

## USING THE PATIENT'S PLAN TO ASSESS PROGRESS IN PSYCHOTHERAPY

GEORGE SILBERSCHATZ    JOHN T. CURTIS    SHELLEY NATHANS

*Mount Zion Hospital and Medical Center*

*The value of adopting a case-specific approach to studies of psychotherapy has been noted in numerous recent reviews. However, few studies have assessed the suitability of therapist behaviors or have tailored process and outcome measures to the specific patients studied. The application of a particular kind of case formulation—a formulation of the patient's plan—to psychotherapy research is described. We review how patient plan formulations are used to study the effects of therapist interventions on patient progress (within-session change), and we describe how the plan formulations are used to develop individualized psychodynamic outcome measures (plan attainment).*

The clinician who is beginning work with a new psychotherapy patient or who hears about a new case in supervision often needs to answer several basic questions: 1) What is bothering the patient and what does the patient hope to accomplish? 2) What is interfering with the patient's pursuing or attaining goals? 3) How is the patient

likely to use the therapeutic relationship to get help? and 4) What kind of knowledge or self-understanding is most likely to be useful to the patient? These kinds of questions form the basic rubrics of a clinical case formulation. Such a formulation frequently guides one's approach to a case, provides a framework for evaluating what may be going on in any given session, and ultimately serves as a guide to assessing the patient's overall progress.

While most psychotherapists would agree that having some kind of clinical case formulation is useful (if not essential) for the conduct of psychotherapy, it is striking how rarely such formulations have been used in psychotherapy research (Curtis et al., 1988). In recent years, many reviewers of psychotherapy process research have been critical of the field for failing to focus adequately on the specific issues and problems of the particular patients studied (e.g., Fiske, 1977; Gottman & Markman, 1978; Greenberg, 1986; Lambert et al., 1986; Malan, 1976; Parloff et al., 1978; Rice & Greenberg, 1984; Schaffer, 1982; Stiles et al., 1986; Strupp, 1986). Many of these reviews emphasize the value of adopting a case-specific approach to psychotherapy. Strupp (1986), to cite just one example, concluded that for psychotherapy research to advance, research methods must be geared to the specific dynamics of particular patient-therapist interactions. In other words, one has to know something about the patient being studied in order to know how to evaluate the meaning of any given interaction. This means knowing much more than diagnosis, level of education, SES, and the like; it means developing something akin to the formulation a clinician might make in seeing this patient in therapy.

In this article we describe how we use a particular kind of case formulation—a formulation of the *patient's plan*—in our psychotherapy research. We review how we use such a formulation to study within-session change, and we describe how

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Correspondence regarding this article should be addressed to George Silberschatz, 3368 Sacramento Street, San Francisco, CA 94118.

the plan is used as an individualized psychodynamic outcome measure.

### The Patient's Plan for Therapy

The concept of a patient's plan for therapy is based on a cognitive psychoanalytic theory developed by Weiss (1986) and empirically tested by the Mount Zion Psychotherapy Research Group (Weiss et al., 1986; see also, Silberschatz et al., 1988; Silberschatz et al., 1986). Weiss has proposed that psychopathology stems from unconscious pathogenic ideas that are typically based on traumatic childhood experience. According to this model, patients come to therapy with the desire to master their conflicts and with a plan, which is often unconscious, for achieving mastery. The patient's plan may be thought of as a strategy for disconfirming pathogenic beliefs by developing greater understanding of them in therapy and by testing them in the relationship with the therapist. In testing a pathogenic belief, the patient carries out a trial action that is intended to provide information about the belief. A response by the therapist that the patient experiences as disconfirming a pathogenic belief "passes" the patient's test, while a response that the patient experiences as confirming a pathogenic belief "fails" the patient's test. For example, a patient whose parents were bothered by his autonomous strivings might develop the belief that his autonomy is harmful or upsetting to others and thus might stifle certain desires and needs. This patient might test the belief that his autonomous behaviors are harmful by behaving independently in the therapy (e.g., by coming up with his own insights, being late to sessions, ignoring the therapist's comments) to see if the therapist can comfortably tolerate these behaviors. Another patient whose parents were uncaring and overtly rejecting might engage in the same behaviors (e.g., coming late to or missing sessions) to test if the therapist cared about him. In the first case, the therapist might pass the patient's test by not commenting on these particular behaviors and by acting unbothered by them. However, the second case might require that the therapist do just the opposite and vigorously address these issues. Thus, a therapist's response that would pass a test in one case could fail a test in another case (for further discussion, see Curtis & Silberschatz, 1986; Silberschatz & Curtis, 1986).

