Chapter 20
Cognitive Behavioral Therapy in Italy

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Psychotherapy Practice and Emotional Disorders in Italy

In Italy, a graduate degree in psychology or medicine is necessary in order to attend a 4-year specialization school in psychotherapy (Borsci, 2005). Psychotherapy can be practiced in both the private and public sector. Public services that provide psychotherapy are departments organized inside the National Health System. Public services are free, or people have to pay a nominal amount for access to all healthcare services including mental health. Theoretical pluralism and the progressive decline of psychoanalysis have favored the development of different therapeutic approaches (Borsci, 2005; Gemignani & Giliberto, 2003).

In Italy one person of five meet diagnostic criteria for at least one emotional disorder across the lifespan (Alleva, 2017; De Girolamo et al., 2005). More specifically, 11% of people interviewed has suffered from an affective disorders or anxiety disorder across the life. Women seem to be more affected by psychological problems (10.4%) compared to men (3.9%) and that in terms of risk factors for predicting a disorder, they identified being unemployed, a housewife, and disabled increased the risk (De Girolamo et al., 2005). Recent research indicates that the prevalence of emotional problems among youngers in Italy shows a decrease of

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mental well-being and that 75% of psychological problems that before 25 years of age (Alleva, 2017; Frigerio et al., 2009).

Beginnings: Behavior Therapy

The practice of cognitive therapy in Italy has at least four distinct traditions which have both interacted which each other and developed separately at different points. We will briefly describe the behavioristic tradition, constructivist tradition, a rational emotive behavior therapy (REBT) tradition, and cognitive behavioral therapy (CBT) tradition. More recently, a "third wave"-oriented tradition has emerged with a focus on mindfulness, metacognitive interventions, acceptance and commitment, and compassion to name a few approaches.

The development of behaviorism in Italy begins with Virgilio Lazzeroni, who in 1942 published a paper focused on behavior as a subject of psychological research (Lazzeroni, 1942). The Italian behaviorism movement had two main roots: the Pavlovian-reflexological-psychiatric tradition and the Skinnerian-psychological tradition (Meazzini, 1978; Moderato & Presti, 2006). These groups focused on both experimental and clinical research specifically in the fields of intervention for regular and special education. Since Lazzeroni's early lessons, behaviorism has reached a fairly good critical mass within psychology in Italy in terms of both experimental research and clinical application and is mainstream in many areas such as anxiety disorder therapies, special education, organizational behavior, and ergonomics (Moderato & Presti, 2006). The Italian behavioristic movement was interested in experimental research on neural reflex arc reactions, behavioral models of classical and operant conditioning, and behavioral modification clinical with a relevant interest in clinical applications regarding special education (Caracciolo & Rovetto, 1988; Meazzini, 1978).

Standard Cognitive Therapy: REBT and CBT

In considering the development of more traditional cognitive therapy in Italy, the seminal figure is Cesare De Silvestri who disseminated REBT in Italy from the 1970s. In 1972, De Silvestri attended the REBT Practicum that took place in Villars-sur-Ollon (Switzerland) conducted by Dr. Albert Ellis in 1979. De Silvestri, along with a German psychology student Carola Schimmelpfennig, founded an affiliated REBT Institute in Rome in 1981. From the 1990s onward, REBT also spread outside Rome, thanks primarily to the efforts of Franco Baldini and Mario Di Pietro. The work of De Silvestri, Schimmelpfennig, Baldini, and Di Pietro is integral to the development of REBT in Italy (Ruggiero et al., 2014).

In comparison to REBT, the development and dissemination in Italy of CBT has been somewhat delayed. In 2001, after a training at the Beck Institute of Philadelphia, Antonella Montano has founded the Institute of Cognitive Behavioral "Istituto A.T. Beck" Therapy in Rome and Caserta, recognized by the Philadelphia Beck Institute.

