Shared Case Formulation as the Main Therapeutic Process in Cognitive Therapies

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The Core Assumption of the Book

Case formulation may be the purloined letter of the therapeutic process in standard cognitive behavioral therapy (CBT) or other CBT approaches. It is the object that has escaped most careful investigations, although it has been visibly displayed on the mantel, as it were. In CBT approaches, clinicians have devoted themselves—not

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G. M. Ruggiero et al. (eds.), *CBT Case Formulation as Therapeutic Process*,
https://doi.org/10.1007/978-3-030-63587-9_1

without reason nor with bad results—to look for irrational beliefs and cognitive biases, sometimes at the price of underrating the explicit sharing case formulation by taking it for granted (Kuyken 2006, p. 12).

The basic assumption of this book is that case formulation is the initial move and main operational tool of CBT approaches by which a therapist manages the entire psychotherapeutic process. The idea is that, in CBT, case formulation incorporates both the specific cognitive and behavioral interventions of the treatment and the non-specific components, including the negotiation of the therapeutic alliance and the management of the therapeutic relationship. In addition, this book assumes that, in CBT approaches, case formulation is a procedure incessantly and openly shared between the patient and therapist from the beginning to the end of treatment. This book aims to show how this aspect is increasingly becoming the hallmark of standard CBT approaches because it is in line with CBT's basic principles. This attitude implies full confidence in the conscious agreement between therapists and patients, transparent cooperation, and an explicit commitment to the CBT model of clinical change.

In summary, the objectives of this book are to:

- Conceptualize shared clinical case formulation as the core and distinctive intervention of the main forms of CBT because it is intrinsically linked to CBT's basic tenets;
- Describe the shared case formulation procedures in CBT approaches to show how, in many of them, this process allows the therapist to manage both CBT-specific and non-specific features of the therapeutic process;
- Review the historical development of the main forms of CBT to show the way in which shared case formulation emerges is a truly unifying and distinctive feature of CBT approaches; and
- Explore the use of case formulation in some relational and psychodynamic approaches close to CBT approaches by discussing similarities and differences.

Of course, case formulation is present in psychotherapeutic approaches beyond CBT. Despite many similarities, it is important to distinguish CBT approaches from other psychotherapeutic treatments in which conscious cognition is an important variable but is neither the cardinal mediator of emotional suffering nor the main target of therapeutic intervention. This theoretical difference also becomes a theoretical divide in the conception and management of shared case formulation during the therapeutic process between CBT and non-CBT approaches.

This book attempts to qualify CBT approaches as treatments in which—by definition—the therapeutic process occurs with full conscious sharing (Dobson and Dozois 2001); it also distinguishes these approaches from other models in which the therapeutic process occurs by not establishing this full sharing from the beginning and conceiving it as a goal to be achieved and a final outcome of the treatment. This latter aspect involves exploring mental states and relational patterns that are not immediately accessible to the consciousness, as happens in psychodynamic psychotherapies (Gabbard 2017) or by looking for personal and existential meanings that are fully constructed only at the end of a long exploratory process, which is a component of constructivist psychotherapies.

For the sake of clarity, we must notice that there are some constructivist approaches (also called constructive approaches) that were born in the CBT domain and in a broad sense belong to this clinical field, but differ in—among many other things—the conception of case formulation. These are the constructivist approaches that target hermeneutic, emotionally charged, and "tacit" cognition (Guidano 1991; Guidano and Liotti 1983; Mahoney 2003; Neimeyer 2009) and may partially diverge from other CBT approaches that favor therapeutic work over shared case formulation. For this reason, the term "constructivist approaches" is sometimes used in this book as distinct from CBT approaches, although we remain aware that they belong to the CBT domain.

Summing up, we propose that this way of sharing case formulation is one of the main qualifying features of many CBT approaches. This particular approach involves unceasingly sharing the case formulation with the patient in three aspects:

1. Formulation of the explanatory model of emotional suffering;
   (a) Formulation of the rationale for the treatment strategy proposed to the patient; and
   (b) Monitoring of therapeutic progress and its feedback action on the treatment strategy, which allows, when necessary:
      i. Reformulation of the case;
      ii. Renegotiation of the goals of therapy; and
      iii. Changing the treatment plan according to the new formulation and new rationale.

