CBT (Cognitive-Behav. Therapy)

+
- consist of a variety of techniques
- is very goal-oriented
- is based on active and explicit collaboration between therapist and patient
- is centered on the patient's current problem
- provides the patient with the tools to become therapist of himself
- its effectiveness is scientifically documented
- is relatively brief
- requires a relatively simple training

-
- is a stereotyped psychotherapy
- is a non-explanatory model
- minimizes the unconscious processes
- considers the emotions a product of beliefs
- sees cognitive processes as a mere stimulus expression and not an epistemic need
- leaves aside the therapeutic relationship
- ignores the sistemic dimension of the patient

CMT (Control Mastery Theory)

+
- the sequence analysis of test-intervention-response is an invaluable tool for monitoring the therapeutic process
- makes possible to effectively monitor the therapeutic relationship
- the unconscious plan concept provides a valuable explanatory element

-
- still remains to demonstrate that it is applicable outside the therapeutic process and therefore usable in the"real life" of the patient

CAT (Cognitive Analytic Therapy)

+
- is a very pragmatic intervention
- is brief
- is very suitable for public territorial services

-

(Same as CBT)
- is a stereotyped psychotherapy
- is a non-explanatory model
- minimizes the unconscious processes
- considers the emotions a product of beliefs
- sees cognitive processes as a mere stimulus expression and not an epistemic need
- leaves aside the therapeutic relationship
- ignores the sistemic dimension of the patient

Schema Therapy

+
- compared to CBT, with which it shares the merits, has a more explanatory and procedural intent
- is attentive to the needs of the patient
- has an undoubted clinical utility
- represents an attempt to integrate different approaches (not necessarily cognitives)

-
- is naive and rough in its epistemology
- does not refer to any scientific theory
- is fragmented and uncoordinated in his quest for description completeness
- assumes a management of the therapeutic relationship potentially hazardous for both patient and therapist as well as confounding

Mindfulness (based Therapy)

+
- interventions are not focused on rationalizing dysfunctional emotions

-
- possible onset of severe dissociative phenomena during treatment
- possible pragmatic switch off and change strategies invalidation in the subject
- possible attitudes of complacency toward the operator

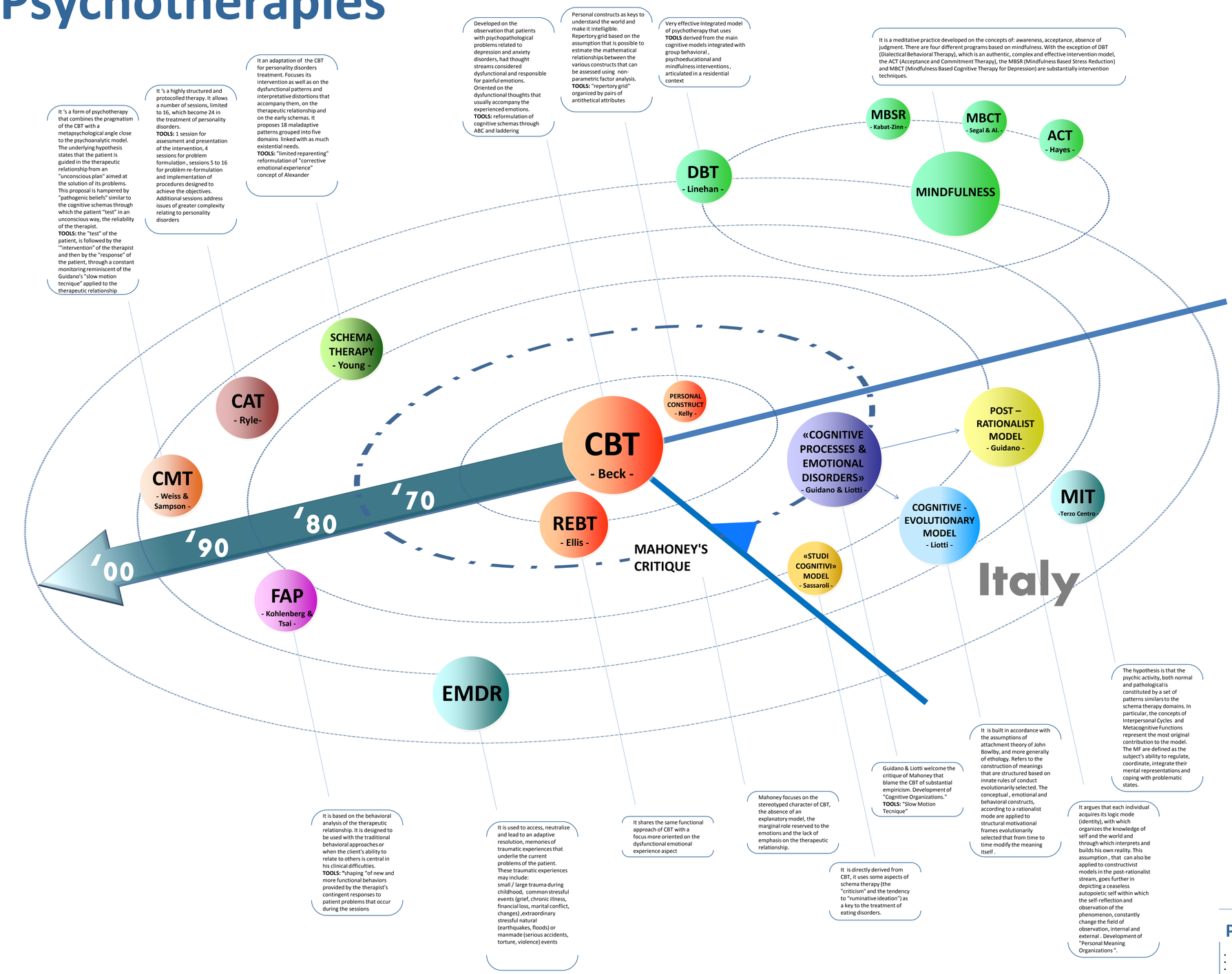
DBT (Dialectical Behavior Therapy)

