Case Formulation in Standard Cognitive Therapy

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The Standard Model of Cognitive Therapy

This chapter deals with the case formulation applied to Beck's cognitive therapy (CT; Beck 1963, 1964; Beck et al. 1979) that, among the cognitive behavioral therapy (CBT) approaches, is the model that has received the most reliable confirmation of effectiveness. For the sake of clarity, it has to be noted that in the UK and sometimes in other European countries, CT is called standard cognitive behavioral therapy (standard CBT; Clark and Beck 2010), leading to the risk of terminological

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confusion between the broad and general domain of the many cognitive behavioral approaches, also called "CBT approaches" and the particular form of CT, also called "standard CBT." For instance, in the domain of all CBT approaches in a broad sense there are also the models of Ellis' rational emotive behavior therapy (REBT; DiGiuseppe et al. 2014; Ellis 1962; Ellis and Grieger 1986) and the many so called constructivist psychotherapies (Feixas and Compañ 2016; Guidano and Liotti 1983; Guidano 1991; Mahoney 1995, 2003; Neimeyer 2009; Neimeyer and Mahoney 1995; Winter and Viney 2005). These cousin models of CT/standard CBT will be discussed in their specific chapters of this book, respectively 6 and 15. In this chapter, therefore, we always use the term "CT" to refer to either CT or standard CBT, while the term "CBT" refers only to the general domain of all CBT approaches.

Of course, the CBT approaches are grouped in the same domain because they show significant commonalities. CT, REBT, and constructivist psychotherapies have all historically adopted the clinical cognitive principle that emotional disorders are dependent on automatically distorted mental contents that can be modified through conscious verbal reattribution. A canonical definition can be found in Dobson and Dozois (2001), according to which the historical CBT approaches share three fundamental principles:

1. The mediational role of cognition, which states that there is always a cognitive processing and evaluation of internal and external events that may influence an individual's response to such events;
2. The possibility that cognitive activity is reasonably accessible to the consciousness and can be monitored, evaluated, measured, and re-elaborated in a limited time through conscious choices in an explicitly negotiated collaboration between patient and therapist;
3. The behavioral change can be mediated and encouraged by these cognitive evaluations and can therefore be considered an indirect sign of cognitive change.

However, these commonalities, although noteworthy, were not so significant as to determine procedures common to all CBT approaches for the management and conception of case formulation. To understand how these three models use case formulation, it is crucial to highlight several of the differences apparent among CT, REBT, and constructivist psychotherapy. In fact, there are other features that are common to some CBT approaches, albeit not to all of them.

As an instance, an aspect absent in REBT but present in both CT and constructivist psychotherapies is that both these traditions have organized their clinical work around biased cognitive contents focused mainly on the self (Wells and Mathews 1994: p. 2), such as the core self-beliefs of CT (Beck 1995: p. 169, 2011: p. 233) and the personality organizations outlined in the constructivist tradition (Guidano and Liotti 1983; Mahoney 2003). In both traditions, we can observe the emergence of a taxonomy of core variables focused on the self that plays a structural role in providing guidance, coherence, coordination, and integration to mental states (Bandura 1977, 1988; Markus 1977; Markus and Nurius 1986; Markus and Sentis 1982; Neisser 1967). On the other hand, an aspect absent in the constructivist approaches but present in both CT and REBT is that, while CT and REBT have tended to

Table 1 Comparison of cognitive therapy (CT), rational emotive behavior therapy (REBT), and constructivist psychotherapy

Emphasis on	CT	REBT	Constructivist psychotherapy
Self-knowledge	X	–	X
Conscious knowledge	X	X	–

emphasize the conscious aspect of cognition, most constructivist cognitive psychotherapies have also shown interest in tacit, perceived, and experienced knowledge not represented in the internal discourse and not easily verbalized (Guidano 1987, 1991; Mahoney 1995, 2003). Table 1 summarizes the differences and similarities between these three historical CBT approaches.

Self-Beliefs, Collaborative Empiricism, and Sharing the Case Formulation

The structural key role attributed to the negative core self-beliefs in the CT model play a key role in its case formulation conception and in its sharing procedure. It plausibly helped Beck to formalize the CT procedures in amenable and user-friendly ways for use by clinicians. However, this advantage was acquired at the price of increasing the risk of conceiving the therapeutic process as the mechanical discovery of biased self-beliefs, in which the active part is fully entrusted to the therapist while the role of the patient may (at least seemingly) look passive, reducing his or her role to being instructed to take note of the cognitive biases and abandon them as an automatic effect of the instruction. The assessment of dysfunctional mechanisms partially risked not being used as a shared tool for conscious and active change—especially by the patient—and the monitoring of clinical work, but as a tool for modification that inadvertently encouraged locking the patient in a passive position. This effect—although always avoided by Beck, who unsurprisingly spoke of collaborative empiricism from the very beginning (Hollon and Beck 1979)—may be implied in the CT theoretical approach that emphasizes the structural role of self-beliefs. It is not coincidental that, notwithstanding the widespread agreement regarding the central role of collaborative empiricism in CT, there has been little theoretical analysis of the construct, as noted by Tee and Kazantzis (2011).