This emphasis on the conscious sharing of case formulation as a tool to obtain full patient cooperation allows us to explain another core feature of many CBT approaches: The patient is a fully active agent in his or her treatment, because the therapeutic model and the rationale of the intervention can be shared with him or her from the beginning. This possibility to manage case formulation in a relentlessly shared way derives from the CBT tenet that dysfunctional states are reasonably accessible to consciousness and significantly tractable at the level of consciousness (Dobson and Dozois 2001).

Even the CBT attention to the patient's specific disorders, problems and symptoms—although shrinking with the emergence of transdiagnostic models (Hayes and Hofman 2018)—would originate from the principle of the shared case formulation: The CBT therapist starts from problem areas defined during case formulation, including the symptoms for which the patient seeks effective and reasonably immediate solutions.

Shared Case Formulation and Therapeutic Alliance

This book also promotes the idea that the principle of shared case formulation can offer CBT approaches a specific terminology to deal with the so-called common and unspecific therapeutic processes, namely the management of the therapeutic alliance and relationship (Asay and Lambert 1999). It is not a coincidence that, in the above-mentioned psychodynamic and constructivist models, cognition is conceived as inseparable from relational experience to such an extent that they consider the relationship as the real significant mediator of the therapeutic change (Bara 2018; Gabbard 2017). Adopting an operationally CBT-specific terminology for the concepts of alliance and therapeutic relationship such as "**shared case formulation"** without borrowing words from approaches that obey different principles allows one to remain focused on the historical proposal of CBT. It also encourages the conceptualization of the therapeutic alliance in terms that are consistent with the principles of CBT approaches (Bruch 1998, 2015; Sturmey 2008, 2009). In CBT approaches, alliance and relationship are an important pre-condition of the therapeutic process but are not a unit of analysis for the change process. This observation is not coincidental; rather, it is significant for maintaining the distinction between CBT approaches and relational models that increasingly; this distinction suggests the resolutive aspects of the therapeutic process are to be found in the therapeutic relationship as, for example, in the case of Wampold and Imel's model (Wampold and Imel 2015). It is therefore not just a matter of terminology: Words are important and reflect the nature of the theoretical model.

Case Formulation in CBT and Non-CBT Approaches

From a historical point of view, a divergence of development in CBT and non-CBT case formulation seems correct. Regarding CBT, behavioral therapies have historically used the term case formulation, as reported by various scholars focused on the history of this term (Bruch 1998, 2015; Eells 2007, 2011, 2015; Sturmey 2008, 2009). Of these, Bruch and Sturmey tell the story from a CBT point of view: They highlight how the term case formulation was initially conceived by Victor Meyer (1957) and finally introduced into CBT approaches in 1985 by Turkat (1985, 1986). Moreover, the term was present in the work of other theorists and clinicians belonging to the CBT domain, such as Shapiro (1955, 1957), Lazarus (1960, 1976), Wolpe (1954), Yates (1958), and Kanfer and Saslow (1969). Meyer's contribution stands out because it introduces to CBT an element of alliance, while for the other authors, case formulation did not contain in itself the element of agreement and sharing with the patient (Meyer and Turkat 1979).

Outside the CBT domain, Eells aimed to outline a more atheoretical story of case formulation. However, Eells did not ignore the contribution of CBT, given that Eells' handbook entrusts to Persons and Tomkins (2007) the account of the

development of CBT case formulation. The atheoretical tradition followed by Eels appears to be more recent, as is clear if we pay attention to the years of publication of the cited texts: It begins with Weerasekera (1996), followed by McWilliams (1999) and Eells (2007). At present, there are many case formulation models outside the CBT line sown by Meyer, such as plan analysis by Caspar (1995, 2007), the mode model by Fassbinder et al. (2019), the formulation of maladaptive patterns by Critchfield et al. (2019), and the dynamic formulation focused on motives, defenses, and conflicts by Perry et al. (2019).

Contents of the Chapters and Structure of the Book

The following chapters of this book develop this program; some chapters, written by the three editors **Giovanni Maria Ruggiero**, **Gabriele Caselli**, and **Sandra Sassaroli**, deal with case formulation in either CBT or non-CBT therapeutic orientations, while other chapters are critical comments on the main assumptions of the book delivered from experts in specific therapeutic orientations. For example, the chapter on case formulation in standard cognitive therapy (CT) is followed by a comment from Arthur Freeman, a clinician and researcher in the CT area.

