an organized way of understanding their patients' psychotherapy process. Joseph Weiss (1993) has proposed that patients unconsciously structure their psychotherapy in the service of their treatment goals. Weiss' theory, called Control-Mastery theory, offers a comprehensive view of how psychotherapy works. The theory has been elaborated and researched by the San Francisco Psychotherapy Research Group, of which I am a member. In this article I show how the therapist can use this approach to create the *Diagnostic Plan Formulation*, an organized concept of the patient's plan for therapy which can help the therapist select useful intervention strategies.

Synopsis of Control-Mastery Theory

People's most powerful motivation is to adapt to the real world. In the service of this motivation they create cognitive constructs of the world, both conscious and unconscious, which are based on their experiences and guide their behavior. Incorrect constructs, inferred from traumatic experiences, are the cause of psychopathology, and are referred to as *pathogenic beliefs* or *pathogenic adaptations*. These constructs are largely unconscious. For example, a child whose

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I would like to thank Joseph Weiss, M.D., for his support and encouragement in the preparation of this article.

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parents are rejecting may unconsciously infer that he/she deserves to be rejected, or a child of parents who are overly involved with the child may conclude that he/she should not become independent for fear of damaging the parents. As a result of these incorrect constructs, certain healthy goals or experiences are given up because the person expects to be endangered if he/she pursues them. The primary danger people face as children is the disruption of the parental ties, and the pathological constructs function to reduce this potential disruption.

People suffer from their pathogenic adaptations and are therefore motivated to overcome them. In order to do so, they must determine that the dangers predicted by the pathogenic adaptations will not occur, and that it is safe to pursue their goals. In life, and in psychotherapy, people wish to find the safety to relinquish their pathogenic adaptations, and will test their environment in search of this safety (to the extent their beliefs permit them to do so). The function of the psychotherapeutic process is to provide this safety. Control-Mastery theory proposes that people enter therapy in order to test the continued necessity for their pathogenic adaptations in the relationship with the therapist, and that therapy progresses to the extent that the therapist *passes* the patient's tests.

The theory holds that people are healthy by nature and that there are no inherent unconscious conflicts. The anticipation of danger as a consequence of healthy behavior comes from expectations people form based on their experience. *Resistance* is seen as a person's attempt to avoid the dangerous consequences he/she expects will result from healthier behavior. Control-Mastery theory emphasizes the role of irrational guilt in psychopathology. It proposes that people often continue dysfunctional behavior because they fear that if they acted in healthier ways they would be blamed for creating problems for those they care about. For example, if a person believed that by adopting a lifestyle different than their parent's they would upset the parent, they might find it difficult to do so because of feelings of guilt and responsibility toward the parent.

Control-Mastery theory has a unique view of patients' activity in psychotherapy, which is that people actively organize the psychotherapeutic process in search of the information they need to overcome their problems. This activity is carried on largely unconsciously. Patients make plans and decisions about which problems to work on, test the therapist to examine how safe it may be to act in healthier ways, make observations of the therapist's behavior and attitudes which bear on these issues, and relax defenses and initiate new behavior as it seems safe to do so. Patients also coach the therapist to convey the attitudes and display the abilities which will help them to progress. Patients work collaboratively with the therapist at the deepest level, despite appearances which may be to the contrary. Weiss (1993) provides an excellent introduction to the theory. A growing body of research is providing support for these views (Broitman, 1985; Davilla, 1992; Norville, Sampson & Weiss, 1996; Silberschatz & Curtis, 1993; Silberschatz,

Fretter, & Curtis, 1986; Weiss, Sampson, & the Mt. Zion Psychotherapy Research Group, 1986).