A possible consequence of the insufficiently explored definition of collaborative empiricism may be that in Beck's initial works, the aspect of sharing the case formulation procedure is present but not always sufficiently emphasized. Perhaps the need to share the case in CT—and in other CBT approaches as well—seemed to be a step that could be taken for granted in the implementation of the formulation process itself. This reduced emphasis on the shared component in the implementation of case formulation exposes CT to an accusation of rationalism, suggesting that its process occurs through the non-shared imposition of a software that has to be implanted in the patient's mind and that can work without his or her active

cooperation. It is a typical accusation by several constructivist theorists who have argued that CT procedures are too didactical and mechanically directive and are therefore at risk of undermining the therapeutic alliance (Guidano 1987, 1991; Mahoney 1995, 2003).

It is not coincidental that Tee and Kazantzis (2011) have responded to this criticism by arguing that Beck's collaborative empiricism "is not simply willing participation by the client nor agreement on tasks or goals. Rather, the cognitive therapist aims to engage the client in a genuine sharing of the work of goal setting and creative authorship of therapeutic tasks, progressively encouraging the client to take the lead role in these activities as far as is practicable" (Tee and Kazantzis 2011, p. 49). Therefore, collaborative empiricism is a "stylistic fulcrum that permits the helping alliance to thrive" (Stein et al. 2006, p. 359).

Moreover, Tee and Kazantzis (2011) argue that collaborative empiricism may act as a specific change process in CT, as well as the classical CBT principle of cognitive mediation: Direct changes in clients' beliefs. In fact, belief change is plausibly more likely to happen if the rationale for change comes from a collaborative task, rather than from didactic illustration by the therapist (Dattilio and Padesky 1990). Tee and Kazantzis (2011) have also argued that a possible theoretical ground for their clinical hypothesis can be found in the model of Self-determination theory by Deci and Ryan (2002). This model states that people's behaviors are regulated on a continuum ranging from intrinsic and autonomous regulation to external regulation and that intrinsic regulation is more likely to lead to significant change. Accordingly, collaborative empiricism clearly parallels the concept of intrinsic regulation.

This definition of collaborative empiricism by Tee and Kazantzis seems to be in line with the concept of shared case formulation discussed in this book. Moreover, from our point of view shared case formulation advances one step forward by being a more operational and specific concept for CBT approaches than that of collaborative empiricism. As an instance, from an operational viewpoint sharing with the patient the case formulation (that means sharing a model of the emotional disfunctions, of the rationale of the behavioral change, and of the interventions) have much in common with the factors of change proposed in the Self-determination model: A meaningful rationale for behavior change, the possibility of active participation and exercising of choice, and the acceptance and acknowledgment of negative feelings (Markland et al. 2005).

From Case Formulation to Shared Case Formulation

In spite of the aforementioned clinical problems, Beck deserves credit for including shared case formulation in the CT procedure from its origins, although he gave it a different name. In 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" of his *Cognitive Therapy and Emotional*

Disorders, Beck (1976) describes his procedure of analysis of problematic situations and introduces the term "formulation" several times. Faced with the objection of the patient's possible resistance, Beck fully agrees that the patient can respond to this initial formulation with the two opposite attitudes of skepticism or condescension. Beck remarks that these difficulties, although present, should not be underrated or exaggerated. The nature of the therapeutic alliance in CT is neither that of immediate adherence nor of continuous and devious sabotage. In reality, it is only natural that sometimes the patient would assume a critical and waiting position; this attitude should not be confused with a more or less unconscious sterile opposition. Understanding should be sought in an initial arrangement in which the patient agrees to test the proposed model and its capacity to generate well-being. The patient is encouraged not to adhere to an abstract and naive dependence of emotion on rationality but rather to trust more his or her capacity of executive mastery of mental states guided by rational reasoning.

Beck insists that it is necessary to negotiate an agreement between the patient's and therapist's expectations (Beck 1976). The difficulties listed by Beck can ultimately be reduced to one: the tension between the patient's hope for emotional relief without active engagement and the therapist's task of encouraging the patient to seek relief through active engagement. In the CT procedure, the patient's hope of passively finding relief is not attributable to more or less unconscious resistance but to erroneous beliefs about mental functioning. The patient underrates his or her capacity to master mental functioning. The core then becomes the active sharing with the patient of the aware knowledge of cognitive and behavioral dysfunctionality, and then sharing the case formulation.

Over time, a growing awareness appears to have emerged in the CBT literature that it is necessary to explicitly instruct the therapist to share the formulation of the case with the patient. CT manuals have increasingly emphasized the need to manage the treatment by sharing case formulations in order to effectively implement the assessment and reformulation of negative core self-beliefs. As an instance, in the classic manuals of CT by Judith Beck (Beck 1995, 2011), we find a definition as well as a detailed and operational description of the therapeutic use of shared case formulation. The main tool in the CT of case sharing is the Cognitive Conceptualization Diagram (CCD, Beck 2011, p. 200). In CT, the therapist uses the components of the CCD—core beliefs, intermediate beliefs, and coping strategies—to provide the patient with a psychopathological interpretation and a therapeutic re-qualification of the reported problematic situations by questioning him or her. The term "sharing" emphasizes the therapist's task of constantly communicating and discussing any emerging aspects of the formulation with the patient and using it as a tool to manage the direction of the therapeutic process. Moreover, in CT the diagram is fundamental in managing the therapeutic relationship in so-called complex cases, i.e. cases that undermine the therapeutic alliance. Beck (2011) suggests that the problem in complex cases should be addressed at the relational level, and the CCD can be used to conceptualize relational obstacles to therapy and find solutions for relational difficulties using a careful analysis of distorted interpersonal beliefs.

