Commentary to Chapter "Case Formulation in Standard Cognitive Therapy": The Use of Goals in Cognitive Behavioral Therapy Case Formulation

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The Role of Goals in Case Formulation

In the formulation of a standard cognitive behavioral psychotherapy (CBT) case, the pathogenic role of dysfunctional (or irrational) *beliefs* (or ideas) is central (Beck 1976; Ellis 1962). The patient suffers because he or she believes that he or she is worth nothing, or that nobody loves him or her or that he or she is selfish, and so on. The mind of human beings, however, is not limited to believing and knowing. The mind also creates representations of what *it wants* and what it does *not want*. Standard CBT seems to neglect—at least in its explicit formulation—the role played by mental representations that are different from beliefs, which we could define as representations of the will: the *goals* or *purposes* (from now on: goals). With this term we refer to the motivations of the individual, his or her plans and mental structures, well described in the work of Miller et al. (1960), without which beliefs would play a mere epistemic function (Castelfranchi and Miceli 2004). More specifically, if we consider the field of psychopathology, it becomes necessary to underline the fundamental role played by a special type of goal: the overinvested *anti-goals*, the states, the scenarios, the unintended facts experienced by the patient as catastrophic, terrible, unacceptable. If every time a patient reveals his or her automatic thoughts to us we do not sense what he or she cares about, what he or she *wants*, and what he or she really does *not want*, how could we understand the reason why a belief causes him or her painful emotions and hinders his or her well-being? For example, if a person believes that having sex exposes him or her to the risk of poor judgment, but he or she does not care much about sex or poor judgments, the belief will not lead him or her to any particular emotional reactions: it would merely and coldly represent a viewpoint. On the other hand, if that person pursues an intense sex life, but does not want in any way to run the risk of a sexual failure (i.e., he or she has the overinvested anti-goal of avoiding any sexual failure and feeling humiliated because of it), then that belief will probably systematically hinder the natural pursuit of a desire and cause suffering. Hence, it becomes pathogenic.

CBT uses two main types of formulation of pathogenic beliefs. One type expresses them through statements, or simple propositions (“I’m ugly,” “I’m not brilliant,” “I’m selfish,” “I’m fragile,” “I’m unpleasant,” “everyone hates me,” “everyone is better than me,” etc.), and inferences like “if...then...,” in which a premise brings to a consequence:

- *if I get engaged to a girl other than the one my mother wants, my mother would feel betrayed;*
- *if I share my viewpoint, I would be ignored;*
- *if I buy the car of my dreams, my brother would feel he is a failure;*
- *if I feel sexual pleasure, my partner would feel used;*
- *if I get intensely moved, I will lose control.*

The possible examples are endless. If we analyze each of the pathogenic beliefs used as examples, we will quickly grasp a constant characteristic: They all imply an anti-goal and all express a conflict between a desire and an anti-goal, or, in more

general terms, a conflict between a goal and an anti-goal. In the premise the desire is often implicit, in the conclusion the anti-goal is expressed, i.e., the feared consequence that hinders the realization of the desire; when the first occurs, the second also occurs or risks occurring:

- *I intensely want to get engaged to that girl, but I don't want my mother to feel betrayed because of it;*
- *I intensely want to express my opinion, but I don't want to run the risk of being ignored;*
- *I intensely want to buy a nice car, but I don't want my brother to feel like a failure because of it;*
- *I intensely want to experience sexual pleasure, but I don't want my partner to feel used for it;*
- *I intensely want to feel intense emotions, but I don't want to lose control of myself in any way.*

In the patient's mind, the satisfaction of a desire involves the realization of an unintended scenario (of an anti-goal, precisely) and the prevention of anti-goal inhibits the satisfaction of desire. There is not much choice: One either tries to satisfy the desire by taking a risk to make the feared scenario possible, or one tries to prevent the feared scenario by giving up desire (Mancini 1996; Mancini and Giacomantonio 2018). This type of belief formulation is very similar to that used by control-mastery theory (Silberschatz 2017). However, even in control-mastery theory, as in standard CBT, the fundamental role played by anti-goals is not made explicit.