Control-Mastery theory shares certain concepts with other theories. As does object relations theory, it emphasizes the importance of real interpersonal relationships in the development of personality and psychopathology. Both approaches consider the relationship with the therapist to be the critical reparative element in the treatment, and both consider it important for the patient to understand the origin and nature of his/her problems. In these ways the theory is related to the work of Fairbairn (1958), Winnicott (e.g., 1965), Sullivan (1953) and others. The theory is similar to cognitive theories (e.g., Beck, Freeman & associates, 1990) in that the faulty cognitive constructs a person forms regarding the self and others are seen as the cause of psychopathology and as that which must be changed for healthier behavior to result. Control-Mastery theory is related to psychoanalytic theory in several ways. It builds on ideas proposed in Freud's later writings that dysfunctional beliefs can cause psychological conflicts (e.g., Freud, 1940/1964). It emphasizes the importance of unconscious mental functioning in ordinary life and in therapy. Control-Mastery theory also considers the therapist's offering of interpretations to be a powerful way of facilitating change. In regard to people's fundamental nature the theory is similar to the humanistic and Rogerian schools, in that people are seen as innately healthy and motivated to change, and that they will respond to appropriate interpersonal conditions by doing so (e.g., Rogers, 1961).

Certain concepts are particularly representative of Control-Mastery theory, such as the emphasis on the role of unconscious guilt in the creation and maintenance of psychopathology and the idea that people are highly capable and active in unconsciously organizing their therapy.

Several authors have worked out a format for the clinical application of Weiss' ideas which makes explicit the structure of a patient's psychotherapy (Curtis & Silberschatz, 1986; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Silberschatz, Curtis, & Nathans, 1989; Weiss et al., 1986). This format is called a *Diagnostic Plan Formulation*. The format can be used reliably (Collins & Messer, 1991; Curtis & Silberschatz, in press; Curtis, Silberschatz, Sampson, & Weiss, 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Persons, Curtis, & Silberschatz, 1991; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986), and it has been used in a number of clinical studies (Broitman, 1985; Davilla, 1992; Fretter, 1984; Linsner, 1987; Norville et al., 1996; Silberschatz et al., 1986).

The Structure of the Psychotherapeutic Process

Elements of the Therapy Process

Patients come to therapy for the (usually unconscious) purpose of *testing*, which is the curative element in psychotherapy. Tests are behaviors designed by the patient to determine whether it is safe for them to change in the manner they wish to. For example, a person who was criticized for assertive behavior as a child might make trial attempts at assertiveness in therapy to assess the therapist's attitude toward this behavior. The major elements in the psychotherapy process which our group has identified are *preparing the therapist*, testing, and *working through*. Preparing the therapist refers to behaviors of the patient designed to set up testing situations. Giving history is an example of preparing the therapist. The purpose of giving history is to orient the therapist to the issues the patient wants to work on so that the therapist is prepared for the tests. It is also a preliminary form of testing, since the therapist's reaction to the history can help the patient anticipate the therapist's reaction to direct testing. *Coaching* is a special case of preparing the therapist. Coaching refers to actions deliberately designed by the patient to help the therapist pass a test. These might be engaged in because the patient thinks the test will be difficult to pass, or because the therapist has failed a similar test previously. For example, if a therapist is late for a session and this is traumatic for the patient, the patient might tell a story about how someone was traumatized by a person being late as a way of coaching the therapist about the importance of this situation. Working through refers to the investigative, exploratory, and integrative functions patients manifest when they are feeling safe, usually as a result of passed tests, at which times they are developing new understandings of themselves and integrating less defensive modes of functioning.

Organization of the Therapy Process

People enter therapy with a *plan* (Curtis & Silberschatz, 1986; Silberschatz & Curtis, 1986; Weiss et al., 1986). The plan consists of the patient's goals, the obstacles to these goals, the general testing strategy they will use in the service of reaching their goals, and the insights they wish to achieve. The therapeutic process is organized by the patient primarily with regard to testing. The general structure of the process involves some degree of preparing the therapist, followed by testing, followed by working through if the test is passed, or by coaching to the degree the test is not passed. Following working through, additional tests are generated, preceded by preparing the therapist as the patient deems necessary. Therapists who are less directive facilitate the patient's overt testing, whereas with therapists who are more directive the patient tends to test covertly.