Shared Case Formulation and Therapeutic Alliance

Therefore, in CT, and also in other CBT approaches (but not in all of them), the explicit sharing of case formulation can be the clinical tool that allows us to manage the therapeutic alliance and relationship in a specific CBT manner. In fact, in the therapeutic tradition of CBT approaches, while the alliance and relationship were mentioned and not underrated, they were not considered to be the theoretical center of therapy. In the worst scenario, the alliance was mentioned only in order to indicate a particular situation of non-cooperation of the patient that must be clinically managed through good practice interventions. Another tradition refers to collaborative empiricism in the CBT literature as the foundation for the alliance (Dattilio and Hanna 2012; Kazantzis et al. 2013; Tee and Kazantzis 2011). Collaborative empiricism parallels Bordin's conception of the alliance that comprises the client-therapist "bond" and "agreement" on the goals and tasks of therapy (Dattilio and Hanna 2012). However, Bordin's "agreement" seems to reveal a lesser degree of both active participation of the patient and shared contribution with him or her in comparison to the CT conception. As written previously, Bordin's working alliance focuses on sharing the tasks and goals of therapy (Bordin 1979, p. 254), while Beck's collaborative empiricism focuses on sharing "the work of goal setting and creative authorship of therapeutic tasks" (Tee and Kazantzis 2011, p. 49).

However, in the common principles of the CBT approaches proposed by Dobson and Dozois (2001), the theoretical and clinical link between case formulation and therapeutic relationship is implied, although not explicitly mentioned (Knapp and Beck 2008). In fact, it follows from those principles that the therapeutic change occurs in a type of collaboration and alliance between therapist and patient that allows the patient to be informed and encouraged to share the formulation of his or her own case and the rationale and objectives of the treatment. This clinical need of the therapist's and patient's full awareness from the very beginning of the therapeutic process implies that in CBT approaches, and particularly in CT, there is a characteristic conception of the use of case formulation. In the CT and CBT approaches closest to it, case formulation can be an operational tool with which the therapist manages the entire psychotherapeutic process, including CT-treatment-specific interventions, as well as non-specific ones, such as the therapeutic alliance and relationship.

Shared Case Formulation: Clinical Examples

Assessment. At this point, we introduce a practical illustration of the management of case formulation in the CT procedure, i.e. through the shared assessment of the CCD. A practical illustration is the best way to highlight the operationally shared character of the formulation procedure. It is not our intention to provide an exhaustive and detailed description of the entire process of assessing emotional disorders

according to the CT procedure; this task is much better performed by Judith Beck (2011) in her manual. We prefer to illustrate and comment on the CT procedure by highlighting and analyzing some of the procedure's steps that are most useful to promote formulation sharing. Of course, these steps are presented and interpreted from our viewpoint and cannot be considered a didactic illustration of the CT procedure.

To achieve this shared agreement, Beck J. uses a simple and straightforward approach, quickly explaining to the patient that the problem depends on the thoughts and ideas that upset him or her, followed by an invitation to actively examine them (Beck 2011, p. 19). This direct approach may appear to be simplistic and is one of the causes of the accusation of rationalism. However, it is not as simple as it first appears: Behind this invitation, there is an immediate encouragement to the patient to detach from such thoughts and start thinking of themselves as beings distinct and separate from their beliefs. This is already a preliminary sharing of the case formulation. Indeed, the most common mistake of patients is the position of merging with their own thoughts, so the person thinks they are wholly resolved in what they think.

CCD fulfillment begins with the identification of problematic situations. In this initial step, we can already identify an element of sharing that should not be overlooked. CT therapy, in fact, tends to be applied to specific problems or disorders and therefore starts from the request to start from typical problematic situations and not from vaguely described problems.

Can you tell me a specific situation in which your problem/disorder occurred?

In the CT setting, this question is not necessarily accompanied by an immediate explanation of its rationale. On the other hand, in a CBT approach that emphasizes the role of shared case formulation, the therapist is encouraged to share with the patient an explanation of why it is preferred to start by assessing a specific situation. Of course, sharing can be done immediately or after an appropriate interval if the therapist perceives a need for a prolonged and relaxed report by the patient without initial interruptions. In both cases, the therapist who pays attention to share the case formulation could say something like this:

In our approach, we prefer to start from specific situations defined in time and space because the treatment is set on specific problems, although of course we will also look for patterns that are repeated in different situations.

The next step is one of the most characteristic strategic actions of CBT approaches: the assessment of automatic thoughts carried out with the classic question:

What was going through your mind at that moment?

Once again, in a CBT approach that emphasizes sharing the case formulation and treatment rationale, this question should be asked to ascertain automatic thoughts and make the patient more aware of the link between thoughts and mental states. This link is not one-sided and mechanical; rather, it comprises encouraging an increase in the ability to executively master mental states. As in the case of the identification of problematic situations, the rationale must be clarified to the client in order to encourage sharing at each step. Therefore, something like the following can be relayed to the patient at the appropriate time:

In this approach, becoming aware of what is going through your mind at the moment of emotional distress is important. We believe that it is precisely in those momentary thoughts to which we often give little importance that there is the key to both understand the reasons of the emotional suffering and get the possibility of getting out of it.

This sharing communicates to the patient that dysfunctional thoughts are processed in an automatic mode, in which the patient takes for granted the notion that no executive control can be exercised. This intervention suggests the idea that, in reality, executive control is possible.