For the sake of clarity, it is not intended to say that beliefs formulated with rules such as "if...then..." should always propose a conflict between a desire and an anti-goal—in fact, in some cases the premise simply expresses the condition that makes the anti-goal come true (e.g., *if* I have anxiety, *then I* am weak; *if* my partner asks for more freedom, *then he does* not love me; *if I* lose my hair, *then* I will be disgusting; etc.). However, these beliefs still include an anti-goal, whereas the feared scenario is an anti-goal by virtue of its valuable correspondence with the terminal or hierarchically superior anti-goal (I don't want to have anxiety because having anxiety means being weak—and I don't want to be weak; I don't want my partner to ask for more freedom because if he does it means he doesn't love me—and I don't want him not to love me anymore; I don't want to lose my hair because if I lose it I will be disgusting—and I don't want to be disgusting).

Let us now consider the beliefs formulated with simple and apparently apodictic propositions ("I am stupid," "I am weak," "everyone hates me," "I am a burden for everyone," "I will be alone forever," and so on). Although these may appear as self-evident truths, they often do not express a conclusive conviction but rather the fear that the described scenario is true, mixed with the hope of discovering it is false. In other words, they also reveal an anti-goal of the patient perceived as more or less current, such as being judged or feeling stupid or fragile or hateful or a burden or selfish or evil or harmful or ugly or unworthy or insecure, or being left, scolded,

deceived, disappointed, humiliated, and so on. As written above, the examples are endless. That is, everything he or she would ever want to come true.

Even when beliefs in the form of simple propositions emphasize a positive and desired quality of self (e.g., "I am good," "I am a balanced person," "I am a good professional," etc.), they could be pathogenic if they hide an overinvested anti-goal (and therefore, for example, the fear of "being judged bad," "losing mental balance," "disappointing expectations," and so on). Therefore, even beliefs expressed with a simple statement, which signal self-criticism or positive qualities, can suggest something the patient defends him- or herself against but, unlike the others (those of the "if... then..." type), they lack the condition that makes the anti-goal come true and do not enlighten on possible conflicts between goals that hinder the pursuit of his or her life plan.

In summary, beliefs, however they are formulated, always signal an anti-goal if they are pathogenic. This is true for those expressed through a simple statement and it is true for those expressed through a hypothetical period of "if... then... ." Among the latter, those that suggest a consequential relationship between the realization of a desire and an anti-goal coming true have a special value because they synthesize in a single sentence both the patient's plans and the reasons that hinder them.

We have a final note on overinvested anti-goals and their role in the genesis of suffering. If there is suffering, it means that some goals are threatened: As described above, the threatened goal is sometimes a desire, a need, mostly healthy and legitimate, different from the anti-goal and in conflict with it (e.g., the desire to have a fulfilling sex life is threatened because it conflicts with the fear—the anti-goal—of failure and feeling humiliated. To defend myself from the risk of humiliation I avoid sexual approaches and by avoiding sexual approaches I suffer because I give up the satisfaction of a desire); other times the overinvestment of the anti-goal causes suffering because it makes the anti-goal come true. In other words, the tenacious attempts to prevent the anti-goal end up having the opposite effect, in a totally unexpected and unintended way by the mind. For example, I live in the terror of not being a good father—anti-goal—and to ward off this fear I behave exaggeratedly scrupulously with my children; the excess of care transmits anxiety and insecurity to them, ending up confirming, despite myself, the fear of not being a good father.

Anti-goals and Their Implications for the Case Formulation Methodology

The idea of placing motivations, and in particular anti-goals, at the center of the structural factors that hinder the well-being of an individual goes beyond mere formal clarification. It has important consequences with respect to the method of case formulation and the principles of therapeutic strategy.

