Cognitive Behavioural Therapy (CBT)

THE TALKING THERAPIES UK PRACTITIONER SERIES



Cognitive Behavioural Therapy (CBT)

The complete practitioner pathway, from foundation through to advanced practice

Advanced level · 126 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

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

Revision 6. This printing was set on 9 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

This volume gathers the whole of the Talking Therapies UK pathway in Cognitive Behavioural Therapy (CBT) into a single book. Each of its parts is a complete course from the practice's training library, and each chapter is a lesson from that course, so the volume covers the subject in the order in which it is taught, from foundation through to advanced practice. It is written for psychotherapists, psychologists and other qualified psychological therapists, and it assumes a caseload and access to supervision.

The constituent courses are: CBT Essentials; CBT in Practice; Trauma-Informed Practice for Therapists; Building Resilience: A Practical Approach to Low Self-Esteem; Working with Clients Presenting with Depression Using CBT; Understanding and Working with Disordered Eating in Psychotherapy; Advanced CBT: Complexity and Process; Advanced Relational Practice: Deepening Clinical Mastery; Advanced Cognitive Behavioural Therapy for Complex Anxiety Disorders.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 126 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

- Explain the cognitive model and how thoughts, emotions, physical sensations and behaviours maintain one another
- Map a presenting difficulty onto the five areas model and identify its maintenance cycle
- Recognise negative automatic thoughts and the common thinking habits that distort them
- Describe how safety behaviours and avoidance keep unhelpful beliefs untested
- Use a thought record to examine evidence and construct a balanced alternative thought
- Explain how graded behavioural work, including activation and exposure, produces change
- 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
- Identify the neurobiological and psychological impacts of trauma on clients.
- Apply the six key principles of trauma-informed care to assessment and treatment planning.
- Select and adapt evidence-based interventions such as TF-CBT and EMDR for diverse client needs.
- Demonstrate strategies for maintaining therapist safety and managing vicarious trauma.
- Integrate trauma-informed documentation and referral pathways within a multidisciplinary setting.

- Identify the cognitive and emotional markers of low self-esteem in clinical practice.
- Apply CBT techniques to challenge and restructure negative core beliefs.
- Understand the role of early maladaptive schemas in maintaining low self-worth.
- Develop strategies to enhance self-compassion and emotional regulation.
- Integrate relational approaches to address attachment-related vulnerabilities.
- Formulate a tailored treatment plan for clients with chronic self-esteem issues.
- 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.
- Differentiate between various clinical presentations of disordered eating and eating disorders using current diagnostic frameworks.
- Assess physical and psychological risk effectively, implementing robust safeguarding and referral protocols.
- Integrate evidence-based therapeutic interventions, such as CBT-ED and CFT, into clinical practice.
- Navigate complex therapeutic dynamics, including ambivalence, resistance, and countertransference.
- Apply ethical and legal principles regarding client autonomy, capacity, and multi-disciplinary collaboration.
- Formulate complex, comorbid and long-standing difficulties where standard protocols fit poorly
- Work at the level of conditional rules and core beliefs, using continua, historical review and behavioural experiments
- Recognise and repair ruptures in the therapeutic relationship within a CBT

frame

- Adapt CBT process and pacing for relational trauma, perfectionism and self-criticism
- Integrate imagery techniques and attention to process alongside protocol content
- Critically evaluate the CBT evidence base and its limits, and reason clearly about when to depart from protocol
- Critically evaluate and apply advanced relational and intersubjective frameworks to complex client presentations.
- Master the therapeutic use of self through sophisticated navigation of countertransference and parallel processes.
- Integrate neurobiologically informed attachment theories into clinical assessment and intervention strategies.
- Effectively identify, hold, and work through ruptures and repairs within the therapeutic alliance.
- Implement trauma-informed interventions that balance stabilization with deep affective processing.
- Maintain robust ethical, legal, and boundary management in high-complexity and high-risk clinical scenarios.
- Utilize deliberate practice and clinical supervision models to sustain lifelong reflective practice and prevent burnout.
- Critically appraise contemporary cognitive behavioural models of anxiety disorders, integrating transdiagnostic mechanisms with disorder-specific maintenance cycles.
- Conduct exhaustive, formulation-driven clinical assessments that differentiate between primary anxiety presentations, subtle avoidance patterns, and complex psychiatric comorbidities.
- Construct individualised, empirically supported cognitive conceptualisations that map out idiosyncratic triggers, core beliefs, and maintaining safety behaviours.
- Implement advanced cognitive restructuring techniques targeting deep-seated core schemas, cognitive rigidity, and metacognitive beliefs maintaining chronic apprehension.
- Design and execute sophisticated behavioural experiments and interoceptive exposure protocols designed to violate threat expectancies and enhance inhibitory learning.

