Working with Clients Presenting with Depression Using CBT

THE TALKING THERAPIES UK PRACTITIONER SERIES



Working with Clients Presenting with Depression Using CBT

A Practical CPD Course for Counsellors and Psychotherapists

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Working with Clients Presenting with Depression Using CBT course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 2. This printing was set on 2 November 2026 from the course as it stood that day.

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.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Welcome to Working with Clients Presenting with Depression Using CBT, an intermediate clinical training programme designed specifically for qualified counsellors and psychotherapists seeking to sharpen their evidence-based competencies. Depression remains one of the most prevalent and debilitating presentations encountered in modern mental healthcare, yet it is also one of the most treatable when approached through a structured, empirically validated cognitive-behavioural framework. This six-hour continuing professional development course bridges the gap between contemporary clinical research and daily practice, equipping you with the precise tools needed to conceptualise and treat depressive disorders effectively across diverse client groups. Throughout this training, you will explore the foundational cognitive mechanisms that maintain low mood, learning to map the intricate feedback loops between automatic thoughts, emotional states, physiological sensations, and maladaptive behaviours. By grounding your clinical work in the proven efficacy of cognitive-behavioural therapy, you will move beyond generic supportive counselling into focused, goal-directed interventions that foster genuine cognitive and behavioural shifts. You will begin by examining the diagnostic criteria for depression alongside the core tenets of the CBT model, gaining a clear understanding of how to engage demoralised clients who present with pervasive feelings of hopelessness and worthlessness. The curriculum then guides you through structured assessment methodologies, teaching you how to integrate validated psychometric measures such as the PHQ-9 to quantify symptom severity, monitor therapeutic progress, and evaluate the efficacy of your ongoing interventions. You will learn to construct robust, individualised CBT case formulations that draw upon longitudinal developmental factors and current maintaining cycles, ensuring your treatment plans are uniquely tailored to each client rather than applied as a rigid template. Central to the programme is an in-depth exploration of core evidence-based techniques, providing hands-on training in behavioural activation to combat anhedonia and withdrawal, alongside cognitive restructuring strategies to identify, challenge, and modify depressogenic assumptions and core beliefs. You will practice pacing interventions to accommodate the often limited energy reserves of depressed clients, ensuring that behavioural tasks remain

achievable and reinforcing rather than overwhelming. The training also addresses the critical phases of monitoring recovery and managing relapse, teaching you how to help clients identify personal early warning signs, consolidate their therapeutic gains, and construct comprehensive relapse prevention plans that safeguard against future depressive episodes. In addition to technical proficiency, the course addresses important aspects of professional practice, including cultural sensitivity, intersectionality, and the complex ways in which Social GGRRAAACCEEESSS influence the therapeutic alliance and the expression of distress. By the conclusion of this intermediate CPD course, you will possess a deepened clinical confidence, a structured toolkit of empirically supported interventions, and the analytical framework required to help your clients achieve sustained recovery and emotional resilience.

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

- Identify the core cognitive and behavioural components that maintain depression.
- Apply evidence-based CBT techniques such as cognitive restructuring, behavioural activation and problem solving.
- Develop a structured treatment plan that incorporates assessment, goal setting and outcome monitoring.
- Evaluate treatment progress and make data-driven adjustments to the intervention.
- Demonstrate ethical and cultural sensitivity when working with diverse clients.

PART 1

Foundations of Depression and CBT

An overview of depression, its diagnostic criteria, and the CBT model that links thoughts, feelings and behaviours.