A hard step then follows, but it may be an opportunity for another shared clarification of the treatment rationale. The patient sometimes responds by not reporting the thoughts that went through his or her head at the moment of the problematic situation. Instead, they might report other subsequent or previous thoughts, or even interpretations he or she is having during the session. These thoughts are sometimes incongruously reasonable—incongruously because at that moment it is not yet useful to produce functional alternatives given that their appearance makes it hard to assess significant dysfunctional thoughts. Instead of reporting dysfunctional beliefs, the patient provides a kind of early questioning of little therapeutic value. For example, he or she might report something like this:

Actually, I know that I worry too much and probably nothing I fear will happen.

This statement, however, must not be devalued: It must be validated and put aside momentarily:

It is important that you are aware that perhaps your fears are exaggerated. This thought, however, is perhaps not what went through your mind when you were upset. Now let's focus on what was going through your mind at that very moment and that didn't help you.

This step can be useful in order to reiterate the rationale of reporting what exactly went through the patient's mind at the problematic moment:

Let's try to understand together why in this approach being aware of what goes through your head at the moment of emotional distress is particularly important. The fleeting thoughts that we do not pay attention to in the moment of emotional distress are the object of our work; by remembering them better and understanding that we can work them out in order to feel better.

The next step is just as significant; it is the *down arrow* procedure, i.e. the assessment of the meaning of automatic thoughts, carried out by asking what the reported thoughts mean or imply in more personal terms.

And what does that mean to you? What's the problem with that?

This question brings us closer to the core belief about the self, which can either emerge spontaneously or be explicitly asked for by the therapist:

So how do you see yourself in that situation? You are ...

In this case, the procedure must not be expressed in a mechanical way. It can once again provide an opportunity to share with the patient the rationale of the CT approach, namely that emotional reactions are related to cognitive states processed in dysfunctional terms (Beck 2011, pp. 159–161). This way of connecting thoughts about the self, the world, and emotions has sometimes been accused of abstract

intellectualism, but it can also be conceived as a validation that normalizes the patient's emotions. For example, you could tell the patient:

The point is to understand that fearing this situation implies that you judge yourself as an inadequate person and/or that the world is a dangerous place. This meaning is what turns a tolerable unpleasant feeling into an intolerable anxiety. In other words, you use emotions not to relate to situations but to judge yourself: because you are worried then you see yourself as stupid or fragile. This chain of thoughts should no longer be considered as an unchangeable object but as something you can work out.

When the patient learns the concept of the maladaptive interpretation of emotional states, he or she also learns that emotions are not necessarily dysfunctional *per se*. Rather, they can read them as a definition of the self or of the world and not as a signal of a problematic scenario. For example, anxiety is not used as a signal of a possible risk but as an evaluation of a supposed personal inadequacy: If I have anxiety, then I am not up to it.

From this viewpoint, the definition of a dysfunctional mental state in the CT model, including the emotional state, welcomes the constructive criticism that has rejected the rationalistic definition of maladaptive states as erroneous evaluations of reality. The constructivist theory is right: Dysfunctionality is better defined as a maladaptive and rigid application of personal meanings that *per se* are neither wrong nor right (Guidano 1987, 1991; Mahoney 1995, 2003). It is important to understand how this normalizing intervention is best carried out by integrating it with the sharing of the case formulation, in the following terms:

The problem is not feeling anxiety but how you use it. The problem is using anxiety to make evaluations about yourself. How do you consider yourself in this situation where you have anxiety?

In this passage, what matters is that, in contrast to the patient's viewpoint in which situations generate emotions, the CCD visually represents a reversed perspective: The core beliefs and the coping strategies are above while the situations are below. In this way, the patient is encouraged to overturn the relationship between mental states and situations. The patient is then invited to reflect on how the subjective hardness of situations may depend on a thought of personal inadequacy and not vice versa. The question that introduces this topic may be as follows:

Now let's think. If you think in some way that you are inadequate (core beliefs) and that consequently (assumptions) you must avoid exposing yourself (coping strategy), what will you think in daily situations and how will you face them?

Followed once again by a generalization of the pattern:

You could apply this way of reworking thoughts to other scenarios as well. The idea would be that every thought should not be taken for granted just because it has crossed our minds but can be critically examined. You can work on that.

In the same natural way, we can introduce the phase of *questioning*:

Now that we have assessed which thoughts are not helping you, we can also question them. Every time we have a thought we take it as true. What if we question it instead? What if we don't take it as true?

But most of all:

What if the therapy consists not only of understanding and reworking these thoughts, but of learning to recognize and to rework them by yourself?

The procedure must be repeated for the assessment of emotions and behaviors, especially safety behaviors. Emotions must be understood by connecting them to thoughts:

Do you see the relationship between what you feel, what you think, and what you do? In this case, between anxiety, thoughts of inadequacy, and a tendency to avoid certain situations?

We can further stress this point:

Once again, it is important not only that you understand this connection but also that you learn to actively seek out these connections on your own. In this way, you can learn to master your mental states.

This statement implies that psychological disorders comprise biased versions of normal emotions and behaviors and are not a condition of insanity.

From what you're telling me, you're suffering from anxiety. This anxiety makes sense and we'll find its meaning together. It's not to be understood as some kind of disease.

In other words, the therapist helps the patient to conceive his or her symptoms in human terms, as dysfunctional forms of mental states that are meaningful and in themselves normal.

You're anxious because you're worried about something. We'll figure out what you're worried about. However, we also have to understand the use you make of your anxiety, the way in which your anxiety can become an obstacle.