- Integrate third-wave principles, including mindfulness and acceptance strategies, to address experiential avoidance and promote psychological flexibility in treatment-refractory cases.
- Systematically manage therapeutic ruptures, alliance strains, and client ambivalence throughout intensive exposure-based interventions.
- Utilise validated psychometric tools and continuous feedback loops to evaluate clinical progress, adjust formulation hypotheses, and ensure measurable therapeutic outcomes.

PART 1

CBT Essentials

The cognitive model from first principles: how thoughts, feelings, body and behaviour interact, and how change becomes possible.

CHAPTER 1

Origins and the central claim

The story of Cognitive Behavioural Therapy begins in the early 1960s, when a young psychiatrist named Aaron Beck was working on an inpatient unit at the University of Pennsylvania. Trained in the psychoanalytic tradition, Beck was accustomed to interpreting patients' distress in terms of unconscious conflicts and early-life trauma. Yet, as he listened to the narratives of people suffering from severe depression, he repeatedly observed a striking pattern: their accounts were dominated by a cascade of negative statements about themselves, about the world, and about the future. This observation, later formalised as the negative cognitive triad, marked a decisive departure from the prevailing models of the time. Beck's colleagues, including the pioneering rationalist Albert Ellis, were also beginning to question the primacy of unconscious drives, and together they forged a new therapeutic direction that placed the mind's information-processing systems at the centre of emotional experience.

Beck's negative cognitive triad consists of three interlocking beliefs. First, a negative view of the self, in which the individual judges themselves as worthless, incompetent, or unlovable. Second, a negative view of the world, in which the environment is perceived as hostile, unforgiving, or devoid of rewarding possibilities. Third, a negative view of the future, in which the prospect of change is dismissed as impossible and hopelessness looms. The triad is not merely a descriptive label; it is a functional hypothesis about how depressive mood is maintained. When a person interprets an ambiguous event through the lens of the triad, the interpretation automatically triggers a cascade of affective and behavioural responses that reinforce the original belief. In this way, two people can encounter the identical circumstance – for example, a colleague's brief email – yet experience dramatically different emotional outcomes because the meaning they assign to the event diverges.

The central claim of the cognitive model, which underlies all contemporary forms of CBT, can be summarised in a single sentence: it is not the events themselves that generate emotional distress, but the meaning that the individual ascribes to those events. This meaning-making process is often

called appraisal, a term borrowed from the stress-and-coping literature of Lazarus and Folkman. When an external stimulus occurs, the brain rapidly generates an automatic thought, a mental shorthand that captures the perceived significance of the stimulus. That automatic thought, together with the underlying belief system that gives it coherence, determines the emotional response. The raw sensory data – the event – remain neutral; it is the interpretive layer that imbues the experience with affective colour.

A crucial feature of the cognitive claim is its testability. Unlike many traditional psychodynamic formulations, which posit unconscious motives that are inherently inaccessible, the cognitive approach treats thoughts as hypotheses that can be examined against empirical evidence. Beck and his collaborators argued that if a thought is a proposition about reality, then it can be verified, falsified, or qualified. This stance transformed psychotherapy into an evidence-led practice, where the therapist and client collaborate to gather data, test predictions, and revise interpretations. The scientific orientation of CBT is reflected in its extensive research base, which consistently demonstrates efficacy across a wide range of disorders, including Social GGRRAAACCEEESSS, depression measured by the PHQ-9, and anxiety measured by the GAD-7. The ability to operationalise thoughts, to rate them on a scale of believability, and to track change over time has allowed CBT to be subjected to rigorous randomised controlled trials, meta-analyses, and implementation studies.