The pace of psychotherapy is set by the rate at which the patient is able to test. To the degree the patient is cautious in his/her testing (feels more endangered), therapeutic progress will be slow. To the extent the patient is able to test vigorously (feels safer), therapeutic progress will

be more rapid. Therapists can accelerate this process by acting on their own initiative to create conditions of safety for the patient. For example, a patient who imagines that others don't find her worthy of their attention might benefit from the therapist referring to something the patient said in an earlier session, or mentioning something he/she learned from the patient.

The Diagnostic Plan Formulation

The Diagnostic Plan Formulation is an organized presentation of our understanding of the patient's plan. It consists of four main sections: *Goals*, *Obstacles* (including *Key Traumas* and *Pathogenic Adaptations*), *Tests* (including *Patient Behavior* and *Therapist Behavior*), and *Insights*. (See Figure 1 for the diagram of the plan formulation; the case it presents will be discussed later).

Goals

Goals are healthy and natural ways of feeling, thinking, and behaving which people have relinquished due to traumatic experiences from which they concluded it was unsafe to continue being healthy. Such relinquishment is painful and constraining, and people seek to reacquire healthy behavior as soon as possible.

Goals are, by definition, healthy. Control-Mastery theory does not allow for the possibility of unhealthy goals. Unhealthy behavior is always considered to be an adaptation to past trauma which the person is trying to overcome. I have suggested (Rappoport, 1996) the term *pathogenic adaptation* to refer to the unhealthy behavior (thought, feeling, or action) which is adopted in place of the healthy one. Goals are often not conscious; the pathogenic adaptations may prevent their being held consciously. For example, if a person has been required to view him/herself as depressed, a trouble-maker, or worthless, such a consciously held view would make it difficult for the person to be aware of their intention to overcome that idea, since they are forbidden to have a positive or optimistic view of themselves. Thus, a person may deny that they consider themselves to have value, or that they deserve to have a better life, while their actions (such as being in therapy) belie this apparent conviction.

Goals, and the priority in which they are pursued, are always the patient's to determine. The therapist's task is to infer the patient's goals, since the patient usually cannot convey them directly. However, people do everything they can to give the therapist this information by describing their current life situation, by giving history, and implicitly by the nature of the relationship they establish with the therapist. All of this is orchestrated, largely unconsciously, by the patient for the purpose of furthering their therapy.

GOALS	OBSTACLES		TESTS		INSIGHTS
	KEY TRAUMAS	PATHOGENIC ADAPTATIONS	PATIENT'S BEHAVIOR	THERAPIST'S RESPONSE	
To consider her own needs, not feel responsible. for others.	Mother's suicide attempts for attention. Mother crying, white, patient holding her hand all weekend.	Overly worried about others, hard to consider self. Others will blame, punish me if I don't attend to them. "*I'm* the parent."	Transference: —Act responsible for therapist. —Don't take responsibility for therapist. Passive-into-active: —Act fragile, needy.	—Don't be gratified; challenge,interpret. —Don't be troubled; support this behavior. —Don't act responsible for pt.	My mother's blame was irrational. I didn't cause and can't solve her problems; I don't have to be afraid for not attending to her needs or others' needs.
Not to have to conform, to have her own views, to not accept criticism she doesn't agree with.	Mother critical of patient for having three children, praises for having two. Mother demands children be prejudiced as she is.	Has to be like whomever she's with, doesn't know who she is, anxious about not fitting in.	Transference: —Conform to therapist. —Don't conform to therapist. Passive-into-active: —Demand therapist conform to her.	—Don't be gratified; challenge, interpret. —Don't be troubled, support this behavior. —Be assertive about not conforming, don't reject patient.	My mother's need for me to identify with her came from her insecurity; I need not think I'm bad for being myself nor fear I will damage others if I am.
To recognize her own importance, to value herself, to appreciate herself.	Mother unresponsive and uninterested in patient except insofar as it reflects on herself. When patient is open about herself, mother changes subject to focus on herself.	Patient feels invisible, unimportant. Patient never spoke in a college class.	Transference: —Act and feel unimportant. —Act and feel important. Passive-into-active: —Don't see therapist.	—Don't be gratified; challenge, interpret. —Value, support, validate. —Be assertive, don't lose self-esteem or feel invisible.	My sense of unimportance came from adapting to my mother's narcissism. It is OK for me to feel worthwhile and value myself; if this threatens others it is not because I have done anything bad, and I need not feel guilty or stop thinking I'm worthwhile.