The Mount Zion Psychotherapy Research Group has developed a protocol for the written formulation of a patient's plan for therapy (see Curtis et al.,

1988). Plan formulations contain the following four components: 1) the patient's conscious as well as unconscious goals; 2) the *obstructions* or pathogenic beliefs preventing or inhibiting the attainment of goals; 3) the means by which the patient is likely to *test* the therapist to disconfirm pathogenic beliefs; and 4) the *insights* that would be particularly useful to the patient. To illustrate the concept of a patient's plan, a brief excerpt from a plan formulation follows (see Curtis et al., 1988, for a more complete discussion of this particular case).

Myra, a 30-year-old photographer, sought therapy because she was depressed about her inability to feel committed to a man with whom she had been involved for about six years. Although she initially described their relationship positively, it quickly became evident that this was another in a series of unsatisfying, if not masochistic, relationships. Her boyfriend was alcoholic, 13 years her senior, and extremely dependent and clingy. From the outset, they had sexual problems for which her boyfriend blamed her entirely. Myra sought treatment ostensibly to cure herself of her sexual problems and of her difficulty committing herself to this relationship. However, the clinical judges who studied the case inferred that Myra's problems in fact stemmed from her extreme worry about her boyfriend—in particular, her fear that he would be destroyed if she left him. These concerns appeared to be related to Myra's relationship with her mother. Her mother was extremely unhappy in her marriage, and throughout the patient's childhood, complained about how victimized she was by Myra's father. She relied on Myra as a confidante and as her primary source of emotional support. Because of these experiences, Myra developed the unconscious belief that if she were separate from her mother and happy and fulfilled in a relationship, her mother would feel abandoned and hurt. Myra therefore remained available to her mother, to the point of allowing her mother to boss her around and intrude in her personal life. Myra also identified with her mother by becoming involved in unhappy and unsatisfying relationships with men. Because Myra's relationships with men were bad, they did not threaten her availability to her mother.

The clinical judges concluded that Myra's primary goal for therapy was to extricate herself from relationships in which she was a caretaker and/or victim. They identified the main obstruction to this goal as being her strong fear of and worry about hurting others (separation guilt) and her unconscious guilt feelings about attaining more than others (survivor guilt). The judges felt that she would work in therapy to disconfirm her pathogenic belief that her mother and others would be devastated as a result of her (Myra's) independence and her belief that by not being a victim she risked victimizing others. It was thus expected that she might test in the transference to see if the therapist would be critical of her attending to her own needs or if the therapist would be hurt or upset when she disagreed with him or defied him. The clinical judges felt that she would be helped by developing insight into her identification and compliance with her mother and by recognizing how she allowed herself to be victimized in order to avoid feeling guilty over separating from or having more than others.

Studies of psychoanalysis (Bush & Gassner,

1986; Caston, 1986) and of brief psychodynamic psychotherapy (Curtis et al., 1988; Rosenberg et al., 1986) have focused on methods for assessing the interjudge reliability of plan formulations. These studies show that when the four components of plan formulations are broken down into discrete units, excellent interjudge agreement can be achieved (for a review of these findings and a detailed illustration of the method, see Curtis et al., 1988).

### **The Patient's Plan as a Criterion for the Suitability of Therapist Interventions**

Though much has been written on the need to recognize the variability between and within patients, therapists, and treatments (Fiske, 1977; Gottman & Markman, 1978; Greenberg, 1986; Kiesler, 1966, 1971; Parloff et al., 1978; Rice & Greenberg, 1984; Schaffer, 1982; Stiles et al., 1986; Strupp, 1986), nonetheless many process studies have attempted to measure the quality of a given therapist behavior without regard to the particular patient or to the context in which it appears (Rice & Greenberg, 1984). What has been needed is a framework for determining whether a therapist's interventions are well suited to a particular patient's problems and goals. The plan concept provides such a framework and has been used in studies to assess the suitability of therapist behaviors (Bush & Gassner, 1986; Fretter, 1984; Silberschatz, 1986; Silberschatz et al., 1986). This research has focused on two different types of significant therapy events: patient initiated events (key tests) and therapist initiated episodes (interpretations). We review two of these studies below.