As far as the case formulation is concerned, it requires that the section dedicated to the internal profile of the disorder is not limited to the search for pathogenic

beliefs, but starts precisely from the assessment of the patient's motivations and in particular from what he or she is most defensive. There is clearly no limit to the number of a person's anti-goals, but clinical observation suggests that those who play a decisive role in the suffering of patients are few and overinvested (in some cases it may even happen that a single anti-goal is enough to summarize an entire pathogenic life theme), so it is not advisable to include in the formulation long lists of goals, it is better to focus on those that better characterize the patient and more clearly related to the psychological problem of the patient. Anti-goals can consist of objective facts (e.g., being abandoned), behaviors (e.g., making a crucial mistake), personal qualities (e.g., being characterfully weak), or internal states (e.g., feeling boredom) that are unwanted, feared, and should be formulated as closely as possible to the patient's subjective representation.

Once the patient's anti-goals have been identified, it will be easy to formulate the beliefs related to them, avoiding lingering over those that are not relevant to the anti-goal and more generally to the patient's problem. As already suggested in the previous section, the beliefs that shed light on the conditions under which the anti-goal comes true are particularly useful, and, among these, those that establish a possible consequential relationship between a desirable and healthy goal and the feared realization of the anti-goal. Let us suppose that the anti-goal is *"to be considered an insignificant and rejected person"* and let us suppose that the patient suffers because he intensely wants to have an intimate relationship, friends, and a job in which he is able to affirm him-, but is far from having all this. Let us now suppose that the patient is convinced that trying to realize his desires, i.e., courting a possible partner or making friends or exposing him- and saying his opinion at work, exposes him to what he fears most: appearing insignificant and being rejected. It is clear that in order to defend him- from this painful scenario, the patient will have to give up trying to realize his desires or try to realize them in such a dysfunctional way that he will end up finding confirmation of his fears. The pathogenic belief could be formulated as follows: *"If I try to approach a possible partner, have close friends, and make myself more visible at work, they will find me insignificant and reject me."* As can be easily observed, here as in the previous examples, the belief is composed of two propositions, the first one contains the possibility of pursuing one's own plans (courting a possible partner and so on), while in the second, the consequence, the feared scenario, the catastrophe, the anti-goal (to be judged insignificant and to be rejected) comes true. To build this kind of belief, therefore, you always need two elements: what the patient wants and would do if he did not have an emotional problem and what prevents him from doing so, that is, the fear that the anti-goal comes true. For this reason, it is fundamental that a well formulated case always foresees not only the anti-goal, but also the healthy goals, the patient's desires, the therapeutic goals: Without the latter, one does not understand what the patient wants to achieve with the help of psychotherapy; without the former one does not understand what prevents the patient from achieving it on his own.

Finally, it is always useful to remember the methodological principles of consistency and economy to be applied when formulating the different points of the case: A common thread must link the problem of which the patient complains, his or her goals (i.e., how he would like his or her life to be), the beliefs and anti-goals that hinder the achievement of these goals, the processes that maintain the problem, the events that produced the clinical decompensation and the onset of the problem, and the early life experiences that have fostered the development of pathogenic beliefs and anti-goals. In a good formulation, everything must be consistent and interconnected and the elements that add nothing to the understanding of the case should be omitted. For example, the patient complains of a *problem* of social inhibition and depressed mood; he *aims* to improve his mood, cultivate social and sentimental relationships, and improve his working position. He has a problem because even if he wants to have a partner, close friends, and a better job, he cannot have any of that because he has overinvested the *anti-goal* of avoiding being judged insignificant and rejected and the *belief* that if he tries to court a possible partner, make friends, and make him- more visible among colleagues and superiors, others will find him insignificant and reject him. He has this fear and this belief because his *life story* has been dominated by a relationship with a depressed mother who showed boredom and disinterest when he spoke to her and a father who mocked him for his thoughts and moods. The *clinical decompensation* occurs at seventeen years after a brief love affair ended because the partner claims to find him not interesting. The *maintenance* of the problem is due to pervasive avoidant behaviors that systematically deprive the patient of the opportunity to lower his guard against his fears (anti-goals) and challenge dysfunctional beliefs.

