# CBT for Depression: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



# CBT for Depression: Practitioner Guide

## Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

**TALKING THERAPIES UK**

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This guide accompanies the CBT for Depression programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 8. This printing was set on 9 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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# How to use this guide

This guide is for qualified practitioners who support clients through the CBT for Depression programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

### What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

# The approach and the evidence

*The model the programme is built on, what the research shows, and who the programme is for.*

### In this part


- Chapter 1, The model behind the programme: the cognitive and behavioural traditions in CBT for depression, the cycle the programme works on, and how the eight modules are built
- Chapter 2, What the research shows: the evidence for CBT and behavioural activation in depression, for guided self-help, and for preventing relapse, with its limits


CHAPTER 1

## The model behind the programme

### Two traditions in one programme

CBT for depression brings together two traditions that grew up side by side. The cognitive tradition began with Aaron Beck's observation that people with depression think about themselves, their world and their future in characteristically negative ways, and that these thoughts are not merely symptoms but help to keep the low mood going (Beck et al., 1979). Treatment teaches the person to notice those thoughts, to test them against the evidence, and to arrive at views that are both more balanced and more believable. Beck called the negative view of self, world and future the cognitive triad, and it is visible in the first contact with most depressed clients: "I'm useless", "nothing goes right for me", "it will always be like this".

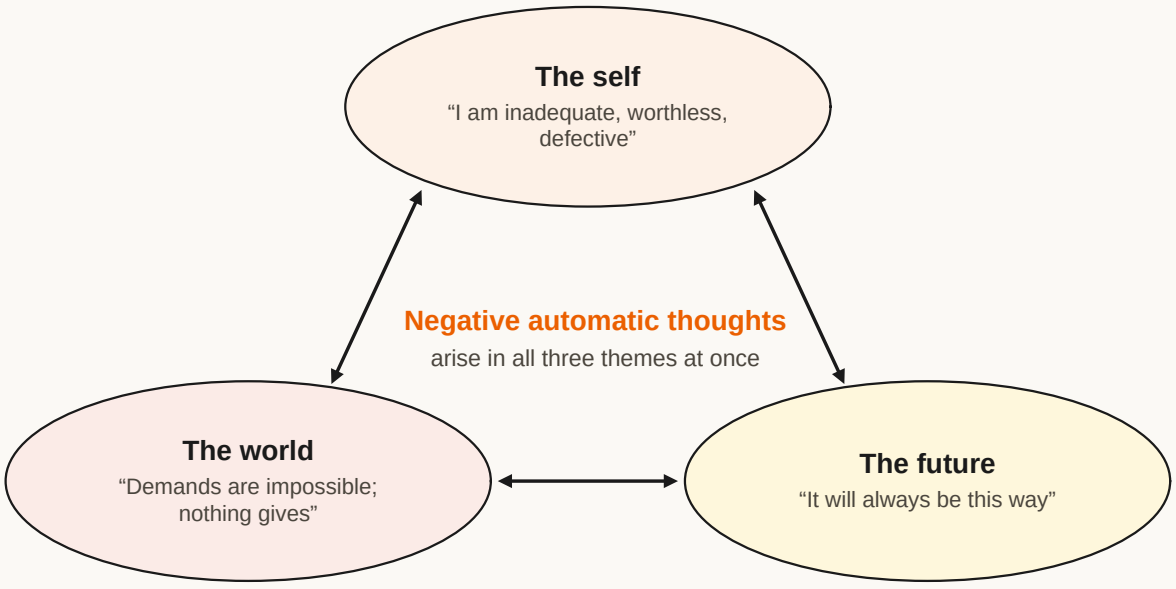



**FIGURE 1.1 Beck's cognitive triad**
*In Beck's cognitive model of depression, negative automatic thoughts cluster into three linked themes: a negative view of the self, of the world and present experience, and of the future. Each sustains the others, which is why hopelessness rarely yields to reassurance about one corner alone.*

The behavioural tradition starts from what depression does to a person's life. When mood falls, people withdraw. They stop seeing friends, give up interests, let tasks slide and spend more time in bed or alone. Each withdrawal makes sense at the time, since it spares the effort that everything has come to require, but together they remove the sources of pleasure, achievement and connection that sustain mood. Behavioural activation reverses this by helping the person to plan and carry out activity, step by step, before motivation returns. Martell, Addis and Jacobson (2001) describe the approach as working "from the outside in", and they give clients a memorable pair of terms for the choice at its centre: the avoidance that deepens depression is a TRAP (a trigger, a response and an avoidance pattern), and the alternative is getting back on TRAC (trigger, response, alternative coping).