#### *The Patient's Tests of the Therapist*

As noted earlier, the therapist's responses to the patient's tests are thought to play a decisive role in the process and outcome of therapy. If the therapist's response to the patient's test is experienced by the patient as disconfirming a pathogenic belief (passing the test), the patient will feel encouraged and is likely to become more involved and productive in the therapy session. If the therapist's response is perceived by the patient as confirming a pathogenic belief (failing the test), the patient will feel discouraged and may show signs of therapeutic retreat.

This hypothesis was tested on the verbatim transcripts of the first 100 hours of a tape-recorded psychoanalysis (Silberschatz, 1986). The patient was a 28-year-old married professional woman

who was unable to enjoy sex with her husband. The therapist was an experienced Freudian psychoanalyst who saw the patient on a daily basis. This research, as is true of all of our studies, was conducted after the therapy was completed. The therapist carried out the treatment as he normally conducted therapy, and he knew nothing about our hypotheses regarding the case or the formulation of the patient's plan. After the completion of therapy, we applied our concepts and methods to determine how well they explain the therapeutic process.

Nine clinical judges read the verbatim transcripts of the first 100 therapy sessions and selected all instances in which the patient attempted to elicit a response from the therapist. It was assumed that many tests would be manifested in this way and that such instructions would help judges identify a large set of potentially relevant test episodes. In all, 87 such episodes were identified. Typescripts of the patient's attempts to elicit a response, together with the therapist's interventions (which included silences), were then prepared. Three psychoanalytically trained judges read a formulation of the patient's plan (which had been reliably identified as part of a separate study; see Caston, 1986) and identified which of the pool of incidents represented the patient's key tests of the analyst. A sample of 46 episodes was selected by all three judges as instances of key tests. A new group of four psychoanalyst judges read the plan formulation and then rated (on a 7-point scale) the degree to which the analyst had passed or failed each test.

The immediate effects on the patient of the analyst's passing or failing a test were assessed using process ratings of the patient's level of experiencing (i.e., degree of involvement and productivity; see Klein et al., 1970), boldness, and relaxation, and an affect classification system which measured the patient's level of fear, anxiety, love, and satisfaction (Dahl, 1979; Dahl & Stengel, 1978). Segments of patient speech immediately preceding the test sequence (presegment) and segments of speech immediately following the test (postsegment) were rated on each of the above measures by different groups of judges. The segments (approximately six minutes of patient speech) were presented in random order without any context and with judges unaware whether the segment was a pretest or posttest segment.

Ratings of the therapist's intervention (the degree to which he passed or failed a key test) were correlated with the pre- to posttest changes (re-

sidualized change scores; Cohen & Cohen, 1975) in each of the patient process measures using a semipartial correlation (Cohen & Cohen, 1975). Significant correlations ( $p < .05$ ) were found between ratings of the therapist's interventions and changes in patient experiencing, boldness, relaxation, and expressions of love, fear, and anxiety. These results support the hypothesis that the patient would become more productive, relaxed, and expansive following passed tests and that she would be more constricted and anxious following failed tests.

A study to replicate these results on brief (16-session) psychodynamic psychotherapies is currently in progress (Silberschatz et al., 1989). Results from this ongoing research indicate that there is a significant correlation between the degree to which tests are passed and immediate patient improvement. The predictive power of our therapist test-passing measure has also been compared with other widely used process scales such as the Vanderbilt Psychotherapy Process Scale (VPPS) and the Penn Helping Alliance Rating Method (PHARM, a therapeutic alliance measure). Results of these studies (Hamer, 1987; Kale, 1986) show that ratings of the degree to which tests are passed or failed add a valuable perspective to the therapeutic process and contribute significantly to the explanatory power of process measures such as the VPPS and the PHARM. These studies of patient tests support the propositions that the meaning of therapist behaviors for the patient can be reliably identified and rated and that this meaning is an important variable in assessing the impact of therapist behaviors.

### *The Impact of Therapist Interpretations*

The importance of considering the suitability of therapist behaviors was also demonstrated in a study of the impact of therapist interpretations on patient productivity in brief dynamic psychotherapy (Fretter, 1984; Silberschatz et al., 1986). This study was designed to test whether the suitability of an interpretation would be a better predictor of immediate (in-session) patient progress than the type of intervention. The suitability of the therapist's intervention was defined as the compatibility of the intervention with the patient's plan (plan compatibility). The type or category of intervention studied was the transference interpretation.