Hereafter, we briefly summarize the content of the chapters and note the names of the authors who comment on them. After this introductory chapter, the second chapter deals with the emergence of shared case formulation in Beck's CT (Beck 1963, 1964; Beck et al. 1979; Clark and Beck 2010) and in Victor Meyer's behavioral approach. The chapter describes how Aaron T. Beck uses the components of his cognitive diagram—central beliefs, intermediate beliefs, and coping strategies—to provide the patient with a psychopathological interpretation and therapeutic reworking of the reported problematic situations by questioning them. Moreover, in CT, the diagram is fundamental to managing the therapeutic relationship by conceptualizing distorted interpersonal beliefs and increasing therapist empathy (Beck 2005).

The first commentary on this chapter is written by **Arthur Freeman** (chapter "The Conceptualization Process in Cognitive Behavioral Therapy. Commentary on Chapter "Case Formulation in Standard Cognitive Therapy"") who describes the conceptualization process of CBT in eleven steps, from the need to develop a working model of the patient's problems to the collaborative work with the patient to refine the conceptualization. **Steven Hollon** (chapter "Case Formulation in Standard Cognitive Therapy: A Commentary on Chapter "Case Formulation in Standard Cognitive Therapy"") confirms many of the theoretical assumptions of the commented chapter from his unique viewpoint as a scholar who significantly contributed to the development of CBT, and explains how cognitive therapists manage the developing relationship across different clients in a manner that is wholly guided by the cognitive conceptualization. Nonspecific processes are relatively secondary with less complicated clients, whereas with more complicated clients they instantiate the case formulation in terms of the "three-legged stool": current life events,

childhood antecedents, and therapeutic relationship. **Angelo Saliani**, **Claudia Perdighe**, **Barbara Barcaccia**, and **Francesco Mancini** (chapter "Commentary to Chapter "Case Formulation in Standard Cognitive Therapy": The Use of Goals in Cognitive Behavioral Therapy Case Formulation") introduce the role of goals in CT case formulation, which are often overlooked and may allow treatment of the problem of motivation from a cognitive viewpoint. It is fascinating to notice how goals and motivations represent a cognitive answer to the problem of the difficult detachment of some patients from their biased beliefs, an answer that makes it possible to conceive the subjective and emotional rationality that keeps patients stuck in their symptoms, an answer related to but distinct from the metacognitive model that we subsequently encounter.

Chapter "Case Formulation in the Behavioral Tradition: Meyer, Turkat, Lane, Bruch, and Sturmey" deals with the use of the shared case formulation in the behavioral tradition. This section owes much to the comprehensive and convincing description from Michael Bruch (2015) of the development of the concept of case formulation by Meyer (1957) and Turkat (1985, 1986). Meyer shares the case formulation with the patient in a way that is itself part of those environmental and behavioral circumstances that must be altered to achieve therapeutic change. The commentary for this chapter is written by **Peter Sturmey** (chapter "Some Thoughts on Chapter "Case Formulation in the Behavioral Tradition: Meyer, Turkat, Lane, Bruch, and Sturmey" *Case Formulation in the Behavioral Tradition: Meyer, Turkat, Lane, Bruch, and Sturmey* by Giovanni Maria Ruggiero, Gabriele Caselli and Sandra Sassaroli"), a major scholar in the behavioral tradition. He addresses four points: what is meant be "sharing a case formulation"; what is the relationship between case formulation and therapeutic relationship; what is the behavioral the conception of cognition and meta-cognition in behavioral case formulation; and, finally, what is the self-managed life?