Constructivism

Victor Meyer is not only one of the seminal figures in the behavioral tradition but also that of constructivism. In fact, the two founding fathers of Italian constructivism, Vittorio Guidano and Giovanni Liotti, were trained by Victor Meyer in London, with whom they learned behavioral techniques, among which the most famous was "exposure and response prevention" (ERP), used to treat agoraphobic and obsessive-compulsive symptoms (Meyer, 1966). However, Guidano and Liotti were also strongly influenced by REBT, constructivism, and evolutionism (Ruggiero et al., 2014). In fact, in Italy REBT also interacted with the birth of the constructivist root of the cognitive psychotherapeutic practice. Guidano and Liotti were aware of some theoretical limitations of the behaviorism model and were looking for a new model that included cognitive mediators between a stimulus and response, and REBT helped them in finding an answer (Guidano & Liotti, 1983). Through their contact with De Silvestri and REBT, Guidano and Liotti became acquainted with a clinical model that was, in the end, quite compatible with their future constructivist path. Further, Mike Mahoney's theoretical development toward constructivism was encouraged by his encounter with other constructivist theorists during his sabbatical mainly spent in Europe at the end of the 1970s. In particular, he cooperated with Vittorio Guidano and encouraged his publications (Guidano & Liotti, 1983; Guidano, 1987, 1991).

Guidano, Liotti, and Mahoney posed the need for a more sophisticated definition of cognition at the ground of the notorious and self-defeating distinction between a "rationalist" and a "constructivist" approach (Mahoney, 1995). The constructivist theorists considered the Beckian style of verbal assessment and reattribution of beliefs as a form of crude computationalism and inapplicable to the complex fluidity of mental reality, preferring to talk about personal meanings (Kelly, 1955). Unlike beliefs, personal meanings would be more closely tied to the personal life history of the patient and to his or her emotional experiences. Personal meanings were not a single set of beliefs about a situation but a vision of the self and the world (Guidano, 1987, 1991; Mahoney, 1995).

From a clinical viewpoint, constructivist therapist interventions focused on personal meanings, reconstruction of the patients' life story, and treatment of recursive vicious circles of discomfort with emotions and fear of fear. This intervention was an earlier model of a metacognitive approach, in a way akin to REBT's concept of secondary ABC (Sassaroli et al., 2005).

Constructivism appeared to be more speculative and it did not focus on research to empirically test the model. For this reason, it's inferior to the evidence-based support of CT and REBT.

Integration of Constructivism and Standard Cognitive Therapy

Efforts to integrate constructivism with standard cognitive therapy have led to a number of important theoretical work on goals in therapy in Italy. Castelfranchi and Paglieri (2007) and Mancini (Capo et al., 2010; Mancini & Gangemi, 2015) defined the importance of aims and goals in the cognitive process and distinguished them from beliefs and schemata. A further integration of REBT and constructivist models is that of Lorenzini and Sassaroli (1987) who borrowed from George Kelly's model, namely, personal constructs psychology (PCP) (Kelly, 1955), the dilemmatic construct concept, and the assessment technique called "laddering," and included them in the cognitive assessment procedures. In addition, Lorenzini and Sassaroli (1995) stressed the importance of interventions focused on personal meanings, reconstruction of the patients' life story, and treatment of recursive vicious circles of discomfort with emotions and fear of fear (Sassaroli et al., 2005).

Process-Oriented Cognitive Therapies

The "third wave" of cognitive behavioral therapy is quite popular in Italy. Process therapy perhaps is viewed as more acceptable from the Italian perspective which has often deemed questionable standard rationalistic interventions of CBT and REBT. There are a number of important Italian psychologists who have helped promulgate these approaches. In Italy, mindfulness-based treatments are perhaps the most popular third wave psychotherapies, and they are promoted by Fabio Giommi and Fabrizio Didonna (Didonna, 2012) who are authors of important publication. Acceptance and Commitment Therapy (ACT, Hayes, 2004) and contextualism as an approach are promoted by Roberto Anchisi, Paolo Moderato, and Francesca Pergolizzi (Anchisi et al., 2017). Perhaps the Italian interest in metacognitive structures may be traced back to the strong importance given to the so-called "secondary" problem in the Italian interpretation of REBT. Generally speaking, the secondary problem is a vicious circle among Italians in which the client has a biased negative belief toward their own mental states. For many Italian theorists, there is the tendency to think that all emotional disorders are, in fact, always generated by a secondary process (De Silvestri, 1989; Lorenzini & Sassaroli, 1987).

