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Case Formulation and Treatment Planning: How to Take Care of Relationship and Symptoms Together

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Most patients present with a combination of symptoms and relational problems, but often psychotherapies are not conducted in a way to deal with both. Many therapists take a *top-down approach* to treatments. That is, the techniques they use are based on their theories of therapy (that suggest how certain diagnoses should be treated) rather than on an understanding of the unique problems and issues of the individual patient. We suggest that what is needed is a *bottom-up approach*, in which the individual patient's goals, conflicts, inhibitions, and so forth are identified and therapeutic interventions are designed accordingly on a case-specific basis. The foundation of such an approach is a case-specific clinical formulation. There are a number of formulation methods; we focus on the plan formulation method to illustrate how to evaluate the individual needs and specificities of the therapy patient and then how to tailor a therapy to the individual patient, regardless of the therapist's theoretical or technical predilections. Finally, we report examples of therapies conducted in this bottom-up approach to demonstrate how symptoms and relational problems can and should be addressed.

Keywords: plan formulation methods, case formulation, psychotherapy techniques, psychotherapy relationship, relational difficulties

Most clients present with a combination of symptoms and relational problems, but often psychotherapies are insufficiently suited to deal with both. Treatments for symptom disorders, especially coming from the cognitive-behavioral therapy (CBT) tradition, often neglect interpersonal issues (e.g., Nordahl et al., 2018). Conversely, psychodynamic and humanistic approaches focus on relational dynamics but usually pay less attention to cognitive and behavioral techniques that target specific aspects of symptom maintenance (e.g., Cain, 2002; Markowitz & Weissman, 2004; Stolorow, Brandchaft, & Atwood, 1987).

As an example of the first, we can point to behavioral activation, a well-documented, effective treatment for depression (Lewinsohn, 1974). Usually the focus of this approach is on changing behavior, with no systematic assessment of the existence of pathogenic schemas that made the person lose motivation to be active in daily life. Third wave cognitive therapies (e.g., Wells, 2011) focus on worry and rumination and are usually as brief in duration as four to five sessions. They teach clients to recognize that they are worrying—and that worry is noxious—and then provide clients with techniques aimed at diverting attention and drifting away from worrying. These approaches might not give attention to existential goals that are unmet and might leave the client unfulfilled and prey to different forms of suffering.

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