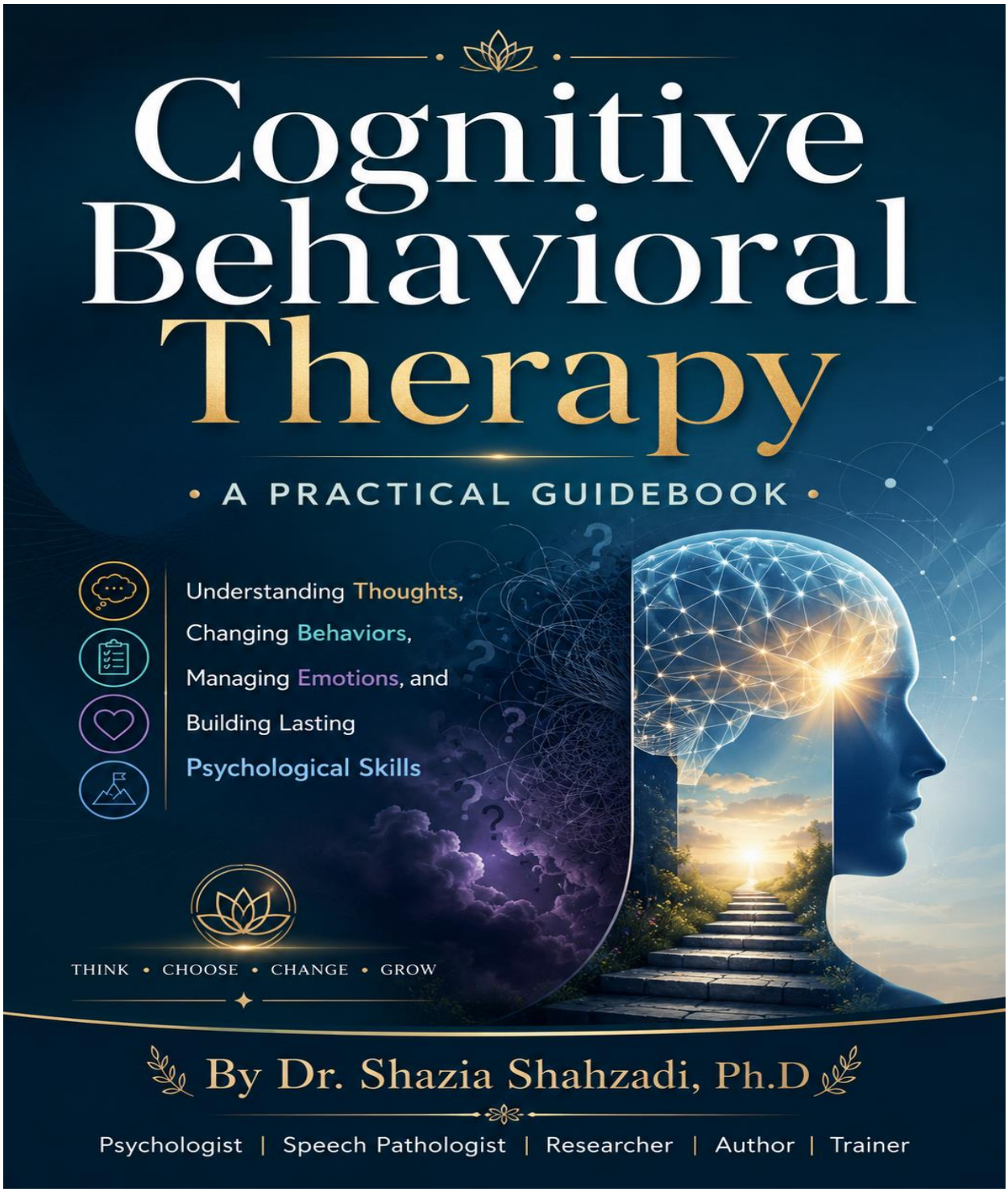
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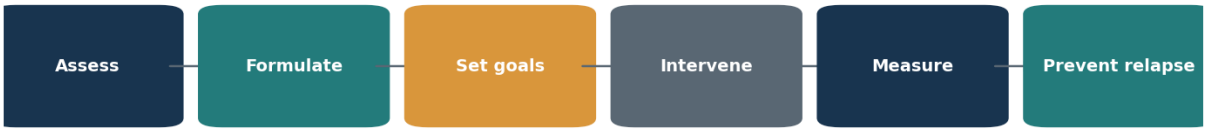
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Cognitive Behavioral Therapy in Clinical Practice

A Practical Guide to Assessment Formulation Therapeutic Sessions and Lasting Change

By Dr. Shazia Shahzadi, Ph.D.
Postdoctoral Research Fellow, MMU Malaysia

The CBT Treatment Process



CBT is a collaborative clinical process, not a collection of isolated worksheets.
Clinical and therapeutic practice edition

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FRONT MATTER

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Purpose

This book is a practical clinical guide. It does not replace professional training, supervision, an individual assessment, medical care, or an evidence-based disorder-specific treatment manual.

Urgent concerns

- Imminent risk of suicide, serious self-harm, or harm to others requires immediate risk management under local law and service procedures.
- Possible psychosis, mania, severe substance withdrawal, delirium, major cognitive change, abuse, or medical emergency requires appropriate urgent evaluation.
- Trauma processing, exposure, ERP, interoceptive exposure, and sleep restriction require competence, informed consent, and careful assessment.

The clinical cases are fictional composites. They are designed to teach reasoning without representing identifiable clients.

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FRONT MATTER

Preface

CBT explores how a person interprets events, responds emotionally and physically, and behaves next. It also examines the environment, relationships, learning history, and real problems that cannot be solved by changing thoughts alone.

Good CBT is not a debate in which the therapist proves the client wrong. Therapist and client work as investigators. They develop a shared explanation, test predictions, practice new behavior, and review what the evidence shows.

The book's clinical position

- Accuracy is more useful than forced positivity.
- Behavior change is often as important as cognitive change.
- Emotion is information, not an enemy.
- Avoidance can protect a person in the short term while limiting life in the long term.
- Treatment must fit the client's culture, language, values, safety, and circumstances.
- Outcome measurement guides decisions but never replaces judgment.

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FRONT MATTER

How to Use This Book

Reader	Recommended use
Professionals in training	Study one method, practice with supervision, and document what was learned.
Qualified clinician	Use the assessment, formulation, session, and troubleshooting guides within competence.
Client or patient	Use selected exercises with a therapist or as agreed guided practice.
Supervisor	Use cases and session guides to examine reasoning and fidelity.

A clinical learning sequence

1. Understand the principle in simple language.
2. Observe it in a case or therapeutic interaction.
3. Practice the skill in role-play or supervised work.
4. Apply it with an appropriate client.
5. Measure the result and revise the formulation.

Clinical safety: Do not apply a technique merely because it appears in a chapter. Begin with assessment, consent, suitability, and a clear therapeutic reason.

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11-15	Therapeutic relationship and assessment
16-18	Formulation, goals, and session structure
19-25	Cognitive methods
26-34	Behavioral methods

Clinical route

- For a first interview, begin at page 15.
- For formulation, begin at page 21.
- For a session structure, begin at page 27.
- For thought work, begin at page 29.
- For behavioral change, begin at page 41.

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Contents Part Two

Pages	Section
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84-96	Structured therapeutic exercises
97-100	Final assessment, evaluation, exercise bank, model answers, and evidence base

Each clinical application describes assessment priorities and treatment components. It is not a substitute for a full protocol or specialist training.

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CHAPTER 1

What CBT Really Is

Cognitive Behavioral Therapy is a family of structured psychological treatments. It connects present problems with patterns of interpretation, emotion, body response, and behavior while recognizing development, relationships, biology, and context.

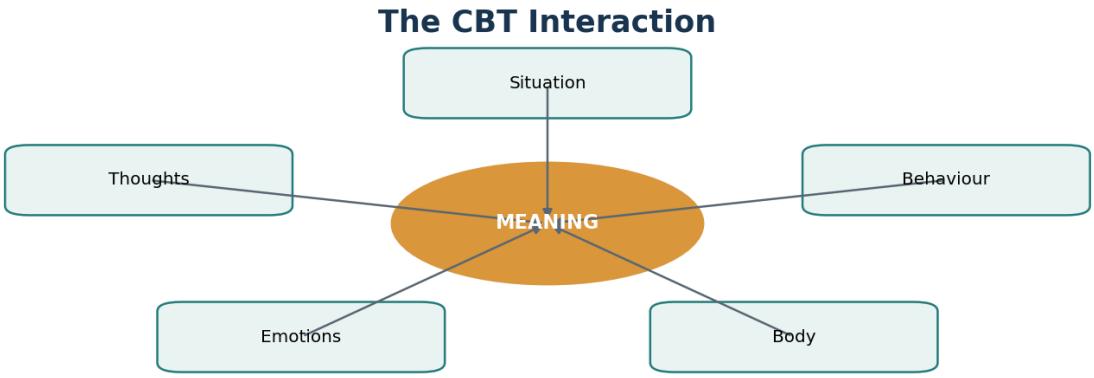


Figure 1.1 The parts of the CBT model influence one another.

Not simply positive thinking

- CBT tests thoughts rather than replacing every thought with a pleasant one.
- It addresses behavior, avoidance, habits, skills, and real-world problems.
- The client's values and goals guide change.

The Cognitive Model

People can react differently to the same event because they give it different meanings. The first thought may be fast, brief, and believable. CBT calls this an automatic thought.

Situation	Possible meaning	Likely response
A friend does not reply	"I have upset her."	Anxiety and repeated messages
A friend does not reply	"She may be busy."	Wait and continue the day
A friend does not reply	"People always leave."	Sadness and withdrawal

Mind exercise: find the missing meaning

1. Choose one recent emotional moment.
2. Write only what a camera could record.
3. Name the emotion and rate its intensity from 0 to 100.
4. Complete: "At that moment, this meant…"
5. Record what you did next.

