CBT in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



CBT in Practice

Disorder-specific models, formulation-driven treatment and the craft of making CBT work with real clients.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the CBT in Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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How to use this manual

Knowing the cognitive model is not the same as making CBT work with a real caseload. This course is written for practising clinicians and advanced trainees who can draw the five-part model but want their CBT to bite: to move beyond generic technique into the disorder-specific models that carry the evidence base, and into the craft decisions that distinguish practitioner-level work.

You will study the specific engines of the anxiety disorders: Clark's catastrophic misinterpretation cycle in panic, and the treatment that follows directly from it; Clark and Wells's account of social anxiety, with its self-focused attention and distorted observer image; and generalised worry through the Dugas model's intolerance of uncertainty and Wells's metacognitive beliefs. You will then turn to the craft itself: building the idiosyncratic case-level formulation, sequencing treatment so early sessions earn the client's confidence, designing behavioural experiments precise enough to move belief, and reading homework, including its absence, as clinical information rather than failure.

Substantial written lessons, each with key points, a practice task tied to real clinical decision-making, and a study tutor on hand throughout. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Structure a complete CBT session, from agenda-setting through homework review to feedback
- Build a collaborative case conceptualisation linking presenting problems, maintenance cycles and underlying beliefs
- Select and deliver core change methods, including cognitive restructuring, behavioural experiments and graded exposure, to fit the formulation
- Design between-session work the client can actually do, and use guided discovery rather than persuasion
- Apply disorder-specific models for depression and the major anxiety presentations
- Monitor progress with measures and adjust the treatment plan when the data say so

PART 1

Core Cognitive-Behavioural Formulations of Common Mental Health Disorders

This module covers evidence-based CBT models and mechanisms for panic, social anxiety, generalized anxiety, obsessive-compulsive disorder, and depression.

CHAPTER 1

Panic and the catastrophic misinterpretation cycle

Clark's cognitive model of panic disorder remains the most parsimonious and empirically supported specific model within contemporary cognitive-behavioural therapy. It articulates a single, self-reinforcing cycle: benign interoceptive cues are catastrophically misinterpreted, the resulting fear intensifies the cues, and the amplified sensations appear to confirm the feared outcome. The loop can be completed in a matter of seconds, which explains why panic attacks often feel as though they erupt from nowhere. The model is deliberately narrow – it does not invoke external threats, traumatic memories or personality pathology – because the internal physiological cascade alone is held to be sufficient to generate full-blown panic when interpreted through a catastrophic lens, a view consistent with expectancy and learning accounts of panic (e.g., Reiss, 1991; Barlow, 2002).

The central premise is that panic attacks are produced by the catastrophic misinterpretation of ordinary bodily sensations. A heart that beats faster than usual is read as an imminent heart attack; a fleeting sensation of breathlessness is construed as suffocation; a brief episode of dizziness is taken as a sign of impending collapse or loss of mental control. These misinterpretations are not merely inaccurate thoughts; they are belief-laden predictions that mobilise a cascade of anxiety-driven physiological responses. The fear that follows the misinterpretation triggers sympathetic arousal – increased heart rate, hyperventilation, muscle tension – which in turn magnifies the original sensation. The client then experiences a vivid sense of confirmation: the heart is pounding harder, the breath feels more shallow, the head feels lighter. The catastrophic belief is thus reinforced in real time, and the cycle closes.

Because the trigger is internal, panic attacks can occur in any context, even in the safety of a therapist's office or a quiet bedroom. This explains the classic clinical observation that attacks often happen in "safe places" and that the client's subsequent avoidance is not directed at external objects but at situations in which the feared bodily sensations are likely to arise or where

escape is perceived as difficult. The avoidance pattern that frequently follows is the hallmark of agoraphobic panic. Clients may avoid crowded public transport, busy supermarkets, or even solitary walks in the park because they anticipate that the physiological arousal that accompanies these contexts will be misread as a sign of imminent catastrophe. The avoidance is reinforced by a repertoire of safety behaviours – sitting down, gripping a trolley, carrying a bottle of water, checking pulse, or positioning oneself near an exit. Each safety behaviour serves a dual function: it reduces the immediate anxiety, and it provides a post-hoc explanation that the catastrophe was averted because of the safety behaviour, thereby preserving the underlying catastrophic belief.