Figure 1. Diagnostic Plan Formulation for Joanna.

Obstacles

That which stands in the way of the patient's goals are called Obstacles. We show them as having two components: the Key Traumas which produced the difficulties, and the Pathogenic Adaptations which resulted from these traumas. (Control-Mastery authors refer to pathogenic *beliefs* rather than pathogenic *adaptations*. I have adopted the current term because I do not consider the consciously or unconsciously held pathogenic beliefs to be the patient's fundamental beliefs, but rather adaptations which they are seeking the safety to relinquish [Rappoport, 1996].)

Key Traumas

These are the paradigmatic events so commonly related by patients which encapsulate a class of events central to some aspect of their difficulties. The physical abuse, the hurtful attitude, the rejection, the incident which is still so painful after so many years, is recounted to give the therapist an understanding of what produced the damage, the kind of damage it produced, and what the person wishes to work on in therapy. Out of a lifetime of experience, the very few incidents that are related have been chosen for their relevance and for their concise and dramatic way of conveying the information.

Pathogenic Adaptations

These are ways of thinking, feeling, and behaving which the patient adopted as a result of the key traumas and the events they represent. Pathogenic adaptations are the modifications which the child made in his/her spontaneous behavior in order to prevent the disruption in relationships with parenting figures which ensued from this behavior. The preservation of these relationships is crucial to the child, and any loss or degradation of them is frightening. Pathogenic adaptations function to preserve the parents' attachment to the child and to reduce the child's sense of danger. For example, a child who was physically abused, and who was told (implicitly or explicitly) that he/she deserved the abuse, probably attempted to resist this characterization initially. But if the child found that the parent became more hostile or more distant when told that the abuse was unfair and undeserved, the child is likely to have acquiesced in the interests of survival and consciously or unconsciously accepted the notion that he/she was bad and deserved the abuse. This idea that the child adopts of being a bad person is a pathogenic adaptation, and to the extent the idea is not overcome in later life, it interferes with living a fulfilled and successful life. Since the person has come to therapy, it is clear that this idea is not the sole motivator of

behavior—there must be a desire to not act in accord with such a destructive self-concept, and a belief that such a change in viewpoint is possible. It is this desire which is the driving force in the therapy, and for which the patient hopes to find an ally in the therapist. The patient hopes that the therapist does not require of him/her the same unhealthy behavior (in the example given, the same unhealthy self-characterization) as did the parent, so as to demonstrate that it is safe to once again act in his/her healthy self-interest.

> Sarah's mother was preoccupied with herself, was not aware of Sarah as an independent being, and related to Sarah primarily in terms of how well she served the mother's needs. As a result Sarah relinquished her healthy self-awareness, and in adult life was overly attentive to others, was not aware of her own wishes and preferences, found it very difficult to be assertive, and tended to take the back seat in interpersonal relationships. She also tended to blame herself when others were in distress, and considered herself responsible for relieving their distress.
>
> Todd had frequently been brusquely dismissed by his father when he wanted his father's attention. His father needed to justify this behavior by blaming his son for the irritation he felt at being interrupted, and needed the son to accept this blame. As an accommodation to his father's need, Todd accepted the view that he deserved to be dismissed and was not justified in wanting his father's attention. As a result, he came to believe that he was a bother to everyone and that nothing about him was of value to others, and was not able to maintain a healthy sense of self-esteem.

