Case Formulation in Process-Based Therapies

Giovanni Maria Ruggiero, Gabriele Caselli, Andrea Bassanini, and Sandra Sassaroli

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The Third Wave: Process Models

Since the end of the 1990s, there has been a turning point in the field of cognitive psychotherapies with the emergence of the so-called "third wave" or process models, namely *acceptance and commitment therapy* (ACT; Hayes and Strosahl 2004),

G. M. Ruggiero (✉)
"Psicoterapia Cognitiva e Ricerca," Cognitive Psychotherapy School and Research Center, Milan, Italy

Sigmund Freud University, Milan, Italy

Sigmund Freud University, Vienna, Austria
e-mail: gm.ruggiero@milano-sfu.it

G. Caselli
Sigmund Freud University, Milan, Italy

Sigmund Freud University, Vienna, Austria

Department of Psychology, London South Bank University, London, UK

A. Bassanini
MeP—Mindfulness e Psicoterapia, Milan, Italy

Società di Psicoterapia Cognitivo Comportamentale CBT-Italia, Milan, Italy

S. Sassaroli
Sigmund Freud University, Milan, Italy

Sigmund Freud University, Vienna, Austria

"Studi Cognitivi," Cognitive Psychotherapy School and Research Center, Milan, Italy

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behavioral activation (BA; Kanter et al. 2009; Martell et al. 2001), the *cognitive behavioral analysis system of psychotherapy* (CBASP; McCullough and Goldfried 1999), *dialectical behavior therapy* (DBT; Linehan 1993), *functional analysis psychotherapy* (FAP; Kohlenberg and Tsai 1991), and *integrative behavioral couples therapy* (IBCT; Christensen et al. 1995; Doss et al. 2002).

Third wave cognitive psychotherapy process models suggest that emotional disorders do not depend on biased mental representations of the self (i.e., self-knowledge and self-beliefs) as Beck (1976) thought. Rather, they rely on the dysfunctional interaction between voluntary and regulatory processes—for example, attention and executive control—and emotionally charged, automatic associative processes (Kahneman and Frederick 2002; Martin and Sloman 2013; Sloman 2002; Stanovich and West 2002; Wells and Mathews 1994).

What is the function of case formulation in these new approaches? To understand this question, we must remember that these models have maintained a strong relationship with the behavioral tradition and represent a return to contextual and functional analysis (Jacobson et al. 2001). The emphasis on functional analysis suggests that in these methods there is a different relationship to case formulation compared to how it is used in Beck's standard *cognitive therapy* (CT; Beck 2011). Indeed, in CT, case formulation is primarily a function of ascertaining and thus preparing for treatment. Through case formulation, the therapist may explore the *core beliefs* and *coping strategies* on which the *questioning*, which is the heart of CT treatment, focuses. Case formulation also serves to establish the therapeutic alliance by sharing the rules of the CT game through the so-called socialization phase, a name that is not far from the term alliance. This conception of case formulation in Beck's CT is in line with the proposal of this book, that shared case formulation not only establishes the sharing of rules but serves to manage the therapeutic relationship in specifically cognitive terms.

Although case formulation had already been important and present in CT, the emphasis and structural centrality of the core schemes on the self in CT's therapeutic process in part did not help to understand the key role that explicit and unceasing sharing of the case formulation plays in the therapeutic process of CT and *cognitive behavioral therapy* (CBT) approaches in a broad sense. Process therapies are therefore a turning point in the theoretical conception of mental functioning as well as the clinical conception of the therapeutic process in which case formulation can definitively assume a key role in either procedural or theoretical terms. Third wave process CBT approaches can be interpreted as a paradigm shift from a concept of psychotherapy as discovery of the self to a model focused on sharing a representation of mental functioning with the patient in order to plan a treatment. These approaches accomplish this goal by encouraging the development of mental flexibility in the management of adverse situations and the promotion of a broader behavioral repertoire in daily life (Hayes and Strosahl 2004; Wells 2008).