The therapeutic implication of Clark's model is strikingly direct: if the catastrophic misinterpretation is the engine that drives panic, then the treatment must systematically disconfirm that engine. The formulation – a diagrammatic representation of the client's most recent panic episode that maps sensation, misinterpretation, fear, and amplification – is not a separate intellectual exercise that precedes treatment; it is the treatment plan itself. In other words, within disorder-specific models the formulation and the treatment plan are one and the same. The therapist and client co-construct a formulation that identifies the precise catastrophic belief (for example, "If my heart races, I will have a heart attack and die"), the associated physiological cue, and the safety behaviours that maintain the belief. The treatment then proceeds by targeting each element of the cycle, most powerfully through interoceptive exposure combined with the deliberate dropping of safety behaviours.

Interoceptive exposure, developed by Barlow and colleagues within their behavioural treatment of panic disorder (Barlow et al., 1989) and set out in later editions of their client workbook (Barlow & Craske, 2007), involves the deliberate induction of feared bodily sensations in a controlled setting. The rationale is that repeated, prolonged exposure to the sensation without the occurrence of the predicted catastrophe leads to a violation of expectancy, which updates the client's predictive model. Crucially, the exposure must be conducted without the client's usual safety behaviours; otherwise the experiment does not test the catastrophic belief directly. The therapist therefore asks the client to commit to "dropping" the safety behaviour for the duration of the exposure, a process that may be supported by a behavioural contract and real-time rating of anxiety and belief strength using visual

analogue scales.

Typical interoceptive exercises include hyperventilation to provoke breathlessness, spinning in a chair to elicit dizziness, running in place or performing step-ups to raise heart rate, and holding one's breath to generate a sense of suffocation. Each exercise is calibrated to produce a sensation that the client has previously identified as a trigger for catastrophic misinterpretation. The client rates the intensity of the sensation, the level of anxiety, and the strength of the catastrophic belief before, during, and after the exposure. Over successive repetitions, the belief rating should show a systematic decline, reflecting the updating of the client's internal prediction model. Dismantling studies support its central role: within CBT for panic disorder with agoraphobia, treatment that included interoceptive exposure was more effective than treatment that substituted breathing retraining (Craske et al., 1997), and adding breathing retraining to CBT conferred no additional benefit (Schmidt et al., 2000).

Behavioural experiments extend the learning from interoceptive exposure into real-world contexts. Once the client has demonstrated that the feared bodily cue can be tolerated without catastrophe in the therapist's office, the next step is to test the belief in the environment where avoidance originally developed. The therapist and client collaboratively design an experiment that removes the safety behaviour (for example, walking through a crowded underground station without checking pulse or holding onto a rail). The client again rates anxiety and belief strength before, during, and after the experiment. The data collected serve both as a therapeutic tool and as a concrete illustration of the formulation-treatment equivalence: the same catastrophic belief identified in the formulation is being directly tested in the behavioural experiment.

A concrete worked example illustrates how the model, formulation, and treatment interlock. Amrita Patel, a 34-year-old accountant, presents with recurrent panic attacks that have been occurring primarily on commuter trains. She reports that each attack begins with a sudden awareness of a racing heart, which she instantly interprets as "my heart is about to stop and I will die." In her formulation, the sensation is the elevated heart rate, the catastrophic misinterpretation is the belief that a racing heart signals imminent cardiac arrest, the emotional response is intense fear, and the amplification is the sympathetic surge that further accelerates the heart rate.

Amrita's safety behaviours include gripping the handrail tightly, repeatedly checking her pulse on her smartwatch, and positioning herself next to the train doors so she can alight at the next stop.

In the first interoceptive exposure session, Amrita and the therapist agree to drop the safety behaviours for the duration of the exercise. The therapist asks Amrita to perform a series of step-ups for sixty seconds, which reliably raises her heart rate to 120 beats per minute – a level she has never experienced on a train. Before the exercise, Amrita rates her belief that "my heart will stop and I will die" at 85 on a 0-100 visual analogue scale. During the exposure, she is instructed to notice the sensation, refrain from checking her pulse, and keep her hands relaxed. After the first repetition, her belief rating falls to 70; after the second, to 55; after the third, to 45; and after the fourth, to 38. The therapist records these data, and Amrita observes that despite the intense physiological arousal, no catastrophe occurs. The repeated disconfirmation weakens the predictive model.