Tests

Tests are ways the patient acts in relation to the therapist when investigating whether it is safe to abandon a pathogenic adaptation. The person hopes to find that the therapist does not require the pathogenic behavior, and that it is safe to act in healthy ways. *Passing the test* means the therapist behaving in such a way that the patient feels safer to abandon the pathogenic adaptation and to act more in accord with his/her goals. Testing, while deliberate, is almost always unconsciously mediated. People's dysfunctional behavior is seen as motivated both by the dictates of their pathogenic adaptations and by the desire to test. Behavior patients engage in with their therapists is always assumed to have a significant testing function, since the whole purpose of this relationship is to provide an arena for testing. The Tests section of the Diagnostic Plan Formulation is divided into two parts: *Patient Behavior*, which describes the behavior which constitutes the test, and *Therapist Behavior*, which describes what is required of the therapist to pass the test.

> How might patients test who had made the pathogenic adaptations described above? Sarah, who had been trained to serve her mother's needs, might begin therapy by acting deferential and accommodating towards the therapist, complying with what she believed might be the therapist's needs of her. She would be interested in determining whether the therapist was gratified by this behavior and encouraged it. If this

seemed true, she would feel discouraged and would be pessimistic about the therapist's ability to be of help. If the therapist did not seem to be gratified by Sarah's compliant behavior, perhaps even questioned or interpreted it, she would be reassured that this was a safer situation than her childhood one, and perhaps one in which she did not have to be so accommodating. She might then try out a bolder strategy: non-compliance. This strategy would entail acting in ways that are not designed to meet the therapist's presumed narcissistic needs, hoping to find that the therapist is not offended, critical, or threatened by such behavior. Such a discovery would increase Sarah's sense of safety to act in her own best interests.

Todd, who believed others would feel irritated if he sought their attention and that nothing about him was of interest to others, initially found it difficult to say much about himself in treatment. He encouraged the therapist to talk and to give direction to the conversation, and frequently inquired about the therapist's life and activities. The therapist did not demonstrate gratification from these solicitous efforts of the patient, but maintained his interest in, and focus on, the patient. He occasionally interpreted these efforts as repetitions of what was required of the patient by his parents. Todd gradually became more confident in the therapist's capacity to attend to him, and in his genuine interest in him. As a result, he became increasingly able to attend to his own purposes in therapy.

Control-Mastery theory has identified two major testing paradigms. These are *transference* testing and *passive-into-active* testing. In transference testing, patients adopt the roles they had as children and place the therapist in the roles of their parents. They then act in ways designed to help them determine how safe it might be to act without regard to the needs their parents had of them. Transference testing may be done in two ways: A patient might act in compliance with past parental needs and assess how gratified the therapist is by this behavior, or might not comply with those needs and see whether the therapist seems threatened. This paradigm is familiar to most therapists, and it is relatively easy to understand and to respond to in helpful ways. The examples given above are both examples of transference testing.

In passive-into-active testing, the patient takes the role of the parent and places the therapist in the role of the child. (The reader may be familiar with this paradigm under the names of *identification with the aggressor* or *projective identification*). Passive-into-active testing is traumatic for the therapist and often produces strong countertransference reactions, since the patient is acting as did the traumatizing parent and may be demeaning, guilt-inducing, critical, rejecting, distant, and so on. The therapist may feel disempowered, self-doubting, inadequate, and defensive in the face of such behavior. (For example, someone who was abused in childhood may be verbally abusive to the therapist, criticizing the therapist's manner, interventions, fees, and so on; a person whose parent was unreliable and uninvolved with them may come late to sessions or miss them altogether, and may seem to take offense when the therapist questions or interprets this behavior.) The patient's purpose in passive-into-active testing is to find evidence in the therapist's behavior that compliance with unhealthy parental demands and characterizations is not necessary, to determine that the therapist is able to resist such compliance, and to learn from the therapist how to do this.