In addition, while traditional-CBT-approach therapies have focused on change, third wave process approaches recommend flexibility in balancing acceptance and change. Consequently, with regard to the clinical practice of case formulation in process therapies, flexibility, acceptance, and commitment to change have replaced

the role that core beliefs play in CT. The basic principle of case formulation in process therapies is that the goal is not to ascertain the structural basis of the emotional disorder in terms of whether, for example, a negative belief underlies and fuels anxiety. Rather, it is to examine the function of the symptom and share it with the patient. In short, what matters is to share with the patient how he or she organizes his or her life around anxiety. Anxiety and its cognitive correlates for the ACT therapist perform a function and are not a mistake, except that they cannot be flexibly applied. This function is presumably to protect against more or less realistic risks and, in a broader sense, to define one's life in terms of safety and prudence as general goals.

Case Formulation in Acceptance and Commitment Therapy

Among process approaches, ACT seems to be the most popular. Its main therapeutic goal is to achieve a state of mind of acceptance, develop flexibility toward personal values, and promote commitment in the patient to change (Hayes et al. 2013). In addition, ACT often shows a sophisticated experiential component that is reminiscent of an updated form of behavioral extinction. However, this concept includes a more extended degree of metacognitive awareness and executive mastery (Hayes et al. 2013). The theoretical background of ACT is the relational frame theory, whose therapeutic principle is that it is not a priority to intervene directly on the contents of dysfunctional thoughts but that it is more convenient to act on how the individual relates to his or her own thoughts. To achieve this goal, ACT therapists do not limit themselves to a question as emblematic of pragmatic CBT questioning as:

What do you need this for?

Instead, they carefully examine the patient's behavior in life situations through a detailed functional analysis that is articulated in various ways in different approaches. For example, ACT is organized in six behavioral repertoires:

Acceptance/experiential avoidance;
Cognitive defusion/fusion;
Contact with the present moment/conceptualized past and feared future;
Self as context/attachment to conceptualized self;
Values/lack of values clarity;
Committed action/inaction, impulsivity, or avoidance.

Let us now discuss them in detail. *Experiential avoidance* comprises the set of strategies we put in place in order to control and/or alter our internal experiences (thoughts, emotions, feelings, or memories), even when this endeavor causes behavioral damage. **The flexible alternative to experiential avoidance is acceptance. When it comes to acceptance,** the therapist uses sentences of more or less the same type with the patient (the following interventions are an adaptation from ACT training in which one of the authors has participated):

What should we accept? The painful emotions, the harmful thoughts that every day our mind proposes to us, the sad impulses and memories.

Cognitive fusion refers to the tendency of human beings to be captured by the contents of their own thoughts. According to the process, CBT updates the cognitive principle: **It is not what we think about that creates problems (standard CBT formulation) and pain but the way we relate to what we think (process CBT formulation).** According to ACT, *the alternative to cognitive fusion is simply defusion. To obtain it,* ACT *promotes the ability to:*

Learn to observe one's own thoughts, images, or memories, recognizing them for what they are, i.e., products of the mind and not absolute realities.

Look at one's experience from above and in a decentralized way, an endeavor that promotes awareness of one's own mental experience.

Conceptualized past and the feared future comprises the difficulty of directing and maintaining attention to the present moment and changing the focus of attention between the various dimensions of one's life. Some useful questions to identify how the conceptualized past influences the way we describe and label ourselves in the present can be formulated as follows:

What rules do you carry around from your past?

When you were a kid, what were the "right" and "wrong" emotions you could and could not feel?

As a child, what did your significant ones tell you about how to deal with your emotions, especially unpleasant ones?

In your family, how did adults handle their negative/unpleasant emotions?

In your family, how did adults react to your unpleasant/negative emotions?

To this dysfunctional process, which increases psychological lack of flexibility, ACT opposes the promotion of contact with the present moment, which involves *being psychologically available to what happens by disengaging the autopilot, using the experience of the five senses (hearing, touch, etc.), and the possibility of cultivating awareness in order to stay tuned with what happens from moment to moment*. *Our actions are often managed according to an automatism that, although useful and functional on many occasions, in other cases is harmful and dysfunctional*. By living automatically, we limit the quality of our experience and are unaware of what is happening to us during the present moment. By living the experiences according to preconceptions learned in the past or to rigid expectations about the future, the patient faces them with an anxiety-inducing emotional burden. Getting in touch with the present moment means encouraging patients to consciously choose to bring their attention to what is happening inside them and in the outside world at that moment. There are many signs to be assessed of the patient's possible tendency to be out of touch with his present moment. For example:

Can the patient maintain eye contact or is he or she lost in his or her own thoughts?