To illustrate how the cognitive model operates in practice, consider a client named Maya who has been referred for treatment after a series of panic attacks at work. The triggering event is a routine staff meeting in which the manager asks Maya to present a project update. During the meeting, Maya experiences a sudden rush of heat, her heart races, and she feels a sense of impending doom. The automatic thought that flashes through her mind is, “If I mess up, everyone will think I’m incompetent and I will lose my job.” This thought encapsulates a meaning that links performance failure with personal worth and future security. According to the cognitive model, the emotional response – intense anxiety and a feeling of panic – is driven not by the objective fact that Maya was asked to speak, but by the appraisal that the situation threatens her self-esteem and livelihood.

In a CBT session, the therapist would first help Maya identify the automatic thought and the underlying belief it reflects. Maya might recognise that the

thought is an instance of the negative self-view component of Beck's triad – a belief that she is fundamentally inadequate. The therapist would then guide her through a systematic test of the thought's accuracy. This could involve gathering evidence from past presentations where Maya received positive feedback, reviewing the manager's prior comments that praised her competence, and examining the realistic consequences of a single slip-up (for example, the likelihood that a manager would terminate employment after one presentation). By juxtaposing the feared outcome with the actual data, Maya learns that the catastrophic prediction is not supported by the evidence. She may also be encouraged to generate alternative, more balanced appraisals such as, "I may feel nervous, but I have prepared well and I can handle the situation." Over successive sessions, the repeated testing of the original appraisal weakens its grip, leading to a reduction in panic symptoms and an increase in confidence.

The process described above exemplifies three core principles of CBT. First, the distinction between event and meaning clarifies that the therapist does not need to change the external circumstance; rather, the focus is on reshaping the client's interpretation. Second, the notion that appraisals are testable provides a concrete method for challenging maladaptive thoughts, turning abstract distress into a problem that can be investigated and solved. Third, the collaborative nature of the evidence-led approach respects the client's expertise about their own life while bringing the rigour of scientific inquiry to the therapeutic encounter.

Historical context enriches our appreciation of why this shift was so revolutionary. Prior to Beck's work, the dominant therapeutic paradigm in the United Kingdom and elsewhere was largely psychodynamic, with an emphasis on uncovering repressed memories and resolving intrapsychic conflict. Ellis's Rational Emotive Behaviour Therapy (REBT), introduced in the late 1950s, had already begun to articulate the idea that irrational beliefs lead to emotional disturbance, but it was Beck's systematic research, including the development of the Beck Depression Inventory (BDI) in 1961, that provided the first quantitative evidence linking specific thought patterns to depressive severity. Beck's subsequent publications, such as Cognitive Therapy of Depression (1979) and the collaborative development of the cognitive model with colleagues like David Burns, solidified the link between theory, assessment, and intervention.

The central claim that meaning drives emotion also resonates with contemporary neurocognitive findings. Functional imaging studies have shown that the prefrontal cortex, a region implicated in appraisal and belief formation, modulates activity in limbic structures such as the amygdala, which are responsible for generating affective responses. When clients learn to reappraise a situation, the neural circuitry reflects a down-regulation of threat-related activity, providing a biological substrate for the psychological change observed in therapy. This convergence of cognitive theory, behavioural experimentation, and neuroscientific evidence underscores the robustness of the CBT framework.

In practical terms, the lesson for beginners is to cultivate a habit of asking, “What is the client’s interpretation of this event?” rather than “What happened?” This simple shift in focus opens the door to a range of therapeutic techniques, from Socratic questioning and guided discovery to behavioural experiments and thought records. By treating thoughts as hypotheses, the therapist invites the client into a collaborative scientific inquiry, where each session becomes a laboratory for testing the validity of the client’s appraisals. Over time, the client builds a repertoire of more accurate, flexible, and compassionate meanings, which in turn leads to more adaptive emotional and behavioural outcomes.

The legacy of Beck’s negative cognitive triad and the central claim of meaning-driven emotion continues to shape the field of psychotherapy. Modern CBT has expanded to incorporate mindfulness, acceptance, and compassion-focused strategies, yet the foundational premise remains unchanged: the way we interpret the world determines how we feel, and those interpretations can be examined, challenged, and revised. As you progress through the CBT Essentials module, you will develop the skills to detect automatic thoughts, to evaluate the evidence for and against them, and to guide clients towards more balanced appraisals. Mastery of this process equips you to help clients move from a state of distress driven by distorted meaning to a state of resilience grounded in realistic, evidence-based interpretations of their experiences.