> Carol's mother could not tolerate things going wrong, and needed to blame and reject someone when they did. The primary objects of such blame and rejection were her children, and Carol suffered greatly from sudden and extreme alienations. In therapy, when something went wrong in Carol's life, she sometimes became enraged at the therapist, claimed he should have foreseen the problem and prevented its occurrence, and either threatened to quit therapy or actually did quit, claiming to have lost confidence in the therapist. During these episodes the therapist accepted whatever responsibility was realistically his, but did not accept unrealistic responsibility. He also maintained a friendly and compassionate attitude toward the patient despite her blaming and critical remarks. When she quit treatment, he encouraged her to return and maintained an attitude of goodwill towards her, and he did not lose self-esteem. Carol returned to treatment each time she quit, usually after several months' absence. She was reassured by the therapist's ability to not be traumatized by her behavior, and by his ability to maintain a good relationship with her. Carol gradually came to see how unfair her mother's attacks on her were, and that they indicated a serious emotional difficulty on her mother's part, a difficulty which Carol had not caused, could not cure, and for which she did not have to accept punishment. Carol became increasingly able to maintain her equanimity in the face of her mother's sporadic rejections (which had continued into Carol's adult life), even though these rejections had previously left her devastated with guilt.

To tell if a test has been passed we look for signs that the patient is feeling safer. Examples of such signs are increased physical relaxation (e.g., taking a deep breath, fuller, more regular breathing, more relaxed body posture, less vocal tension, smoother flow of speech), less interpersonal defensiveness (e.g., the person is less guarded, more emotionally open, more collaborative, emotionally closer to the therapist), less intrapsychic defensiveness (the person is more able to associate and reports memories, dreams, or current events which confirm the therapist's understanding of the test), or by the appearance of insight (some aspect of the test is understood in regard to the relationship with the therapist or to other areas of the person's life). If these signs of a passed test are absent, *the test has not been passed*, and the therapist's technique or case formulation must be reexamined.

At the beginning of therapy, tests are usually presented tentatively so as not to place the patient at great risk if the therapist fails them. As the patient becomes more confident in the therapist he/she becomes freer to construct more powerful tests. The same themes may constitute the entire focus of a therapy, as is often the case, or the patient may switch to another issue after making sufficient progress with one line of work.

Countertransference can affect the therapist's case formulation and interventions and can produce defensive responses to testing. The Control-Mastery concept of test passing is of great help to the therapist in this regard, for the therapist always looks to the patient for confirmation that his/her understanding is correct. This attention to feedback from the patient is built in to the theory and helps the therapist recognize and correct for the deleterious effects of countertransference.

We find that a patient's general testing strategy can be reliably formulated based on the

first few sessions (Collins & Messer, 1991; Curtis et al., 1994; Persons et al., 1991). Tests follow relatively directly from the patient's Goals, Key Traumas, and Pathogenic Adaptations. As these emerge, they have immediate implications for testing. The general principle in formulating the testing process is the idea that the patient has given up healthy behavior in order to protect his/her relationship to others. For example, if a patient gives a history of providing support to an emotionally dependent parent, the therapist might hypothesize that the patient has become overly responsible for others and is looking for the safety to stop taking such responsibility. This safety would be provided in the relationship with the therapist if the therapist seemed functional and competent, and not in need of emotional support from the patient. The patient might test for this by providing support to the therapist (e.g., being overly solicitous of the therapist) and observing whether the therapist seemed to need, encourage, and benefit from this support (this would be testing by complying). Alternatively, the patient might test by withholding support and noting how the therapist does on his/her own (testing by non-compliance). Such a preliminary formulation of the testing process could be arrived at rapidly, and would be refined or altered as further data emerged. To test the validity of the formulation, the therapist would make trial interventions and look for evidence that he/she is on the right track. For example, with regard to the tests by compliance, the therapist might call attention to the patient's supportive behavior, or interpret it as behavior which was expected or needed by a parent, and watch for signs that the patient responds positively to these interventions, for example, by becoming more relaxed, more insightful, freer not to be so solicitous, or by providing confirming historical material. If the patient responded in these ways, the therapist would gain confidence in the formulation, and if not, it would suggest that the formulation might not be valid. The therapist might also make similar trial interventions in regard to the patient's descriptions of interactions with others. If the patient reported overly solicitous behavior, the therapist might question or interpret it, and if the patient reported acting independently and in his/her own healthy self-interest, the therapist might encourage or appreciate it. The patient's responses to these interventions would again provide guidance to the therapist regarding the correctness of the formulation.