Is repetitive thinking present?

Does he or she get distracted often and easily?

When asked to change the subject or address a specific aspect, does he or she succeed?

Once established as signs of a poor ability to stay in the present moment, the signs should be shared with the patient so that they become part of the shared

formulation. The difficulty of being in the present moment should be shared precisely by pointing out to the patient some of his or her attitudes that might suggest difficulty in pursuing this goal.

Conceptualized self is the set of definitions that our mind tells itself. When this process is present, we strongly identify ourselves with the contents of our mind by wearing the mask that our life story has built for us. ACT suggests as a virtuous counterpart the conceptualized self as a context or a perspective. In other words, ACT provides a new point of view, sometimes never experienced before, in which we learn to observe our internal and external experience from a privileged point of view, that is a participating, kind, compassionate, and curious observation of our own experience. We could call this a "participating witness." ACT promotes the observation of experiences as they happen, through a careful, conscious, and metacognitive self-reflection of one's own experience as it happens.

The next process is called the *lack of clarity of values*, the difficulties of identifying what is important and makes our life meaningful and rich. It can manifest in various forms and ways, but the central point is the confusion and vacuity of goals. It is necessary to specify that the term *values* in ACT means something other than concrete objectives, aspirations, and moral values. ACT defines values as a desired long-term quality of life, the factor that motivates people to change and to face difficult times (Hayes and Strosahl 2004).

In addition, the intervention on values does not take the form of a mentalistic conversation about what is or is not important for the individual, despite the verbal construction of the values. Knowing the person's world of values implies the ability to notice what moves the person him- or herself, what produces a change in physical sensations, what allows the emergence of emotions in the concrete aspect of activating the body and behaviors. In this way, it is possible to move in the area of values beyond and with words. The ACT therapist who works with the patient's value repertoire is careful to grasp the internal and external movements that some themes activate. In other words, one could understand the value as a discriminatory stimulus for the emission of productive behavior during that very moment of the session. A more technical definition of value is given by Wilson and Dufrene (2009): They are consequences, verbally built, of continuous, dynamic, evolving, and freely chosen activity patterns, which establish predominant reinforcements for that activity which are intrinsic to the implementation of the same behavioral pattern.

In formulating this problem in a way that is shared with the patient, we may meet many clinical scenarios. A frequent case is the utterance of a feeling of strong confusion, with respect to what the person considers important and significant for him- or herself, which can be expressed in sentences such as follows:

I just don't know what I want, what matters to me right now...

A second scenario emerges when the individual shows an apparent lack of significant areas of life interests, such as work, self-care, family, and social relationships, among others. In a third situation, all or almost all areas are considered to be of great importance for the individual but at the same time there is no real investment. Here, we can find patients blocked by an ideal of exceeding perfectionism that causes a lack of commitment:

I'm never happy anyway, so I don't even get into it.

According to ACT, important work to do with these patients is to reflect on the values—not only how to achieve them but also to become aware of the importance of being committed to values, considering the difficulties that could be encountered in the short term.

The last process of the ACT model is *inaction, impulsivity, or avoidance*, which means that the patient, even if aware of his dysfunctional processes, still has a significant step to face: to commit to action and pursue his or her own values. The ACT alternative is called *committed action*, that is:

Continuously choosing to engage in actions in the direction of your personal values, despite the painful emotions you may encounter along the way;

To maintain this commitment, keeping in mind the obstacles and difficulties, e.g., fear of making mistakes, painful memories, guilt, shame, and so on.

What is striking in ACT is how case formulation and therapeutic intervention are closely interwoven with each other. While in Beck's CT we can distinguish the assessment of *core beliefs* and *coping strategies* from the *questioning* and behavioral exposure intervention, in ACT, the six-point formulation is so interconnected with the intervention that it is indistinguishable in clinical practice. A second characteristic element of ACT case formulation is that its eminently qualitative nature perhaps hinders implementation of quantitative monitoring of clinical gains as happens in CT; this specific feature entails pros and cons. In general, ACT's reduced focus on the formalization of interventions in terms of protocols is a feature that perhaps also stems from the already mentioned close interconnection between intervention and case formulation. This aspect may be either a strength or a weakness of this approach.