Chapter "How B-C Connection and Negotiation of F Allow the Design and Implementation of a Cooperative and Effective Disputing in Rational Emotive Behavior Therapy," written by the editors in cooperation with **Diego Sarracino**, discusses how in Albert Ellis' rational emotive behavior therapy (REBT; DiGiuseppe et al. 2014; Ellis 1962; Ellis and Grieger 1986), the therapist uses three specific steps from the basic ABC DEF procedure of REBT—namely the B–C connection, D rationale, and F negotiation—to formulate the patient's problems, regulate the therapeutic process, and manage the therapeutic alliance. The healthy attitude is not to have negative thoughts but rather to tolerate them and not take their demands seriously and awfulize aspects. This REBT attitude anticipates metacognitive procedures. It is this unceasing sharing of the rationale of the therapy that allows the REBT therapist to show empathy and respect toward the patient. **Raymond DiGiuseppe** and **Kristene Doyle** (chapter "Commentary to Chapter "How B-C Connection and Negotiation of F Allow the Design and Implementation of a Cooperative and Effective Disputing in Rational Emotive Behavior Therapy." REBT's B-C connection and Negotiation of F") and **Wouter Backx** (chapter "Commentary to Chapter "How B-C Connection and Negotiation of F Allow the Design and Implementation of a Cooperative and Effective Disputing in Rational

Emotive Behavior Therapy." Commentary on Chapter "How B-C Connection and Negotiation of F Allow the Design and Implementation of a Cooperative and Effective Disputing in Rational Emotive Behavior Therapy": REBT Provides a firm Basis for Case Formulation by Employing an Ongoing, Implicit and Hypothetico-Deductive form of Data Collection in Critical Collaboration, Negotiation and an Equal Relationship with the Client"), who are among the major heirs of Albert Ellis' legacy, comment on this hypothesis. DiGiuseppe and Doyle expand on several points made in the commented chapter, including the importance of a solid therapeutic alliance and strategies to attain this, common factors in psychotherapy as they relate to REBT, the often overlooked and/or underrecognized behavioral consequences of irrational beliefs, important aspects of assessment and how it contributes to case conceptualization, how REBT in most cases involves a simultaneous process of assessment and treatment, a method that often deviates from many other CBT approaches, and important considerations of cognitive process and content domain. On the other hand, Backx emphasizes how in REBT the case formulation process is implicit and ongoing and the hypothetico-deductive method is used. While in chapter "How B-C Connection and Negotiation of F allow the Design and Implementation of a Cooperative and Effective Disputing in Rational Emotive Behavior Therapy" the editors have focused on the B–C connection, D rationale, and F negotiation, Backx stress that it takes place as well during the search for the critical A, the accurate IB (Irrational Belief), and during the formulation of the EB (Effective New Belief). The whole approach is built upon critical collaboration, negotiation and equality between client and therapist.

Chapter "Case Formulation in Process-Based Therapies," written by the editors in cooperation with **Andrea Bassanini**, discusses case formulation in more recent CBT approaches focused on cognitive processes. In schema therapy (ST; Arntz and van Genderen 2009; Young et al. 2003), the case is formulated in terms of cognitive patterns of the self that are not purely cognitive (as in Beck's CT). Further, this approach shows a strong interpersonal aspect rooted in the development of the patient and conceptualized in the so-called "modes" that are stereotypical and inflexible relational models. ST organizes case formulation in terms of schemata and modes to manage its therapeutic strategy. In the metacognitive therapy model (MCT; Wells 2008; Wells and Mathews 1994), case formulation is focused on the function of conscious executive choice that can become dysfunctional because of metacognitive biases. Given the importance of the concept of choice in MCT (Mathews and Wells 1999), case formulation in this model is, by definition, fully shared with the client on a conscious and collaborative level. The acceptance and commitment therapy model (ACT; Hayes and Strosahl 2004) belongs to the so-called "third wave" process of cognitive therapies and can be conceptualized as a reincarnation of Meyer's functionalist conception of case formulation in which the therapeutic task is focused on evaluating and sharing with the patient his or her mental functioning in order to plan the treatment (Hayes and Strosahl 2004). Finally, process-based CBT (PB-CBT; Hayes and Hofman 2018) integrates the standard CT approach into a process framework by formulating the case around fundamental biopsychosocial processes in target-specific situations with specific clients. **Avigal**