## The cycle the programme works on

Module 1 gives the client a simple account of how depression keeps itself going. Low mood leads to doing less; doing less means fewer rewards; fewer rewards leave more room for self-critical and hopeless thinking; and that thinking lowers mood further. The cycle is a formulation in miniature. It tells the client that their symptoms are connected rather than random, that the connections run in both directions, and that a change at any point in the cycle will be felt at the others.

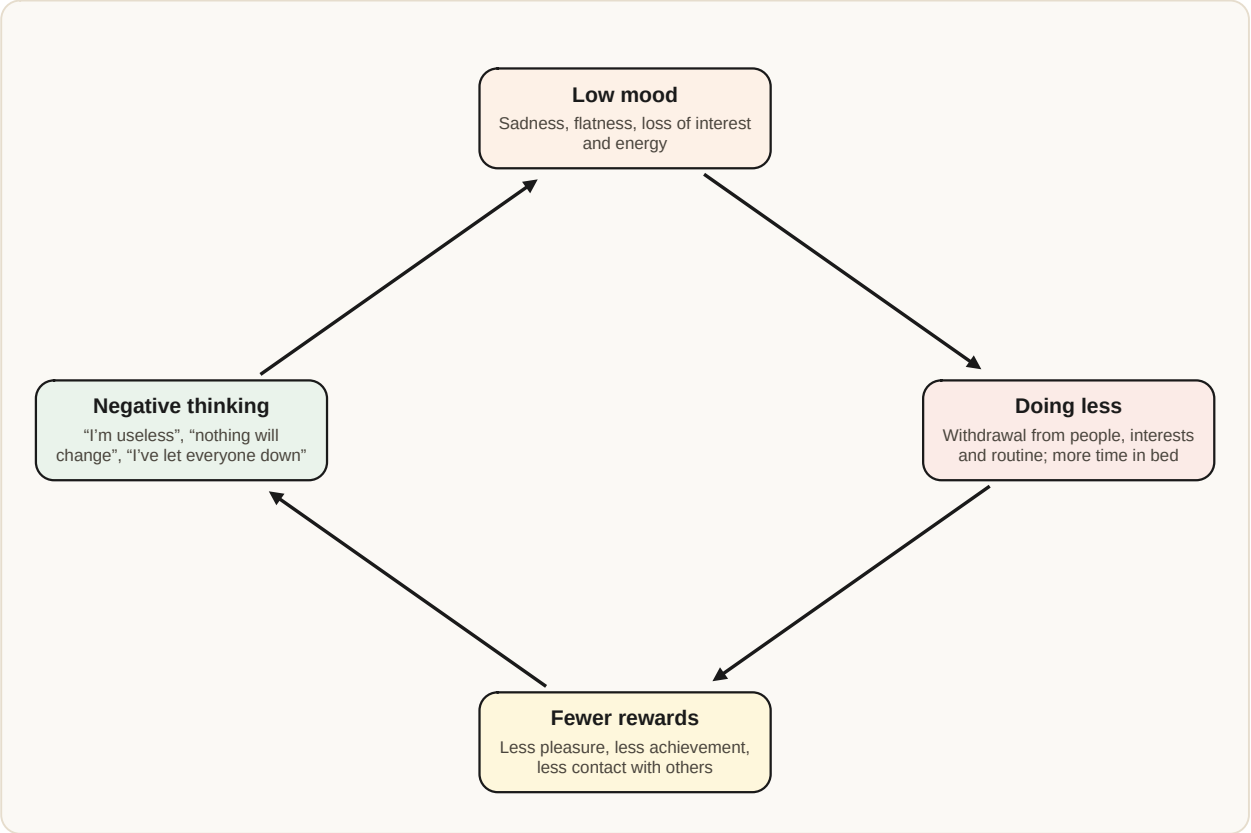



**FIGURE 1.2 How depression keeps itself going**
*The cycle the programme works on. Low mood makes everything harder, so the person does less; doing less removes the small rewards that sustain mood; their absence leaves room for self-critical and hopeless thinking; and that thinking lowers mood further. Each module enters the cycle at a different point.*

The cycle also explains the order of the modules. Behaviour comes first, in modules 2 and 3, because when mood is low it is usually easier to change what a person does than what they believe, and because activity produces the experiences that the later cognitive work can draw on. A client who has kept a coffee date they expected to dread has evidence to set against the thought "there's no point". Thinking follows, in modules 4 and 5. Module 6 turns to sleep, energy and the body, which depression erodes and which recovery depends on, and modules 7 and 8 are about keeping the gains.




