15.1

THE PLAN FORMULATION METHOD

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Supplementary material for Integrating counselling and psychotherapy: Directionality, synergy, and social change (Sage, 2019).

The *plan formulation method*, developed by Silberschatz, Curtis, and colleagues, has parallels with Caspar's plan analysis (see Chapter 15, this volume), but is more explicitly psychodynamic (Curtis, Silberschatz, Sampson, & Weiss, 1994; Silberschatz, 2017; Silberschatz, Curtis, & Nathans, 1989). It was also developed specifically for research, but can be adapted for therapeutic practice. The basic hypothesis underlying this method, consistent with the present framework, is that clients' strivings towards higher order-goals are blocked by pathogenic beliefs about the consequences of pursuing these goals: that such actions will endanger self or others. It is hypothesised, however, that clients (generally unconsciously) use therapy to disconfirm these pathogenic beliefs, often through their relationship with the therapist. This is the patient's *plan* for therapy (Silberschatz, 2017). Formulation, therefore, consists of four elements: identifying the client's goals for therapy (for instance, 'To feel more positive about myself'), the pathogenic beliefs that obstruct them from pursuing and achieving these goals (for instance, 'People will reject me if I am successful'), the tests that the client will carry out to try and disconfirm these beliefs (for instance, 'I will put myself down in the sessions to see if the therapist colludes with me'), and the insights that may help them achieve their goals (for instance, 'Others have more respect for me than I assume'), (Curtis et al., 1994, p. 198). Clients may be identified as having several goals, obstructions, tests, and insights; and these can be drawn together into a summary plan formulation.

Because this process has been developed for a research context, with an aim of reliable formulation, the plan formulation is based on transcripts of early therapy sessions, such as an assessment interview and the first two therapy sessions. It proceeds by five stages (Curtis et al., 1994). First, clinical judges independently review the transcripts, and come up with a list of goals, obstructions, tests, and insights that they believe are relevant to the case, and also some that they think are less relevant (to see if the judges can discern more and less relevant items). These are all then pooled together, and the judges then rate all items on how relevant they are to the case. Low scoring and redundant items are then dropped, and that leaves a list of agreed goals, obstructions, tests, and insights for each client, which form the basis for an agreed-upon formulation. Encouragingly, research shows that the agreement between judges on the relevance of items is high.

Research using the plan formulation method has shown that the more the therapists' interventions and interpretations correspond to the agreed-upon plan (*plan compatability*), the better that clients do in therapy (Curtis et al., 1994). Indeed, recent analysis by Silberschatz (2017) suggests that it may contribute as much as 25% of the variance in outcomes. It has also shown that better outcomes are associated with more progress towards the goals specified in the plan.

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