Process-Based Cognitive Behavioral Therapy as an Approach to Case Conceptualization

Although process-based CBT models have opposed standard CT and repudiated its structuralist approach, with a focus on self-beliefs, it cannot be denied that they still belong to the CBT domain and that there are important lines of continuity with Beck's CT. Many process-based aspects of ACT were somehow already present in CT in a clinical form, although conceptualized differently from a theoretical viewpoint. For example, CT's *questioning* is a form of defusion from thoughts and behavioral exposure is a form of commitment to action. For these reasons, Hayes and Hofmann (2018) have committed themselves to an integration effort between standard CT and process-based CBT approaches, calling it *process-based CBT* (PB-CBT). PB-CBT, like ACT, departs from CT's protocol approach targeted toward psychiatric diagnoses and focuses on how best to address and modify key biopsychosocial processes in specific situations with specific clients for specific clinical purposes. PB-CBT, however, also recommends beginning treatment by

adopting a standardized CT protocol for the most important problem; a standardized protocol provides a reference point that can be profitably used to evaluate results and offer heuristics that usefully simplify complex situations, although admittedly the evidence is not strong enough to treat protocols as algorithms.

On the other hand, when the therapist has to go beyond established protocols because a standard one is not available or does not assure the expected results, PB-CBT encourages therapists to use explicit case formulation to tailor interventions, assuming that they will exceed the limits of the standardized protocols. Hayes and Hofmann believe that case formulation specifies the hypothesis based on the variables that influence the disorder and on which the therapy acts (according to the rationale of the treatment). Although there is currently no clear evidence to suggest that tailor-made interventions based on case formulations are superior (Kuyken 2006), the idea is that the case formulation, if used systematically, can serve as a method for applying the scientific method to clinical work (Persons 2008).

Notably, PB-CBT does not yet seem to have developed its own specific method of case formulation. Currently, Hayes and Hofmann (2018) have merely suggested that the available guidelines, e.g., those of Persons (2008) or Kuyken et al. (2011), should be followed. This deficit is probably temporary because PB-CBT is recent, and partly understandable because PB-CBT does not present itself as an independent explanatory model, but rather as an integration between various CBT approaches, either core-belief-centered or process-based models. Moreover, the original contribution of Hayes and Hofmann's PB-CBT is the review of various CBT interventions (see Table 1). This effort reformulates the rationale of action of each of them in terms of functional processes and not core cognitive contents.

This task is not easy because functionalist and content approaches in psychology are situated at two distinct levels of explanation (De Houwer 2011; Hughes et al. 2016). Admittedly, functional psychology focuses on explanations of behavior in terms of dynamic interaction with the environment, while cognitive structuralism aims to explain environment–behavioral relationships in terms of contents, for example, core beliefs.

The conciliation encouraged by PB-CBT is that the two approaches are not in opposition with each other. Instead, they are two philosophically different levels of talking about similar events. Once this fact has been fully recognized, professionals and researchers from both traditions can begin to have a meaningful and hopefully mutually beneficial dialogue about human cognition and how it can be encouraged to change. PB-CBT also looks to suggest that the relationship between the two different levels of analysis, instead of ending in a theoretical incompatibility, can have a fruitful clinical outcome because it would help psychotherapists to identify the moments in which an analysis is more appropriate at either the cognitive or the environmental and behavioral level.

Overall, it appears that the PB-CBT solution adheres more to the analytical functional approach than the core content approach because it tends to interpret cognitive contents and beliefs in terms of functions. This factor is admittedly its true innovation. At the present moment, the two levels of PB-CBT analysis for different clinical situations constitute an extended functionalistic model that attempts to

Table 1 Repertoire of the process-based cognitive behavioral therapy approach

Behavioral activation
Cognitive defusion
Cognitive reappraisal
Contingency management
Coping and emotion regulation
Cultivating psychological acceptance
Enhancing motivation
Exposure strategies
Interpersonal skills
Mindfulness practice
Modifying core beliefs
Problem solving
Self-management
Shaping
Stimulus control
Values choice and clarification

preserve the results of content-based CBT approaches, first of all Beck's CT. Therefore, the provisional conclusions of PB-CBT seem to suggest that we are not dealing with two different levels of analysis but with two different points of view that describe the same phenomenon by using different languages.

