

PSYCHODYNAMIC AND COGNITIVE-BEHAVIORAL FORMULATIONS OF A SINGLE CASE

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A single case was formulated using the psychodynamic approach developed by Weiss and Sampson and the cognitive-behavioral approach developed by Turkat and Persons. This article outlines similarities and differences of the two formulations. We describe the advantages of a case-specific research approach for comparing theories of psychotherapy, studying the efficacy of psychotherapy, and learning about both general and specific mechanisms of psychotherapy.

Studies comparing the efficacy of empirically evaluated psychotherapies frequently find few differences between treatments (*cf.* Luborsky, Singer & Luborsky, 1975). These findings are often attributed to nonspecific factors common to all psychotherapies, such as the quality of the patient-therapist relationship (Strupp, 1973). We propose an alternative explanation: the key ingredient of therapeutic success is the matching of the therapist's interventions to the patient's central underlying psychological problem. A small, but growing, amount of evidence supports this hypothesis, which we label the *formulation hypothesis* (Crits-Christoph, Cooper & Luborsky, 1988;

Fretter, 1984; Silberschatz, 1986; Silberschatz, Fretter & Curtis, 1986).

If the formulation hypothesis is correct, and if it explains the failure to find differences between therapies in controlled outcome studies, then it should be possible to demonstrate that therapists from different psychotherapeutic modalities, asked to independently assess a single case, will offer similar formulations. In an informal examination of this hypothesis, we compared the formulations proposed for a single case by therapists from two theoretical orientations: psychodynamic theory and cognitive-behavior theory. Following a description of the patient, we present the two formulations, each preceded by a brief account of the theoretical model on which it is based. Next, we outline similarities and differences between the formulations and we offer suggestions for further tests of the formulation hypothesis.

The Case

John was a 25-year-old single Asian American living alone and working as a technical assistant for an engineering firm. His chief complaint was: "I've had some major depressions and I have difficulty relating to people."

When John began treatment, he was moderately depressed (Beck Depression Inventory score was 15). His chief depressive symptoms were self-criticism, guilt, fatigue, and difficulty getting things done. He had difficulty interacting with others: "I'm afraid I'll say the wrong thing and be rejected or ignored." He had no friends and was not dating. At work, he spent hours on minor tasks; then he felt too guilty to go home at a reasonable time, so he worked 60 hours a week but accomplished little. John had moved to his apartment 15 months earlier but he had not yet finished unpacking. He had planned to apply to graduate school but had not followed through. His only recreation was masturbation, but he felt guilty about this, saying, "If my parents knew about this, especially my father, they would be disappointed in me." John's parents lived nearby and visited frequently though John wished they would not. He rarely made these feelings known and when he did, his parents ignored him. The parents fought frequently and John reported, "The fights always revolve around me somehow." John's mother confided her marital problems to him and told him, "If it weren't for you, I would never have stayed married."

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When John tried to discuss anything with his parents, his mother interrupted with irrelevancies and his father criticized and became overcontrolling.

John was the second of two sons; his brother was 12 years older. When he was 9 or 10, John overheard a conversation between his mother and brother that revealed that his "brother" was actually a half-brother, the product of his mother's first marriage. John's father, a business executive in a technical field, was described as "very interested in controlling all situations at home." He made rigid rules and would tolerate no discussion of them. For example, he would go in the patient's room on Sundays and throw away anything he found on the floor that was not supposed to be there. No talking was permitted during dinner and self-expression was discouraged: "If I expressed an opinion, an argument usually resulted." To cope with conflict at home, John decided, "It's best just to keep quiet. If I speak up it will just cause trouble."

John believed his father was largely uninterested in him, except that "occasionally my father would get into his caretaking mode and he would come home from work and do my homework." The father blocked the son from developing peer relationships: "it seemed like my father was always saying things to embarrass me in front of the other boys." John's father played checkers with him "until I got good enough to beat him—then he refused to play anymore." John got outstanding grades and won many awards but his father's response to these achievements was, "Oh, that's normal. You worked hard, you should do well."