In sum, the new models propose that emotional disorders do not depend on mental representations of the self as Beck thought (Beck, 1975), but on the "process" (i.e., dysfunctional mechanisms in which voluntary attention and executive control play various roles in different models). These models have maintained a strong relationship with the behavioral tradition and represent a return to contextualism and functional analysis (Jacobson et al., 2001). This may explain why process models recruit practitioners from either the behavioristic or the constructivistic tradition. In addition, we may quote a genuinely Italian approach to process therapies which is

the *Metacognitive and Interpersonal Therapy* (MIT, Dimaggio et al., 2007, 2015; Semerari et al., 2007, 2014) which can be considered a development of the constructivist model of Guidano and Liotti (1983) and Mahoney (2003). In the MIT model, the emotional pain would depend on the metacognitive deficits in the skills to identify emotions, to interpret our own mental states, to distinguish them from those of others, and finally to behaviorally master them (Semerari et al., 2007, 2014).

Adaptation of CBT in Italy

As we wrote in the previous section, CBT in Italy has been influenced by different approaches, and it integrated all of them. What a CBT therapist does is to analyze symptoms, with particular attention for internal structure of pathology (Chiesa & Pizzone, 2005) and beliefs of the client. Great attention has been given to irrational beliefs and automatic thoughts, emotions, and dysfunctional behaviors that cause psychopathology. Italian CBT therapists start clinical work using the ABC model of Ellis, to better understand the problem of the client. This is a very important part of the work, because it allows for the development of a sound case formulation to guide clinical planning.

What characterizes the first part of psychotherapy is to define what in the history of the client made the client more vulnerable to specific beliefs and themes (these are called "historical factors of psychopathology") and then examination of what may have happened that "broke the balance" in the life of the client and when the symptoms of psychopathology started (these are called "collapse factors of psychopathology"); lastly, therapist analyzes what is happening inside the client that blocks resolution of the problem (these are called "maintenance factors of psychopathology") (Perdighe & Mancini, 2010). These elements make up the case formulation.

Then, what is typical of the work of Italian CBT psychotherapist is to more closely look at the irrational beliefs (IBs) and automatic thoughts (ATs) of the clients. In working with the client to understand their faulty thinking, great attention is given to consider if the client experiences difficulties because he thinks in terms of demands ("I must reach that goal in my job"), awfulizing ("It's terrible if my partner leaves me"), frustration intolerance ("I can't stand if my friend doesn't like what I think"), or self/other downing ("If I cannot have the work I want, it means I am a loser"). Secondly, it's important to find out if there are any automatic thoughts that characterize the way of thinking of the client. These could be over-generalizing ("I seem to fail at a lot of things"), emotional reasoning ("I feel depressed; therefore, my marriage is not working out"), etc.

Another part of the work of the Italian CBT therapist is the attention given to the therapeutic alliance with the client. Many psychotherapists effectively use the therapeutic relationship as an instrument for intervention. They analyze behaviors that the client shows during sessions with the psychotherapist and they use this material to discuss with the client about their behavior outside of the session, with other people, in order to help them to change their dysfunctional relational behaviors

(DiMaggio et al., 2007). This is important especially with clients who suffer for personality disorders, who involuntarily create what is called "interpersonal cycles" (DiMaggio et al., 2007) that are dysfunctional behaviors that they repeat, based on irrational ways to consider their relationships ("Everybody will leave me").