Thoughts Feelings Body and Behavior

Part	Question	Example
Thought	What went through the mind?	"I will fail."
Emotion	What feeling appeared?	Anxiety 75/100

Part	Question	Example
Body	What sensations followed?	Tight chest and shaking
Behavior	What happened next?	Avoided the meeting
Consequence	What happened now and later?	Relief now; fear remained

The therapist looks for a change point. Sometimes cognitive reappraisal is useful. Sometimes approaching, resting, communicating, problem solving, or changing the environment is more important.

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CHAPTER 2
How Difficulties Continue

A Maintaining Cycle



Figure 2.1 A response can reduce distress now but maintain the problem later.

Maintaining processes may include avoidance, reassurance seeking, rumination, checking, withdrawal, sleep disruption, self-criticism, substance use, interpersonal patterns, and practical stress.

Map one cycle

1. Name the trigger.
2. Write the prediction or meaning.
3. Record emotion and body response.
4. Describe the coping behavior.
5. Write the short-term benefit.
6. Write the long-term cost.

Learning Beliefs and Schemas

Core beliefs are broad conclusions about the self, others, or the world. Intermediate beliefs include rules, assumptions, and attitudes. They often developed as understandable attempts to make sense of earlier experience.

Level	Example
Core belief	"I am inadequate."
Rule	"I must never make a mistake."
Assumption	"If I ask for help, people will judge me."
Coping strategy	Overprepare, hide uncertainty, avoid feedback
Cost	Exhaustion and no chance to disconfirm the belief

A formulation should explain a pattern without blaming the client.

Evidence Based and Person Centered CBT

- Use research relevant to the client's presentation.
- Combine evidence with clinical expertise and client preferences.
- Agree goals and explain the rationale for each method.
- Measure symptoms, functioning, quality of life, and goal progress.
- Adapt language and materials without losing the active treatment principles.

- Review nonresponse early rather than repeating the same task.

Clinical safety: Medication, physical illness, social danger, poverty, discrimination, grief, and relationship violence require attention. CBT must not turn real adversity into a "thinking error."

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CHAPTER 3

The Therapeutic Relationship

Warmth and collaboration are not additions to CBT. They make accurate assessment, honest feedback, and behavioral learning possible.

Therapist action	Clinical purpose
Validate experience	Shows understanding without automatically agreeing with every conclusion.
Share a rationale	Allows informed choice.
Ask rather than assume	Supports guided discovery.
Invite feedback	Detects misunderstanding and rupture.
Adjust pace	Keeps work tolerable and useful.

Therapist reflection

1. What did the client need me to understand?
2. Where did I move too quickly?
3. What did the client disagree with?
4. How will I check the alliance next session?

Guided Discovery and Socratic Questions

Guided discovery helps the client examine experience and reach a personally meaningful conclusion. Socratic questioning is curious, focused, and nonjudgmental.

- What happened just before the feeling changed?
- What went through your mind?
- What makes that conclusion understandable?
- What evidence supports it? What does not fit?
- What would you say to someone you care about?
- How could we test this safely?

Questions should not become cross-examination. Reflection, summaries, silence, and emotion-focused listening remain important.

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Cultural Humility in CBT

Ask about	Examples
Meaning	How does the client's community understand the problem?
Language	Which words best describe distress and recovery?
Identity	Which identities shape safety belonging and expectations?
Religion or spirituality	Is faith a resource conflict or both?
Family	Who participates in decisions and support?
Power and context	What discrimination financial pressure or danger is present?

Adapt examples, metaphors, goals, and delivery collaboratively. Do not label culturally expected beliefs as cognitive distortions without understanding their context.

CLINICAL ASSESSMENT

The First CBT Assessment

Assessment should explain the client's difficulties, strengths, risks, context, and maintaining processes. A score alone is not a formulation.

Area	Clinical focus
History	presenting problem, onset, course, previous treatment, medication, medical history, development, relationships, work, sleep, substances, strengths and priorities
Domains	symptoms, emotions, thoughts, behavior, physical responses, functioning, supports, risk and protective factors
Methods	clinical interview, observation, appropriate diagnostic assessment, validated measures, records and collateral information with consent
Decision	working hypotheses, immediate safety actions, referrals, suitability for CBT, and questions still unanswered

Interpretation checks

- Use validated measures only for their intended purpose.
- Consider culture, language, health, medication, sleep, substance use, and life conditions.
- Compare self-report, interview, observation, and change over time.
- State uncertainty and arrange referral when the presentation is outside competence.

CLINICAL ASSESSMENT

Risk Assessment and Safety Planning

Risk assessment is a continuing process, not a single form. Ask directly, calmly, and specifically when concern is present.

Area	Examples to explore
Suicide or self-harm	thoughts intent plan access past behavior triggers deterrents
Harm to others	thoughts intent targets access impulse control
Vulnerability	abuse exploitation neglect domestic violence safeguarding
Mental state	psychosis mania severe agitation intoxication withdrawal
Protective factors	relationships beliefs responsibilities reasons for living access to care

Clinical safety: Follow local law, safeguarding duties, documentation standards, and emergency procedures. A written safety plan does not replace clinical action when imminent risk is present.

CLINICAL ASSESSMENT

Mental State and Functional Review

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Domain	Observe or ask
Appearance and behavior	engagement movement self-care eye contact as culturally appropriate
Speech and thought	rate form coherence content and preoccupation
Mood and affect	reported mood range reactivity congruence
Perception	hallucinations dissociation unusual experiences
Cognition	orientation attention memory and executive function
Insight and judgment	understanding decisions and ability to use support
Function	self-care work relationships parenting sleep and daily routine

Record observations precisely. Avoid vague labels such as “normal” or “poor.”

CLINICAL ASSESSMENT

Outcome Measures

Measures can support screening, baseline description, progress monitoring, and shared decisions. They do not diagnose on their own.

- Choose measures with suitable validity, language, and licensing.
- Explain why the measure is being used.
- Review item-level risk responses, not only the total score.
- Plot change against goals and functioning.
- Consider reliable change, deterioration, and nonresponse.
- Discuss results with the client in plain language.

Measurement plan

1. Select one symptom measure.
2. Select one functioning or quality-of-life measure.
3. Select one personal goal measure.
4. Decide when each will be repeated.
5. Write what result would lead to a plan change.

CLINICAL ASSESSMENT

Suitability and Treatment Planning

Question	Why it matters
Is CBT relevant to the formulation?	A diagnosis alone does not choose the method.
Can the client participate now?	Acute risk intoxication mania or cognitive impairment may change priorities.
What adaptations are needed?	Language literacy disability age and culture affect access.
Is specialist treatment required?	Trauma ERP eating disorders psychosis and complex comorbidity may require expertise.
What does the client prefer?	Choice supports consent and engagement.

A treatment plan should name the target problem, proposed method, expected monitoring, foreseeable risks, alternatives, and review point.

CHAPTER 4

What a CBT Formulation Does

A formulation is a shared, testable explanation of why this client has these problems now and what keeps them going. It guides treatment and changes when new evidence appears.

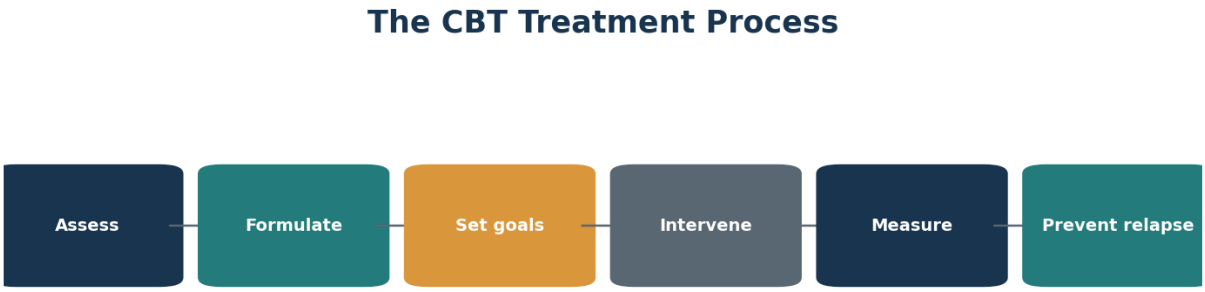


Figure 4.1 Assessment and formulation guide intervention and review.

A useful formulation

- is specific to the client
- connects past learning with present patterns without overexplaining
- includes strengths and protective factors
- shows maintaining cycles
- suggests clear intervention points
- is understandable and acceptable to the client

The Five Areas Formulation

Area	Example question
Situation	Where when and with whom does the problem occur?
Thoughts and images	What prediction memory or meaning appears?
Emotions	Which feelings and intensities follow?
Physical sensations	What happens in the body?
Behavior	What does the client do avoid or seek?

Collaborative map

1. Choose one recent example.
2. Fill each area using the client's words.
3. Draw arrows showing influence.
4. Circle one maintaining process.
5. Ask the client what fits and what is missing.

Longitudinal Formulation

Part	Clinical question
Early experience	What learning history may be relevant?
Core beliefs	What broad conclusion formed?

Part	Clinical question
Rules and assumptions	What conditions or standards developed?
Coping strategies	How did the person protect themselves?
Critical incidents	What activated the pattern recently?
Maintaining processes	What keeps it going now?
Strengths	What resources challenge the pattern?

Past experience informs the map, but therapy does not require a speculative story presented as fact.

Formulation as a Hypothesis

Treat every arrow as a hypothesis. Ask what evidence would support or weaken it. Formulation errors often occur when therapists confuse a familiar model with the client's actual pattern.

Quality questions

- Does the map explain the client's main difficulties?
- Does it include external and interpersonal factors?
- Can the client recognize themselves in it?
- Does it suggest why the problem persists?
- Does it lead to an intervention that can be evaluated?
- What alternative formulation should remain open?