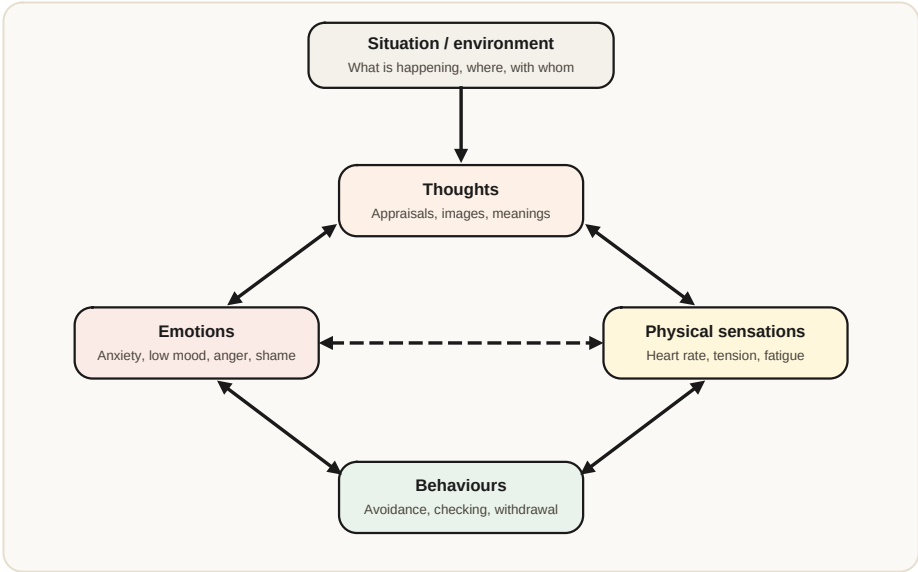


FIGURE 1.1 The five areas model

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

- CBT began with Beck's negative cognitive triad: self, world, future
- The central claim: meaning, not events, drives emotional response
- Appraisals are testable, which made CBT an evidence-led therapy

PRACTICE TASK

Write down one recent situation in which two people responded differently to the same event, and identify the appraisal each must have made.

CHAPTER 2

The five-part model and maintenance cycles

The cognitive model remains the cornerstone of cognitive behavioural therapy, asserting that emotional distress arises not from events themselves but from the meanings individuals ascribe to those events. In the early 1990s Christine Padesky and Aaron Beck formalised this insight into the five-part model, a diagrammatic framework that maps the reciprocal interplay between situation, thoughts, emotions, bodily sensations and behaviour. The model is deliberately non-linear; each component both influences and is influenced by the others, creating a dynamic system that can sustain psychological difficulty long after the original trigger has passed. By rendering these interactions visible, the five-part model equips clinicians with a shared language for collaborative formulation and a clear target for intervention.

The first element, the situation, refers to the external or internal context that occasions a response — a conversation, a memory, a physiological cue, or a life event. The second element, thoughts, captures the automatic interpretations, appraisals or images that arise in that moment; these are often fleeting, evaluative and laden with personal meaning. Emotions constitute the third component, representing the affective tone — anxiety, sadness, anger, shame — that follows the appraisal. The fourth component, bodily sensations, records the physiological correlates such as tachycardia, muscle tension, gastrointestinal disturbance or the subjective sense of heat. Finally, behaviour denotes the observable or covert actions taken in response, ranging from overt avoidance to subtle safety-seeking manoeuvres. In practice, a client may notice a racing heart (bodily sensation) and interpret it as evidence of impending catastrophe (thought), which intensifies fear (emotion) and prompts escape (behaviour), thereby feeding back into heightened physiological arousal.

Maintenance cycles emerge when these reciprocal links become self-reinforcing. Avoidance is perhaps the most pervasive maintaining process: by evading the feared situation the individual secures immediate

relief, yet the avoidance prevents the acquisition of disconfirming evidence, leaving the catastrophic belief intact. Safety behaviours — actions designed to avert a feared outcome without fully confronting the situation — operate similarly; they “steal the credit” for survival, as the client never tests whether the feared catastrophe would have occurred in their absence. Rumination, a repetitive, self-focused analysis of distress, prolongs negative affect and narrows attentional scope, while attentional bias directs perception towards threat-relevant stimuli, further confirming the maladaptive appraisal. Together these processes form a closed loop that can persist for years, a phenomenon documented extensively in the work of Clark and Wells on social anxiety and of Salkovskis on obsessive-compulsive disorder.