Psychodynamic Formulation

The Model

The Plan Formulation Method was developed in studies of a cognitive psychoanalytic theory of therapy (the control-mastery theory) developed by Joseph Weiss and Harold Sampson (Weiss, Sampson & the Mount Zion Psychotherapy Research Group, 1986). Weiss's (1986) 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 could also threaten someone else. Consequently, a patient is highly motivated to change or disconfirm these beliefs in order to pursue his/her goals.

One primary means by which a patient attempts to disconfirm pathogenic beliefs is through the relationship with the therapist. The therapist's function is to help the patient understand the nature and ramifications of the pathogenic beliefs by interpretation and by allowing the patient to test these beliefs in the therapeutic relationship. The manner in which an individual works 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 invariably follows. It describes general areas that the patient will want to work on and

the manner in which the patient is likely to carry out this work (see Curtis & Silberschatz, 1986; Silberschatz & Curtis, 1986).

Formulations developed according to this theory have five parts: (1) The patient's *goals* for therapy, (2) the *obstructions* (pathogenic beliefs) that inhibit the patient from pursuing these goals, (3) the *insights* that will help the patient achieve therapy goals, (4) the manner in which the patient will work in therapy to overcome the obstacles and achieve the goals (*tests*), and (5) *key traumas*, the actual events or patient experiences that contributed to the formation of pathogenic beliefs (Curtis & Silberschatz, 1991; Curtis, Silberschatz & Sampson, in press).

The Plan Formulation Method

The Plan Formulation for John was developed from transcripts of the first 3 therapy hours; no additional information was employed. We used three experienced clinical judges, all of whom shared the cognitive psychoanalytic theoretical orientation described above. There were five steps in developing the Plan Formulation for John.

1. The clinical judges independently reviewed the transcripts, and each formulated the case. Each judge then listed goals, obstructions, tests, and insights for the case. They included in their lists items they believed were relevant to the case and also items they believed were reasonable, but of lesser relevance (e.g., items of which they were unsure or items that they at one point thought were highly relevant but ultimately decided were of lesser relevance). These alternative items were not "straw men" that could be readily discounted. Indeed, some of these items were given high ratings by other judges.
2. The judges' lists were combined into master lists of goals, obstructions, tests, and insights. The authors of the items were not identified, and the items developed by any given judge were randomly distributed.
3. The master lists were returned to the clinical judges who independently rated the items on a 5-point Likert scale for their relevance to the case (0 = not relevant; 4 = very highly relevant).
4. Reliability was measured for goals, obstructions, tests, and insights by calculating an intraclass correlation for pooled judges' ratings (Shrout & Fleiss, 1979). Two figures were

calculated, the estimated reliability of the average judge ($r_{(I)}$)—referred to by Shrout and Fleiss as ICC 3,1) and coefficient alpha, which is the estimated reliability of K judges' ratings ($r_{(k)}$)—referred to by Shrout & Fleiss as ICC 3,K). For the case of John, the reliabilities ($r_{(I)}/r_{(k)}$) were: goals .77/.91; obstructions .79/.92; tests .77/.91; insights .81/.93.

5. Development of the final formulation involved two steps. First, items rated as being of lesser relevance to the case were deleted. This was done by taking the mean of the judges' ratings per item, determining the median of the mean item ratings per category (goals, obstructions, etc.), and then deleted all items within each category that fell below the median rating for that category. Second, a separate team of judges reviewed the items to eliminate redundancies. The remaining items were included in the final formulation.
6. Key traumas were identified by having judges develop these items at the same time they developed their lists of goals, obstructions, tests, and insights. After step 5 above, two judges reviewed the key traumas identified by the judges, removed any redundancies, and deleted those that did not pertain to the final list of obstructions (none were dropped for this reason). The remaining key traumas were then added to the final Plan Formulation.