Verbatim transcripts of three brief psychotherapy cases were the primary data for the study. All

transference and nontransference interpretations were identified using Malan's intervention typology (Malan, 1963, 1976; Marziali, 1984). To determine the plan compatibility of interpretations, previously developed plan formulations of each case were employed (Curtis et al., 1988; Rosenberg et al., 1986). A group of clinical judges read the plan formulation and then rated each interpretation for its degree of plan compatibility. For example, in the case of Myra the following interpretation was rated as highly plan-compatible: "You feel guilty about leaving your boyfriend because you believe that he, like your mother, would be hurt if you left." By contrast, the following interpretation was rated as incompatible with the patient's plan: "Your problems with your boyfriend are a manifestation of your feelings that you would be lost if he left you." Three- to five-minute segments of patient speech immediately preceding (presegment) and immediately following therapist interpretations (postsegment) were rated on the patient experiencing scale (Klein et al., 1970).

In this study, plan compatibility scores were correlated significantly with changes (residualized gain scores) in patient experiencing. That is, interpretations judged to be plan-compatible tended to be followed by an increase in the patient's level of experiencing, whereas interpretations judged to be incompatible with the patient's plan tended to be followed by a decrease in the patient's level of experiencing. By contrast, the category of therapist interpretations (transference vs. nontransference) did not predict shifts in patient functioning. These findings, together with results obtained in the patient testing studies, suggest that simple assessment of broad categories of process events in psychotherapy are unlikely to yield consistent results unless the meanings of such events for a particular patient are taken into account. These findings strongly support the view that case-specific methods are necessary to understand and assess the impact of therapist behaviors on the patient's therapeutic progress.

### *Relating Process to Outcome*

In the studies described above, it was assumed that if the therapist made a preponderance of "good" or accurate (i.e., plan-compatible) interventions then the outcome of the treatment would be favorable. That is, if a therapist repeatedly *confirms* the patient's pathogenic beliefs (i.e., by failing the patient's tests or behaving in a plan-incompatible manner) the outcome is likely to be poor.

If the therapist helps the patient *disconfirm* pathological beliefs (by passing tests or intervening in plan-compatible ways) the patient is likely to make significant progress toward achieving therapy goals, and the outcome is more likely to be favorable.

Pilot data from our testing and interpretation studies are consistent with this hypothesis. For instance, in one case with a poor therapy outcome (as defined by conventional therapy outcome measures), the average rating of the therapist's responses to the patient's tests throughout the therapy was 1.5 (on a 7-point scale ranging from 1—therapist fails the test to 7—a clear instance of passing the patient's test). By contrast, in a second case with a successful outcome, the average of the therapist's responses to tests was 5.5. Similarly, in our interpretation study (Silberschatz et al., 1986) we found that the case with the highest percentage of plan-compatible interpretations had the best outcome, while the case with the highest percentage of plan-incompatible interpretations had the worst outcome.

A study to assess the relationship between plan-compatibility of therapist interventions and treatment outcome is currently under way at Mount Zion Hospital. In this research, the verbatim transcripts of 38 completed brief dynamic psychotherapies are being studied. All therapist interventions from a sample of five therapy sessions are being rated for their degree of plan-compatibility. Mean ratings are then computed for each of the five sessions and these averaged plan-compatibility ratings will then be correlated with outcome assessment.

### Assessment of Outcome

The research summarized above demonstrates the feasibility of using case-specific methods in process research and the increase in precision that such methods provide in explaining and predicting patient-therapist interactions. How can case-specific methods be applied to the study of treatment outcome?

The need for case-specific outcome measures has been widely discussed in the psychotherapy literature (e.g., Bergin & Lambert, 1978; Garfield et al., 1971, 1974; Lambert et al., 1986; Malan, 1973; Mintz & Kiesler, 1982; Strupp, 1982, 1986; for a methodological critique of individualized measures, see Beutler & Hamblin, 1986). Typically, the outcome measures employed in studies of psychotherapy are generic; that is, the same criteria of improvement (or deterioration) are ap-

plied to all patients. An example of such a generic measure is a symptom checklist that measures the severity of various symptoms such as depression, anxiety, sleeplessness. Even though these measures are applied in the same way to all patients, their interpretation needs to be guided by a case-specific approach. Consider, for example, the case of a young man who sought psychotherapy because he became intensely anxious after leaving home and beginning college. If his anxiety was secondary to irrational guilt over abandoning his parents and it lessened (or disappeared) because he dropped out of college and returned home, the treatment could not be considered successful in spite of improvement in the presenting symptom. A case-specific outcome measure for this patient would have to include the extent to which he had attained pertinent goals (e.g., going to college, achieving greater emotional separation from his parents, functioning independently) as well as changes in symptoms. A case-specific analysis of outcome is also necessary to interpret the direction of change on generic measures. For instance, while a drop in anxiety may be a desirable outcome for many psychotherapy patients, for some (e.g., sociopathic patients) an increase on this measure might indicate progress.