Another important intervention that is often used at the beginning of CBT psychotherapy in Italy is to share case formulation and aims of the psychotherapy with the client. This intervention is important because the client can understand disturbance and the rationale of the clinical approach to psychotherapy. In this part of the work, attention is given to how a client may experience a meta-disturbance (i.e., getting upset about being upset), because it could influence the process of psychotherapy. When a psychotherapist considers: "Does the client feels specific emotions about the problem?" and "Could these emotions influence psychotherapy?"; if the answer is "Yes", this meta-emotion problem may be among the first part of the clinical work focused on.

Italian CBT psychotherapists will provide psychoeducation about the clinical problem to make the client more aware about psychopathology. At the same time, they will provide information about the nature of the clinical intervention. Specific clinical work is made to debate the irrational beliefs and automatic thoughts that provoke psychopathology. Finally, these approaches are then integrated with behavioral intervention in order to work on changing dysfunctional behaviors.

An important role played in psychotherapy in Italy is that of the use of language. In Italy, language that is used in CBT therapy is provided to be consistent with British and American English. What has been done is to translate from English to Italian names of irrational beliefs, automatic thoughts, emotions, etc. An important area to consider the influence of language is the use of names of emotions. They are all labeled with specific words, but some words are a little bit different in the Italian language. For example, in English "sadness" is considered to be a functional emotion, whereas in Italian, its meaning is more similar to depression. In Italian, it's better to use "depression/sadness" as dysfunctional emotion and *dispiacere* (regret) to name a functional emotion.

Surprisingly, there are not many significant differences in the use of names of irrational beliefs and automatic thoughts. They have been translated into Italian and are similar to the original American English. Italian clients can understand their meaning, and it's possible to debate them using the same terms.

An interesting observation of CBT work in Italy is that to work on beliefs needs time, especially for those that are crucial for the client. More specifically, in Italy beliefs connected to guilt are difficult to change. This, probably, may depend on the Italian Christian background that influences culture and as a result psychotherapy. It's often difficult for the clients to change their irrational beliefs about guilt, because they are strongly reinforced by their cultural and historical background. Further, it may be difficult to change demands about themselves, because there are social rules that support this way of thinking.

Another aspect connected to debating is the concept of "acceptance" based on REBT tradition (Ellis, 1962). In Italy, clients often confuse acceptance with resignation. It's difficult to draw the distinction between the two as it relates to acceptance.

Often Italian clients confuse the two concepts and they think that, to feel better, they have to be passively subjected to negative events of life. It's particularly difficult for them to judge only one part of self or of the others or of the life and to practice the idea of unconditional self, others, and world acceptance (Dryden, 2008).

Clinical sessions in Italy for CBT psychotherapy typically are between 45 and 60 min in length; it depends on psychotherapist choice and the needs of the client. If a client is struggling considerably and may need more time, the psychotherapist may modify the structure as a result. What's important is to share the language with the client and to adapt it to the specific client with whom psychotherapist is working. This is particular important when the work is focused on emotions. What we can see is that for clients it is often difficult to find the "right" name for emotions. Italian is a complex language, and there are many words and expressions that can be used to define emotions. What CBT psychotherapist does, at the beginning of psychotherapy, is to use words of the client to name emotions, in order to reinforce therapeutic alliance and to help the client better understand his emotional world, and then the creation of a common emotional vocabulary for this client may assist in clinical work.

Professional and Cognitive Behavioral Therapy Organizations

In 1972, Vittorio Guidano, Giovanni Liotti, and other scholars founded the *SITC-Società Italiana di Terapia Comportamentale (Italian Society of Behavior Therapy)* (Chiesa & Pizzone, 2005). The SITC was one of the first societies of behavioral therapy across Europe, but, during the first part of its existence, its impact was primarily local (Sanavio, 2012). Beginning in 1973, Guidano and Liotti received a number of requests to organize trainings to disseminate behavioral therapy knowledge and techniques throughout Italy. In the national conference of Italian Society of Cognitive Therapy in 1981, the formal change of the name from SITC to SITCC by adding the term "cognitive" (Chiari & Nuzzo, 1982).