However, this provisional solution, while useful, risks underestimating the paradigmatic difference between the functionalism of processes and the structuralism of self-beliefs. Flexibility, acceptance, and commitment to change in processualism should not be confused—despite possible similarities—with any concept of self-knowledge. Behaviors related to action and governed by rules do not represent internal knowledge of the self (Cordova 2001; Hayes and Strosahl 2004; Hayes et al. 2013). When PB-CBT really comes to identify specific indicators for the appropriate use of two different levels of analysis, it will also provide a clinically useful integration and a theoretical synthesis of the available literature on what is known about the function of the interventions in order to be able to evaluate the specific rationale for the various types of dysfunction and provide the indicators to the therapist for the choice of the interventions to be applied.

Currently, integration of PB-CBT has achieved a less ambitious purpose of helping clinicians who use different languages to communicate with each other. These indicators, being presented as heuristics to relate appropriate interventions to specific dysfunctions, can be suitable for case formulations to be shared with the patient and, therefore, essential tools for the management of the therapeutic alliance in functionalistic terms. In this way, the therapist would really get to customize the treatment in operational terms (Carlbring et al. 2010). As written above, provisionally the really original contribution of Hayes and Hofmann's PB-CBT is the capacity to reformulate the rationale of action of each CBT intervention in terms of functional processes.

Case Formulation in Schema Therapy

Schema therapy (ST; Arntz and van Genderen 2009; Young et al. 2003) is a model that has developed from the clinical and theoretical background of Beck's CT. In this modality, case formulation absorbs process-based elements while simultaneously maintaining a strong interest in self-centered schemes. As its name implies, ST conceptualizes emotional disorders in terms of self-schemata and self-beliefs. These constructs are not only purely cognitive as in Beck's CT; they also show a strong emotional and interpersonal aspect rooted in the personal development of the patient. These interpersonal characteristics are represented in so-called "modes," which are stereotypical and inflexible interpersonal patterns. Moreover, these "modes" have a significant metacognitive and functional component because their dysfunctional rigidity depends on a state of cognitive fusion between patients and these "modes" (Arntz and van Genderen 2009). Therefore, the clinical procedure of ST includes interventions aimed at regulating emotional and cognitive processes through experiential exposure and re-education, guided imagination, or role-playing (Bell et al. 2015; Hackmann et al. 2011) and cognitive and metacognitive interventions aimed at acting at the declarative level of verbal re-attribution (Wells and Mathews 1994; Williams et al. 1988).

In ST, the dysfunctionality depends on a functional deficit because the emotional pain seems to be contingent on traumatic experiences that leave the primary emotional needs of the child unsatisfied. As a result, early maladaptive patterns are generated that attribute a distorted meaning to the vision of self and the world. The aim of ST is to modify these patterns through cognitive and emotional–experiential techniques as well as the therapeutic relationship oriented to balance the unsatisfied needs of the patient's childhood. From this approach emerges: (1) a structuralist vision of the self that is similar to Beck's CT; (2) a theory of deficit that explains the impairment of functions; and (3) a vision of the therapeutic alliance as a relational compensation for missed needs.

From a clinical and therapeutic point of view, ST integrates metacognitive, developmental, experiential, and relational interventions. In particular, *guided imagery* and *self-disclosure* interventions seem to seek an **interpersonal experience of strong emotional sharing** that fosters **cognitive restructuring**. In ST, we explicitly speak of corrective emotional experience in which the painful events that serve as the basis of psychological dysfunctionality are relived in a non-traumatic, compensatory manner and are followed by a verbal re-elaboration that allows the definitive detachment from the dysfunctional modalities (Young et al. 2003). Notably, in ST we are not dealing with a generic and non-specific relational aspect that is already present in every psychotherapy and can be integrated in every paradigm. Instead, this technique uses a defined procedure consistent with the theory of the ST model. ST can show strong efficacy data in its favor (Bamelis et al. 2014).