Ordinarily, the Plan Formulation is cast in the following format: There is a description of the patient and the patient's current life circumstances, followed by a narrative of the patient's presenting complaints. Then the goals, obstructions, tests, insights, and key traumas are listed. We will only summarize the Plan Formulation here. The complete Plan Formulation is available from the authors.

Plan Formulation of John

John entered therapy with the goal of being able to comfortably pursue his interests. He wanted to feel more comfortable being successful and standing out from others and to feel less responsible for and burdened by his family's problems. He wanted to develop fulfilling social relationships and have more fun. John's feelings of responsibility for his parents were among the primary obstacles to the pursuit of his goals. He believed that if he successfully pursued his goals it would distance

him from his parents and highlight their shortcomings. He unconsciously equated his successes with putting down and abandoning others, especially his parents. These beliefs developed out of John's early experiences with his parents. For example, his father was excessively controlling and critical and never allowed John to enjoy his abilities or achievements—indeed, he seemed threatened by his son's capabilities. John's parents never got along well, and his mother often confided in him, claiming that she only stayed in the marriage for his sake. As a result of these and other experiences, John developed an excessive sense of responsibility for his parents and the belief that he had to closely monitor his own behaviors to avoid hurting them.

John will be helped by developing insight into how his relationships with and feelings about his parents have inhibited him. It will be useful for him to understand how his work and social inhibitions stem from unconscious identifications with his impaired parents. He has also complied with what he perceives to be his parents' need for him to be both dependent upon and available to them. To test these pathogenic beliefs in therapy, John will carefully monitor whether the therapist, like his parents, will need to control his life or see him as incompetent. He will test to see if the therapist is bothered by his competence or independence. Examples of the goals, obstructions, tests, insights, and key traumas developed for John are listed in Table 1.

Cognitive-Behavioral Formulation

The Model

The cognitive-behavioral model proposes that psychological problems occur at two levels: overt difficulties and underlying mechanisms (Beck, 1983; Persons, 1989; Turkat, 1985; Turkat & Maisto, 1985). Overt difficulties are the actual problems in life that patients experience—depression, anxiety, procrastination, relationship difficulties, and so on. Underlying mechanisms are the psychological problems that cause and maintain the overt difficulties, often in conjunction with life events. The underlying mechanisms are difficult to measure directly; therefore, the therapist's ideas about them are viewed as working hypotheses. Underlying mechanisms can often be expressed in the form of dysfunctional beliefs, but might also include behavioral or physiological deficits.

Psychodynamic and Cognitive-Behavioral Formulations

TABLE 1. Examples of Plan Formulation Items for John

Goals

- To become able to express his opinions freely and comfortably.
- To feel more comfortable going to graduate school.
- To have a good, intimate relationship with a woman.
- To feel less anxious being envied or praised by others.
- To be able to comfortably say “no” to his parents.

Obstructions

- He cannot be freer sexually because he believes it would hurt his possessive mother.
- He is uncomfortable taking pride in his accomplishments because he believes it would hurt his ineffective and vulnerable father.
- He cannot be bold and assertive because he believes that others will be hurt.
- He hesitates to go away to graduate school because he believes his parents need him (and would be deprived by his going away).
- He feels that if he disagrees with others he may make them feel vulnerable and humiliated.

Tests

- He will criticize the therapist to see if it threatens her as it threatened his parents.
- He will be unhappy to see if the therapist feels responsible for him as he does for his parents.
- He will act independently to see if the therapist needs him to be needy as his parents do.
- He will tentatively brag about his accomplishments or his intellect to see if the therapist acts derisively.
- He will dismiss the therapist’s ideas or act derisively toward them to see if she feels overwhelmed and becomes withdrawn as he did with his father.

Insights

- To become aware that his failure to do as well as possible in school and to pursue his education further are due to his guilt over leaving his parents and surpassing his father.
- To become aware that his difficulty expressing himself and his opinions is based on compliance with father’s need to be in control and on top.
- To become aware that he complies with his father’s “put-downs” in order to avoid threatening father’s fragile self-esteem.
- To become aware that dating a woman would feel disloyal to his possessive and needy mother.
- To become aware that putting himself down is a way to stay loyal to his parents.