CHAPTER 1

Understanding Major Depressive Disorder

To practise effectively with clients presenting with depression, we must first establish a robust, shared understanding of what constitutes Major Depressive Disorder (MDD). As intermediate practitioners, you likely encounter clients who describe themselves as 'depressed' in a colloquial sense, often conflating transient low mood with a clinical syndrome. Distinguishing between the two is not merely an academic exercise; it is the foundation upon which all subsequent cognitive-behavioural interventions rest. Without a clear diagnostic anchor, our formulation risks being vague, and our interventions may lack the necessary targeted intensity. This lesson reviews the diagnostic criteria from the DSM-5 and ICD-10, explores the epidemiological landscape, and examines how MDD impacts functioning, providing the clinical context required for effective CBT practice. We will move beyond simple checklist diagnosis to understand the dimensional nature of severity, the specific cognitive and behavioural mechanisms that maintain the disorder, and the critical role of functional impairment in guiding our therapeutic strategy. This foundational knowledge ensures that when we begin to apply techniques such as behavioural activation or cognitive restructuring, we are targeting the specific deficits that are driving the client's distress, rather than applying a generic protocol to a complex individual presentation.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), and the International Classification of Diseases, Tenth Revision (ICD-10), provide the standard frameworks for diagnosis. While there are subtle differences in their structural approaches, the core symptoms of MDD are largely concordant. According to the DSM-5, a diagnosis of Major Depressive Episode requires the presence of five or more of the following nine symptoms during the same two-week period. At least one of these symptoms must be either (1) depressed mood or (2) loss of interest or pleasure (anhedonia). The full list includes: depressed mood most of the day, nearly every day; markedly diminished interest or pleasure in all, or almost all, activities; significant weight loss or gain, or decrease or increase in appetite; insomnia or hypersomnia; psychomotor agitation or retardation;

fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. These symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not attributable to the physiological effects of a substance or another medical condition. It is vital to emphasise that the two-week duration is a minimum threshold, not a maximum. Many clients present with symptoms that have persisted for months or years, and the chronicity of the episode often correlates with the entrenchment of maladaptive cognitive and behavioural patterns. Furthermore, the requirement for 'nearly every day' ensures that we are identifying a pervasive syndrome rather than a reactive, situational response to a specific stressor, which might be better addressed through brief supportive counselling or problem-solving therapy rather than a full CBT protocol for MDD.

It is crucial to note the specifier of severity. Mild depression involves five to seven symptoms, moderate involves eight to nine, and severe involves ten or more symptoms, often with psychotic features. In the UK context, we also frequently reference the ICD-10, which categorises depressive episodes into mild, moderate, and severe, with or without somatic symptoms. The ICD-10 places a particular emphasis on the duration of symptoms, requiring at least two weeks for a definite diagnosis, though it allows for a shorter period if the symptoms are of unusual severity. Understanding these nuances is vital because the severity specifier directly influences the intensity of the intervention. For instance, a client with mild depression might benefit significantly from brief CBT or self-help resources, whereas a client with severe depression, particularly with psychotic features, may require a combination of pharmacological intervention and intensive psychotherapy. As therapists, we must be clear about our scope of practice; while we do not diagnose, we must be able to recognise the severity markers to ensure clients are referred appropriately for medical assessment if necessary. This triage function is a core competency for the private practitioner. If a client presents with severe depression accompanied by psychotic features, such as delusions of guilt or nihilistic delusions, or if there is a significant risk of suicide, the ethical and clinical imperative is to refer for psychiatric assessment and potential medication management. CBT alone is rarely

sufficient for severe MDD with psychotic features, and attempting to treat such a presentation in isolation can be both ineffective and dangerous. Conversely, underestimating the severity of a presentation can lead to a mismatch between the client's needs and the intensity of the intervention, resulting in treatment resistance or dropout.

Prevalence data provides the background against which we understand the scope of this condition. MDD is one of the most common mental health disorders globally. In the UK, the Office for National Statistics and various epidemiological studies suggest that approximately 5.5% of the adult population experiences MDD in any given year. However, lifetime prevalence is significantly higher, with estimates suggesting that around 12% to 15% of adults will experience MDD at some point in their lives. The condition is not equally distributed; it is more prevalent in women than in men, with a ratio of approximately 1.5 to 1. It typically emerges in late adolescence or early adulthood, with the median age of onset in the mid-20s. However, onset can occur at any age, and late-life depression is a distinct clinical entity that requires specific consideration regarding comorbid medical conditions and cognitive decline. Recognising these demographic patterns helps us in risk assessment and understanding the typical trajectory of the disorder, although individual cases will always deviate from the statistical norm. The higher prevalence in women is a subject of significant research, with hypotheses ranging from biological factors, such as the impact of hormonal fluctuations across the menstrual cycle, pregnancy, and menopause, to psychosocial factors, such as the disproportionate burden of unpaid care work and higher exposure to adverse childhood experiences. For the CBT practitioner, this means being particularly attuned to the specific stressors and cognitive vulnerabilities that may be more common in female clients, while avoiding stereotyping. Similarly, the onset in late adolescence is often linked to the developmental tasks of identity formation and independence, and depression in this age group can be particularly insidious, often masked by school or work performance issues rather than overt emotional expression.