As another example, consider a patient who gives a history of disinterested parents who did not offer much advice and encouragement nor did they share in the child's successes and difficulties. The therapist might hypothesize that this patient would find it very important that the therapist actively display an interest in his/her life, looking for ways to make suggestions, show caring, and demonstrate that what happens in the patient's life matters to the therapist. Again, such a formulation can be arrived at readily if the history seems clear. Trial interventions would be made by the therapist to test the formulation. If the therapist intervened by expressing support, and the patient reacted negatively, the therapist might consider the possibility that there

is also an issue of distrust, or perhaps of being overly managed, which the patient has to work on first before the issue of disinterest can be approached.

Insights

Insights are a person's conscious understandings about the causes and nature of their pathogenic adaptations. They emerge as a result of the patient's increased sense of safety. Insights result from interpretations not because of new information the therapist has given the patient, but because the interpretation has made the person feel safe to have the knowledge by demonstrating that the therapist believes it is safe to have this knowledge. Insights can also appear spontaneously following passed tests, without interpretive help from the therapist:

> Carl's parents were not particularly empathic or attentive to him, but it had been difficult for Carl to recognize this. When his therapist took the initiative to inquire into his thoughts and feelings in a way he perceived as truly caring, Carl became tearful and recalled how lonely his childhood had been, and how unavailable his parents were.

Carl was unable to see his parents clearly because he feared that to do so would threaten them and thereby reduce their goodwill toward him. Feeling cared for by the therapist removed this danger (in the transference) and thereby made it safe for Carl to be aware of the way he actually had experienced his parents. The fact that insight can emerge spontaneously, without interpretation, (Weiss et al., 1986), shows that it is not new knowledge that patients need in order to be insightful, but rather the safety to know consciously what they have heretofore believed must be kept unconscious.

Case Example and Diagnostic Plan Formulation

> Joanna and her younger brother were raised by a mother who was quite insecure and preoccupied with her own needs. The parents divorced when Joanna was ten, and she remembers this time as one when her mother required her total devotion. There was a weekend when her mother cried for two days while Joanna held her hand. There were suicide attempts "for attention", histrionics, and demands for loyalty. Joanna remembers thinking, "I'm the parent here, rather than my mother." Her mother was unable to empathize with her children, nor was she able to see them clearly as individuals. To the extent they were like her, they received her approval, and to the extent they were unlike her, she was unable to value them. She was rejecting of her children when they did not accept or agree with her racial stereotypes.

The following discussion relates to the first five months of Joanna's once-weekly treatment:

Joanna worked on all of the above issues in her therapy. In regard to the first theme, that of feeling overly responsible for others, she was initially quite accommodating to the therapist, looking to her for direction in regard to what to talk about and how to proceed in therapy. She was very concerned about "taking up too much time" talking about herself, which she was afraid would be "selfish" of her. She asked about how the therapist felt, was concerned about burdening her with her problems, and seemed to find it hard to proceed without checking with the therapist frequently to be sure that she had her approval. The therapist did not demonstrate gratification with Joanna's deferent behavior, but pointed out that it seemed hard for her to follow her own direction in treatment. She also interpreted Joanna's behavior as a transference of her relationship with her mother, that is, that Joanna was taking care of the therapist because she believed the therapist had the same need to be taken care of as did her mother. (An alternative interpretation might have been that Joanna was taking care of the therapist as a way of finding out whether the therapist needed such care, as her mother did.) Joanna responded to these interventions by becoming more self-directed in her therapy and less worried about whether or not she was pleasing the therapist. She seemed to feel increasingly safe to attend to her own interests. When she did so, the therapist was accepting and supportive of this behavior, which encouraged Joanna to make further advances in this direction.

Joanna's passive-into-active tests were relatively weak, as would be expected from someone in the early stages of therapy who was concerned about the therapist's fragility. Joanna asked the therapist for guidance on how to proceed, saying that she didn't know what to talk about in treatment and that perhaps the therapist had some suggestions. (The passive-into-active aspect of this test was the repetition of the mother's demands for support. The test has transference aspects as well, in that Joanna is inviting the therapist to take over for her.) The therapist maintained an empathic attitude towards these requests, expressed confidence that Joanna had ideas and motivations of her own which would emerge, and did not offer suggestions on how to proceed. These responses were designed to demonstrate the therapist's capacity not to feel responsible for another person without fearing that she would thereby harm the other person, and seemed to encourage Joanna's belief that it was possible for her to do the same.