One-sentence formulation

1. Write: "When ___ happens, the client predicts ___, feels ___, and responds by ___, which helps briefly but maintains ___."
2. Add one strength or protective factor.

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CHAPTER 5
Goals That Can Guide Therapy

Vague wish	Workable clinical goal
Feel better	Return to two valued weekly activities and monitor mood.
Stop anxiety	Complete agreed approach tasks while reducing avoidance.
Think positively	Evaluate a recurrent prediction using evidence and experiments.
Be confident	Speak once in each team meeting with planned coping.

Goal checks

- owned by the client
- linked to functioning or quality of life
- specific enough to measure
- realistic for the treatment period
- reviewed when circumstances change

Planning Treatment From Formulation

Intervention order matters. Immediate safety, stabilization, sleep, substance use, practical barriers, and engagement may need attention before deeper cognitive or exposure work.

Maintaining process	Possible intervention
Withdrawal and loss of reward	Behavioral activation
Catastrophic misinterpretation	Cognitive reappraisal and behavioral experiment
Avoidance	Graded approach or exposure
Compulsion	Exposure and response prevention by trained clinician
Rumination	Attention shift behavioral activation and process-focused work
Skill deficit	Problem solving communication or other skills training

Structuring a Therapeutic Session

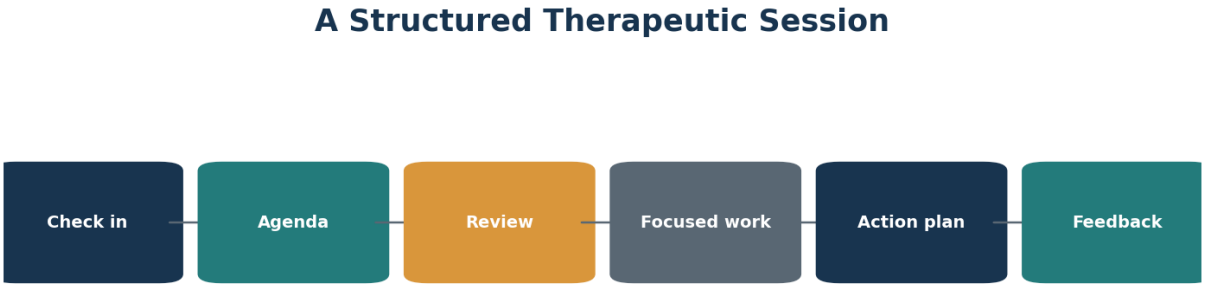


Figure 5.1 Structure supports focus while allowing clinical flexibility.

A session is collaborative rather than mechanical. Crisis, major new information, or rupture may require a different agenda.

Useful habits

- agree priorities rather than impose them
- link work to the formulation and goals
- practise during the session
- summarize learning in the client's words
- agree an action plan with likely barriers
- ask what was useful and what should change

THERAPEUTIC SESSION GUIDE

A Complete CBT Session

This template fits many routine sessions after assessment and formulation.

Session sequence

1. Complete a brief check-in and risk update.
2. Review symptom, function, and goal indicators.
3. Agree a short agenda.
4. Review the previous action plan with curiosity.
5. Complete one focused intervention or skills practice.
6. Summarize the learning.
7. Agree a specific action plan and problem-solve barriers.
8. Invite feedback about the session.

Evaluate the session

Record the client's main learning, observed response, agreed action, risk update, and whether the formulation changed.

CHAPTER 6

Finding Automatic Thoughts

Automatic thoughts may be words, images, memories, predictions, or meanings. They are easiest to identify near a change in emotion.

Down to the moment

1. Choose a recent specific event.
2. Replay the moment slowly.
3. Ask: "What went through your mind just then?"
4. If no words appear, ask about an image or feared meaning.
5. Rate belief from 0 to 100.
6. Link the thought with emotion and behavior.

Do not invent a thought for the client. Offer tentative summaries and ask whether they fit.

Images Memories and Meanings

Experience	Therapist question
Mental image	"What picture appeared in your mind?"
Memory	"Did this remind you of another time?"
Prediction	"What did you fear would happen next?"
Meaning	"If that were true, what would it say about you?"
Emotion	"Which feeling changed and how strongly?"

Clinical safety: Distressing imagery or trauma memories may require pacing, grounding, and specialist competence. Do not intensify exposure accidentally during simple thought monitoring.

Thinking Patterns Without Labels

Terms such as catastrophizing, mind reading, all-or-nothing thinking, selective attention, overgeneralization, emotional reasoning, and rigid "should" rules can help describe patterns. They should not be used to dismiss the client.

Pattern	Plain question
Mind reading	What do I know and what am I assuming?
Catastrophizing	What is the feared outcome and how would I cope?
All or nothing	What lies between the two extremes?
Emotional reasoning	Does feeling unsafe prove danger?
Overgeneralization	How broad is the conclusion compared with the evidence?

Evidence Review

Balanced evidence

1. Write the exact thought.
2. Rate belief from 0 to 100.
3. List evidence that supports it.
4. List information that does not fit or suggests limits.
5. Separate facts from interpretations.
6. Write a balanced conclusion that includes both sides.
7. Rerate belief and emotion.

A balanced thought does not need to be comforting. It needs to be more accurate, flexible, and useful.

Alternative Perspectives

- What are three possible explanations?
- How would a trusted person view this?
- What would I say to another client in this situation?
- What information might I be missing?
- If the feared event happened, what resources could I use?
- Will this matter in one week, six months, or five years?

New mind exercise: three lenses

1. Write the harshest interpretation.
2. Write the most hopeful interpretation.
3. Write the most evidence-based interpretation.
4. Choose an action that fits the evidence-based view.

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CHAPTER 6

Probability and Cost

Question	Purpose
What exactly is predicted?	Makes the fear testable.
What base-rate or past evidence exists?	Reduces vague certainty.
What factors increase or reduce likelihood?	Improves accuracy.
What would be difficult if it happened?	Acknowledges real cost.
How could the client cope?	Reduces confusion between possibility and helplessness.

Low probability does not mean zero probability. Therapy helps the client make proportionate decisions, not demand certainty.

De-catastrophizing

Face the feared story carefully

1. Name the feared event in one sentence.
2. Separate the worst, best, and most likely outcomes.
3. Estimate likelihood for each.
4. If the feared outcome occurred, list immediate and later coping steps.
5. Identify people and services that could help.
6. Choose one proportionate action now.

Clinical safety: Use this method carefully with genuine danger. Safety planning and practical action come before reframing.

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The Simple Thought Record

Situation	Thought	Emotion 0–100	Response
What happened?	What went through my mind?	What did I feel?	What did I do?

Clinical use

1. Complete one real example in the session.
2. Check that the situation is specific.
3. Use the client's exact thought.
4. Name emotions rather than broad words such as "bad."
5. Look for a maintaining behavior.
6. Decide whether further evaluation or a behavioral test is useful.

The Full Thought Record

Step	Entry
Situation	
Automatic thought or image and belief %	

Step	Entry
Emotion and intensity	
Evidence supporting	
Evidence not supporting or limiting	
Balanced response	
New belief and emotion rating	
Next helpful action	

A thought record is useful when it changes understanding or action. It becomes unhelpful when completed mechanically, used for reassurance, or assigned beyond the client's capacity.

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CHAPTER 7

Core Beliefs

Core beliefs are broad and deeply felt, but they are not permanent facts. They are often activated selectively and supported by biased attention, memory, and coping.

Belief	Possible maintaining strategy
I am unlovable	Withdraw or seek repeated reassurance
I am incompetent	Avoid challenges or over-prepare
I am unsafe	Monitor threat and avoid uncertainty
Others cannot be trusted	Keep distance and test relationships

Work begins with compassion, developmental understanding, and present evidence—not confrontation.

Rules and Assumptions

Find the hidden rule

1. Choose a repeated difficult situation.
2. Ask: "What must I do to prevent the feared outcome?"
3. Write the rule using must, should, always, or never.
4. Identify how the rule once helped.
5. Identify its current cost.
6. Write a flexible alternative.
7. Design one small test of the new rule.

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Strengthening a Balanced Belief

New mind exercise: evidence portfolio

1. Write the old belief and a balanced alternative.
2. Define what would count as evidence for the alternative.
3. Record small daily examples, including effort and coping.
4. Ask trusted people for specific observations when appropriate.
5. Act once each week in line with the balanced belief.
6. Review the evidence without demanding perfection.

The aim is not to replace one absolute statement with another. A balanced belief can include limits, learning, and context.

CHAPTER 8

Why Behavior Changes Emotion

Action affects mood, attention, learning, confidence, and access to reward. Waiting to feel ready can keep a client trapped. CBT often uses planned action to create new evidence.

Pattern	Behavioral direction
Withdrawal	Reconnect with routine and valued activity
Avoidance	Approach in manageable steps
Reassurance	Build independent uncertainty tolerance
Inactivity	Use graded tasks and scheduling
Skill gap	Teach rehearse and generalize the skill

Behavioral Activation

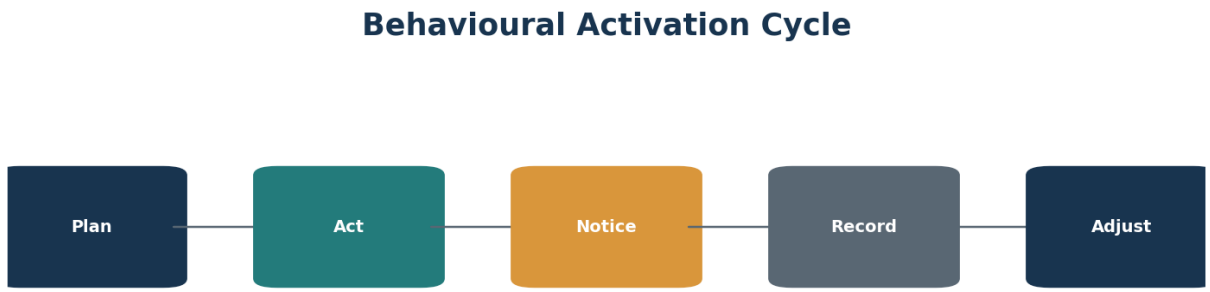


Figure 8.1 Behavioral activation uses planned action and review.