Key Traumas

- Excessively controlling, critical, disapproving father never allowed him to enjoy his intellect and accomplishments.
 - When father “helped” the patient with school assignments, he took them over and did them on his own; this made him feel that father needed to be in control.
 - Father’s inability to get along with his peers—at parties he would play with the children rather than interact with the adults—lead him to feel sorry for his father and responsible for his well-being.
 - Father was easily wounded by patient’s knowing more than he or surpassing him (e.g., they stopped playing checkers once the patient could beat father).
 - Mother and father’s frequent fights (often over him, and for which he felt responsible) made him become isolated and withdrawn.
 - Mother has always confided in the patient and told him that she remained in an unhappy marriage for the patient’s sake; consequently, he has felt overly responsible for and worried about her.
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The cognitive-behavioral case formulation has seven parts:

1. The *problem list* is an exhaustive list of the patient's overt difficulties, including a description of the cognitive, behavioral and affective components of the problems.
2. The *hypothesized mechanism(s)* is the heart of the formulation. Here the formulator proposes a primary (and perhaps one or two secondary) psychological mechanisms underlying the patient's overt difficulties.
3. The formulator then tells a story about *how the proposed mechanisms lead to the overt difficulties*. This exercise serves as an indirect test of the formulation; if some problems are not readily accounted for by the proposed mechanism, the mechanism may be incorrect.
4. The *current precipitants* section describes the events or situations that are activating the patient's psychological vulnerability at this time. Again, this exercise serves as an indirect test of the formulation; we expect to find a direct link between the precipitating events and the nature of the patient's underlying mechanism—if we do not, our hypothesized mechanism may be incorrect.
5. The *origins of the underlying vulnerability* include a description of key events or relationships in the patient's early upbringing that would explain how the patient came to learn the dysfunctional beliefs.
6. The *treatment plan* is based directly on the formulation.
7. The formulator uses the proposed mechanism to make predictions about *obstacles to treatment*, including relationship difficulties (between the patient and therapist) that might be expected (on the basis of the therapist's hypothesis about the central underlying mechanisms) to arise. For example, the patient who believes, "I must get approval from others to survive" may have difficulty bringing homework assignments to therapy sessions for review, fearing the therapist's disapproval.

Formulation of the Case

1. *Problem list*. John's problems are: (a) depression; (b) difficulties in interpersonal relationships; (c) procrastination; (d) overworking; (e) no fun, recreation; (f) guilt about masturbation; (g) difficulties in relationships with parents.

Problems were described above, so will not be repeated here.

2. *Hypothesized mechanisms*. This patient's primary fear appears to be: (I) "If I push ahead with my own interests (separate from my parents), something bad will happen (I'll be attacked, I'll fail, my parents will abandon me, my parents will be hurt, disappointed, betrayed)." Two secondary mechanisms are: (II) "I am responsible for the happiness of others, particularly members of my family; my needs don't count and I don't deserve to have them met" (the subjugation problem described by Young, 1987.) In addition, John appears to have a social skills deficit (III).
3. *How the mechanisms produce the problems*. John's depression (a) can result directly from the belief that he doesn't deserve to have his needs met (II) and indirectly from the lack of gratification resulting from his inability to pursue personal (b) or career (c) interests.

Interpersonal difficulties (b) can stem from all three mechanisms. John has a social-skills deficit (III)—he simply does not know how to interact easily with others. In addition, he has a fear of failing in social interactions, a fear of losing his relationship with his parents (I), and a fear that his parents will be disappointed or feel betrayed (II) if he develops relationships outside the family.

John procrastinates (c) on developing his own home and career because he fears separating from his parents and moving ahead with his own interests (I). Procrastination (c) may also result from the belief that it is his responsibility to meet the needs of his family (II). In John's case, moving ahead with his own career and personal development does not meet his father's need to control him and his mother's need for a confidante.