In 1977 in Verona, a second society of behavioral therapy was founded, called *AIAMC, Associazione Italiana di Analisi e Modificazione del Comportamento (Italian Association of Analysis and Modification of Behavior).* Quickly, AIAMC developed across Italy and internationally with the first international conference being held in 1978 in Venice, during which a number of influential participants attended. In 1992, AIAMC also added term "cognitive" to its name to highlight the attention toward the cognitive aspect of therapy (Sanavio, 2012).

The first journal of behavior therapy in Italy was founded in 1979, *Italian Journal of Analysis and Modification of Behavior*, that has published many important national and international studies. Another important journal is the *Italian Journal of Behavioral and Cognitive Psychotherapy*, born in 1995. The journal publishes Italian and international papers about different arguments like clinical assessment, rehabilitation, behavioral medicine, methodology, and research connected to psychotherapy (Sanavio, 2012).

Organization of Trainings

Practical lectures include lectures about different theories and models of CBT from the seminal work to present scholarly and professional activities as well as practical lectures during which case formulation and techniques are explained. The training aims are to teach participants how to do the work of psychotherapist, to have a good knowledge about themselves, and to be aware of how certain characteristics of the psychotherapist could influence the therapeutic relationship with clients. One important part of the practical training is moments where trainees can share with the group their experience and thoughts about the clients with particular attention to beliefs and emotions of the trainees themselves. There are two important components during the training lectures: (1) group work and (2) clinical supervision (Pelliccia et al., 2005). Clinical supervision is a fundamental experience where each student can discuss about his/her client with the supervisor and other students. A collaborative atmosphere is promoted, and all participants can express their point of view and thoughts about cases that are presented (Pelliccia et al., 2005).

Current Regulations Regarding Psychotherapy Provision

In Italy, psychotherapy can be practiced in both the private and public sector. Public services that provide psychotherapy are departments organized inside the National Health System. Public services are free or people have to pay a nominal amount for access to all health-care services including mental health. In Italy, there are, also, private services that provide psychotherapy and include private family counseling and social coops or private practice.

Another type of private service provided has been organized by a private school of psychotherapy (SPC, School of Cognitive Psychotherapy) and in the last years is called "ethical psychotherapy" (APC, 2018). This project developed as a result of the increased need of psychotherapy but inadequate access to services due to a myriad of reasons, chief among them is the fact that therapy is too expensive. As such, this model allows clients to have access to psychotherapy where costs are lower. Ethical psychotherapy is conducted by students who are in the third and fourth year of a school of psychotherapy under the supervision of certified supervisors. The cost for every session is cheaper than a "traditional" session of psychotherapy, and, at the same time, students have the opportunity to gain clinical experience in their work with clients.

CBT with Specific Clinical Populations in Italy

While the approaches of the varied models of CBT differ in structure and focus, they often share some common expectations in terms of delivery of service. However, different countries and cultures may have specific clinical populations that may warrant further elaboration in terms of how CBT is applied. This section describes different approaches that are used in Italy to work with groups of clients with specific disorders. Clinical models and work with schizophrenia and psychosis, personality disorders, OCD, developmental psychopathology, and anxiety disorders will be reviewed.

Residential Interventions for Psychosocial Rehabilitation

During the 1960s, Italy dismantled the psychiatric system based on hospital confinement and introduced a system of social integration of patients. Psychosocial programs include meetings with families, social skills learning programs, and integration between rehabilitations and are integrated with psychotherapy (Gigantesco et al., 2007).

CBT techniques are delivered as part of a rehabilitation program for clients with psychiatric diseases in either inpatient or residential settings with the aim to reinforce social, relational, and working autonomy. Psychotherapy focuses on having clients learn adaptive behaviors and will use reinforcers and motivational training (Gigantesco et al., 2007).