Activation is not "stay busy." It identifies patterns between activity and mood, reduces avoidance, reconnects the client with values, and builds pleasure, mastery, or connection.

Clinical safety: Assess suicide risk, bipolar-spectrum symptoms, substance use, physical health, and severe exhaustion. Activity planning must fit clinical status.

THERAPEUTIC SESSION GUIDE

Behavioral Activation Session

Use the client's activity and mood pattern to choose one meaningful, achievable next action.

Session sequence

1. Review the past week hour by hour or by key periods.
2. Identify withdrawal, rumination, and moments of improved mood or mastery.
3. Choose one valued area.
4. Break one activity into the smallest workable step.
5. Schedule when where and with whom.
6. Predict mood and barriers.
7. Agree how completion and learning will be recorded.

Evaluate the session

Review completion without blame. If the task was not attempted, examine the plan, barrier, prediction, and formulation.

Activity Monitoring and Scheduling

Time or situation	Activity	Mood 0–100	Pleasure	Mastery	Learning

Clinical tips

- Record enough to see patterns; do not create an exhausting diary.
- Rate experience after the activity, not only before.
- Include rest, care, connection, routine, and values.
- Use graded steps when initiation is difficult.
- Distinguish restorative rest from withdrawal that deepens depression.

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CHAPTER 9

Avoidance and Safety Behaviors

Avoidance prevents feared outcomes but also prevents new learning. Safety behaviors may include checking, carrying a "rescue" object, rehearsing excessively, staying near exits, speaking quietly, or relying on reassurance.

Function analysis

1. Describe the behavior precisely.
2. What threat is it meant to prevent?
3. What short-term relief follows?
4. What does the client never learn because of it?
5. Is it genuinely protective or unnecessarily restrictive?
6. What graded reduction could be tested?

Exposure Principles

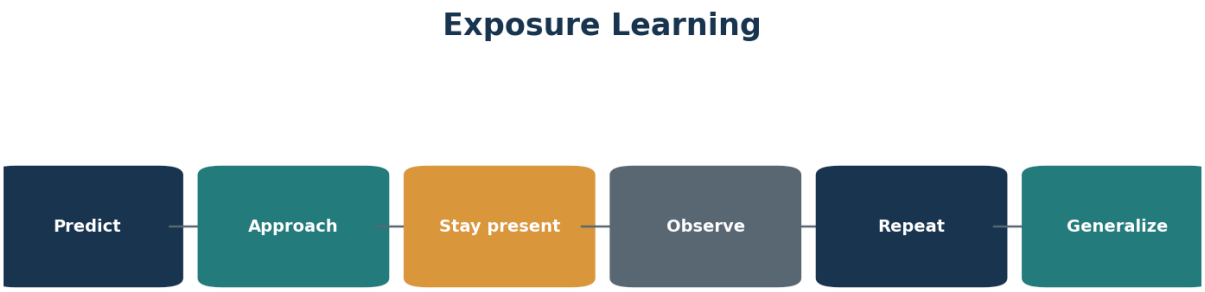


Figure 9.1 Exposure creates new learning through approach and repetition.

- Choose targets from a clear formulation.
- Obtain informed consent and explain discomfort.
- Create learning goals rather than a demand for zero anxiety.
- Vary contexts and reduce unnecessary safety behaviors.
- Remain long enough to gather evidence, guided by the protocol.
- Review what happened versus what was predicted.

Clinical safety: Exposure is not flooding a client without choice. Specialist protocols apply to OCD, PTSD, panic, and other conditions.

Building an Exposure Hierarchy

Situation	Prediction	Distress 0–100	Safety behavior	Learning goal

Create the ladder

1. List avoided situations from easier to harder.
2. Make each step specific and repeatable.
3. Record the feared outcome, not only distress.
4. Choose a challenging but workable starting point.
5. Agree what safety behavior will be reduced.

6. Plan repetition and generalization.

THERAPEUTIC SESSION GUIDE

Reviewing Exposure

Exposure review turns an experience into learning rather than a test of bravery.

Session sequence

1. Record the exact prediction before exposure.
2. Complete the planned task with agreed support.
3. Observe sensations thoughts urges and external events.
4. Record what actually happened.
5. Name any safety behaviors used.
6. Write the new learning in the client's words.
7. Plan the next repetition or variation.

Evaluate the session

Measure prediction outcome, approach, safety-behavior reduction, and learning. Anxiety reduction may occur, but it is not the only outcome.

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CHAPTER 10
Behavioral Experiments



Figure 10.1 A behavioral experiment tests a belief under planned conditions.

Experiments differ from ordinary practice because they begin with a clear prediction and end with a conclusion based on observation.

Weak plan	Stronger plan
"Be more social."	Ask one colleague a question and observe the response.
"Try not to worry."	Delay one reassurance check for 20 minutes and record the outcome.
"Be confident."	State one opinion without apologizing and compare prediction with result.

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THERAPEUTIC SESSION GUIDE
Designing a Behavioral Experiment

The therapist and client design a fair, ethical, and safe test of a belief.

Session sequence

1. Write the belief and belief rating.
2. State a specific prediction with observable criteria.
3. Identify alternative outcomes.
4. Design the smallest valid test.
5. Specify safety limits and what will be recorded.
6. Complete or rehearse the test.
7. Compare result with prediction.
8. Update the belief and next step.

Evaluate the session

A useful experiment produces information even when the feared outcome partly occurs. Avoid designing a test that depends on controlling another person.

Problem Solving
Six-step method

1. Define one solvable problem in specific terms.
2. Separate changeable and unchangeable parts.
3. Generate several options before judging them.
4. Compare benefits, costs, risks, and values.

5. Choose the first practical step and time.
6. Review the result and revise.

Problem solving is appropriate when distress reflects a real, manageable problem. Cognitive restructuring should not replace action on housing, finances, safety, health, or relationship decisions.

Skills Training

Need	Possible clinical practice
Assertiveness	Clear request refusal or boundary statement
Communication	Listening summary and repair
Emotion regulation	Naming pacing grounding and action choice
Organization	Priorities steps reminders and review
Relaxation	Applied breathing or muscle release when clinically appropriate
Self-compassion	Responding to pain without attack or avoidance

Teach one skill, model it, practise it in the session, give specific feedback, and plan real-life use. Do not label a problem as a skill deficit without assessment.

Action Plans Between Sessions

Between-session practice helps therapy enter daily life. The plan should be collaborative, relevant, and small enough to complete.

Plan element	Question
Task	What exactly will the client do?
Reason	How does it test the formulation or support the goal?
Time and place	When and where?
Barrier	What may interfere?
Support	What reminder cue or person may help?
Record	What outcome or learning will be noted?

Review incomplete practice with curiosity. Non-completion is clinical information, not disobedience.

Relaxation Grounding and Attention

Breathing, muscle relaxation, sensory grounding, and attention training can support regulation. They may be misused if the client believes anxiety is dangerous and must always be removed.

Use with a purpose

1. Name the target: regulation, present focus, sleep preparation, or skill rehearsal.
2. Explain that discomfort may remain.

3. Practice briefly in the session.
4. Ask what changed and what did not.
5. Decide where the skill helps and where approach learning is more useful.

Clinical safety: Some trauma, panic, respiratory, pain, or medical presentations require adaptation. Stop if the method increases distress or symptoms.

CLINICAL APPLICATIONS

CBT for Depression

Depression may involve low mood, loss of interest, reduced energy, hopelessness, self-criticism, sleep or appetite change, and impaired function.

Assessment focus

- severity duration courses and previous episodes
- suicide and self-harm risk
- bipolar-spectrum symptoms psychosis substances and medical contributors
- activity withdrawal rumination and life stress
- function strengths support and treatment preference

Common CBT components

- behavioral activation and graded tasks
- problem solving
- work with hopeless automatic thoughts and self-criticism
- routine sleep and social reconnection
- relapse-prevention planning

Clinical safety: Severe risk, psychosis, catatonia, mania, inability to care for self, or major medical concern requires urgent or specialist care.

THERAPEUTIC SESSION GUIDE

Depression Activation Session

Begin with one behavior linked to withdrawal and reduced reward.

Session sequence

1. Review risk mood function and the previous plan.
2. Map one depression-withdrawal cycle.
3. Identify one valued area that has narrowed.
4. Choose a small activity with a clear time and place.
5. Predict difficulty pleasure and mastery.
6. Problem-solve energy and practical barriers.
7. Agree a simple record.

Evaluate the session

At review, compare prediction with actual mood, mastery, and learning. Adjust task size rather than interpreting difficulty as failure.

CLINICAL APPLICATIONS

Depression Cognitive Work

Theme	Balanced clinical direction
Hopelessness	Examine time frame exceptions and next

Theme	Balanced clinical direction
	controllable step.
Worthlessness	Separate global identity from specific difficulty.
Guilt	Assess responsibility intention context repair and proportion.
Self-criticism	Compare effect of attack with constructive accountability.
Rumination	Notice the process and shift toward action or problem solving.

New mind exercise: specific not global

1. Write the global conclusion.
2. Name the exact event that triggered it.
3. Describe one limited difficulty.
4. Add context strengths and what can be learned.
5. Choose a repairing or constructive action.

CLINICAL APPLICATIONS

CBT for Generalized Anxiety and Worry

Generalized anxiety often involves repeated future-oriented worry across several areas, difficulty tolerating uncertainty, tension, sleep disruption, reassurance, and mental over-preparation.