Overworking (d) may result from John's fear of disappointing his boss (II) and may also be a passive mechanism for avoiding the fear of moving ahead and developing his own interests (I).

The lack of fun (e) can stem directly from the belief "I don't deserve to get my needs met" (II) and from the inhibitions about developing his own interests and concerns (I).

Guilt about masturbation (f) may stem from John's belief that he must behave in a manner that will make his father happy (II). In addition, the patient may use masturbation because, as

a result of his interpersonal difficulties (b), he is not getting sexual or other gratification elsewhere.

John's difficulties with his parents (g) can result both from the parents themselves, who are difficult, and from his beliefs that if he takes care of his own needs the parents will be hurt (I) and that it is his responsibility to prevent them from getting hurt (II). For example, when they want to visit he cannot say, "No, I have other plans" because he feels guilty about disappointing them.

4. *Current precipitants of the problems.* Two months before beginning therapy, John finished an important project and realized he would no longer be spending long hours at work. This realization brought the social and other difficulties he had been avoiding to the surface. The deadline for graduate school applications also passed at this time, reminding John that he had failed to follow through with his plans. In addition, his father retired, and this exacerbated the conflict between the patient's needs (to break away) and the parents' needs (to hold on to their son).

5. *Origins of the mechanism(s).* The patient's fear that something bad will happen if he moves ahead with his own interests (I) has its origins in many childhood experiences in which his moving ahead with his own interests would cause something bad to happen. For example, when John beat his father at checkers, his father stopped playing with him (therefore, achievement led to abandonment). When John attempted to assert or express himself, the result was often a fight between the parents or criticism from the father. When John focused on a special project, his father often moved in to dominate it. John frequently observed his father humiliating his mother in public, and observed many fights between the parents about the mother's wishes to work outside the home.

John's view that the needs of his family are primary, and that his needs don't count (II) are to some degree a product of his Asian heritage, which frowns on individual striving. His mother confirmed this idea when she told him "If it weren't for you, I never would have stayed married." John's father's way of working on his son's school projects taught the idea: "Your projects are not for you—they are for me."

The patient did not learn social skills at home or at school (III); dinner table conversation,

for example, was prohibited. John's father devalued casual conversation, describing it as a waste of time. John's mother appeared to chatter aimlessly without listening, and at social gatherings, the patient's father spent his time with the children, probably because of an inability to interact with adults.

6. *Treatment plan.* To treat the fear of separating from his family (I) and the idea that he is responsible for his family (II), the therapist can begin by pointing out these beliefs whenever they come up. Next, the usual cognitive-behavioral strategies can be used to tackle them. For example, John may be reluctant to undertake social interactions, fearing, "I'll fail and I'll be humiliated." The therapist can help John observe his negative thinking, pinpoint cognitive distortions, develop tests of these ideas, including role plays during the therapy session, and gradually expose himself to feared social situations.

To tackle the fear of hurting his parents (I), John can be asked, "If you tell your parents you don't want them to visit you on Saturday, what will happen?" John probably has distorted expectations about what will happen. However, even if his expectations are accurate ("They will feel devastated and rejected,") the therapist can help him evaluate the idea, "It is my responsibility to make sure they are not upset."

To address the social-skills deficit (III), role-playing can be used to model, rehearse, and provide feedback about appropriate social behavior.

In addition to these technical interventions, the establishment of a collaborative relationship in which the therapist's role is to listen to John and work with him to help him accomplish his goals should serve as a powerful *in vivo* experience contradicting John's beliefs that "If I move ahead, others will be hurt" and "My job is to meet others' needs."

7. *Predicted treatment obstacles.* John may have difficulty expressing his feelings and wishes to the therapist because he may feel that he will be punished or that the therapist will be hurt (I); as a result, he may begin to feel controlled and dominated by the therapist. He may feel that if the therapist offers a suggestion, he must follow it or her feelings will be hurt. He may be overly compliant, agreeing with the therapist because he feels he must please her (II).