Snir and **Stefan Hofmann** comment on the description of case formulation in PB-CBT (chapter "Commentary on Chapter "Case Formulation in Process-Based Therapies": Process Based CBT as an Approach To Case Conceptualization") and describe how PB-CBT works under the assumption that the symptom is maintained and is also maintaining a network that is maladaptive and resilient for change; PB-CBT aims to help the client replace a maladaptive network with an adaptive one, to strengthen processes that promote well-being and experiences that goes in line with the clients' values and ambitions. **Paolo Moderato** and **Kelly Wilson** comment on the description of case formulation in ACT (chapter "Clinical Behavior Analysis, ACT and Case Formulation. A Commentary on Chapter "Case Formulation in Process-Based Therapies"") and stress how it is deeply rooted in Behavior Analysis. The basic points of Behavior Analysis are psychological flexibility, non-mentalistic assumption, functional analysis, and values. Psychological flexibility is an overarching complex repertoire of skills that allow clients to be open to the experience of the present moment and to direct their lives. Non-mentalistic assumption implies that ACT processes are behavioral patterns in context and shouldn't be cognitivized. Functional analysis is helpful to assess the patient's patterns of behavior that in many occasions were useful and functional and are maintained by strong contingencies of reinforcement but can be very harmful and dysfunctional in different contexts**.** In ACT the term values refers to patterns of activities that give our lives meaning. Regarding the rise of PB-CBT, the authors suggest that it could be a new version of the functional analysis integrated within multi-level, multi-dimensional evolutionary science. **Eckard Roediger**, **Nicola Marsigli** and **Gabriele Melli** in ST (chapter "Schema Therapy, Contextual Schema Therapy and Case Formulation: Commentary on Chapter "Case Formulation in Process-Based Therapies"") describe how schema therapy combines cognitive theory and developmental concepts. The impact of early childhood need frustrations leads to biased cognitive schemata. The focus on aversive early childhood experiences and resulting schemas broadens the scope of conventional cognitive case formulations into the very early childhood years. The experiential interventions used in Schema Therapy add an emotional dimension to the initial cognitive framework, by bringing the clients in touch with significant childhood experiences. All of these models introduce a second level of metacognitive processes in mental activity that allows the conceptualization of the difficulties of patients who are seemingly less able to detach from their biased cognitive contents. In addition, ST adds a developmental level in which cognitive biases are learned during the personal life of the patient, while ACT considers a motivational component: values.

Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies" is devoted to constructivist approaches. The central hypothesis of the chapter is that, in constructivist models, sharing case formulation is the outcome of an explorative process and not an initial move that sets the rules of the game. Of course, constructivism has contributed to the development of the practice of case formulation in the CBT domain: It introduced the concept of personal meanings with Bruner (1973) and Kelly (1955), and then transformed it into a clinical concept with Guidano (1991), Mahoney (2003), Neimeyer (2009),

and other constructive thinkers and clinicians (Neimeyer and Mahoney 1995). On the other hand, as noted above, constructivist approaches that target hermeneutic, emotionally charged, and "tacit" cognition (Guidano 1991; Guidano and Liotti 1983; Mahoney 2003; Neimeyer and Mahoney 1995) may diverge from more standard CBT approaches in the use of case formulation. The most promising developments rooted in this tradition are the models of metacognitive and interpersonal therapy (MIT; Dimaggio et al. 2007; Semerari et al. 2014), which integrates interpersonal and metacognitive concepts, and dilemma focused therapy (DFT, Feixas and Compañ 2016). DFT is derived from Kelly's personal construct theory (Kelly 1955) and psychotherapy (Winter and Viney 2005) and proposes an interesting case formulation procedure based on a dilemmatic conception of the constructs of the self and of significant others. The comments on this chapter are written by many clinicians and theorists of the constructivist tradition: **Guillem Feixas** and **David Winter** (chapter "A Constructivist Pioneer of Formulation. A Commentary on Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") discuss how George Kelly introduced the notion of formulation in his personal construct psychology and its associated form of psychotherapy. The process of assessing and sharing the formulation, in which the clinician attempts to construe the construction processes of the client using a set of diagnostic constructs, is an example of what Kelly termed sociality. **Antonio Semerari** and **Antonino Carcione** (chapter "Commentary on the Presentation of the Metacognitive Interpersonal Therapy Model in Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") explain how their MIT is a treatment specific to relatively difficult patients with complex personality and psychotic disorders. Owing to their relational difficulties, these patients can activate problematic interpersonal cycles during treatment, in which the therapist is involved. In turn, relational difficulties are related to reduced metacognitive skills. **Benedetto Farina** (chapter "The Role of Trauma in Psychotherapeutic Complications and the Worth of Giovanni Liotti's Cognitive-Evolutionist Perspective (CEP): Commentary on Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") discuss how Liotti's cognitive-evolutionist perspective is a cognitive psychotherapeutic perspective focused on the treatment of psychopathology resulting from abusive and, more specifically, neglectful family and interpersonal contexts. CEP attempts to solve the problems and obstacles that developmental trauma generates on a relational, cognitive, and metacognitive level in psychotherapy and to provide theoretical and practical solutions to the relational difficulties of psychotherapy, in particular in the therapeutic alliance. **Maurizio Dodet** (chapter "The Case Formulation in the Post-Rationalist Constructivist Model. Commentary on Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") explains how the core of radical post-rationalist constructivism is the exploration of the self and of its identity and continuity processes. The model has a vision of the individual as an autonomous complex system builder of meanings, generating a feeling of continuity and unity central to the maintenance of a stable identity. An emotional disorder represents the attempt to maintain this feeling of continuity and unity of identity.