Clinical work with this population involves helping clients understand and evaluate dysfunctional behavior as well as what may be a helpful alternative behavior. Clients are taught a number of coping strategies as well as problem-solving and self-instructional training and through the use of reinforcement will hopefully generalize and maintain these skills (Gigantesco et al., 2007).

Rezzonico and Ruberti (1996) suggests that it is important to consider the attachment style of this group of clients. The affective behavior of a client may be influenced by attachment difficulties that may make behavior that is more difficult to manage by the clinician.

Clinically, clients work to help to develop new competencies to discriminate between internal and external world, to improve metacognitive, communication, and relational abilities (Dimaggio and Semerari, 2007). Another important part of the protocol is the work on deficits of short-term memory, focalization of attention, and elaboration of logical reasoning (Scrimali, 2006).

Interpersonal Metacognitive Therapy/TMI and the Treatment of Personality Disorders

TMI-interpersonal metacognitive therapy is an integrated approach for treatment of personality disorders developed by Third Centre for treatment of Personality Disorders in Rome that is used at different centers across the country (Carcione et al., 2008). What TMI asserts is that personality disorders are characterized by impairment in metacognition ability (Semerari et al., 2014). Metacognition is the ability to reflect and to modify representations of mental objects that humans create from what they think, image, remember, dream up, and predict (Carcione et al., 2008). Proponents of TMI argue that personality disorders are characterized by metacognition disorder and that malfunction in specific areas of metacognition influence how disorders are expressed. Metacognitive skills include *monitoring*, the ability to recognize emotions and thoughts, motivations, and goals that drive behavior and to understand the relationship between beliefs and emotions; *integration*, the ability to reflect about different mental states and mental processes in order to organize them on the basis of their relevance and to make behavior uniform with goals; *differentiation*, the ability to discriminate between internal representations and external world; *decentering*, the ability to put ourselves in the other persons' shoes, to think about how others could think, and to think about other minds; and *mastery*, the ability to regulate internal states of psychological suffering and interpersonal conflicts (Carcione et al., 2008).

Developmental Psychology and CBT

The constructivist roots of Italian CBT (Guidano & Liotti, 1983; Mancini & Romano, 2010; Semerari et al., 2014) have favored the integration with the model of d*evelopmental psychopathology* applied to children and adolescent (Cicchetti & Cohen, 1995). Treatment involves changing variables of the child or of the environment where child lives. From this point of view, the child is considered a central part of this dynamic system, and the main aim of treatment is the adjustment of the young client. So, it's necessary to consider personal vulnerability, stress sources, protection variables, and the presence of social support and how all of these factors interact with each other (Mancini & Romano, 2010).

Another important model of children and adolescents psychopathology is attachment theory that asserts importance of relationship between mother and child as crucial factor for development (Bowlby, 1988). The development of the child is influenced by support and care provided by the mother that creates a regulatory and interactive system (Malagoli Togliatti & Zavattini, 2006). The work with children and adolescents includes the use of different behavioral and cognitive techniques, like psychoeducational interventions, cognitive restructuring, conditioning, techniques to manage anxiety and anger, exposure and response prevention,

self-instructions, relaxation, social skills training, and parent training (Fabbro, 2016). This part of treatment is integrated with the clinical work with the family. The model used for the work with parents is *Family-Based Cognitive Behavioral Therapy* and includes psychotherapy with the child and the family where dysfunctional relations and situations are changed and the work is focused on all family members (Barrett et al., 2008).