Formulation is the clinical art of translating this generic model into a client-specific hypothesis. Unlike a diagnostic label, a formulation is a provisional, testable map that identifies the idiosyncratic maintenance cycle for the individual. It integrates information from the clinical interview, self-report measures such as the PHQ-9 for depressive severity and the GAD-7 for generalised anxiety, and behavioural observations. The formulation highlights the precise nodes — a particular automatic thought, a characteristic safety behaviour, a recurrent physiological cue — where therapeutic intervention can interrupt the cycle. Because the formulation is collaborative, the client becomes an active co-investigator, increasing engagement and fostering a sense of agency.

Intervention strategies are then selected to target the identified nodes. Cognitive restructuring addresses distorted appraisals by examining evidence for and against the automatic thought, generating alternative balanced perspectives, and testing these through behavioural experiments. Behavioural activation and exposure directly confront avoidance, allowing the client to gather experiential data that contradicts the feared outcome. Safety-behaviour experiments involve dropping the protective action in a graded fashion, demonstrating that the anticipated catastrophe does not materialise. Attentional training and mindfulness techniques broaden perceptual focus, reducing the grip of threat-biased scanning. Each technique is chosen because the formulation predicts that altering that specific component will reverberate through the system, weakening the overall maintenance cycle.

A concrete worked illustration clarifies how these concepts translate into

practice. Consider Sarah, a 32-year-old marketing executive who presents with marked anxiety in professional networking contexts, a difficulty that intersects with aspects of Social GGRRAAACCEEESSS. Her five-part cycle can be mapped as follows. The triggering situation is an invitation to a quarterly industry conference where she is expected to mingle with senior colleagues. In that moment Sarah's automatic thought is "If I speak, I will sound foolish and everyone will judge me as incompetent." This appraisal elicits a sharp surge of anxiety (emotion) accompanied by a pounding heart, sweaty palms and a sensation of tightness in the chest (bodily sensations). To manage the distress she adopts two safety behaviours: she consumes two glasses of wine before entering the venue and she positions herself near the refreshment table, avoiding eye contact and limiting conversation to brief, scripted pleasantries. Because she never engages in unguarded dialogue, she never discovers that colleagues are generally receptive and that minor verbal slips are quickly forgotten. Consequently, the belief that she will be judged remains unchallenged, the anxiety recurs at the next invitation, and the cycle perpetuates.

In supervision the therapist and Sarah co-construct a formulation diagram that makes this loop explicit. The diagram situates the conference invitation at the top, arrows linking it to the automatic thought, the emotional and physiological response, and the safety behaviours, with a feedback arrow returning from the safety behaviours to the thought "I cannot cope without alcohol." The formulation also notes a secondary loop: the physiological arousal fuels the thought "My body is out of control," which intensifies anxiety and reinforces the urge to drink. Guided by this map, the therapeutic plan begins with psychoeducation about the five-part model, followed by a behavioural experiment in which Sarah attends a low-stakes networking event without alcohol, deliberately initiating a brief conversation and recording the actual outcome. Simultaneously, cognitive restructuring sessions examine the evidence for "I will sound foolish," using thought records and Socratic questioning to generate a more balanced appraisal such as "I may feel nervous, but I have contributed useful ideas before." Over successive weeks, graded exposure to larger events, combined with the systematic dropping of the safety behaviour, leads to a measurable reduction in anticipatory anxiety, as reflected in a falling GAD-7 score, and an increase in self-reported confidence.

The power of the five-part model lies in its capacity to transform a seemingly

intractable symptom cluster into a set of observable, modifiable processes. By making the maintenance cycle visible, the therapist and client can identify the most efficient leverage points — whether a single catastrophic thought, a habitual safety behaviour, or a pattern of avoidance — and apply evidence-based techniques with precision. This approach aligns with the broader CBT tradition championed by Beck, refined by Padesky, and extended by contemporary researchers such as Harvey, Watkins and Mansell, who emphasise the transdiagnostic relevance of maintenance mechanisms. Mastery of the model therefore equips the practitioner not only to treat the presenting problem but to foster a collaborative, empirical stance that can be applied across the spectrum of psychological disorders encountered in routine Talking Therapies practice.