The next phase involves a behavioural experiment on the train. Amrita is asked to travel one stop on a quiet line without her smartwatch, without gripping the handrail, and without positioning herself near an exit. She rates her belief before boarding at 40, after the first minute at 35, and after the stop at 30. Encouraged by the data, the therapist then schedules a subsequent experiment on a rush-hour train, again without safety behaviours. Over the course of six weekly sessions, Amrita's belief ratings decline steadily, her anxiety ratings drop from a peak of 90 to an average of 25, and the frequency of panic attacks on trains falls from four per month to none. The formulation that originally identified the catastrophic belief, the physiological cue, and the safety behaviours has been directly transformed into a treatment plan that systematically dismantles each component.

The evidence base for this approach is robust. Randomised controlled trials comparing panic-focused CBT that includes interoceptive exposure with control conditions have consistently shown superior outcomes on standard measures such as the Panic Disorder Severity Scale (PDSS) and the Anxiety Sensitivity Index (ASI); in the largest such trial, CBT was superior to placebo on the PDSS both after acute treatment and after six months of maintenance (Barlow et al., 2000). A review of 106 meta-analyses concluded that the support for CBT is strongest for anxiety disorders, alongside somatoform disorders, bulimia, anger control problems and general stress (Hofmann et

al., 2012). Moreover, longitudinal follow-up studies demonstrate that the gains are maintained at 12-month follow-up, suggesting that the learning achieved through disconfirmation of catastrophic beliefs is durable.

A further nuance worth noting is the role of anxiety sensitivity – the fear of anxiety-related sensations themselves – which is a well-established vulnerability factor for panic (Reiss & McNally, 1985). In clients with high anxiety sensitivity, the catastrophic misinterpretation often extends beyond a single belief ("I will die") to a broader schema that anxiety sensations are inherently dangerous. In such cases, the therapist may need to broaden the interoceptive exposure hierarchy to include a range of sensations (e.g., light-headedness, chest tightness) and to address the meta-cognitive belief that "any anxiety is a sign of loss of control." The underlying principle, however, remains unchanged: the formulation identifies the specific catastrophic belief, and the treatment plan directly tests it.

The lesson for practitioners at an intermediate level of CBT training is that a mature disorder-specific model eliminates the artificial divide between formulation and treatment planning. The formulation is not a static description; it is a dynamic map that points to the precise engine that must be turned off. When the therapist and client co-construct a formulation that spells out the sensation, the catastrophic interpretation, the emotional amplification, and the safety behaviours, the next step is automatically the selection of interventions that target each element – interoceptive exposure to challenge the sensation-interpretation link, safety-behaviour omission to prevent reinforcement, and behavioural experiments to generalise learning to real-world contexts. If a therapist finds themselves drafting a formulation and then searching for a technique that "fits," this signals that the formulation is incomplete – perhaps the catastrophic belief has not been fully articulated, or the safety behaviours have not been enumerated. The model demands that the treatment plan be readable directly off the formulation.

In practice, this integration streamlines case conceptualisation and enhances therapeutic efficiency. The therapist can present the formulation to the client as a visual diagram, invite the client to rate each component, and then collaboratively decide on the sequence of interoceptive exposures. The client's active involvement in rating belief strength provides immediate feedback that the therapist can use to adjust the exposure intensity or to

introduce additional experiments. This collaborative, data-driven approach aligns with the broader CBT emphasis on collaborative empiricism and the scientific method applied to the therapeutic relationship.

Finally, it is essential to acknowledge the limits of the model. While catastrophic misinterpretation is central to panic disorder, comorbid conditions such as major depressive disorder, substance use, or medical illnesses may introduce additional maintaining factors that require adjunctive interventions. Nevertheless, the core panic cycle remains the primary target, and the formulation-treatment equivalence continues to hold as the guiding principle for the panic-focused component of therapy.