The impact of MDD on functioning is profound and multifaceted. It is not merely a subjective experience of sadness; it is a syndrome that disrupts biological, psychological, and social systems. Biologically, MDD is associated with dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, leading to elevated cortisol levels, which can contribute to the fatigue,

sleep disturbance, and cognitive slowing often reported by clients. Psychologically, the core features of negative automatic thoughts, cognitive distortions, and reduced self-efficacy create a feedback loop that maintains the depressive state. Socially, the withdrawal and anhedonia characteristic of MDD lead to isolation, which further exacerbates the condition. Clients often report a decline in occupational performance, with increased absenteeism and presenteeism (being at work but not functioning effectively). This functional impairment is a key criterion for diagnosis and a primary target for CBT intervention. Our goal is not just to reduce symptom severity but to restore the client's capacity to engage in valued activities and maintain meaningful relationships. In CBT terms, we view this functional impairment as the result of a vicious cycle where avoidance behaviours maintain negative beliefs. For example, a client who believes they are incompetent may avoid challenging tasks at work, leading to a lack of positive feedback, which in turn reinforces the belief of incompetence. The CBT formulation must explicitly map out these maintaining factors, linking the cognitive distortions to the behavioural avoidance and the resulting functional decline. This map becomes the blueprint for our interventions, ensuring that we are addressing the root causes of the dysfunction rather than just the surface-level symptoms.

A worked clinical example illustrates the application of these criteria. Consider 'Sarah,' a 34-year-old accountant who presents to your practice. She reports feeling 'down' for the past three weeks. She states that she has lost interest in her usual hobbies, such as running and reading. She is sleeping poorly, waking at 3 am and unable to return to sleep. She feels guilty about not being able to keep up with her work, despite her colleagues noting a significant drop in her output. She has lost 4 kg in weight due to a lack of appetite. She denies suicidal ideation but states that she feels like a burden to her family. When you assess her against the DSM-5 criteria, you identify: depressed mood, anhedonia, insomnia, fatigue, feelings of worthlessness/guilt, and diminished concentration. This totals six symptoms. Since she has more than five symptoms, including depressed mood and anhedonia, and these have persisted for more than two weeks, causing significant impairment in her work and social life, she meets the criteria for a Major Depressive Episode. The severity is likely moderate, given the number of symptoms and the degree of functional impairment. This assessment allows you to formulate a CBT case concept that targets her

cognitive distortions (e.g., guilt, catastrophising) and behavioural withdrawal, while also considering the need for medical review to rule out thyroid dysfunction or other medical causes that could mimic or exacerbate depression. In Sarah's case, the cognitive formulation might identify a core belief of 'I am inadequate' triggered by a recent work challenge. This core belief leads to automatic thoughts such as 'I can't do this job' and 'I am a burden.' These thoughts result in behavioural avoidance, such as procrastinating on reports and withdrawing from social invitations. The avoidance prevents her from experiencing mastery and social support, thereby maintaining the core belief. The CBT intervention would therefore involve behavioural experiments to test the belief of inadequacy, behavioural activation to re-engage with valued activities, and cognitive restructuring to challenge the automatic thoughts of guilt and worthlessness. This integrated approach ensures that we are addressing the cognitive, behavioural, and functional aspects of her depression simultaneously.

In summary, understanding MDD requires a precise grasp of diagnostic criteria, an awareness of prevalence and risk factors, and a recognition of the broad impact on functioning. As you proceed through this course, keep this foundational knowledge in mind. Every intervention you design, from behavioural activation to cognitive restructuring, is informed by your understanding of the specific symptoms and functional deficits present in the client. By anchoring your practice in a clear diagnostic framework, you ensure that your work is targeted, evidence-based, and responsive to the client's specific needs. This lesson provides the necessary clinical context for the subsequent modules, where we will explore the theoretical underpinnings of CBT and begin to apply these principles to the specific challenges of treating depression. Remember that diagnosis is not a static label but a dynamic process that informs our formulation and treatment planning. It is the lens through which we view the client's suffering and the guide for our therapeutic actions. As you develop your skills as a CBT practitioner, your ability to accurately assess and understand MDD will be a cornerstone of your clinical effectiveness. This understanding will allow you to work with confidence, compassion, and precision, helping your clients to navigate the complexities of depression and move towards recovery and well-being.