Comparison of the Two Approaches to Formulation

Despite the fact that the formulations for this case were developed under different theoretical perspectives, they are remarkably similar in structure and content (*see* Table 2). Each approach breaks a complex formulation into component parts, and the components are often quite similar, as are the items within each component (for example, compare Hypothesized Mechanisms with Obstructions, and Origins of the Mechanism(s) with Key Traumas).

We believe that the similarities of these formulations reflect similarities of the theories upon which they are based. Both the cognitive-behavioral and the control-mastery theory emphasize the centrality of beliefs in the development and maintenance of psychopathology and the importance of a formulation for guiding therapy. Formulations based on models that were more dissimilar (including, of course, other psychodynamic models that are less cognitively based) would probably have fewer similarities. Alternatively, perhaps the nature of the patient's problems is so apparent or universal that any therapist, regardless of theoretical orientation, would be likely to develop a formulation similar to those presented here. We believe this is unlikely, given the many past failures in obtaining agreement even among judges who share a common theoretical orientation (*e.g.*, DeWitt, Kaltreider, Weiss & Horowitz, 1983; Seitz, 1966).

The similarities of the formulations cause us to believe that a therapist from either school could conduct therapy following a formulation from the other. John was treated by a cognitive-behavioral therapist (JBP) who was guided by the cognitive-behavioral formulation. However, the clinicians who developed the psychodynamic case formulation felt that the treatment was proceeding in accordance with their formulation, even though the therapist's approach and style of interventions often differed from theirs. This illustrates our hypothesis that the effectiveness of therapeutic interventions depends more upon their adherence to an accurate case formulation than on the therapist's theoretical orientation.

The similarities between these formulations should not overshadow the significant differences between them. The cognitive-behavioral formulation emphasizes loss or threat to the patient more than does the psychodynamic formulation. The

psychodynamic formulation describes the patient's concerns about endangering himself as a mechanism unconsciously designed to inhibit himself in the service of protecting others. These different perspectives suggest different therapist behaviors. The cognitive-behavioral formulation focuses on the patient's fears of being abandoned, criticized, rejected or otherwise harmed by social or occupational progress and suggests that the therapist work to defuse these fears. According to the psychodynamic formulation, such an approach would be counter-therapeutic because it could lead the patient to believe that the therapist (like the patient's parents), needs to see him as weak and incompetent.

Discussion

The formulation hypothesis proposes that treatment outcome is more related to the accuracy of the formulation than to the intervention strategies employed. This hypothesis explains the familiar tie result of horse races between psychotherapies.

However, not all comparisons between psychotherapies result in a tie. For example, exposure and response prevention (a behavioral treatment), has been shown to be more effective than other treatments of obsessive-compulsive disorder (Steketee & Foa, 1985). To account for this finding, the formulation hypothesis would suggest that behavior therapists may be better at formulating cases of obsessive-compulsive disorder in a manner that allows effective treatment to occur. For example, the behavioral formulation includes a detailed description of the obsessions and compulsions that are the targets of exposure and response prevention, whereas a psychodynamic formulation does not.

A difficulty with the formulation hypothesis, of course, is the question of what criterion can be used to determine the accuracy of the formulation. The usual approach to this problem has been the use of multiple judges; if multiple judges agree on a formulation, this enhances the sense that the formulation is correct. The research strategy illustrated here can also be used. That is, if multiple judges using different models agree on a formulation, this provides even stronger evidence of the accuracy of the formulation. Both these methods are incomplete, however. Additional work is needed to solve this problem.