In summary, Clark's cognitive model of panic disorder offers a concise, evidence-based framework that links catastrophic misinterpretation of interoceptive cues to the rapid onset of panic attacks. The formulation that maps sensation, misinterpretation, fear, amplification, and safety behaviours is itself the treatment plan. Interoceptive exposure, carried out with the intentional dropping of safety behaviours, provides the most direct test of the catastrophic belief, while behavioural experiments extend the learning into the client's everyday life. The worked example of Amrita Patel illustrates how the model translates into concrete therapeutic steps, measurable belief changes, and lasting symptom remission. For practitioners, the overarching message is clear: in a mature disorder-specific model, the formulation is not a precursor to treatment but the treatment plan, and the therapist's task is to systematically disconfirm the engine that drives panic.

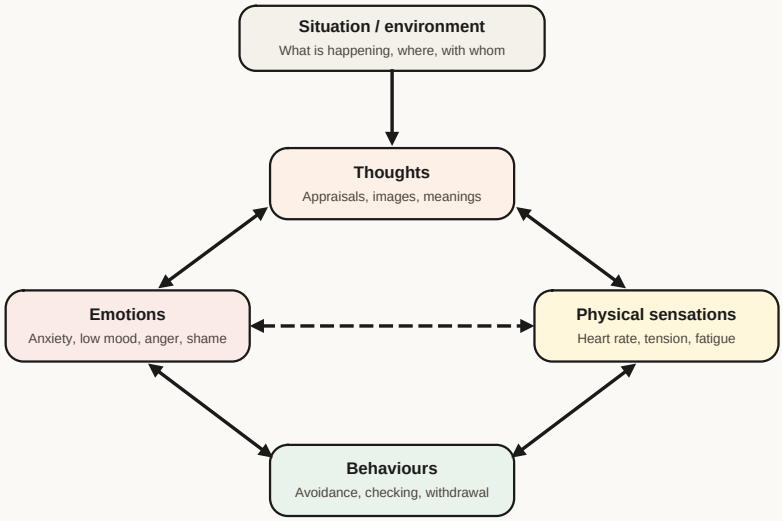


FIGURE 1.1 The five areas model

Greenberger and Padesky's five areas ("hot cross bun") model: a situation is processed through thoughts, emotions, physical sensations and behaviours, and every element influences every other. Change introduced at any point, most often at thoughts or behaviours, alters the whole system.

Points worth keeping

- Panic runs on catastrophic misinterpretation of body sensations
- Interoceptive exposure plus dropped safety behaviours is the treatment
- In specific models, formulation and treatment plan are the same thing

PRACTICE TASK

Map a panic episode reported by a client (or a plausible composite) onto Clark's cycle, labelling sensation, misinterpretation and response.

CHAPTER 2

Social anxiety and worry: self-focus and intolerance of uncertainty

Social anxiety disorder and pathological worry are often lumped together under the broad heading of anxiety, yet the cognitive-behavioural mechanisms that sustain them differ in crucial ways. The distinction matters because the therapist's first task in CBT is not to apply a generic anxiety protocol but to identify the specific "engine" that is driving the client's distress and to select the formulation-driven interventions that target that engine. In the case of social anxiety, the engine is self-focused attention coupled with an internally generated observer self-image; in the case of worry, the engine is intolerance of uncertainty together with metacognitive beliefs about the usefulness and danger of worry. Understanding these processes, and being able to articulate them in a formulation, allows the practitioner to move beyond habit and to apply the most potent, evidence-based techniques for each client.

The Clark and Wells (1995) model remains the benchmark for understanding the maintenance of social anxiety. When a socially anxious individual enters a feared social situation, attention narrows dramatically onto internal cues – heart rate, sweating, trembling – and onto a vivid, distorted mental picture of how they appear to others. This observer self-image is constructed from interoceptive sensations and from a repertoire of negative self-statements that have been rehearsed over years. The client may feel a flush and instantly visualise a "scarlet face"; a tremor may be interpreted as "shaking like a leaf". The imagined image, rather than the actual reactions of the audience, becomes the primary source of evidence for humiliation. Because the client's perception is filtered through this self-image, even a successful performance can be re-interpreted as a failure, and the memory of the encounter is stored as a vivid, self-critical replay that reinforces the belief that social situations are dangerous.