Same with the behavior:

And when you feel this anxiety, what do you do?

And after the patient's response:

If I may summarize, it seems to me that when you feel this anxiety you tend to avoid situations.

Such behavior, which we call avoidance, could in turn be understood as a kind of illness. It must therefore be reformulated as a behavior that may make sense.

Avoidance in itself is not wrong. Sometimes it can be useful. It can be a wise behavior that indicates awareness of one's limits. The problem, however, is the mechanical use of this behavior.

In this way, we provide the patient with a model in which his or her "disease" corresponds to emotional states that are used as obstacles and not as signals for appropriate behaviors. It may be useful to add:

I would like you to keep these two variables in mind: emotions as obstacles and not as signals and behaviors as understandable but rigid reactions.

And further:

Whenever you feel the emotional distress that brought you into therapy, you may ask yourself: What is the emotion that I am using as an obstacle and what behavior am I tempted to put into action mechanically?

The relentless sharing of case formulation, as well as the treatment rationale serves to build what in other orientations is called a therapeutic alliance. Beck

herself reports that the first principle of CT is a constantly evolving formulation of patients' problems (Beck 2011).

After problem situations have been ascertained in the lower half of the CCD, they will be combined into a unitary model in the upper half, in which we find core beliefs, intermediate beliefs, and coping strategies. As is well known, in core beliefs the meanings of automatic thoughts are summarized in general thoughts about the self, the world, relationships, or the future.

Although CT is focused on the here and now, Judith Beck added a focus on relevant childhood data in which the therapist seeks to understand with the patient how core beliefs were born and maintained and what events in life (especially childhood events) might be related to the development and maintenance of a belief (Beck 2011, pp. 32–35). This developmental procedure—even if more abstract— adds a level of awareness that is useful in CT questioning.

Furthermore, in this case, the core of shared case formulation remains that every step is implemented in order to increase the patient's awareness of the treatment's formulation and rationale. It is easy to lose this awareness because too many steps may seem obvious in the eyes of the therapist and are therefore not shared with the patient. During the assessment of relevant childhood experiences, the patient could be told:

Your anxiety or tendency to avoid problematic situations may be related to past experiences. Somehow you have learned in past moments that anxiety means something hopelessly negative about yourself and that it is preferable to avoid situations of this kind.

Judith Beck's practical use of the CCD helps us to understand how case formulation in the CT model is not just a theoretical framework. Rather, it is a concrete intervention that allows the therapist to establish a therapeutic alliance in emotional terms, namely by creating an atmosphere of trust, cooperation, and pragmatic terms and sharing with the patient a general hypothesis of his or her psychological distress and the treatment mechanism. When the therapist shares the case formulation with the patient, it should not be presented as a theory of the mind working without the patient's consent but as a common working hypothesis that establishes a set of rules. It describes the patient's ongoing attempt to deal with the emotional and external limitations of his or her development. Therefore, the following is inappropriate:

NON-SHARED FORMULATION: *Your distress depends on a series of biased thoughts that this therapy will change.*

In reality, the following is appropriate:

SHARED FORMULATION: *My job is to encourage and help you to understand the connection between your distress and the thoughts that do not help you, to question them in order to detach from them and look for other more helpful thoughts.*

Questioning. The next step is the classic CT *questioning* and all the other cognitive techniques of change. The risk is—once again—implementing them in an unshared manner. Good *questioning* or good motivation for behavioral exposure is not sufficient. It is, however, necessary to make the patient fully aware that the therapeutic goal is not to passively receive the new rational belief that the feared scenario is either unlikely (which is not even always true) or at least tolerable (which

is more probable). Rather, it is crucial to become aware of the mind's ability to question negative thoughts and detach from them.

What matters is not that I show you how unlikely it is that the feared event would happen or that all in all you are capable of tolerating negative states, but that you realize that you can be aware of your negative thoughts and stop giving them credit just because they have crossed your mind.

Monitoring clinical progression. Monitoring clinical progression is the last element that should be performed in a fully shared rather than a mechanical and passive way. By monitoring the progression, the therapist and patient continuously refocus on case formulation, which increasingly clearly becomes the real measure of therapeutic progress. Not coincidentally, the monitored variables are the adherence to *core beliefs* and *coping strategies*, evaluated according to scales from 1 to 10, in order to evaluate the degree of detachment as a clinical index of progress.

Shared Case Formulation as a Theoretical Shift Towards Functionalism

In this final section of the chapter, we suggest that case formulation as a shared operation between therapists and patients has become clinically important because some limitations of the structuralist self-centered conception of CT have emerged. Shared case formulation has favored and encouraged a theoretical shift of CT towards functionalism. This functionalist perspective of CT enables one to conceptualize the alliance and the therapeutic relationship around the pivot of sharing case formulation.

A first argument in favor of this hypothesis is that the shared case formulation can be conceived as a process managed by mental functions, at least from an operational—if not theoretical—viewpoint: The patient is encouraged to understand that his or her mental states derive from executive choices that can be governed cognitively. The therapist then explains to the patient how his or her mental states derive from beliefs about him- or herself, life, the world, others, and the future. These beliefs are, after all, ways of consciously formulating how the mind works.