Assessment focus

- worry topics triggers duration and controllability
- positive and negative beliefs about worry
- avoidance reassurance checking and rumination
- sleep substances medical factors and depression
- risk function and cultural context

Common CBT components

- worry awareness and formulation
- distinguish solvable problems from hypothetical worry
- problem solving for current problems
- behavioral experiments about uncertainty and worry beliefs
- graded reduction of reassurance and avoidance

Clinical safety: Rule out urgent medical issues and assess depression, suicide risk, substance use, and other anxiety or trauma presentations.

THERAPEUTIC SESSION GUIDE

Worry Session

Help the client distinguish productive action from repetitive hypothetical thinking.

Session sequence

1. Select one recent worry episode.
2. Identify trigger prediction emotion and coping response.

3. Ask whether the problem is current and solvable.
4. If solvable, use a specific action plan.
5. If hypothetical, practice noticing uncertainty without extended analysis.
6. Test one reassurance or checking behavior.
7. Record what happened.

Evaluate the session

Evaluate time spent worrying, functional impact, behavior change, and the client's ability to act without certainty.

CLINICAL APPLICATIONS

The Worry Decision

Question	Direction
Is the problem happening now?	Define the practical problem.
Can action be taken?	Use problem solving and schedule the step.
Is it a future possibility?	Name the uncertainty and return attention to the present task.
Is reassurance being sought?	Test delay or reduction where safe.
Is worry being used to feel prepared?	Design an experiment comparing worry with planned action.

The goal is not to guarantee that feared events cannot occur. It is to respond proportionately while living with ordinary uncertainty.

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CLINICAL APPLICATIONS

CBT for Panic and Agoraphobia

Panic involves sudden intense fear with physical sensations and catastrophic interpretations. Agoraphobic avoidance develops when situations are feared because escape or help may feel difficult.

Assessment focus

- panic symptoms onset frequency triggers and unexpected attacks
- catastrophic meanings of sensations
- avoidance escape and safety behaviors
- medical conditions medication caffeine and substances
- risk function and comorbidity

Common CBT components

- panic psychoeducation
- intero-ceptive exposure by a competent clinician
- in-situation exposure
- behavioral experiments and safety-behavior reduction
- cognitive work on catastrophic interpretations

Clinical safety: New chest pain, fainting, neurological signs, significant breathing difficulty, or other concerning symptoms need medical evaluation. Do not assume every symptom is anxiety.

CLINICAL APPLICATIONS

The Panic Cycle



Figure 11.1 Catastrophic interpretation can intensify ordinary or anxiety-related sensations.

Map a panic episode

1. Record the first sensation.
2. Write the feared meaning.
3. Name the attention shift or monitoring.
4. List escape and safety behaviors.
5. Record the immediate effect.
6. Identify what the client did not learn.

THERAPEUTIC SESSION GUIDE

Panic Learning Session

This session prepares a formulation-based behavioral test. Interoceptive exercises require competence and medical consideration.

Session sequence

1. Review health information and suitability.
2. Explain the panic cycle collaboratively.
3. Choose one feared sensation or situation.
4. Write the catastrophic prediction.
5. Agree a safe protocol and stop rules.
6. Complete the exercise or in-situation test.
7. Compare outcome with prediction.
8. Plan repetition and reduction of safety behaviors.

Evaluate the session

Record feared outcome, actual outcome, new learning, and any clinical or medical concern.

CLINICAL APPLICATIONS

CBT for Social Anxiety

Social anxiety involves fear of negative evaluation, self-focused attention, anticipatory worry, avoidance, safety behaviors, and post-event rumination.

Assessment focus

- feared situations predictions and images
- self-focused attention and perceived self-image
- avoidance and subtle safety behaviors
- post-event processing and standards
- depression risk substances and function

Common CBT components

- individualized cognitive model
- attention training toward the interaction
- behavioral experiments
- video or other feedback when appropriate
- graded approach and reduced safety behaviors

Clinical safety: Respect cultural communication norms. Do not define quietness, modesty, accent, or limited eye contact as pathology without functional assessment.

THERAPEUTIC SESSION GUIDE

Social Anxiety Experiment

Test one feared social prediction while reducing one safety behavior.

Session sequence

1. Choose a specific situation.
2. Write the predicted judgment and how it would be detected.
3. Identify self-focused attention and safety behavior.
4. Plan an outward attention task.
5. Complete a role-play or real experiment.
6. Collect observable data.
7. Review post-event rumination and balanced learning.

Evaluate the session

Do not use the absence of obvious criticism as the only evidence. Review participation, attention, behavior, and tolerance of uncertainty.

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CLINICAL APPLICATIONS

Social Anxiety New Mind Exercise

Observer versus participant

1. Describe what the client imagines others see.
2. List the cues used to support that image.
3. Shift attention to three external details during a brief interaction.
4. Record what the other person actually did.
5. Compare imagined appearance with observable evidence.
6. Choose one safety behavior to reduce next time.

The aim is not to prove everyone approves. It is to reduce distorted self-monitoring and support valued participation.

CLINICAL APPLICATIONS

CBT for Obsessive Compulsive Disorder

OCD includes intrusive thoughts, images, or urges and compulsions or mental rituals intended to reduce distress or prevent feared outcomes.

Assessment focus

- obsessions overt and covert compulsions
- avoidance reassurance and family accommodation
- time impairment insight and responsibility beliefs
- risk including self-harm assessment without confusing intrusive content with intent
- depression tic symptoms and comorbidity

Common CBT components

- specialist psychoeducation
- exposure and response prevention
- reduction of reassurance and accommodation
- work on inflated responsibility threat and certainty beliefs
- relapse-prevention practice

Clinical safety: ERP should be delivered by a clinician competent in OCD. Do not provide reassurance that becomes part of the compulsion cycle.

CLINICAL APPLICATIONS

The OCD Cycle

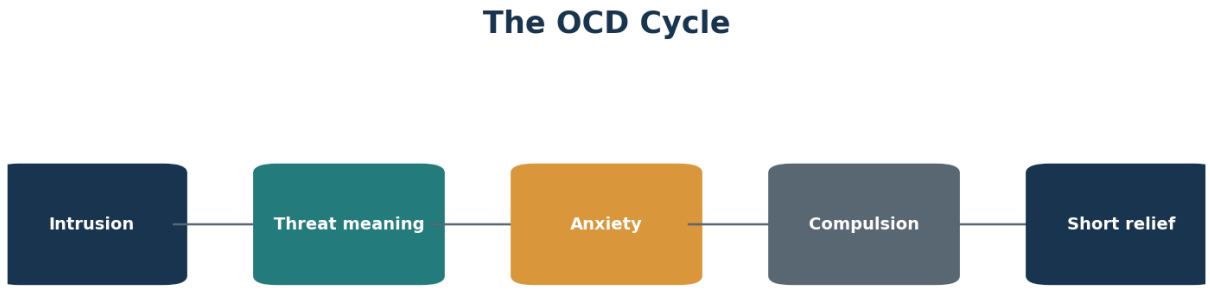


Figure 12.1 Compulsions reduce distress briefly and strengthen the cycle.

Possible compulsion	May be hidden as
Checking	reviewing memory or asking others
Washing	mental cleansing or avoiding contact
Repeating	redoing until it feels right
Neutralizing	praying counting or replacing a thought
Reassurance	researching confessing or repeated questions

THERAPEUTIC SESSION GUIDE

ERP Planning Session

ERP pairs planned contact with a trigger and prevention of the ritual so new learning can occur.

Session sequence

1. Confirm diagnosis formulation readiness and consent.
2. Build a hierarchy based on triggers and rituals.
3. Choose a workable target.
4. Write the feared outcome and learning goal.
5. Specify all overt and covert rituals to prevent.
6. Plan therapist support and repetition.
7. Complete only within competence or rehearse the plan.
8. Review learning without reassurance.

Evaluate the session

Track exposure completion, rituals resisted or delayed, distress tolerance, functioning, and new learning not perfect certainty.

CLINICAL APPLICATIONS

CBT and Trauma Related Problems

Trauma-related problems may involve intrusive memories, avoidance, hyper-arousal, negative beliefs, shame, dissociation, sleep problems, and altered safety.

Assessment focus

- trauma exposure symptoms onset and function
- current safety and ongoing threat
- suicide self-harm substances psychosis and dissociation
- medical needs social support and legal context
- readiness preferences and previous treatment

Common CBT components

- evidence-based trauma-focused CBT protocol when indicated
- psychoeducation and collaborative formulation
- memory and meaning work within the protocol
- reducing avoidance and rebuilding life
- relapse and safety planning

Clinical safety: Trauma-focused treatment requires competence and should not begin from a generic worksheet. Stabilize immediate safety and coordinate care when needed.

CLINICAL APPLICATIONS

Trauma Informed Preparation

Prepare	Clinical question
Safety	Is threat current or historical?
Consent	Does the client understand options and possible distress?
Regulation	Can the client remain sufficiently present?
Dissociation	What signs and response plan are needed?
Support	What resources exist between sessions?
Protocol	Which evidence-based treatment fits and is the clinician trained?

Avoidance can maintain PTSD, but pacing is not avoidance when it protects safety, consent, and treatment engagement.

THERAPEUTIC SESSION GUIDE

Trauma Focused Session Safety

This is a preparation and review guide, not a stand-alone trauma-processing protocol.

Session sequence

1. Update risk current safety and significant symptoms.
2. Review the shared trauma formulation.
3. Confirm consent and the agreed protocol stage.
4. Identify signs that require slowing or grounding.
5. Complete the protocol-specific task within competence.
6. Orient fully to the present before ending.
7. Review learning and post-session support.
8. Document risk response and plan.

Evaluate the session

Evaluate PTSD symptoms, functioning, dissociation, risk, avoidance, treatment fidelity, and client feedback.

CLINICAL APPLICATIONS

CBT for Insomnia

CBT for insomnia addresses sleep-related habits, timing, arousal, and beliefs. It is more than general sleep hygiene.