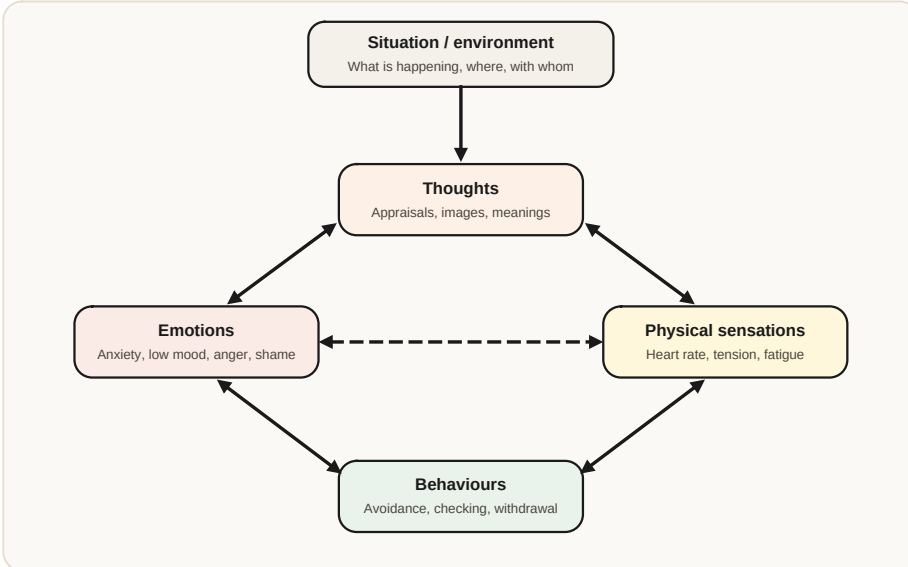


FIGURE 1.1 The five areas model

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

- The DSM-5 requires five or more symptoms for two weeks, including depressed mood or anhedonia, to diagnose MDD.
- Severity specifiers (mild, moderate, severe) guide the intensity of intervention and referral decisions.
- MDD is more prevalent in women and typically emerges in late adolescence or early adulthood.
- Functional impairment in social, occupational, and biological domains is a core feature and treatment target.
- Accurate symptom assessment distinguishes clinical depression from transient low mood and guides CBT formulation.

PRACTICE TASK

Review your current caseload and identify one client presenting with depressive symptoms. Using the DSM-5 criteria, list the specific symptoms present, note the duration, and assess the level of functional impairment. Reflect on how this symptom profile informs your current or planned CBT formulation.

CHAPTER 2

CBT Theory for Depression

In the previous lesson, we established the diagnostic criteria for Major Depressive Disorder, recognising it as a multifactorial condition involving biological, psychological, and social factors. This lesson moves into the specific psychological mechanisms that CBT posits as central to the maintenance of depression. It is crucial to understand that CBT does not view depression as caused solely by 'negative thinking.' Rather, it proposes a transactional model where cognitive, emotional, and behavioural processes interact to sustain the disorder. The core theoretical framework rests on the concept of cognitive distortion, but more importantly, on the hierarchical structure of cognition: automatic thoughts, intermediate beliefs, and core beliefs. Understanding this hierarchy is essential for effective formulation and intervention.

At the most superficial level are automatic thoughts. These are the immediate, fleeting cognitions that arise in response to specific situations. In a non-depressed individual, these thoughts are typically balanced and reflect reality. In a depressed individual, automatic thoughts are characterised by negativity, selectivity, and rigidity. They are often experienced as facts rather than interpretations. For example, a client who is late for a meeting might automatically think, 'I am always late; I am incompetent and will be fired.' This thought is not a logical deduction but a rapid, heuristic response. The cognitive model suggests that these automatic thoughts directly influence emotional responses. The belief that one is incompetent leads to feelings of shame, anxiety, or sadness. Importantly, these thoughts are often outside the client's immediate awareness, operating as background noise that colours their perception of the world. As therapists, our initial task is to help clients identify these thoughts, moving them from implicit to explicit, so they can be examined.