Fabio Monticelli (chapter "Case Formulation and the Therapeutic Relationship from an Evolutionary Theory of Motivation. Commentary to Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") clarifies some fundamental principles of the clinical use of the case formulation and the therapeutic relationship from an evolutionary theory of motivation (ETM) viewpoint. From an ETM perspective, the case formulation is conceived as a dynamic, concrete, and intensely emotional and relational element. It is formulated and shared with the patient at the beginning of the therapy—as happens in other cognitive behavioral treatments—but it is subject to continuous verification, especially during relational events. **Raffaella Visini** and **Saverio Ruberti** (chapter "Emotion, Motivation, Therapeutic Relationship and Cognition in Giovanni Liotti's Model: Commentary on Chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies"") explain how Liotti based much of this relational elaboration on the construct of the interpersonal motivational system, using it as a privileged tool for the identification and exploration of universal rules based on innate and phylogenetically grounded principles which guide and orient intersubjective dynamics. Evolutionary, motivational and biological aspects are necessary in order to understand human emotional experiences and relational behavior. In Liotti's cognitive evolutionary orientation, the shared formulation of the case can be considered one of the effective interventions, but it does not in itself constitute the main instrument of therapeutic intervention and the therapeutic relationship. All of these theorists and clinicians seem interested in exploring the level of mental activity attentive to perceptual, non-verbal, relational, and traumatic-based aspects, which are emotional and not controlled by rational calculation and voluntary faculties.

Chapter "Case Formulation as an Outcome and Not an Opening Move in Relational and Psychodynamic Models" deals with case formulation models that emphasize the role of the therapeutic relationship, whether psychodynamic (e.g., Mitchell and Aron 1999) or constructivist (Bara 2018; Liotti and Monticelli 2014). The possible assumption of these models is that the case formulation cannot be completely shared at the beginning of treatment but is rather an outcome of the therapeutic process. These conceptions consider the therapeutic relationship as the unit of analysis for the disorder and as the field in which the psychopathological mechanism acts and the therapeutic process is applied. The consequence is that relational models share case formulation as the final result of an explorative path. This hypothesis is also applicable to modern psychodynamic models such as the control mastery theory (Silberschatz 2013), which includes a formulation procedure that can only be fully understood and shared after the client has unconsciously tested the therapist by recreating previous interpersonal experiences in the therapeutic relationship. Passing the tests creates conditions that allow the patient to acquire new emotional experiences that will help to disconfirm dysfunctional beliefs. The first commentary on this chapter is written by **Francesco Gazzillo** and **George Silberschatz** (chapter "Commentary to Chapter "Case Formulation as an Outcome and not an Opening Move in Relational and Psychodynamic Models": Plan Formulation vs. Case Formulation: The Perspective of Control-Mastery Theory")