With regard to the issue of conformity, Joanna sought the therapist's opinion on a variety of matters. At times the therapist did not venture an opinion, but instead inquired about Joanna's opinion, and at other times she did express her views. When Joanna seemed to adopt the therapist's view uncritically, the therapist pointed this out or asked if Joanna had any other ideas about the subject, thereby indicating that she did not require conformity of Joanna. By expressing her own views at times, the therapist hoped to encourage Joanna to be similarly open and expressive. As the therapy progressed, Joanna did become more able to express herself, and seemed less concerned about whether she was conforming to others' expectations of her.

Joanna tested the therapist's need that she be invisible and unimportant by behaving in a self-effacing way and noticing the therapist's responses. The therapist did not seem pleased by Joanna's self put-downs, but challenged them whether they occurred in the therapy hour or were mentioned in reports of her behavior in other situations. When Joanna did display an increased sense of self-esteem, the therapist was supportive and encouraging. As it became apparent that the therapist was not gratified by Joanna's invitations that she take center stage, but was consistently interested in Joanna and showed genuine caring for her, Joanna became freer to see herself more clearly and to have a more natural sense of herself as a worthwhile person.

After several months of these kinds of transference tests, Joanna missed a therapy appointment because she "fell asleep." At the next session she was quite apologetic for "disrupting the therapist's day." After all, the therapist was "expecting me and had planned to see me," and by her absence she had inconvenienced her. This is an example of transference testing by non-compliance, since Joanna is not complying with her mother's need for support when she does not attend to the therapist's imagined needs. The therapist did not act injured or critical, as Joanna's mother would have if she had not been attended to, but investigated Joanna's suggestion that Joanna had injured the therapist by ignoring her. This response

to the transference test increased Joanna's confidence that it was safe for her to not be so concerned that others have narcissistic needs for attention.

This sequence also displays an element of passive-into-active testing. This aspect of the test is demonstrated by the meaning it had for Joanna to ignore the therapist by missing her appointment. In the passive-into-active test, Joanna is ignoring the therapist as her mother ignored her, and she is investigating whether the therapist complied with being ignored by feeling invisible and losing self-esteem as Joanna did when she was ignored.

Joanna's three goals (not feeling overly responsible for others, being independent, and valuing herself) are shown in Figure 1, along with the obstacles, tests and insights associated with them. Each theme identified in the plan formulation as a Goal is carried through each element of the formulation schema. The responses Joanna hopes the therapist will make to her tests are shown in the "Therapist" column under "Testing." These responses follow readily from the specified goals, obstacles and tests. This specificity regarding how to respond helpfully to the patient's tests is one of the most valuable aspects of the Diagnostic Plan Formulation for the clinician.

In this brief description of Joanna's testing process I give an example of how she addressed each of the themes shown in her plan formulation. During the course of her therapy, each theme was tested many times and in many different ways, with incremental progress made following each passed test.

Conclusion

Control-Mastery theorists believe that patients organize their psychotherapy capably and efficiently. Our group has found it possible to reliably construct plan formulations based on patients' behavior in their first few sessions of treatment. Use of this formulation can aid the therapist greatly in understanding the patient's process, and in designing a case-specific treatment approach. Use of the formulation also helps reduce the strong countertransference reactions which occur during passive-into-active testing, because the testing function of the patient's behavior is more readily understandable, and the response the patient needs from the therapist can be determined. The therapy process becomes easier and more rewarding for the therapist because it is more understandable, collaborative, and effective. It also allows the therapist freedom to be him/herself, since as long as tests are passed there is no other constraint on the therapist's behavior. The use of this model provides a clear, organized way for therapists to understand the behavior of their patients, and results in an economy of style, a focused and efficient treatment approach, and a more enjoyable experience for the therapist.

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