Safety behaviours are the behavioural counterpart of this self-focus. The client may rehearse sentences repeatedly, grip a glass tightly, avoid eye contact, or position themselves at the periphery of a room. Each safety

behaviour serves to keep the client's attention inward and to prevent the disconfirmation of the feared outcome, but it also subtly degrades performance. The result is a self-fulfilling prophecy: the client's anxiety remains high, the performance is slightly compromised, and the post-event rumination confirms the original catastrophic belief. The Clark and Wells model therefore identifies three interlocking maintaining factors: (1) self-focused attention, (2) the observer self-image, and (3) safety-behavioural strategies.

The treatment of social anxiety, when guided by this formulation, proceeds by targeting each factor in turn. Attention training is the first step. The therapist helps the client shift from an internal to an external focus, encouraging them to attend to the other person's facial expressions, the content of the conversation, or the physical environment. Wells and Papageorgiou (1998) found that, in people with social phobia, exposure combined with an external focus of attention reduced anxiety more effectively than exposure alone and shifted their imagery from an observer to a field perspective. In practice, the therapist may use a structured exercise in which the client lists three external cues to notice during a conversation and practices returning to those cues whenever they notice their attention drifting inward.

Correcting the observer self-image is often achieved through video feedback, a technique that capitalises on the discrepancy between the client's predicted appearance and the recorded reality. The client is asked to predict, in detail, how they will look and sound during a brief social interaction. The video is then reviewed together, and the therapist guides the client to notice the gaps between prediction and observation. Research by Clark and colleagues has shown that video feedback can correct the negative self-impressions of socially anxious people, and that its benefits are greater when it is preceded by cognitive preparation (Harvey et al., 2000). The power of this method lies in its direct confrontation of the client's internal narrative with objective evidence.

Behavioural experiments, the third pillar of the Clark and Wells approach, involve systematic manipulation of safety behaviours. The therapist and client collaboratively design experiments that drop one safety behaviour at a time, or that deliberately introduce a minor "failure" such as spilling a drink or losing a train of thought. The client records predictions about how others will

react, engages in the experiment, and then evaluates the outcome. The repeated disconfirmation of catastrophic predictions erodes the belief that others will judge harshly, and it also demonstrates that performance does not catastrophically deteriorate when safety behaviours are omitted.

While the Clark and Wells model provides a comprehensive account of social anxiety, worry – the hallmark of generalized anxiety disorder and of many comorbid presentations – is underpinned by a different engine. Two influential models dominate the literature: the intolerance of uncertainty model proposed by Dugas and colleagues (1998) and the metacognitive model advanced by Wells (1995). Both models agree that worry is a repetitive, predominantly verbal process, but they diverge on what fuels its persistence.

The Dugas model posits that intolerance of uncertainty (IU) is the core dispositional factor. Individuals high in IU experience uncertainty as threatening and attempt to reduce it through worry, which they view as a problem-solving strategy. Because uncertainty is inevitable, the worry cycle becomes chronic. The model also incorporates positive beliefs about worry (e.g., “worry helps me prepare”) and negative beliefs about worry (e.g., “if I don’t worry, something terrible will happen”). Treatment, therefore, focuses on increasing tolerance of uncertainty through graded exposure to uncertain situations, challenging positive beliefs about the utility of worry, and restructuring negative meta-beliefs.

Wells’ metacognitive model, by contrast, locates the problem at the level of beliefs about thinking. Positive metacognitive beliefs (e.g., “worry helps me avoid danger”) initiate the worry response, while negative metacognitive beliefs (e.g., “my worry is uncontrollable and will damage me”) generate a secondary layer of distress known as meta-worry. The core therapeutic aim is to modify these metacognitive beliefs and to teach the client a detached stance towards worry-triggering thoughts, often using techniques derived from Metacognitive Therapy (MCT) such as worry postponement, attention training, and the “detached mindfulness” approach.

Both models have robust empirical support. A meta-analysis of 181 studies by McEvoy and colleagues (2019) found a moderate association between intolerance of uncertainty and symptoms across a range of disorders, generalised anxiety disorder among them, while a meta-analysis of metacognitive therapy found large effects for anxiety and depression

(Normann, van Emmerik & Morina, 2014). The practitioner's challenge is to determine, through formulation, which engine is predominant in a given client and to select the corresponding intervention package.