Anti-goals and Their Implications for the Therapeutic Strategy

Let us consider the implications regarding the principles of therapeutic strategy due to the centrality of motivations, and in particular of anti-goals. One of the classic ways CBT produces therapeutic change involves correction of the dysfunctional belief. To simplify: I believe I am an insignificant person; if the therapist shows me through disputing and behavioral exercises that things are not as I believe, the belief will be challenged and reframed and I will feel better. Here the therapeutic strategy basically follows a *truth/falsity* criterion: I think I am an insignificant person when I talk to others, and thanks to the therapy, I discover that this belief *is not true*. But if we analyze the pathogenic belief (and its anti-goal), we discover that the therapeutic path can also be another one. Let us start again from the pathogenic belief: *"If I try to court a possible partner, have close friends, and make myself more visible at work (desires), others will find me insignificant and reject me (anti-goal).*" It is pathogenic not only because it is largely false and painful in itself, but also and

above all because, by causing overinvestment in the prevention of anti-goal, it hinders or completely blocks the pursuit of one's desires. This scenario is a bit like a severe reaction of the immune system to a pathogen that inflames the patient's lungs so severely that it prevents him or her from breathing: The extent of the immune reaction is either reduced or the patient dies, killed by the attempt of his body to defend itself. In the same way, if it is true that the pathogenic power of the belief also originates from an excess of defense against the anti-goal, then it is necessary to divest from it in order to counteract its harmful effects and encourage the pursuit of healthy objectives (courting a possible partner, have friends, and so on).

In other words, The patient can also walk the road of reducing his defensive investment, i.e., to defend him- less from the feared scenario in order to devote himmore freely to his life plans. From this point of view, the therapeutic aim would not only be to falsify the belief, but also to favor the lowering of the guard against what is feared and to encourage the patient to *accept* the reasonable risk that the anti-goal will come true in order to dedicate him- to the realization of its plans. Specifically, the classic strategy of correcting the belief comprises demonstrating with logical arguments or empirical evidence (Ruggiero and Sassaroli 2013) that the link between the premise and the conclusion of the belief is false (i.e., it is not true that if you try to court a possible partner you will appear insignificant and will be rejected. It will be all right, the anti-goal will not come true) or, even more incisively, convey the idea that even if the scenario described in the belief (to be rejected, i.e., the anti-goal) were to come true, this would not affect the overall and intrinsic quality of the person (i.e., whatever happens, whatever they tell you, this does not make you an insignificant person).

In both forms, this strategy rests on a *truth/false* criterion, but the second one opens more interesting perspectives because distinguishing facts from the intrinsic value of the person allows you to accept and challenge even painful scenarios (e.g., possible rejections) to invest in the achievement of your goals. The limits of the strategies that aim at pure falsification are, however, at least three: (1) feared things can happen; the therapist works on the perception of probability of the worst scenario, usually unrealistically too high from the patient's view, but the therapist should also encourage the patient to be ready for the worst scenarios; (2) the strategy very often clashes with general beliefs about oneself that are apodictic and therefore not very permeable to attempts at falsification; and (3) even when they break the patient's belief system, his fear of the anti-goal is sometimes so high that he prefers cautious and complacent solutions with the pathogenic belief. In other words, the patient can agree that perhaps it is true that he is not an insignificant person, but it is better not to believe too much in this healthy belief in order not to feel too bad afterward in case the worst scenario comes true. This means that, the patient adopts a cognitive strategy known as *better safe than sorry* that maintains the dysfunctional belief (Mancini et al. 2007).