Beneath automatic thoughts lie intermediate beliefs, which consist of rules, attitudes, and assumptions. These are the 'if-then' statements that guide behaviour and interpret events. For instance, a rule might be, 'If I make a mistake, I am a failure.' An assumption might be, 'People will reject me if they see my true self.' These intermediate beliefs act as filters through which

automatic thoughts are generated. They are more stable than automatic thoughts but less rigid than core beliefs. They represent the client's operational manual for navigating social and professional life. In depression, these rules are often excessively demanding, punitive, or unrealistic. They create a high threshold for success, meaning that any minor setback is interpreted as catastrophic failure. This rigidity prevents the client from adapting to changing circumstances, leading to chronic distress.

At the deepest level are core beliefs, or schemas. These are the fundamental, global beliefs about the self, others, and the world. They are formed in early childhood and are often held with absolute certainty. Common core beliefs in depression include 'I am unlovable,' 'I am inadequate,' or 'The world is dangerous.' These beliefs are not consciously accessible in the same way as automatic thoughts; they are experienced as a deep-seated feeling or a sense of identity. They are resistant to change because they have been reinforced over years. However, they are the root of the depressive cycle. When a situation threatens a core belief of inadequacy, it triggers a cascade of negative automatic thoughts and emotional distress. The therapeutic goal in CBT is not merely to challenge individual automatic thoughts but to eventually address the underlying core beliefs that generate them.

The maintenance of depression is further explained by the interaction between these cognitive processes and behavioural patterns. CBT emphasises that behaviour is not just a consequence of cognition but also a driver of it. This is where the concept of behavioural avoidance and withdrawal comes in. Depressed clients often engage in behaviours that provide short-term relief but long-term harm. For example, a client who feels socially anxious may avoid social invitations. This avoidance reduces immediate anxiety, reinforcing the belief that social situations are threatening. However, it also prevents the client from gathering disconfirming evidence that they can cope with social interaction. This lack of positive reinforcement leads to further isolation, which in turn fuels feelings of worthlessness and hopelessness. This cycle is known as the vicious cycle of depression. The client's behaviour maintains the cognitive distortions, which in turn drive further maladaptive behaviour.

Another key behavioural component is the reduction in reward. Depression is characterised by anhedonia, the loss of pleasure or interest in previously

enjoyable activities. As clients withdraw from activities, they experience fewer positive reinforcements. This lack of reward leads to a decrease in motivation, which further reduces activity levels. This behavioural inertia is a powerful maintainer of depression. CBT addresses this through behavioural activation, which aims to break the cycle by systematically reintroducing rewarding activities. However, it is important to note that behavioural activation is not just about 'doing things.' It is about helping clients understand the relationship between their behaviour and their mood. By observing how specific activities influence their emotional state, clients can begin to challenge the core belief that 'nothing matters' or 'I am incapable of change.'

To illustrate this theoretical framework, consider a worked clinical example. Sarah, a 34-year-old accountant, presents with a six-month history of low mood, fatigue, and social withdrawal. She reports that she has stopped attending her weekly tennis club and has cancelled several work meetings. In session one, we explore a recent incident where Sarah missed a deadline for a report. Her automatic thought was, 'I am a fraud; I will be exposed and fired.' This thought was accompanied by intense shame and anxiety. We identify the intermediate belief: 'If I make a mistake, I am a failure.' Digging deeper, we uncover the core belief: 'I am fundamentally inadequate.' Sarah's behaviour in response to this thought was to avoid checking her email for three days, fearing criticism. This avoidance provided temporary relief from anxiety but increased her workload and stress, reinforcing her belief that she could not cope. The cognitive model explains how the core belief of inadequacy triggered the automatic thought, which led to the emotional response of shame, which drove the behavioural avoidance, which in turn maintained the core belief. The therapeutic intervention would involve challenging the automatic thought by examining the evidence for and against being a 'fraud,' testing the intermediate belief through behavioural experiments, and gradually addressing the core belief through schema work.