A concrete worked example illustrates how formulation guides engine selection. Anna, a 28-year-old marketing executive, presents with intense anxiety about delivering presentations. She reports that before each meeting she feels her heart race, her hands tremble, and she imagines herself "looking like a nervous wreck". During the presentation she avoids eye contact, rehearses her sentences silently, and clutches the podium. Afterwards she spends hours replaying the event, convinced that colleagues thought she was incompetent. A formulation based on the Clark and Wells model identifies self-focused attention, an exaggerated observer self-image, and safety behaviours as the maintaining factors. The therapist begins with attention training, asking Anna to note three external cues (e.g., the colour of a colleague's shirt, the sound of the projector) during a brief role-play. When Anna's attention drifts inward, she gently redirects it to the external cue, noting a reduction in heart rate over successive trials. Next, the therapist arranges a short video-recorded presentation. Anna predicts that she will appear "flushed and shaky" and that the audience will stare disapprovingly. The video reveals that Anna's facial expression is neutral, her voice is clear, and audience members nod in agreement. The discrepancy is highlighted, and Anna's observer self-image is updated. Finally, a behavioural experiment is planned: Anna will deliver a ten-minute update without holding the podium and will refrain from rehearsing silently. She predicts that colleagues will think she is unprepared; after the meeting she rates the actual reactions, noting that several colleagues compliment her clarity. The experiment is repeated, each time dropping an additional safety behaviour (e.g., avoiding eye contact). Over several sessions Anna's self-focus diminishes, her observer image becomes more realistic, and her anxiety levels drop markedly.

Contrast this with Mark, a 45-year-old father who reports chronic worry about his teenage children's safety. He spends hours each night checking their phones, calling them repeatedly, and rehearsing worst-case scenarios. He believes that if he does not worry, something terrible will happen, yet he also feels that his worry is uncontrollable and that it will eventually cause him to lose his mind. A formulation reveals two possible engines. The presence of strong positive beliefs about the protective function of worry points to the

Dugas IU model, while the conviction that worry is uncontrollable and dangerous aligns with Wells' metacognitive model. The therapist explores which belief set is more salient. Mark describes that the urge to check is driven by a fear of uncertainty – he cannot tolerate not knowing whether his children are safe – and that the distress he feels when he tries to stop checking is largely about the feeling that his mind has "run away". The therapist therefore adopts a hybrid approach: graded exposure to uncertainty (e.g., delaying a check-in call by 30 minutes) to increase IU tolerance, combined with a worry-postponement experiment to challenge the belief that worry is uncontrollable. Mark schedules a "worry slot" each evening, during which he is allowed to engage in worry for 15 minutes, after which he must stop. Over two weeks he records the number of times he successfully postpones worry, noting a steady increase. Simultaneously, he practices exposure to uncertainty by leaving a message for his children and waiting an hour before checking for a reply. He learns that the children are safe even when he does not have immediate confirmation, thereby weakening the positive IU belief. The combined formulation-driven strategy leads to a significant reduction in both the frequency of checking behaviours and the intensity of meta-worry.

The lesson for the practitioner is clear: the engine that powers anxiety must be identified before treatment can be effective. A generic anxiety management protocol that teaches relaxation, deep breathing, or generic cognitive restructuring without reference to the underlying maintenance mechanisms will at best produce modest gains and at worst reinforce maladaptive patterns. Formulation is the tool that reveals whether the client's distress is driven by self-focused attention and an observer self-image, by intolerance of uncertainty, by metacognitive beliefs, or by a combination of these factors. The therapist's questions become diagnostic: "What does the client attend to in the moment?" "What mental image or belief is being maintained?" "Which safety behaviours or avoidance strategies are present?" The answers guide the selection of the appropriate model-specific interventions.