For all the reasons explained above, the strategies of *falsification*, while remaining fundamental throughout the course of therapy, must be accompanied by

strategies of *acceptance* (Perdighe and Mancini 2012). The term acceptance should of course not be understood as resignation to pathogenic beliefs; on the contrary, it means disinvesting, at least partially, from a purpose that has become pathogenic (i.e., the anti-goal) in order to encourage the pursuit of healthy goals. Acceptance cannot be prescribed, but it can be encouraged. How? Human beings usually reduce investment in a purpose when they realize that it is *useless*, unproductive (pragmatic criterion; Ruggiero and Sassaroli 2013), when it is too *expensive*, inconvenient (economic criterion), when it is *legitimate or due to* reduce it—or illegitimate and not due to maintain it (moral criterion).

The therapist concretely encourages a process of acceptance in the patient if he succeeds in showing that continuing to invest in the pathogenic belief and in the relative anti-goal of being rejected: (1) does not completely eliminate the risk of being rejected and does not bring it closer to his objectives (pragmatic criterion); (2) involves enormous costs in psychological, practical, and relational terms (economic criterion); and (3) is neither right nor fair. In other words, to point out that the patient has the right (and the duty toward him-) not to deal with the belief (true or false) and the related anti-goal to freely dedicate him- to the pursuit of his psychological well-being.

To sum up, pathogenic beliefs are always evaluative with respect to a goal. Without desires, without motivations, without conflicts, beliefs are neutral, they lose any emotional color and any pathogenic power. They do not facilitate or hinder anything. For these reasons, it might be useful not to limit the formulation of the internal profile of the disorder to beliefs but to extend it to the formulation of anti-goals. In addition, the pathogenic goal is rarely such because it is in itself wrong or harmful; it becomes so if it chronically complicates the person's healthy plans. Indeed, in many cases it is the excessive investment of the anti-goal, the strenuous defense against it, that makes it pathogenic. To put it bluntly, always with the help of a few examples: There is clearly nothing wrong with the aim of preventing the unhappiness of a loved one, but if the fear of this goal systematically hinders the fulfillment of the legitimate desire for personal affirmation, then the aim of preventing the unhappiness of the other becomes pathogenic. Furthermore, if the abnormal investment in the purpose leads to self-feeding spirals that undermine the purpose itself (e.g., a doctor who worries a lot about the therapy to be prescribed in order to be sure not to harm his or her patient and ends up delaying the treatment too much is really damaging his or her patient), then the goal becomes pathogenic. From this perspective, it is fair to suggest that a good therapeutic strategy should always include how to encourage the patient both to withdraw the investment from his or her pathogenic anti-goal and to pursue his or her desires, rather than just trying to establish whether a belief is true or false.

The Five Components of the CASE Formulation

The core of the formulation is the hypothesis about the nature of the difficulties underlying the symptoms presented by the patient, i.e., the description of the factors that determine, regulate, and maintain the patient's suffering (Eells 2009; Eells et al. 1998; Persons 2008). Translated into cognitive terms, it is the reconstruction of the representations and mental processes that cause specific symptoms and that will be the guide in treatment planning. We present below a formulation scheme based on five points (Barcaccia 2010; Mancini and Barcaccia 2009; Mancini and Perdighe 2009).

Target Definition of the Intervention: Description of Symptoms and Problems

This first component of the formulation is the one in which the therapist strives to give a synthetic picture of the symptoms and problems that the patient brings and in which, therefore, the level of inference is at its lowest. This does not mean that the therapist simply records and reports the patient's answers to the question "why is he or she here?"; rather it is the description of the problems presented from the therapist's point of view and, if possible, his or her assessment in nosographic terms. The key questions are:

- *How and when do the symptoms occur? Under what circumstances? With what frequency, intensity, duration?*
- *How much do the symptoms interfere with the patient's overall functioning?*
- *Why is the patient asking me for help? Why now?*

How Do I Explain the Problem Presented: The Internal Profile

The heart of the formulation is the explanatory hypothesis on what generates and regulates the patient's behavioral, emotional, and somatic symptoms. The core question to answer is: What are the reasons that determine and regulate the patient's symptoms? From a cognitive point of view, the idea is to focus on what goals and beliefs regulate the symptomatology.