The application of generic measures in a case-specific fashion implies an understanding of the underlying psychological processes that account for the patient's problems. We believe that these underlying processes can and should be an integral part of an outcome battery. For instance, in the case described above, a measure of the extent to which the patient had achieved appropriate psychological separation from his parents is essential to the assessment of symptomatic or behavioral change. In theory, a measure of the underlying psychological process (here, emotional separation) should have more predictive validity, that is, be a better predictor of how the patient will function at a later time because it measures primary rather than secondary (i.e., symptomatic) problems.

The patient plan formulation can serve to identify crucial underlying processes that should be associated with significant positive change. We have developed an individually tailored measure of outcome, the Plan Attainment Scale, that is derived from the plan formulation and assesses changes in both behaviors and underlying psychological processes that represent successful therapeutic change. The scale measures the patient's progress in three areas: the degree to which the patient achieved the goals for therapy, overcame obstruc-

tions to attaining these goals, and developed pertinent insights. Each of these three sections contains individualized items (taken from the plan formulation) that are rated on a 7-point Likert scale. In addition to rating individual items, judges make global ratings for goals, obstructions, and insights, as well as a global rating for overall plan attainment.

In research currently under way, the reliability and validity of plan attainment scaling is being investigated. Eight brief therapy cases from the Mount Zion psychotherapy archives have been selected to include good and poor therapy outcomes by conventional outcome measures (e.g., SCL-90, target complaints, global improvement ratings, etc.). Plan formulations have been developed for each of these cases. Trained clinical judges, who are kept blind to what occurred in the therapy process and to the results of other outcome measures, independently rate each of the cases. To develop a baseline measure for each patient, the judges read the intake interview and then study the plan formulation. These same judges then read the posttherapy evaluation interview and rate the patient's progress from pre- to posttherapy on the plan attainment measure. After rating the patient's progress from pre- to posttherapy, a 6-month follow-up interview is also rated. The results obtained thus far have been very promising. To date, the Plan Attainment Scale has been applied to four cases with good interjudge reliability.

## Conclusion

The psychotherapy research literature has been moving in the direction of identifying effective ingredients of psychotherapeutic treatments. Luborsky (1984), for instance, has noted the "growing feeling that it is necessary to do for the psychotherapies what has been done for the pharmacotherapies, namely, to try to calibrate *what* and *how much* was being delivered, and then to find out how effective it was" (p. 31, italics ours). The most frequent response to the "what" question noted by Luborsky has been the development of treatment manuals that can be used to document what kind of psychotherapy (e.g., cognitive therapy, interpersonal therapy) has been delivered. Treatment manuals have been very useful for delineating therapeutic procedures and strategies. The next step in the search for effective components of therapy is to identify significant critical incidents or key events in therapy and to identify the therapist's role in the emergence of such change-producing events (Rice & Greenberg, 1984; Stiles et al., 1986).

Our efforts to identify effective ingredients in psychotherapy are based on a "treatment manual" that is patient specific: the patient plan formulation. Our process research is designed to measure the degree to which the therapist's behaviors and interventions facilitate the patient's plan. These process studies can thus be seen as quantifying "how much" of an effective ingredient was delivered by the therapist while the Plan Attainment Scale measures the degree to which the patient has incorporated or absorbed the effective agent. Our concepts and methods are aimed at explaining how therapist behaviors facilitate or impede the patient's progress and are thus directed at showing how psychotherapy works and at improving the effectiveness of psychotherapy.

Clearly, the research presented here grows out of a particular cognitive-psychodynamic theory. Nonetheless, we believe that our concepts and methods cut across various types of therapy and may contribute to the understanding of how the therapist's behavior (regardless of the type of therapy practiced) affects the patient's progress. Our techniques for developing reliable case formulations, for measuring the therapist's adherence to these formulations, and for measuring the impact of therapist behaviors on the process and outcome of therapy can be used by investigators with differing conceptual views. This kind of case-specific strategy can be profitably built into comparative studies in which the predictive validity and the efficacy of different therapies can be compared.

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