It is vital to recognise that this model is not deterministic. CBT acknowledges the role of biological and environmental factors. However, it provides a practical, testable framework for understanding and treating depression. The strength of the CBT model lies in its focus on the present and the future, rather than solely on past trauma. By changing current cognitive and behavioural patterns, clients can alter their emotional responses and improve their quality of life. This lesson has outlined the

hierarchical structure of cognition and the behavioural maintenance of depression. In the next lesson, we will explore how to use standardised measures to assess the severity of these symptoms and track progress over time. Understanding this theoretical foundation is essential for designing effective interventions and communicating with clients about the rationale for treatment.

In summary, CBT views depression as a self-perpetuating cycle where negative core beliefs lead to distorted automatic thoughts, which cause emotional distress and maladaptive behaviours. These behaviours, in turn, reinforce the core beliefs. The therapeutic task is to interrupt this cycle by identifying and challenging cognitive distortions, testing intermediate beliefs, and modifying behavioural patterns. This requires a collaborative, empirical approach where the therapist and client work together to gather evidence and test hypotheses. By understanding these mechanisms, clinicians can move beyond symptom management to address the underlying structures that sustain depression. This theoretical knowledge underpins all subsequent lessons in this course, from formulation to relapse prevention. It is the lens through which we view the client's experience and the basis for our therapeutic interventions. As you progress through this course, keep this model in mind, and observe how it manifests in your own clinical work. The more familiar you become with these concepts, the more naturally they will guide your practice.

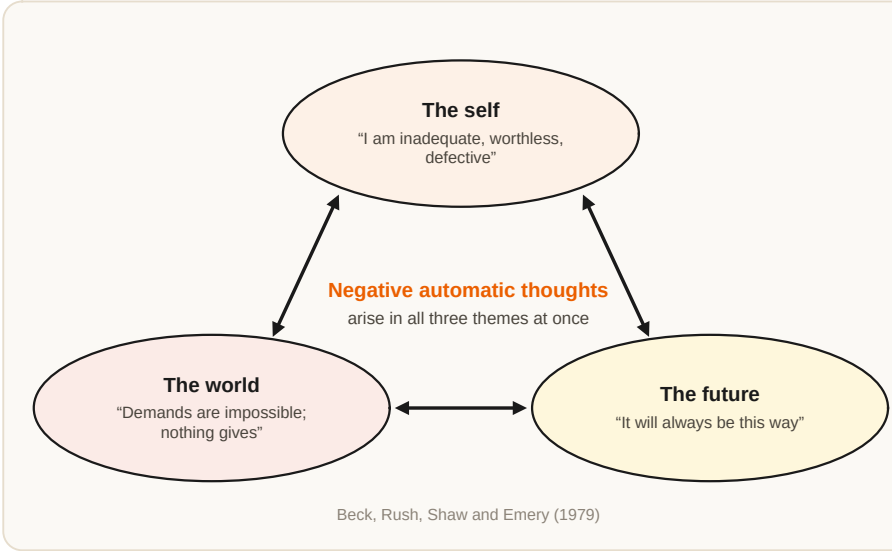


FIGURE 2.1 Beck's cognitive triad

In Beck's cognitive model of depression, negative automatic thoughts cluster into three linked themes: a negative view of the self, of the world and present experience, and of the future. Each sustains the others, which is why hopelessness rarely yields to reassurance about one corner alone.

Points worth keeping

- Depression is maintained by a transactional cycle involving cognitive, emotional, and behavioural processes.
- Cognitive hierarchies consist of automatic thoughts, intermediate beliefs, and core beliefs, with core beliefs being the deepest and most resistant to change.
- Automatic thoughts are immediate, negative interpretations of events that directly influence emotional responses.
- Intermediate beliefs are rules and assumptions that filter experiences and generate automatic thoughts.
- Core beliefs are global, fundamental views of the self, others, and the world, often formed in early childhood.
- Behavioural avoidance and withdrawal maintain depression by preventing the gathering of disconfirming evidence and reducing positive reinforcement.

PRACTICE TASK

Select a recent case where a client presented with depressive symptoms. Identify one automatic thought, one intermediate belief, and one core belief that may be operating in that case. Write a brief formulation linking these cognitive elements to the client's behavioural patterns and emotional responses. Share this formulation in your next supervision session for feedback.