Assessment focus

- sleep schedule variability and opportunity
- sleep onset awakenings early waking and daytime effect
- medication substances pain breathing movement and medical disorders
- mood bipolar risk trauma and safety
- sleep diary and client goals

Common CBT components

- stimulus control and consistent scheduling
- sleep-window intervention by a trained clinician
- cognitive work on sleep effort and predictions
- wind-down and arousal-management methods
- relapse planning

Clinical safety: Sleep restriction or compression may increase sleepiness and risk. Assess driving, falls, epilepsy, bipolar disorder, pregnancy, medical illness, and occupational hazards.

CLINICAL APPLICATIONS

Sleep Diary and Formulation

Record	Purpose
Bed and rise time	Shows sleep opportunity and timing.
Estimated sleep onset	Identifies prolonged wakefulness.
Night waking	Estimates continuity.
Naps and substances	Identifies behavioral contributors.
Daytime function	Connects sleep with impairment.
Sleep effort and worry	Shows cognitive arousal.

Use estimates rather than clock-watching during the night. Review the pattern across several days instead of judging one night.

THERAPEUTIC SESSION GUIDE

Insomnia Session

Build an individualized behavioral and cognitive sleep plan after assessment.

Session sequence

1. Review the diary and medical concerns.
2. Explain the client's sleep-maintaining cycle.
3. Agree consistent rise time and other protocol elements.
4. Address time awake in bed within the chosen method.
5. Review sleep-related worry and effort.
6. Plan safety for daytime sleepiness.
7. Agree monitoring and follow-up.

Evaluate the session

Monitor sleep efficiency or continuity as clinically appropriate, daytime function, adherence, adverse effects, and mood activation.

CLINICAL APPLICATIONS

CBT for Stress and Anger

Stress and anger may signal overload, threat, injustice, frustration, or blocked goals. Assessment should examine triggers, meanings, arousal, behavior, consequences, and safety.

Focus	Possible intervention
Overload	priorities boundaries and problem solving
Threat interpretation	evidence review and perspective
Arousal	early cue detection and applied regulation
Aggressive behavior	time-out safety communication and specialist work
Rumination	attention shift and constructive action

Clinical safety: Threats, violence, coercive control, weapon access, or child and partner safety concerns require direct risk management and safeguarding—not only anger skills.

CLINICAL APPLICATIONS

Perfectionism

Clinical perfectionism ties self-worth closely to demanding standards despite significant cost.

Flexible standards experiment

1. Choose one costly rule.
2. Define the feared consequence of a "good enough" performance.
3. Set a reasonable alternative standard.
4. Complete one task at that level.
5. Do not add checking or overcorrection.
6. Record outcome, time saved, and discomfort.

7. Revise the rule from evidence.

High standards are not automatically a problem. The focus is rigidity, self-worth, and cost.

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CLINICAL APPLICATIONS

Procrastination

Maintaining factor	Clinical response
Task feels vague	Define the next visible action.
Fear of failure	Use graded exposure to imperfect work.
Low reward	Add immediate reinforcement and valued purpose.
Overwhelm	Use time-limited work periods.
Decision avoidance	Set criteria and a decision point.
Low mood or ADHD features	Assess and adapt rather than moralize.

Five-minute start

1. Name the next physical action.
2. Set five minutes.
3. Begin without promising to finish.
4. Stop or continue by choice.
5. Record what the mind predicted and what happened.

CLINICAL APPLICATIONS

Low Self Esteem

Low self-esteem may involve global negative beliefs, biased attention to failure, discounting strengths, avoidance, and self-criticism.

- Develop an individualized formulation.
- Track evidence that is normally ignored.
- Test rules that block participation.
- Build skills and relationships where needed.
- Practice balanced self-evaluation.
- Address trauma, depression, abuse, or discrimination when relevant.

Clinical safety: Do not ask a client to “love yourself” as a substitute for treating depression, trauma, harmful relationships, or real social barriers.

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CLINICAL APPLICATIONS

Compassionate Cognitive Work

Supportive accountability

1. Describe the painful event accurately.
2. Name what was and was not under the client's control.
3. Use the tone that would help a respected person learn.
4. Acknowledge harm or disappointment without global condemnation.
5. Choose repair, boundary, learning, or rest.
6. Write one sentence that combines responsibility with humanity.

Compassion is not denial or permission for harmful behavior. It reduces attack so constructive action becomes possible.

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CHAPTER 13
Adapting CBT Across Age and Ability

Need	Adaptation
Child or adolescent	developmental language play visual methods caregiver involvement and safeguarding
Older adult	sensory access health cognition loss context and pace
Cognitive difficulty	shorter tasks repetition external memory support and functional practice
Low literacy	oral visual and demonstration-based methods
Disability	accessible format environment communication and realistic pacing

Adapt the delivery while preserving the active therapeutic principle. Review understanding rather than assuming.

Family and Support Involvement

- Obtain consent and clarify confidentiality.
- Define the supporter's role.
- Teach validation and helpful prompting.
- Reduce reassurance or accommodation when it maintains the problem.
- Protect the client's autonomy.
- Address family stress and safeguarding.

Support plan

1. What should the supporter do?
2. What should they reduce or stop?
3. How will the client ask for help?
4. What information remains private?
5. When will the plan be reviewed?

Religion Spirituality and Values

Beliefs may offer meaning, community, ritual, hope, conflict, guilt, or fear. The therapist should explore rather than assume.

Helpful question	Purpose
Is faith important in understanding this problem?	Invites the client's framework.
Which beliefs or practices support you?	Identifies resources.
Is any part increasing distress or conflict?	Identifies clinical concerns.
Would consultation with a trusted faith leader help?	Supports collaboration with consent.

Do not debate doctrine or label a belief irrational without cultural and clinical understanding.

Online Group and Guided CBT

Format	Clinical requirements
Online individual	privacy emergency location identity technology and access
Group CBT	screening consent group rules risk and cohesion
Guided self-help	appropriate severity regular support progress and escalation plan
Digital programme	evidence accessibility data privacy and clinician oversight

Clinical safety: Know the client's location and emergency pathway in remote work. Digital convenience does not reduce duty of care.

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CHAPTER 14
When CBT Gets Stuck

Problem	Questions
No shared focus	Are goals meaningful and agreed?
Little change	Is the formulation accurate and treatment delivered with sufficient dose?
Action plans not completed	Were they collaborative clear small and relevant?
Alliance strain	Has the therapist asked directly for feedback?
Complex comorbidity	Are priorities sequencing or referral wrong?
Deterioration	What risk or diagnosis needs urgent review?

Do not respond to nonresponse by blaming motivation or adding more worksheets.

THERAPEUTIC SESSION GUIDE
A Troubleshooting Session
Use direct feedback and fresh assessment when therapy is not progressing.

Session sequence
1. Share the observed lack of progress respectfully.
2. Ask how the client understands it.
3. Review goals and whether they still matter.
4. Reassess risk diagnosis context and barriers.
5. Check the formulation and treatment fidelity.
6. Consider adaptation consultation referral or another treatment.
7. Agree a time-limited revised plan.
8. Measure the result.

Evaluate the session
Document feedback, alternative explanations, consultation, risk decisions, and the criteria for continuing or changing treatment.

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CHAPTER 15

Ending Therapy Well

Ending begins early by helping the client understand the model and practise independent skills. A planned ending reviews gains, unfinished needs, warning signs, and future support.

- Compare baseline with current symptoms function and goals.
- Review which methods helped and why.
- Discuss mixed feelings about ending.
- Practice responding to a likely setback.
- Agree booster or follow-up arrangements.
- Document referral or continuing care needs.



Figure 15.1 A setback is a signal to use the plan, not proof that therapy failed.

Relapse Prevention Plan

Area	Client plan
What I learned	
My early warning signs	
Common triggers	
Skills that help	
People and services	
What I will do in the first 24–48 hours	
When I will seek professional help	

Differentiate a lapse from a full return of the problem. Encourage rapid response without catastrophizing normal fluctuation.

CHAPTER 15
Evaluating Treatment

Question	Evidence
Did symptoms change?	Repeated validated measure and clinical interview
Did function change?	Work relationships self-care and participation
Were goals achieved?	Goal-based measures and examples
Was treatment acceptable?	Client feedback attendance and burden
Was treatment delivered as intended?	Session records supervision and fidelity review
Any harm or deterioration?	Adverse events risk and outcome monitoring

A positive testimonial is not enough. Evaluate both benefit and harm, and report limits honestly.

Ethics Boundaries and Competence

- Practice within training and supervision.
- Use informed consent and shared decisions.
- Protect confidentiality and explain its limits.
- Maintain professional boundaries in person and online.
- Use secure records and communication.
- Avoid dual relationships and conflicts where possible.
- Respond to culture, disability, language, and power.
- Refer when another treatment or service is more appropriate.

Clinical safety: This book cannot grant competence in trauma-focused treatment, ERP, interoceptive exposure, severe mental illness, or other specialist work.

Supervision and Deliberate Practice

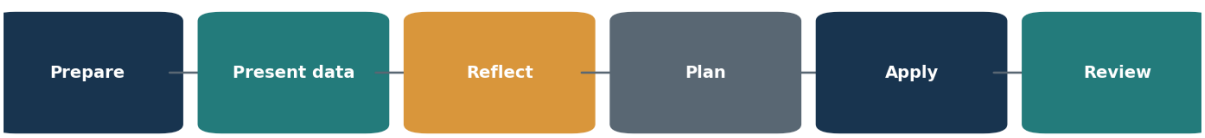


Figure 15.2 Supervision links clinical data, reflection, planning, and review.

Prepare for supervision

1. State the clinical question.
2. Summarize risk and safeguarding.
3. Bring formulation, measures, and session evidence.
4. Identify what you tried and the client's response.
5. Name uncertainty and emotional reactions.