who clarify how in the Control-Mastery Theory (CMT) perspective both clinicians and researchers talk about *plan formulation* and not case formulation. The *plan formulation* includes the description of the adaptive *goals* that patients wish to achieve by disproving their unconscious *pathogenic beliefs*, and that derive from early attempts to deal with *traumatic and adverse developmental experiences*. In addition, in order to master their traumas, patients aim to disprove their pathogenic beliefs by unconsciously posing *tests the therapists*. Last, the *plan formulation* includes a description of *new experiences* or *insights* patients would like to have in order to better understand their problems. **Marco Innamorati** and **Mariano Ruperthuz Honorato** (chapter "Some Historical and Theoretical Remarks about Psychodynamic Assessment. Commentary on Chapter "Case Formulation as an Outcome and not an Opening Move in Relational and Psychodynamic Models"") discuss how the difference of attitude, with respect to case formulation, is tied to many factors, like the general setting of therapy and the theorists' epistemological attitude, which can be more or less realist, or, on the contrary, more or less hermeneuticist or constructionist. Single theorists' beliefs about the effect of case formulation are also important. They are, linked to the beliefs about *when* or even *if* it is possible to verbalize a case formulation to the patient. **Paolo Migone** (chapter "Case Formulation in Psychoanalysis and in Cognitive-Behavioral Therapies: Commentary on Chapter "Case Formulation as an Outcome and not an Opening Move in Relational and Psychodynamic Models"") writes that in psychodynamic therapy, case formulation is always present; it can be conceived in terms of understanding the patient's history, his or her life narrative. In a way, interpretation itself (a central concept of psychoanalysis) can be seen as a case formulation, i.e., the explanation to the patient of the meaning of his/her symptoms, the reason why he or she asked for help. The commentary discusses why case formulation at the beginning of the therapy is questionable in the treatment of difficult patients both in psychoanalysis and in cognitive behavioral therapies. These comments develop the theme of the non-rational mental states already explored in the previous chapters, taking it to the further level of the unconscious states of the psychodynamic models.

Chapter "The Empirical State of Case Formulation: Integrating and Validating Cognitive, Evolutionary and Procedural Elements in the CBT Case Formulation in the LIBET Procedure" presents a case formulation model by the editors of this book; it explores the possibility of integrating standard CBT, developmental, and process elements in case formulation. The model is called *Life Themes and Plans: Implications of Biased Beliefs Elicitation and Treatment* (LIBET; Sassaroli et al. 2017a, 2017b). The emotional disorder is conceptualized on two axes: (1) A negative evaluation of events and relational patterns, called "painful life themes," learned in significant experiences and relationships evaluated as intolerably painful and formulated in terms of self-beliefs, a concept based both on Kelly's personal constructs (Kelly 1955) and Beck's core belief concepts (Beck 1963); and (2) a rigid and one-dimensional management of life themes achieved by using avoidant, controlling, and/or impulsive coping strategies called "semi-functional plans," privileged even at the cost of renouncing to a significant degree areas of personal, relational, emotional, cognitive, and behavioral development. There is a third process level that

keeps themes and plans dysfunctionally active. The LIBET procedure is both a process and a developmental response to the problem of conceptualizing and formulating the case in patients who show irrational and seemingly uncontrollable mental states, and it is aptly commented on by constructivist scholar **David Winter** (chapter "Commentary on Chapter "The Empirical State of Case Formulation: Integrating and Validating Cognitive, Evolutionary and Procedural Elements in the CBT Case Formulation in the LIBET Procedure": A Constructivist Perspective on LIBET"). His commentary endorses the use of shared case formulation as main therapeutic tool, and discusses the role of personal meanings and constructions, and their level of awareness. In addition, the capacity of the axes of the LIBET procedure of case formulation to describe the adaptive value of clients' constructions in certain areas of their lives, or at particular times, is acknowledged. On the other hand, the commentary critically remarks on the occasional difficulty of completely shedding a rationalist cognitive approach.

Last, **Christiane Eichenberg** (chapter "New Dimensions in Case Planning: Integration of E-mental Health Applications") discusses the most recent technological developments in case formulation and planning: the integration of online E-mental health applications. This paper treats the integration of digital support into psychotherapy, its impact on past case formulations, and recommendations on effective implementation of digital technology in the psychotherapeutic field. In the final section are discussed the empirical evidence on the inclusion of E-mental health in the case formulation. In the final afterword (chapter "Now's the Time: CBT Shares Case Formulation more (But not *too*) Easily"), the three editors themselves briefly discuss how the core assumptions of this book can be influenced by and profit from the observations and criticisms presented in the commentaries.

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