The same idea also applies to the sharing of the treatment rationale. Sharing with the patient the rationale of a *questioning* intervention, pro and con analysis, and behavioral exposure does not imply faith in a mechanical action of a rational tool on the emotional experience. Rather, it indicates the choice to consciously activate a series of mental functions that can be mastered together, and that the patient has so far largely chosen to neglect to activate—considering them uncontrollable by default. It is clear that by reasoning in this way, the true mechanism of therapeutic action turns out to be more functionalist and metacognitive than structuralist and cognitive. Due to its simplicity, it cannot be denied that the CT procedure is effective in setting the patient's disposition in the direction of mastery rather than passivity.

It is true that case formulation in the clinical model of CT is a theoretical simplification. Reducing mental states to verbal cognitive content is questionable, just as it is questionable to reduce the relationship among thoughts, emotions, and behaviors to a one-way direction. The mind-body system and the set of mental states and behaviors are a continuum and so are not easily reducible to verbalizations. Clearly, executive control of behaviors—and even more so of emotional states—is a complex process that only partially occurs at the conscious executive level. It is also true, however, that this process is partially controllable, and to a greater extent than we think, in everyday life. The real basic principle of cognitive psychotherapy may no longer be that this process is entirely controllable by executive consciousness but rather that it is controllable to a greater extent than the patient believes. Emotional distress also depends on the extent to which the patient underestimates this power. From this viewpoint, the cognitive principle must be rethought, transforming the relationship between thoughts and emotions into a metacognitive distortion of low mastery of mental states.

It is not easy to reconstruct the development of clinical knowledge that has led to the current highly explicit and shared case formulation using the CT diagram or other tools. We certainly know that Aaron T. Beck's training was psychoanalytic (Rosner 2014a, 2014b) and that Beck continued to consider the early stages of development of his model as belonging at least in part to the psychodynamic world, as reported in his 1984 work in which he defines a continuum between CT, behavioral therapy, and psychoanalysis and unexpectedly states that his attention to consciousness came from psychoanalysis, or rather from the particular psychoanalysis he knew (Beck 1970a, 1970b, 1970c, 1971). In fact, the American psychoanalysis in which Beck was trained was influenced by both the neo-Freudian ego-psychology current developed by both Anna Freud (1936/1966) and Hartmann, Kris, and Loewenstein (Hartmann 1964; Hartmann and Loewenstein 1964; Hartmann et al. 1946); this favors conscious ego functions at the expense of the unconscious ego and id, and the interpersonal tradition dating back to Alfred Adler and Otto Rank and arriving at Karen Horney and Harry Sullivan, which emphasizes the importance of understanding and treating patients' conscious experiences and the need to treat the meanings that patients attribute to the events in their lives. CT focused on intrapsychic processes rather than manifest behavior is more a legacy of these neopsychoanalytic theories.

On the other hand, it is true that Beck's therapeutic procedures are more similar to behavioral therapy (Rosner 2014a, 2014b). In fact, we also know that from the 1970s onwards, Beck approached the behavioral world and combined the concepts borrowed from psychoanalysis with behavioral functional analysis. As is widely known, functional behavioral analysis is an assessment procedure that searches for an explanatory model of patients' behaviors in terms of antecedents and consequences which either influence or retroactively condition it.

Admittedly, the rationale of functional analysis is in turn metacognitive because it presupposes that the person, once aware of his or her functional model, can modulate the interactions with the behavioral antecedents and consequences. However, even the neo-analytical model is metacognitive in its own way; this model

influenced Beck because its basic assumption is that conscious mental states can modulate unconscious mental drives once a person becomes aware of them. In both cases, it is believed that it is possible to move from the automatic management of behavioral sequences or drives to executive management via a metacognitive analysis. The final result is the fully shared formulation contained in the manual signed by Judith Beck (2011).

However, while in functional analysis the content of variables is always open, in CT's CCD, the content of the cognitive mediator is predetermined, tending to be conceptualized in terms of beliefs about the self, the world/environment (including interpersonal relationships), or the future. Over time, beliefs about the self have gained a prominent role within the cognitive triad of CT (Wells and Mathews 1994: p. 2). This final prevalence of pattern theory about the self is also attributable to the influence of the clinical applications of Bandura's (1977, 1988) fundamental work on self-efficacy (Maddux and Kleiman 2012) and Neisser's (1967) and Markus' (1977) models of the self. In summary, positive self-judgements about the ability to manage and control events and emotional reactions are considered largely responsible for emotional well-being and effectiveness in daily life, while negative self-judgements are what make us depressed or anxious (Williams 1996). Self-beliefs are stable, hierarchically superordinate organizations of knowledge because they integrate and summarize a person's thoughts, feelings, and experiences (Markus and Sentis 1982), including their physical characteristics, social roles, personality traits, and areas of special interest and ability (Markus and Nurius 1986).

It is also possible that the emphasis in Beck's CT on the self depends on the influence of Bandura, Neisser, and Markus in cognitive science, as well as Beck's own psychoanalytic background. In this psychodynamic paradigm, it is assumed that the human mind possesses conscious adaptive functions called ego functions that are not influenced by aggressive and libidinal conflicting drives (Rosner 2014a, 2014b). In short, the ego plays a key organizational role in mental activity that seems to be similar to the role played by self-beliefs in Beck's CT.

The concept of self-knowledge likely helped Beck formalize his procedures in ways that are more understandable and manageable to clinicians. Furthermore, Beck's crucial advantage was his commitment to the development of replicable protocols applicable to psychiatric diagnoses of emotional disorders (Rush et al. 1977).