6. Agree a specific skill or decision to practise.
7. Review the effect at the next meeting.

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CLINICAL FORMS

CBT Assessment Planner

Area	Notes
Presenting problems and priorities	
Symptoms course and triggers	
Function and quality of life	
Risk and protective factors	
Medical medication sleep and substances	
Relationships culture identity and context	
Strengths and previous coping	
Measures used and limits	
Initial formulation hypotheses	
Referral or immediate action	

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CLINICAL FORMS

Five Areas Formulation

Area	Client's words
Specific situation or trigger	
Thoughts images memories meanings	
Emotions and intensity	
Physical sensations	
Behaviors avoidance safety responses	
Short-term effects	
Long-term effects	
Strengths and alternatives	

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CLINICAL FORMS

Longitudinal Formulation

Component	Notes
Relevant early experience and context	
Core beliefs	
Rules assumptions and attitudes	
Coping strategies	
Recent activating events	
Current maintaining cycles	
Protective factors and strengths	
Treatment implications	
Questions still to test	

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CLINICAL FORMS

Thought Record

Step	Entry
Situation	
Automatic thought or image	
Belief rating 0–100	
Emotion and intensity	
Evidence supporting	
Evidence not supporting or limiting	
Balanced response	
New belief and emotion ratings	
Next helpful action	

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CLINICAL FORMS

Behavioral Experiment Record

Field	Plan or result
Belief to test	
Prediction and confidence	
Alternative outcome	
Experiment	
Safety and ethical limits	
What happened	
Safety behaviors used	
Learning	
Updated belief	
Next experiment	

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CLINICAL FORMS

Therapeutic Session Record

Field	Entry
Check-in risk and measures	
Agreed agenda	
Previous action plan review	
Formulation focus	
Intervention and in-session practice	
Client response and learning	
Action plan and barriers	
Client feedback	
Risk referrals and next decision	

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CLINICAL FORMS

Clinical Practice Guide

A practice task should have one purpose, one observable target, and one review question. It should be agreed with the client and fit the formulation.

Plan	Write here
Skill or process to practise	
Clinical reason	
Client or role-play context	
Steps	
What will be measured	
Expected barrier	
Support or supervision	
Safety or stop rule	

Learning after practice

Use feedback to refine the skill. Repetition without reflection can strengthen the wrong habit.

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REFERENCE TOOLS

Quick Glossary

Term	Simple meaning
Automatic thought	A fast thought image or meaning in a specific moment.
Behavioral activation	Planned action to change withdrawal and restore valued activity.
Behavioral experiment	A planned test of a belief or prediction.
Case formulation	A shared explanation of the client's problem and maintaining processes.
Cognitive restructuring	Evaluating and updating a thought or belief.
Compulsion	A repeated act or mental ritual used to reduce threat or distress.
Exposure	Planned approach to feared cues for new learning.
Guided discovery	Helping a client examine experience and reach a conclusion.
Safety behavior	An action used to prevent a feared outcome that may block learning.
Schema or core belief	A broad deeply held belief about self others or the world.
Socratic questioning	Curious focused questions used to examine meaning and evidence.
Therapeutic alliance	The working relationship agreement and bond in therapy.

REFERENCE TOOLS

Selected References and Author Note

Clinical guidance changes over time. Clinicians should consult current local law, professional standards, validated measures, and full disorder-specific protocols.

- American Psychological Association. Clinical practice guidelines for depression and post-traumatic stress disorder. https://www.apa.org/about/offices/directorates/guidelines/clinical-practice
- Beck Institute for Cognitive Behavior Therapy. Clinical resources and CBT training materials. https://beckinstitute.org/
- National Institute for Health and Care Excellence. Guidance for depression, anxiety, panic, OCD, PTSD, and related conditions. https://www.nice.org.uk/guidance
- World Health Organization. Mental health resources and mhGAP guidance. https://www.who.int/health-topics/mental-health
- International OCD Foundation. Professional information on exposure and response prevention. https://iocdf.org/
- U.S. Department of Veterans Affairs National Center for PTSD. Treatment information and professional resources. https://www.ptsd.va.gov/

About the author

Dr. Shazia Shahzadi, Ph.D., is a Postdoctoral Research Fellow at Multimedia University, Malaysia. Her work spans psychology, speech-language pathology, behavioral sciences, research, supervision, training, and clinical interventions.

Closing clinical principle

CBT is most useful when the therapist listens carefully, formulates collaboratively, practices actively, measures honestly, and changes course when the evidence requires it.

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ADVANCED CLINICAL PRACTICE

Using the Advanced Clinical Practice Section

Pages 61-100 deepen assessment, risk management, case formulation, treatment selection, therapeutic exercises, and outcome evaluation.

Clinical sequence

Begin with consent and access, clarify the referral question, assess risk and function, build a collaborative formulation, agree measurable goals, choose an evidence-informed intervention, practice actively, review data, and revise the plan.

Limits

The material supports qualified practice and supervised learning. It does not authorize work beyond competence, replace diagnosis, or substitute for emergency, medical, psychiatric, safeguarding, or specialist care.

- Distinguish client report, observation, measure score, interpretation, and hypothesis.
- Use current local law and professional standards.
- Document uncertainty and reasons for every major decision.

Clinical application

Select one existing case and write the next safe assessment step before choosing a technique.

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ADVANCED CLINICAL PRACTICE

Diagnostic Screening and Differential Assessment

CBT formulation complements diagnosis; it does not replace a careful diagnostic and medical assessment.

Screening

Establish onset, duration, severity, course, impairment, previous episodes, treatment history, medication, physical health, sleep, substance use, trauma, neurodevelopment, cultural context, and protective factors.

Differential questions

Consider whether symptoms may reflect a medical condition, medication effect, substance use, grief, bipolar spectrum, psychosis, obsessive-compulsive processes, trauma, eating disorder, neurocognitive change, or another condition requiring different care.

- Check current and past risk.
- Ask about strengths and previous recovery.
- Use collateral information only with appropriate consent or lawful justification.

Clinical application

Turn “anxiety” into five differential questions covering panic, worry, trauma, OCD, and physical health.

Safety and scope

Urgent or unexplained physical and mental-status changes require appropriate medical or emergency assessment.

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ADVANCED CLINICAL PRACTICE

Measurement Based Care

Measures support conversation and decisions; they do not speak for the client.

Choosing a measure

Select a validated tool that matches the clinical question, language, age, culture, reading level, setting, and intended use. Confirm scoring rules, licensing, cut-offs, and limitations from the official manual.

Interpreting change

Review total score, item pattern, functioning, risk items, client experience, and contextual change. Reliable or clinically important change is more informative than a small raw-score difference, but calculations require appropriate norms and error estimates.

- Administer at agreed intervals.
- Use the same version and conditions when possible.
- Discuss results collaboratively and record missing items.

Clinical application

Create a measurement schedule with baseline, session monitoring, midpoint, ending, and follow-up.

Safety and scope

Never use a questionnaire score alone to determine diagnosis, safety, or discharge.

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ADVANCED CLINICAL PRACTICE

Depression Measures PHQ 9 and BDI II

Depression measures should be combined with interview, functional assessment, risk evaluation, and clinical judgment.

PHQ 9

The PHQ-9 is a brief symptom measure reflecting the previous two weeks. Review each item, impairment, change, and especially any response concerning thoughts of death or self-harm. Follow the official scoring and local response procedure.

BDI II

The BDI-II is a proprietary self-report measure. Use an authorized copy and current manual. Interpret severity bands cautiously and consider language, literacy, medical symptoms, grief, and response style.

- Clarify duration and episode history.
- Screen for past elevated mood and activation before assuming unipolar depression.
- Assess functioning, hopelessness, agitation, substance use, and support.

Clinical application

Compare symptom score, activity level, functioning, and personal goal progress across treatment.

Safety and scope

Any risk item requires timely clinical follow-up; the total score must never substitute for direct risk assessment.

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ADVANCED CLINICAL PRACTICE

Anxiety Measures GAD 7 and BAI

Anxiety measurement should distinguish generalized worry from panic, trauma, OCD, health anxiety, social fear, and medical causes.

GAD 7

The GAD-7 is a brief measure of generalized anxiety symptoms over the previous two weeks. Review impairment and symptom context rather than relying on a cut-off alone.

BAI

The Beck Anxiety Inventory emphasizes common anxiety symptoms, including physical sensations. Medical conditions, medication, caffeine, withdrawal, pain, and panic can affect responses; use the licensed tool and manual.

- Ask what triggers symptoms and what the person predicts.
- Map avoidance, reassurance, checking, and safety behavior.
- Clarify whether physical symptoms need medical evaluation.

Clinical application

Use one weekly measure plus a personalized indicator such as minutes spent worrying or number of avoided situations.

Safety and scope

Do not interpret chest pain, fainting, severe breathlessness, or new neurological symptoms as anxiety without appropriate medical assessment.

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ADVANCED CLINICAL PRACTICE

Trauma Assessment and PCL 5

Trauma assessment must protect dignity, choice, pacing, and safety.

Assessment

Clarify current safety, trauma exposure only as needed, symptom clusters, dissociation, sleep, substance use, shame, guilt, avoidance, functioning, supports, and readiness. Do not require a detailed trauma narrative during initial screening.

PCL 5

The PCL-5 is a self-report PTSD symptom measure linked to DSM-5 criteria. Use the official version and guidance. It can monitor symptoms but does not establish diagnosis by itself.

- Explain why questions are being asked.
- Offer pauses and grounding when needed.
- Assess risk, dissociation, psychosis, substance withdrawal, and current threat.

Clinical application

Develop a stabilization and support plan before trauma processing.

Safety and scope

Trauma-focused work requires appropriate training, informed consent, and a plan for crisis, dissociation, and deterioration.

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ADVANCED CLINICAL PRACTICE

OCD Assessment and Severity Measures

OCD assessment distinguishes obsessions, compulsions, avoidance, reassurance, and mental rituals from ordinary worry or preference.

Interview

Clarify intrusive thoughts, images, urges, meanings, distress, rituals, time, interference, insight, family accommodation, avoidance, and feared consequences. Ask sensitively about taboo content without assuming intent.