**FIGURE 1.3 The eight modules and what each works on**
*Module 1 explains the cycle. Modules 2 and 3 work on behaviour, by scheduling activity and anchoring it to values; modules 4 and 5 work on thinking; module 6 works on the body; and modules 7 and 8 keep the gains. Behaviour comes first because, when mood is low, it is easier to change what a person does than what they believe.*

## How the modules are built

Each module has the same shape: a short introduction, three or four teaching sections, a practical worksheet, a summary headed “What you have learned”, and a closing reflection, “Taking this forward”, which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do in that moment. The check-in questionnaires come in modules 1, 4 and 8: the PHQ-9 and the Work and Social Adjustment Scale each time, with the GAD-7 added in module 8. The programme does not follow named characters through its modules; its examples are short and varied. The worked examples in this guide follow one composite client, Claire, through all eight contacts, so that they can be read as a single course of guided self-help.

## What the practitioner adds

The programme carries the teaching. The practitioner supplies what a text cannot: helping the client to apply the material to their own week, adjusting the size of each step so that it is achievable, noticing when the depression is talking the client out of the practice, and watching for signs that guided self-help is not enough. In depression the last of these includes asking about risk at every contact. Hopelessness and thoughts of death are part of the condition rather than rare complications of it, and Chapter 10 sets out how to ask and what to do with the answer.

CHAPTER 2

# What the research shows

## Cognitive therapy and behavioural activation

Cognitive therapy for depression was first set out as a treatment manual by Beck and colleagues (1979), and CBT has since become one of the most extensively tested psychological treatments for depression. Behavioural activation, once treated as one component of cognitive therapy, now has a substantial evidence base of its own. A meta-analysis of randomised trials found behavioural activation more effective than control conditions and comparable in effect to CBT (Ekers et al., 2014). The largest trial in the United Kingdom, COBRA, randomised 440 adults with depression to behavioural activation delivered by junior mental health workers or to CBT delivered by experienced therapists. At twelve months behavioural activation was no less effective than CBT, and the authors concluded that it can be delivered by workers with less intensive and less costly training (Richards et al., 2016).

That conclusion matters to a guided self-help programme. Behavioural activation is relatively simple to teach and to learn, and it does not depend on the client being able to work with abstract ideas while depressed. That is one reason this programme puts it first and gives it two modules, and why the contacts in modules 2 and 3 keep returning to what the client has done rather than what they have understood.

## Guided self-help

Guided self-help based on the principles of CBT is one of the established forms of treatment for depression. In comparative trials, guided self-help and face-to-face psychotherapy for depression and anxiety have been found to produce similar effects (Cuijpers et al., 2010). The National Institute for Health and Care Excellence (2022) includes guided self-help among the treatments to consider first for less severe depression, alongside group and individual CBT and behavioural activation, and asks that the choice be made with the person after discussing the options. For more severe depression the guideline gives priority to treatments with more therapist contact, such as a combination of individual CBT and an antidepressant, or individual CBT or behavioural activation.

## Sleep and the body

Module 6 explains sleep with the two-process model of sleep regulation, in which sleep pressure that builds during waking interacts with a daily rhythm set by the body clock (Borbély, 1982). The model is old but remains the most widely used account of sleep timing, and it gives clients a clear reason for the module's two central changes, a fixed wake time and morning light. For clients whose insomnia persists, cognitive behavioural therapy for insomnia (CBT-I) has good evidence: a meta-analysis of randomised trials found clinically meaningful improvements in how long people took to fall asleep and how long they lay awake during the night (Trauer et al., 2015).

### Preventing relapse

Depression often returns. Bockting and colleagues (2015) reviewed the psychological interventions that reduce the risk of relapse and recurrence, including continued or preventive cognitive therapy and mindfulness-based cognitive therapy, and argued for a lifetime approach in which prevention is planned from the start of treatment rather than added at the end. Modules 7 and 8 are the programme's version of that approach: a personal relapse prevention plan and a maintenance plan, written while the client is well.

Module 7 explains why depression recurs with the kindling hypothesis, the idea that each episode lowers the threshold for the next (Post, 1992). Practitioners should know that the support for this idea is mixed. Monroe and Harkness (2005) showed that the research fits two different accounts, one in which later episodes come to need less stress to begin and another in which they become more independent of stress altogether, and that few studies measured stress well enough to tell the two apart. The practical lesson is the same under either account, and it is the one the module draws: early warning signs matter, and early action is easier and more effective than late action.

### What the research does not show

No trial has tested this programme in its present form. The evidence above comes from therapist-delivered CBT and behavioural activation, from guided self-help in other formats, and from relapse prevention studies, mostly with adults in Europe and North America. The programme applies that evidence with care, and the stepping-up guidance in Part 2 is the safeguard for clients for whom it is not enough.