Subsequently, Beck's CT model has been applied to a wide range of emotional disorders such as panic disorder (Clark 1986), social phobia (Clark and Wells 1995), post-traumatic stress disorder (Ehlers and Clark 2000), eating disorders (Fairburn et al. 1999), and obsessive-compulsive disorder (Salkovskis 1985). These scholars both borrowed Beck's "psychodynamic" treatment for verbal reattribution focused on personal beliefs (Rachman 2015) and strongly reintroduced the behavioral element grounded on the work of Meyer and Turkat (1979). British behaviorism merged with Beck's CT (Marks 2012) due to Meyer's efforts to develop appropriate case formulation procedures (Bruch 2015; Rachman 2015). In turn, Beck also increased the behavioral components in its model (Beck et al. 1979, 1985). Therefore, a standard CT clinical model was born that has the basic principle that emotional disorders depend on biased automatic cognitive processes that can be

changed through verbal reattribution in therapy (Beck 1976; Clark et al. 1999; Clark and Beck 2010; Dobson and Dozois 2001; Ellis and Grieger 1986; Kazdin 1978; Kelly 1955; Mahoney 1974; Meichenbaum 1977; Rachman 1977). It was a sort of psychotherapeutic counterpart of the anthropological reflections about the executive brain and of the civilized mind (Goldberg 2001). In this way, Beck consolidated his success and managed to characterize his CT approach as the standard one. The disadvantage of this success, however, is that the functional analysis model has been overshadowed by the cognitive assessment of Beck's CT on which it was modeled.

References

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*, 191–215.

Bandura, A. (1988). Self-efficacy conception of anxiety. *Anxiety Research, 1*, 77–98.

Beck, A. T. (1963). Thinking and depression: I. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*, 324–333.

Beck, A. T. (1964). Thinking and depression: II. Theory and therapy. *Archives of General Psychiatry, 10*, 561–571.

Beck, A. T. (1970a). The core problem in depression: The cognitive triad. *Science and Psychoanalysis, 17*, 47–55.

Beck, A. T. (1970b). Cognitive therapy: Nature and relation to behavior therapy. *Behavior Therapy, 1*, 184–200.

Beck, A. T. (1970c). Roles of fantasies in psychotherapy and psychopathology. *Journal of Nervous and Mental Disease, 150*, 3–17.

Beck, A. T. (1971). Cognitive patterns in dreams and daydreams. In J. H. Masserman (Ed.), *Dream dynamics* (pp. 2–7). New York, NY: Grune and Stratton.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York, NY: International Universities Press.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York, NY: Basic Books.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. London/New York, NY: Guilford Press.

Beck, J. S. (2011). In London (Ed.), *Cognitive therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*, 252–260.

Bruch, M. (2015). *Beyond diagnosis: Case formulation in cognitive behavioural therapy*. Chichester/New York, NY: John Wiley & Sons Ltd.

Clark, D. A., & Beck, A. T. (2010). *Cognitive Therapy of Anxiety Disorders: Science and Practice*. New York, NY: Guilford.

Clark, D. A., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. New York, NY: Wiley & Sons.

Clark, D. M. (1986). A cognitive approach to panic disorder. *Behaviour Research and Therapy, 24*, 461–470.

Clark, D. M., & Wells, A. (1995), A cognitive model of social phobia. In R.G. Heimberg, M. Liebowitz, D. Hope, D. e F. Scheier (Eds.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 66–93). New York, NY: Guilford.

Dattilio, F. M., & Hanna, M. A. (2012). The collaborative relationship in cognitive-behavioral therapy. *Journal of Clinical Psychology, 68*, 146–158.
Dattilio, F. M., & Padesky, C. A. (1990). *Cognitive therapy with couples*. Sarasota, FL: Professional Resource Exchange.
Deci, E. L., & Ryan, R. M. (Eds.). (2002). *Handbook of self-determination research*. Rochester, NY: University of Rochester Press.
DiGiuseppe, R., Doyle, K. A., Dryden, W., & Backx, W. (2014). *A Practioner's guide to rational emotive behavior therapy*. New York, NY: Oxford University Press.
Dobson, K. S., & Dozois, D. J. A. (2001). Historical and philosophical bases of the cognitive-behavioral therapies. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 3–39). New York, NY: Guilford.
Ehlers, A., & Clark, D. M. (2000). A cognitive model of post-traumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.
Ellis, A. (1962). *Reason and emotion in Psychotherapy*. New York, NY: Stuart.
Ellis, A., & Grieger, R. M. (Eds.). (1986). *Handbook of rational-emotive therapy* (Vol. 2). New York, NY: Springer.
Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of eating disorders. *Behaviour Research and Therapy, 37*, 1–13.
Feixas, G., & Compañ, V. (2016). Dilemma-focused intervention for unipolar depression: A treatment manual. *BMC Psychiatry, 16*, 235. https://doi.org/10.1186/s12888-016-0947-x.
Freud, A. (1936/1966). Ego and mechanisms of defense. In *The writings of Anna Freud* (Vol. 2, Rev. ed.). New York: International Universities Press
Goldberg, E. (2001). *The Executive Brain: Frontal Lobes and the Civilized Mind*. Oxford: University Press, Oxford.
Guidano, V. F. (1987). *Complexity of the Self*. New York, NY: Guilford Press.
Guidano, V. F. (1991). *The self in process: toward a post-rationalist cognitive therapy*. New York, NY: Guilford Press.
Guidano, V. F., & Liotti, G. (1983). *Cognitive processes and emotional disorders: A structural approach to psychotherapy*. New York, NY: Guilford Press.
Hartmann, H. (1964). *Essays on Ego psychology*. New York, NY: International Universities Press.
Hartmann, H., Kris, E., & Loewenstein, R. M. (1946). Comments on the formation of psychic structure. *The Psychoanalytic Study of the Child, 2*, 11–38.
Hartmann, H., & Loewenstein, R. M. (1964). *Papers on psychoanalytic psychology. Psychological issues monograph*. New York, NY: International Universities Press.
Hollon, S. D., & Beck, A. T. (1979). Cognitive therapy of depression. In P. C. Kendall & S. D. Hollon (Eds.), *Cognitive-behavioral interventions: Theory, research, and procedures* (pp. 153–203). New York, NY: Academic.
Kazantzis, N., Beck, J. S., Dattilio, F. M., Dobson, K. S., & Rapee, R. M. (2013). Collaborative empiricism as the central therapeutic relationship element in CBT: An expert panel discussion at the 7th International Congress of Cognitive Psychotherapy. *International Journal of Cognitive Therapy, 6*, 386–400.
Kazdin, A. E. (1978). *History of behavior modification: Experimental foundations of contemporary research*. Baltimore, MD: University Park Press.
Kelly, G. A. (1955). *The psychology of personal constructs: Vol 1 and 2*. New York, NY: Norton.
Knapp, P., & Beck, A. T. (2008). Fundamentos, modelos conceituais, aplicações e pesquisa da terapia cognitiva [Cognitive therapy: foundations, conceptual models, applications and research]. *Brazilian Journal of Psychiatry, 30*, s54–s64.
Maddux, J. E., & Kleiman, E. M. (2012). Self-efficacy. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 89–101). New York, NY: Oxford University Press.
Mahoney, M. J. (1974). *Cognition and Behavior Modification*. Cambridge, MA: Ballinger.
Mahoney, M. J. (1995). Theoretical developments in the cognitive and constructive psychotherapies. In M. J. Mahoney (Ed.), *Cognitive and constructive psychotherapies. Theory, research,*