Research underscores the superiority of formulation-driven treatment. A randomised controlled trial by Clark, Ehlers and colleagues (2006) found that cognitive therapy based on the Clark and Wells model was superior to exposure plus applied relaxation in the treatment of social phobia. Similarly, in a randomised trial for generalised anxiety disorder, both metacognitive

therapy and intolerance-of-uncertainty therapy produced large reductions in symptoms, with metacognitive therapy producing the better results (van der Heiden, Muris & van der Molen, 2012). In a further trial, metacognitive therapy led to higher recovery rates than CBT for generalised anxiety disorder, 65 per cent against 38 per cent, and the difference was maintained at two years (Nordahl et al., 2018).

In practice, the therapist moves fluidly between models as the formulation evolves. A client may present with social anxiety that is exacerbated by worry about uncertain outcomes, thereby displaying both self-focus and IU. The therapist can integrate attention training with graded uncertainty exposure, ensuring that each intervention targets the relevant maintaining factor. The flexibility afforded by a formulation-centred approach is what distinguishes a skilled CBT practitioner from a therapist who merely recites a manual.

To summarise, social anxiety is maintained by a triad of self-focused attention, an internally generated observer self-image, and safety behaviours; worry is maintained by intolerance of uncertainty and by metacognitive beliefs about the usefulness and danger of worry. The practitioner’s primary skill is to construct a clear, hypothesis-driven formulation that identifies which engine is operative for the individual client. Once identified, the therapist selects the corresponding evidence-based techniques – attention training, video feedback, behavioural experiments for social anxiety; graded exposure to uncertainty, belief restructuring, and metacognitive interventions for worry. By anchoring treatment decisions in formulation rather than habit, the therapist maximises therapeutic potency and aligns practice with the robust evidence base that underpins modern CBT.

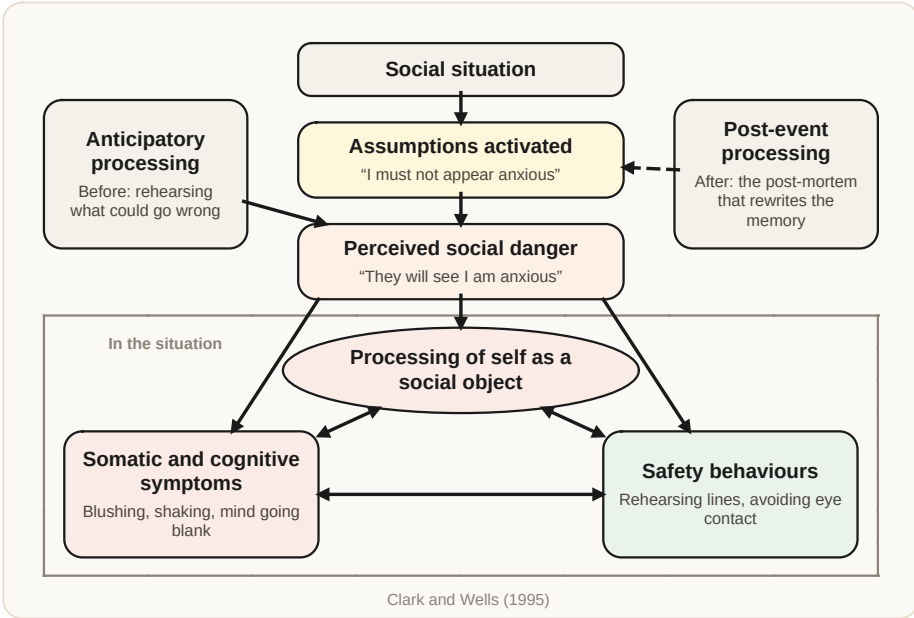


FIGURE 2.1 The cognitive model of social anxiety

Clark and Wells's model. Entering a feared social situation activates assumptions, perceived social danger follows, and inside the situation three things maintain each other: an impression of how one appears built from felt experience rather than from the room, the somatic and cognitive symptoms, and the safety behaviours. Perceived danger drives all three directly. Anticipatory processing before the event and the post-mortem afterwards sit outside the situation and feed it, which is why a social occasion that goes well changes nothing.

Points worth keeping

- Social anxiety is maintained by self-focused attention and the observer self-image
- Worry runs on intolerance of uncertainty and metacognitive beliefs about worry
- Practitioner CBT selects the engine by formulation, not by habit

PRACTICE TASK

For one anxious client you know of, name the maintaining engine you would test first, and the evidence that would confirm or refute it.