For example, in the case of a patient with obsessive symptoms, a well-constructed internal profile will be able to explain what goal regulates the entire symptomatology and make predictions about how the patient will react to possible stimulus situations, in order to confirm or reject the formulated hypothesis of functioning. For example, consider the patient Ms. F., who presents ruminations, avoidance, anxious

activation, and request for reassurance; all her symptoms are regulated by the fear of ruining her life and her family due to her own negligence (anti-goal): F. believes that if she does not constantly and scrupulously prevent it, she risks becoming like her mother, ruining her life and the life of her children and her partner. The anti-goal is to do everything in her power to prevent this "ruin" and protect herself from this guilt. From this hypothesis, we can predict that any event that corresponds to an increase in responsibility toward the family or a risk of distraction from one's commitment will trigger more fear of feeling negligent and guilty and, consequently, will exacerbate symptoms, i.e., an increase in attempts to prevent the feared scenario.

The key questions that can help are:

- What are the independent variables that regulate the symptomatology?
- What are the states of mind, and in particular the goals and beliefs that underlie the problem?

What Prevents a Resolution of Suffering: Maintenance Factors

An important aspect of understanding a disorder or symptom is to answer the question: How is possible that the patient does not obtain a solution, even though he or she usually has the resources, information, and possibilities? Understanding why the patient cannot find or implement the solution means understanding that her/his solution attempts are often part of the problem.

Maintenance factors are all the processes and mechanisms—intra-psychic or interpersonal—that feed the credibility of dysfunctional beliefs and the investment in pathogenic goals; they are dynamic and interactive factors triggered by the activation of the patient's pathogenic structures (his or her overinvested anti-goal and dysfunctional beliefs described in the internal profile) that end up reinforcing the same structures in a vicious circle. For example, F., when a stimulus activates her fear of feeling guilty due to negligence, compulsively asks her partner for reassurance about the correctness of her conduct; the partner, after some unsuccessful attempt of reassurance, bursts out and accuses her of ruining everyone's life with her absurd demands, ending up reinforcing F.'s fear of being negligent and guilty and her need to protect herself from such an eventuality. In other words, F.'s attempts at a solution have, in spite of herself, triggered a self-feeding spiral that has exacerbated her fear of guilt.

The key questions that can help are:

- What prevents spontaneous remission of symptoms?
- Which processes or mechanisms (individual and/or interpersonal) prevent the resolution of the patient's problem and suffering? In what way? What goals/beliefs do they reinforce?
- How do any attempts to solve the problem fuel the problem? How do interpersonal reactions and cycles contribute to the stabilization of the disorder?

What Made the Patient's Functioning Fail: The Clinical Decompensation

One of the most interesting aspects of a clinician's work is to understand why a person at a certain point in his or her life goes into crisis and starts to function differently from what has happened up to that point. To reconstruct the clinical decompensation is, therefore, to investigate what happened in the patient's life before or at the beginning of the symptomatology, to analyze what significant events occurred before, and, above all, what meaning and cognitive-emotional impact they had on the patient's aims and beliefs. For example, a job promotion can be considered a positive event, but for a patient it can also be equivalent to a threat of some of his or her own relevant purpose—for example, the goal of protecting him- or herself from the possibility of revealing him- or herself to others as unsuitable—and, therefore, become a disruptive event.

The key questions are:

- What has happened in the life of the patient that has caused a crisis (or aggravated) the previous psychological functioning?
- What living conditions preceded and facilitated the onset of the problem (described in the profile)?
- What psychological variables have been altered by the decompensating events? In other words: What significance did these events have for the subject and how did they modify the psychological functioning of the patient?