ST uses case formulation that is oriented on interpersonal, emotional, and cognitive self-patterns as well as procedural modes. To understand the role of case formulation in ST, it is necessary to appreciate where ST places the strategic bottleneck of

the therapeutic change, the decisive target of the treatment process. In fact, case formulation depends on the most significant process: Is the bottleneck located in the metacognitive awareness of modes or in the corrective emotional experience obtained by means of imaginative and relational interventions? Among these interventions are:

1. Relational intervention;
2. Shared cognitive formulation of self-patterns;
3. Shared metacognitive formulation of modes;
4. Imaginative intervention.

The question is which of the above is the key intervention that allows the implementation of others?

If the shared formulation of either the cognitive or metacognitive elements precedes the other interventions, then ST places itself among the approaches that consider the cognitive and metacognitive intervention as resolutive. Consequently, their shared formulation must always precede—at least ideally—the others. In this scenario, shared case formulation is an intervention that should be implemented at the beginning of ST. By contrast, in the second scenario, shared case formulation follows temporally—and above all ideally—relational and imaginative interventions because the corrective experience that occurs both in the management of the therapeutic relationship and during the imaginative exercises creates the ideal emotional conditions that promote metacognitive awareness of the "modes."

At this point, let us remember that the thesis of this book is to distinguish therapeutic approaches into two models. One proposes that shared case formulation is possible from the beginning of the treatment as an opening move of the therapeutic process. By contrast, the other model believes that the formulation is an outcome to be achieved during the course of the therapeutic process, basically emotional and neither cognitive nor metacognitive.

If we examine the role that case formulation plays in the ST process (Roediger et al. 2008), we see that it is immediately claimed that when working with clients with personality disorders, their maladaptive behavior will soon affect the therapeutic relationship. This phenomenon seems to support a scenario where initial sharing is difficult. However, it is also said that by quickly implementing and sharing a case formulation at the beginning of the treatment, both client and therapist are provided with a joint reference point outside of any turbulence in their relationship. In other words, in ST the case conceptualization allows the therapist and the patient to orient themselves toward a mutual understanding of what is happening and helps them to find common ground in case of alliance ruptures. This second scenario seems to favor an early shared formulation.

ST usually bases case formulation on what the patients report—questionnaires, evaluation scales, therapist's observations, third party stories (spouses, parents, or others)—as well as on a significant work called imaginative diagnostics. This technique utilizes videos that clarify the "modes" to the patient in a vivid way. This design suggests that in ST the imaginative interventions are preceded and supplemented by interventions that clarify for the patient the rationale of the intervention.

Hence, this procedure somehow always presupposes a high level of sharing of the case formulation at the beginning of the treatment.

This conclusion is confirmed by continuing the analysis of other steps of the ST procedure, such as the suggested usefulness of providing the client with texts on ST to support the intervention on "modes" (Jacob and Arntz 2013) and schemes (Young et al. 2003). Other cases in which the conclusion favors early and full sharing of the case formulation are confirmed by the use of a genogram, which serves to share with the patient the idea that both patterns and maladaptive modes feature an adaptive basis that is subsequently stiffened. Dysfunctional modes had previously been the best way to deal with our problems, but when applied mechanically they become mismatched. The developmental and evolutionary basis of this hypothesis, which is also shared with constructivist models, as we will see in chapter "Strengths and Limitations of Case Formulation in Constructivist Cognitive Behavioral Therapies" of this book, is found in the model of Cannon (1915, 1936). Healthy adult modalities, learned in therapy, can help people find more adaptive solutions.

In conclusion, ST seems to be placed among the therapies that share the case formulation from the beginning of the therapeutic path. In ST, shared case formulation plays a key role for management of the assessment and implementation of the interventions. Furthermore, the therapeutic alliance is definitively confirmed by the formalization effort pursued by the working group of the International Society of Schema Therapy, which is developing a training procedure for case formulation in ST.