Obsessive-Compulsive Disorder (OCD): A Goal-Focused Model

Another development of CBT in Italian cognitivism was the analysis of its relationship with the psychological theory of goals and the latter's existential aspects. Castelfranchi and Paglieri (2007) and Mancini and Gangemi (2012) defined the importance of aims and goals in the cognitive process and distinguished them from beliefs and schemata. The focus of Italian cognitive approach on aims, goals, and purposes makes it possible to conceptualize patients as individuals following a functional (or dysfunctional) life plan. This focus provides a breath of existentialism to the clinical view of cognitive therapy (Mancini & Gangemi, 2012). A life plan is the long-term set of goals that an individual pursues in his or her life and which enables him or her to give a direction and a meaning to life. Mancini applied this model specifically to obsessive-compulsive disorder: his model asserts that obsessions and compulsions depend on the specific biased beliefs of the client whose goals are to prevent guilt to be irresponsible and to protect from contamination risk (Mancini & Perdighe, 2010).

Anxiety Disorders: A Developmental Approach

Another example of constructivist influence is the model that describes anxiety disorders in Italy in terms of attachment theory (Sassaroli et al., 2006). In this model clients who present anxiety problems are included in two groups of people: *dependent* and *autonomous*. The first group includes patients who are worried to lose love and significant relationships because they think they *cannot stand* a life without significant others or they think *they are so loser* and without value that everybody will leave them. The second group are individuals who apparently are not interested in relationships. They seem to have strong character and tend to do everything by their own, looking for independence from all relationships (Sassaroli et al., 2005). From this perspective, the onset of anxiety disorders occurs when important goals for the client are threatened: separation or loss of significant others or demanding experience that threat autonomy and avoidance. Strategies that clients use to protect themselves are control, avoidance, and worry that contribute to maintain irrational

beliefs and anxiety. Another important factor that contributes to maintain anxiety is the secondary ABC: patients worry about anxiety as a danger in itself (Sassaroli et al., 2005). Therapy aims to improve awareness of the client about anxiety and beliefs underneath and to improve metacognitive abilities. Through challenging automatic thoughts and irrational beliefs such as need of control or clinical perfectionism (Sassaroli et al., 2008a, b) that maintain the disorder, the clinician then works with the client to conduct exposure to anxiety situations and to work on acceptance of the risk not to have total control of the situation. Finally, the clinician works to increase client awareness about where he/she learned irrational beliefs during his/her history (Sassaroli et al., 2006).

Research on CBT in Italy

Interest for research in psychotherapy in Italy began in the 1980s and rapidly increased (Dazzi et al., 2006). Within the cognitive field, Francesco Mancini conducts research on obsessive-compulsive disorder (OCD) and analyzing what type of reasoning influences this group of clients. Specifically, this group examined what they call "obsessive thinking" and a specific type of guilty, called "ontological guilty" that characterizes people with OCD. "Ontological guilty" is a specific type of guilty that derives from the idea to transgress moral rules or natural order of things (Mancini & Gangemi, 2004; Gangemi & Mancini, 2007; Gangemi et al., 2010).

Other research has focused on characteristics of personality and cognition of people who suffer from eating disorders. The role of control, criticism, clinical perfectionism, and worry in eating disorders has led to the development of a standardized protocol to work with this group of clients (Sassaroli et al., 2008a, b; 2010). Relatedly, this has led to research within this group that examines metacognitive factors of addictions (Spada et al., 2013) and a study about "night eating disorder" (Vinai et al., 2009).

Another line of research in cognitive psychotherapy is focused on the role of metacognition in the development of personality disorders and schizophrenia. Recent studies show that metacognition includes two factors: one is related to theory of mind (decentration and differentiation), and the second is related to self-reflection (monitoring and integration) (Dimaggio et al., 2007; Carcione et al., 2008; Lysaker et al., 2010; Semerari et al., 2012).

Research in Italy on CBT has examined and refined international approaches and has also created new instruments and areas that have been utilized internationally (Dazzi et al., 2006). In order to achieve these aims, in the field of research in psychotherapy, different international collaborations have been developed with support from different professional organizations such as the Italian section of the Society for Psychotherapy Research (SPR) that publishes the bilingual journal called *Research in Psychotherapy: Psychopathology, Process and Outcome* (Gemignani & Giliberto, 2003).

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