How the Patient Has Built Up His or Her Psychological Functioning and What Aspects of His Current Life Stress His Weaknesses: Vulnerability

The reconstruction of vulnerability is always a point of great interest for the clinician. It involves what makes or has made the patient vulnerable to a certain theme, and can therefore concern two distinct aspects, one synchronic and another diachronic and biographical. The first has to do with the current living conditions that expose the patient to continuous stress capable of permanently affecting his or her structural fears, regardless of his or her actions. A chronic illness, a low socioeconomic status, a degraded social context, and a particularly competitive working environment are examples of current vulnerability factors that, mind you, will be mentioned in the formulation if—and only if—they contribute to the patient's subjective fragilities, and not because of objectively stressful conditions. Not all stressors take on the same meaning in the eyes of different people. For example, a very competitive environment for someone will be a cause of continuous distress of his or her fear of not being suited or adequate; for someone else it will be a stimulating condition and therefore a protective factor.

The second way of understanding vulnerability is the historical-biographic one and concerns the traumas of the past or more generally the early experiences that have sensitized the patient to certain issues and therefore contributed to the development of his or her overinvested anti-goal and related dysfunctional beliefs. That is, historical vulnerability gives an account of the remote causes of the patient's problem. Mr. E., for example, depressed and suffering from severe social inhibition, had developed the fear and belief that he was insignificant and rejected during childhood because of a mother who showed boredom when he spoke to her and a father who mocked him no matter what he said or did.

What is important is not the detailed description of the life story, but rather the elements plausibly associated with the development of the specific beliefs and purposes that govern the symptomatology presented. It is guided, therefore, by the hypothesis on the functioning of the patient.

The key questions that can help are:

- How did you build the goals, patterns, and beliefs that generated and maintain your problem?
- What elements of life history have fostered the development of psychological sensitivities that make him or her vulnerable to a given problem?
- What current and permanent conditions in his or her life contribute to making him or her vulnerable to a given issue?

Conclusions

The mind constructs representations of what it wants, needs, and desires, and also of what it fears and really does not want. In other words, it takes the structure of goals and anti-goals. The beliefs inform it of where it is in relation to them: If it is more or less close to reaching what it wants or to suffering what it does not want, it will experience anxiety or hope, joy or sadness.

The formulation of the case in cognitive psychotherapy has always given great importance to the dysfunctional beliefs of the patient, less to his or her pathogenic goals. Yet, clinical observation suggests that a dysfunctional belief is such because it always implies an anti-goal, threatened, or already currently undermined. In the absence of an anti-goal, the dysfunctional belief would simply not be one. For these reasons, it would always be appropriate, at the beginning of any psychotherapy, to first identify and formulate the patient's anti-goal. The formulation of his or her dysfunctional beliefs will then be necessary to establish the conditions under which the patient believes the most feared scenarios are fulfilled.

The centrality attributed to aims in the formulation of a case also determines a clear strategic perspective: The therapist's task is not limited to correcting false and irrational beliefs; rather, it aims to encourage disinvestment, at least partially, from certain goals and anti-goals.

Good case formulation should always include five key points:

1. the description of the problem presented by the patient in quantitative terms and if possible, on the basis of this, as a nosographic diagnosis;
2. the definition of the proximal psychological determinants that explain the presence of the problem (purposes and beliefs that cause the symptoms);
3. the factors that maintain the problem, i.e., the self-feeding circle processes that reinforce purposes, dysfunctional beliefs, and symptoms;
4. the clinical decompensating (or precipitating) events that determined the onset of the problem, i.e., justifying the passage from a pre-morbid state to a morbid outcome;
5. finally, vulnerability, understood in two distinct meanings, as a set of stable and current stressful conditions for the specific mental structure of the patient, and as the remote origin of his psychological problems.

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