+
- has an unsurpassed efficacy in the treatment of severe personality disorders

-
- is a complex intervention
- requires a powerfully organized implementation structure
- is socially costly
- requires accurately trained therapists

Cognitive Psychotherapies

(v 1.3.1)



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Post-Rationalist Model

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- is very elegant in epistemological sense
- is an explanatory model
- is centered on an inalienable individual need : the narrative continuity

-
- is not interested in nosography
- is not suitable for treatment of childhood
- does not take adequate account of the narrative discontinuity, characteristic not only of some psychopathological situations, but also of normality
- does not address the issue of metacognition
- can leave aside the experiential reality of the patient concentrating more on the therapeutic process

FAP (Functional Analytic Psycht.)

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- has a great attention to the therapeutic relationship

-
- the focus on the therapeutic relationship can scotomize the problematic reality of the patient out of the setting

EMDR

+
- is effective
- is simple to implement
- does not require metacognitive skills in the patients
- does not require complex training by the therapist

-
- has an unclear scientific basis
- not always provide stable results
- could be effective in terms of "nonspecific factors" (not controlled and in this sense potentially iatrogenic)

«Studi Cognitivi» Model

+
(The same as CBT and Schema Therapy)
- is simple
- appears to be effective in the treatment of eating disorders
- Is suitable for quantitative outcome studies

-
- is not an explanatory model
- leaves aside the therapeutic relationship
- leaves aside some clinical evidence

MIT (Metacognitive Int. Therapy)

+
- is an integrated model
- try to take the best of many cognitive models
- allows outcome studies
- is applicable in any clinical setting

-
- sometimes lack of theoretical roundedness
- leaves aside the subjective dimension of the therapist
- can produce empathic failures in the therapeutic relationship

C.P. & E.D (Guidano & Liotti '83)

+
- is an explanatory model
- offers suggestions for clinical intervention
- allows the patient to be recognized in his identity and in his narratives
- is suitable for treatment of personality disorders as for Axis I disorders

-
- does not explain the concept of disorganization and discontinuity of narrative and consciousness
- focus on the therapeutic process rather than on the real life of the patient
- leaves aside the subjective dimension of the therapist

Cognitive-Evolutionary Model

+
- is a real explanatory model
- is perfectly adapted to the treatment of childhood
- focus on patients needs
- is suitable in multiple contexts
- is perfectly compatible with CBT, which appears as a development

-
- explicitly neglects the narrative dimension
- leaves aside other motivational aspects related to the theory of evolution
- set the therapist in a position close to that expressed by the "limited reparenting" of the schema therapy (with the related difficulties)