Going deeper: the neglected fifth part, and a second cycle worked through.

The environment ring around the four internal systems is the part beginners most often forget to draw, and its neglect has consequences. A five-part formulation that treats a client's low mood as thought-mood-behaviour traffic, while omitting that they are in insecure housing, caring alone for a parent with dementia, or facing discrimination at work, is not merely incomplete; it quietly relocates a partly environmental problem inside the person's head. Drawn properly, the environment part does two jobs. It dignifies reality: the arrows into the person show that some of what they feel is accurate signal about a hard situation, which is validating and true. And it routes treatment: problems living in the environment ring call for problem-solving, advocacy, welfare advice and behavioural change upon the world, while problems living in the appraisal arrows call for cognitive work, and most clients need named amounts of both. The model's respectful question is always: how much of this is a thinking problem, how much a circumstances problem, and which parts of each can we move?

A second worked cycle shows the model's range beyond mood. Amara notices a skipped heartbeat while watching television. Thought: something is wrong with my heart. Emotion: fear. Body: adrenaline, a faster and more irregular-feeling heartbeat, tight chest. The new sensations feed the thought, which sharpens the fear, which loudens the body. Behaviour: she checks her pulse repeatedly, searches symptoms online for two hours, and books an urgent appointment; each check finds something ambiguous, each search finds a catastrophe that matches, and the reassurance of Tuesday's normal

ECG decays by Friday because reassurance treats the feeling and leaves the appraisal untouched. Environment: a father who died of cardiac disease, which gave the first thought its plausibility and its heat. Every part of the model is present, the arrows run in circles, and the maintaining engine is visibly the checking and searching, which is why the treatment, when she reaches it, will target exactly those behaviours first.

Notice, finally, what the model does to blame. Nothing in either cycle requires a weak character or a faulty person; both require only a normal mind running normal processes on frightening material. That reading is not a comfort added to the science; it is the science, and clients who grasp it often describe the diagram session as the day the problem became an it rather than a me.

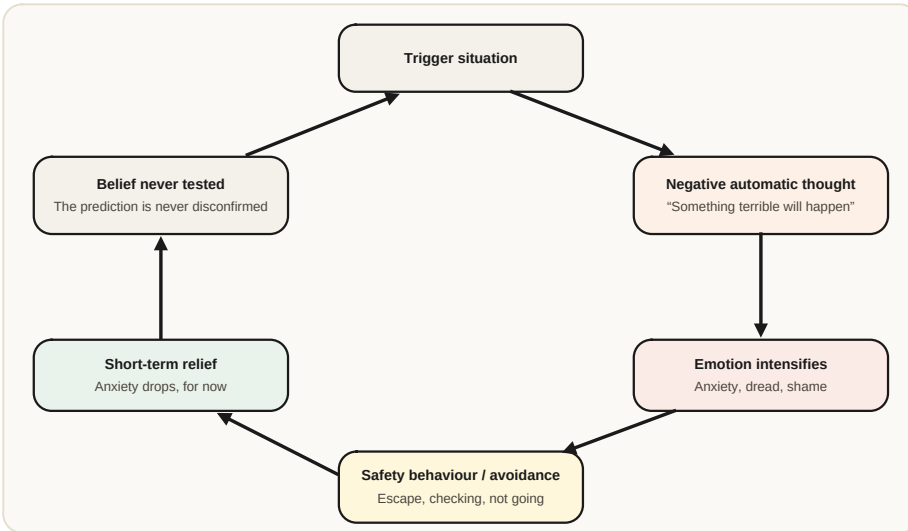


FIGURE 2.1 A maintenance (vicious) cycle

How problems keep themselves alive: a trigger activates a negative automatic thought, the emotion rises, a safety behaviour or avoidance brings short-term relief, and because the feared prediction is never tested, the underlying belief survives to fire again. Treatment interrupts the loop, usually at the behaviour.

Points worth keeping

- The five parts: situation, thoughts, emotion, body, behaviour
- Distress is maintained by cycles, especially avoidance and safety behaviours
- Formulation draws the specific cycle so intervention can break it

PRACTICE TASK

Draw a five-part model of a mild recent stress of your own, and mark where a cycle keeps it going.