and practice (pp. 103–120). Springer and American Psychological Association: New York, NY, Washington, D.C.
Mahoney, M. J. (2003). *Constructive psychotherapy: A practical guide*. New York, NY: Guilford.
Markland, D., Ryan, R. M., Tobin, V. J., & Rollnick, S. (2005). Motivational interviewing and self-determination theory. *Journal of Social and Clinical Psychology, 24*, 811–831.
Marks, S. (2012). Cognitive behaviour therapies in Britain: The historical context and present situation. In W. Dryden (Ed.), *Cognitive behaviour therapies* (pp. 1–24). New York, NY: Sage Publishing.
Markus, H. (1977). Self-schemata and processing information about the self. *Journal of Personality and Social Psychology, 35*, 63–78.
Markus, H., & Nurius, P. (1986). Possible selves. *American Psychologist, 41*, 954–969.
Markus, H., & Sentis, K. (1982). The self in social information processing. In J. Suls (Ed.), *Social Psychological Perspectives on the Self* (pp. 41–70). Hillsdale, NJ: Erlbaum.
Meichenbaum, D. H. (1977). *Cognitive behavior modification*. New York, NY: Plenum Press.
Meyer, V., & Turkat, I. D. (1979). Behavioral analysis of clinical cases. *Journal of Behavioral Assessment, 1*, 259–270.
Neimeyer, R. A. (2009). *Constructivist psychotherapy. Distinctive features*. London: Routledge.
Neimeyer, R. A., & Mahoney, M. J. (Eds.). (1995). *Constructivism in Psychotherapy*. Washington, DC: APA Press.
Neisser, U. (1967). *Cognitive Psychology*. Englewood Cliffs, NJ: Prentice-Hall.
Rachman, S. (1977). The conditioning theory of fear acquisition: a critical examination. *Behaviour Research and Therapy, 15*, 375–387.
Rachman, S. (2015). The evolution of behaviour therapy and cognitive behaviour therapy. *Behaviour Research and Therapy, 64*, 1–8.
Rosner, R. I. (2014a). Aaron T. Beck's drawings and the psychoanalytic origin story of cognitive therapy. *History of Psychology, 15*, 1–18.
Rosner, R. I. (2014b). The "Splendid Isolation" of Aaron T. Beck. *Isis, 105*, 734–758.
Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. *Cognitive Therapy and Research, 1*(1), 17–37.
Salkovskis, P. M. (1985). Obsessional-compulsive problems: a cognitive behavioural analysis. *Behaviour Research and Therapy, 23*, 571–583.
Stein, D. J., Kupfer, D. J., & Schatzberg, A. F. (Eds.). (2006). *The American Psychiatric Publishing textbook of mood disorders*. Washington, DC: American Psychiatric Publishing.
Tee, J., & Kazantzis, N. (2011). Collaborative empiricism in cognitive therapy: A definition and theory for the relationship construct. *Clinical Psychology: Science and Practice, 18*, 47–61.
Wells, A., & Mathews, G. (1994). *Attention and emotion: A clinical perspective*. Hove/Hillsdale, NJ: Erlbaum.
Williams, J. M. G. (1996). Depression and the specificity of autobiographical memory. In D. Rubin (Ed.), *Remembering Our Past: Studies in Autobiographical Memory* (pp. 244–267). Cambridge: Cambridge University Press
Winter, D. A., & Viney, L. L. (Eds.). (2005). *Personal construct psychotherapy. Advances in theory, practice and research*. London: Whurr Publishers.