Case Formulation in Metacognitive Therapy

In the clinical procedure of *metacognitive therapy* (MCT; Wells 2008, 2013), early implementation of sharing the case formulation is extremely important. In the theoretical model of the mental functioning of MCT, the executive and voluntary function of free choice plays a key role. This function can become dysfunctional due to metacognitive biases that lead the patient to misjudge the usefulness or controllability of so-called repetitive negative thinking (RNT), i.e., worry, rumination, anger rumination, desire thinking, brooding, and so on. Case formulation in MCT aims to share with the patient how these metacognitive biases work. Consequently, in the MCT clinical procedure, the case formulation is shared quickly and early with the client.

In detail, MCT assesses the dysfunctional processes that are activated when the person reacts to a triggering distress—turning it into an emotional disorder—by activating cycles of the abovementioned RNT that thrive on three main processes (Mathews and Wells 1999, 2004; Segerstrom et al. 2003; Wells 2008, 2013; Wells and Mathews 1994; Williams et al. 1988):

1. RNT can be erroneously conceived as a functional plan to deal with reality and its problems;

2. RNT is considered an uncontrollable state that is stronger than executive personal will;
3. RNT is considered harmful and dangerous and therefore fuel other worries.

From a clinical point of view, MCT has developed its case formulation implementation by adapting the procedures derived from Beck's CT socialization. However, the voluntary executive function of choice and attention play a different role in the two models. In Beck's CT model, voluntary attention and executive control depend on the elaboration of cognitive content related to self-beliefs. The model assumes that the therapeutic process works by the exploration and modification of these cognitive evaluations. Once the cognitive contents have been explored, voluntary attention will spontaneously adopt a more functional attitude and stop obsessively monitoring possible threats (Wells and Mathews 1994, p. 2).

In MCT, case formulation focuses on metacognition, i.e., beliefs about cognitive processes and beliefs. Therefore, MCT interventions mainly target a second-order metacognitive level in which mental states are regulated by attention, but are not completely controlled by rational reasoning. This theoretical difference helps us understand the difference between MCT and CT in the implementation of case formulation. Indeed, it is true that the importance of metacognitive components in normal and psychopathological functioning had already been intuited in previous CBT approaches, e.g., by Beck himself when he described the vicious cycles of fear of fear (Beck et al. 1985), by Ellis with his concept of secondary ABC (DiGiuseppe et al. 2014, pp. 64–65), or in Leahy's *emotional schema therapy* (EST; 2015), a CT-derived therapeutic model that focuses entirely on meta-emotional patterns, i.e., beliefs about emotions. However, only the MCT model places metacognition at the center of the psychopathological process and firmly states that metacognitive beliefs about mental states are psychopathological biases among many others and are the fundamental explicative principle of emotional disorders (Mathews and Wells 1999, 2004; Wells and Mathews 1994; Wells 2008, 2013).

MCT attributes a key role to the functions of attention and executive will and choice. This approach makes case formulation and therapeutic intervention in MCT even more closely interwoven with each other than in ACT. In Beck's CT, there is an ambiguity that makes the questioning intervention apparently able to function without its rationale being shared between therapist and patient. By contrast, in MCT, implementation of explicit sharing of the rationale, which is admittedly the case formulation—before the execution of the changing techniques of MCT, first of all detached mindfulness—is ineludible. Therefore, MCT more than any other psychotherapy places sharing the case formulation at the heart of the therapeutic process.

The way the case formulation is shared in MCT comprises a few simple questions and statements. As in the previous cases of CT and *rational emotive behavioral therapy* (REBT), we do not intend to display the whole procedure but only to comment on some steps as happens in our clinical practice. The MCT therapist encourage patients to recognize that the emotional problem depends on the fact that they focus their attention too much on threats by worrying and thinking too much:

How do you think you would be if you didn't think about it? if you didn't notice it? if you didn't pay so much attention to the problem?

The assessment of metacognitions occurs through equally simple questions:

Why do you think so much? What makes you worry?

After the initial assessment, the therapist works out an MCT case formulation in terms of trigger, level of rumination and reasons for rumination as already written, utility, and uncontrollability and shares it with the patient:

In summary, I would suggest that your emotional problem depends on a level of excessive worrying and attention to the problems that seems justified to you because it looks useful but also because you seem unable to stop it. The idea that I propose is that worrying over the problems is less useful than you thought and it is not at all true that you cannot stop it. You can control your worry more than you think.

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