The ability to identify similarities and differences between formulations in a first step toward clinically relevant empirical research on different theories of therapy. By pinpointing how theories of therapy overlap and diverge in their views of cases, it will

Psychodynamic and Cognitive-Behavioral Formulations

TABLE 2. Comparison of the Structures of the Cognitive-Behavioral and Psychodynamic Formulations

Cognitive-Behavioral	Psychodynamic
<i>Problem list</i>	<i>Goals</i>
Difficulties in interpersonal relationships	To feel at ease
<i>Hypothesized mechanism</i>	<i>Obstructions</i>
If I push ahead with my own interests (separate from my parents), something bad will happen (I'll be attacked, I'll fail, my parents will abandon me; my parents will be hurt, disappointed, betrayed).	He cannot be bold and assertive because he believes that others would be hurt.
<i>How the mechanisms product problems</i>	<i>Obstructions</i>
John's fear of separating from his parents and moving ahead with his own interests leads directly to procrastination, particularly regarding his career and professional aims.	He procrastinates because he believes his freedom to act would distance him from his needy parents
<i>Current precipitants of the problems</i>	(No equivalent category.)
In October, the patient began to see the "light at the end of the tunnel" of an important project at work; he realized he may not need to continue spending long hours at work.	(No equivalent item.)
<i>Origins of the mechanism(s)</i>	<i>Key Traumas</i>
The patient's fear that if he moves ahead with his own interests, something bad will happen, has its origins in many childhood experiences; particularly those with his father, in which if he moved ahead with his own interests something bad <i>did</i> happen.	Excessively controlling, critical, disapproving father never allowed him to enjoy his intellect and accomplishments.
<i>Predicted treatment obstacles</i>	<i>Tests</i>
John may have difficulty making assertive requests to discuss certain topics during the sessions, to change the time of the session, to refuse to do a certain homework assignment, etc., because he may feel that the therapist needs him to do these things and will be hurt if he does not. He may feel that it is his responsibility to make sure the therapist is not upset in any way.	The patient will criticize the therapist to see if it threatens her as it threatened his parents. The patient will be passive to see if the therapist needs to take over as both parents did.
<i>Treatment plan</i>	(No equivalent category.)
To address the fear of separating from his family and the idea that he is responsible for his family, the therapist can start by pointing out (over and over) these issues when they come up.	(No equivalent item, though some overlap with Tests.)
(No equivalent category.)	<i>Insights</i>
(No equivalent item, though some previous categories contain similar elements.)	To become aware that he has inhibited his career in order not to abandon his needy parents.

be possible to identify curative elements that cut across modalities and to test the power of elements peculiar to a given theory of therapy (Collins, 1989; Collins & Messer, 1988, 1991).

One method for further comparison of the theories represented in this paper would be to formulate a variety of different cases from each perspective. Such a project would be made easier if a common formulation method was employed. It appears that either of the methods described in this article could be used by both cognitive-behavioral and psychodynamic clinicians with few modifications.

When formulations of a case from different perspectives are compared, the validity of each can be determined by using them in empirical studies to predict changes in the therapy process and outcome. For instance, to compare the two formulations developed for the case of John, interventions that are in accord with one formulation but not the other (e.g., interventions about his fears of being harmed if he is bold and/or successful) could be identified and then the patient's response to these interventions measured. Such a strategy (see also, Strupp, Schacht & Henry, 1988) has been successfully employed to study particular theories of therapy (e.g., Crits-Christoph et al., 1988; Silberschatz, Curtis, Fretter & Kelly, 1988; Silberschatz, Curtis & Nathans, 1988; Silberschatz, Curtis, Sampson & Weiss, 1991; Silberschatz et al., 1986). To test competing psychoanalytic theories of the psychotherapeutic process (Silberschatz, Sampson & Weiss, 1986; see also, Curtis, Silberschatz, Collins & Messer, 1990). The same strategy could be used to compare different theories of psychotherapy (see also Saltzman & Norcross, 1990).

The case formulation can also be useful in comparative outcome studies (Persons, 1991). Comparative outcome studies generally use standardized protocols for assessment and treatment. The standardized approach does not allow therapists to make a formulation and design an individualized treatment on the basis of the formulation. However, this could be done by designing treatment protocols in which the therapist devises a case-specific formulation and carries out an individualized treatment based on the formulation. If this approach were followed, it might be easier to show differences between diverse therapeutic approaches that continue to elude psychotherapy researchers.

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