Measures

The OCI-R is a brief self-report measure. The Y-BOCS is a clinician-rated severity measure requiring training and correct administration. Neither replaces a diagnostic interview.

- Identify covert mental rituals.
- Separate obsessional content from risk intent through careful assessment.
- Map family or partner participation in rituals.

Clinical application

Create one OCD cycle showing trigger, obsession, meaning, anxiety, ritual, relief, and long-term cost.

Safety and scope

ERP should not begin without a clear OCD formulation, consent, competence, and review of genuine safety requirements.

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ADVANCED CLINICAL PRACTICE

Insomnia Assessment and Sleep Measures

Sleep difficulty requires evaluation of timing, opportunity, habits, medical factors, medication, substances, and other sleep disorders.

Sleep diary

Record bedtime, intended sleep time, estimated sleep onset, awakenings, final waking, rising time, naps, substances, medication, and daytime effect. Estimate patterns rather than demanding impossible precision.

ISI (Insomnia Severity Index)

The Insomnia Severity Index is a brief self-report measure of perceived insomnia severity and impact. Use an authorized version and interpret it with the sleep diary and clinical assessment.

- Screen for sleep apnoea, restless legs, parasomnias, mania, pain, and substance effects.
- Assess daytime sleepiness and driving or occupational risk.
- Review the bedroom, schedule, caregiving, and cultural routines.

Clinical application

Calculate time in bed and estimated sleep time across one week, then discuss patterns without blame.

Safety and scope

Sleep restriction or compression requires competence and caution with bipolar disorder, epilepsy, pregnancy, falls risk, driving risk, and severe sleepiness.

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ADVANCED CLINICAL PRACTICE

Suicide and Self Harm Assessment

Risk assessment is a direct, compassionate, collaborative process, not a checklist or prediction score.

Ask clearly

Explore current and recent thoughts, intent, plan, access to means, preparation, previous behavior, triggers, substance use, agitation, psychosis, hopelessness, reasons for living, supports, and willingness or ability to use help.

Formulate risk

Describe acute and longer-term risk, foreseeable changes, protective factors, uncertainty, actions, consultation, and follow-up. Static labels such as low, medium, or high are insufficient without a formulation.

- Follow local emergency and safeguarding procedures.
- Involve appropriate supports with consent when possible.
- Document decisions, consultations, and communication.

Clinical application

Write a risk formulation linking current state, history, upcoming stressors, protective factors, and an immediate action plan.

Safety and scope

If there is imminent danger or inability to maintain safety, arrange urgent emergency intervention; do not rely on a routine appointment or workbook task.

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ADVANCED CLINICAL PRACTICE

Collaborative Safety Planning

A safety plan is brief, personal, accessible, and rehearsed before crisis intensity rises.

Core elements

Identify warning signs, internal coping strategies, safe people and places, people to ask for help, professional and emergency contacts, and steps to reduce access to lethal means according to local law and practice.

Make it usable

Write in the client's words, remove barriers, store copies safely, consider language and disability access, and rehearse how the person will move from one step to the next.

- Specify who will do what and when.
- Plan follow-up after crisis or discharge.
- Update the plan when circumstances change.

Clinical application

Role-play noticing a warning sign and contacting one support while the therapist checks practical barriers.

Safety and scope

A no-suicide contract is not a substitute for assessment, safety planning, treatment, or emergency action.

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ADVANCED CLINICAL PRACTICE

Comorbidity and Treatment Priorities

Many clients have overlapping problems; treatment order should follow risk, impairment, maintaining processes, and client priorities.

Prioritize

Address immediate safety, severe medical or substance risk, acute mania or psychosis, safeguarding, and barriers to engagement first. Then identify whether one maintaining process affects several difficulties.

Sequence

Agree what will be treated now, monitored, coordinated with another professional, or deferred. Avoid running several full protocols simultaneously without a coherent formulation.

- Map interactions between sleep, mood, worry, pain, substances, and avoidance.
- Review medication and physical-health care.
- Reassess when the clinical picture changes.

Clinical application

Create a staged plan with stabilization, primary target, secondary target, relapse prevention, and referral points.

Safety and scope

Complexity is a reason for careful formulation and supervision, not automatic exclusion from CBT.

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ADVANCED CLINICAL PRACTICE

Medication and Multidisciplinary Coordination

CBT clinicians should understand the treatment context without advising beyond prescribing competence.

Medication review

Record medication name, purpose, dose as reported, adherence, recent changes, benefits, adverse effects, withdrawal concerns, and prescriber. Explore beliefs and practical barriers without pressuring the client.

Coordination

With appropriate consent, communicate formulation, risk, progress, and concerns to relevant professionals. Clarify roles and avoid contradictory plans.

- Monitor activation, sedation, sleep change, agitation, and functioning.
- Encourage medication questions to the prescriber.
- Document urgent communications.

Clinical application

Write a concise letter summarizing CBT target, progress, risk, and a specific question for the prescriber.

Safety and scope

Do not advise starting, stopping, or changing prescribed medication unless professionally authorized.

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ADVANCED CLINICAL PRACTICE

CBT with Children and Adolescents

Developmental level, family context, school environment, consent, and safeguarding shape every intervention.

Adaptation

Use concrete language, drawing, stories, games, visual scales, shorter practice, repetition, and caregiver coaching. Assess development, learning, language, neurodiversity, family stress, bullying, sleep, and school attendance.

Collaboration

Explain confidentiality and its limits to both young person and caregivers. Include the child's goals and voice. Decide what information can be shared and how.

- Use age-appropriate measures.
- Reinforce approach and skill use, not forced disclosure.
- Coordinate with school or pediatric care when indicated.

Clinical application

Translate one adult thought record into a picture-based situation-thought-feeling-action activity.

Safety and scope

Follow child-protection law and local safeguarding procedures; do not promise absolute confidentiality.

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ADVANCED CLINICAL PRACTICE

CBT with Older Adults

Adapt CBT to sensory, cognitive, medical, social, and life-stage factors without assuming decline.

Assessment

Review hearing, vision, cognition, medication burden, pain, mobility, sleep, bereavement, caregiving, isolation, role change, and practical access. Distinguish depression from delirium or neurocognitive change.

Adaptation

Use clear print, slower pace, written summaries, repetition, memory aids, meaningful examples, and shorter tasks. Build on experience, values, strengths, and existing routines.

- Check capacity for the specific decision when relevant.
- Include supporters with consent.
- Coordinate medical review for new confusion or rapid change.

Clinical application

Redesign a behavioral activation plan for limited mobility using connection, mastery, pleasure, and pacing.

Safety and scope

Sudden confusion, falls, neurological change, or marked functional decline requires timely medical assessment.

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ADVANCED CLINICAL PRACTICE

Neurodiversity and Cognitive Adaptation

CBT should reduce distress and improve functioning without trying to erase identity or harmless difference.

Assessment

Ask about communication preference, sensory needs, executive functioning, interoception, routine, masking, previous invalidation, strengths, and the environmental source of distress.

Adaptation

Use explicit agendas, visual formulation, concrete examples, predictable structure, written choices, processing time, interest-based materials, and environmental modification. Check whether metaphors are helpful.

- Do not require eye contact.
- Separate distress from neuro-divergent traits.
- Adjust homework for initiation, memory, and sensory barriers.

Clinical application

Convert an abstract Socratic question into three concrete choices and one visual prompt.

Safety and scope

Seek specialist consultation when cognitive, language, or sensory needs exceed competence.

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ADVANCED CLINICAL PRACTICE

CBT for Health Anxiety

Health-anxiety treatment validates distress while testing the processes that keep threat beliefs active.

Formulation

Map bodily sensation, catastrophic interpretation, attention, checking, internet searching, reassurance, avoidance, short-term relief, and long-term uncertainty. Confirm appropriate medical assessment.

Intervention

Use attention experiments, reduction of reassurance and checking, behavioral experiments, probability and coping work, and graded return to valued activities. Agree how genuine new symptoms will be handled.

- Never dismiss symptoms as “just anxiety.”
- Coordinate with medical providers when appropriate.
- Define safe limits for checking and consultation.

Clinical application

Design an experiment comparing symptom monitoring with externally focused attention while recording anxiety and function.

Safety and scope

New, severe, or changing symptoms require appropriate medical review rather than automatic psychological interpretation.

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ADVANCED CLINICAL PRACTICE

CBT for Chronic Pain and Long Term Illness

CBT supports coping, function, pacing, sleep, and values; it does not imply that symptoms are imaginary.

Assessment

Understand diagnosis, medical plan, pain pattern, fatigue, sleep, mood, fear of movement, overactivity-underactivity cycles, medication, work, relationships, and valued roles.

Intervention

Use collaborative pacing, graded activity, problem solving, sleep support, attention flexibility, compassionate cognitive work, and communication with the medical team.

- Set functional goals rather than promising pain elimination.
- Balance activity and recovery.
- Avoid pushing through medical warning signs.

Clinical application

Create a one-week pacing plan using a sustainable baseline and small planned variation.

Safety and scope

Follow medical restrictions and refer new neurological, systemic, or rapidly worsening symptoms.

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ADVANCED CLINICAL PRACTICE

CBT for Grief and Adjustment

Grief is not automatically a disorder. CBT may help when avoidance, guilt, hopelessness, trauma, or disrupted routines maintain severe distress.

Assessment

Explore the loss, cultural and spiritual meaning, relationship, expected grief practices, support, functioning, trauma, depression, guilt, substance use, and risk. Avoid rigid timelines.

Intervention

Support oscillation between loss-focused and restoration-focused coping, meaningful remembrance, re-engagement, sleep, problem solving, and balanced work with guilt or self-blame.

- Use the client's language for the loss.
- Respect rituals and continuing bonds.
- Differentiate compassionate remembrance from forced exposure.

Clinical application

Plan one restorative action and one chosen remembrance activity, then review emotional and functional impact.

Safety and scope

Refer or coordinate when risk, severe impairment, traumatic grief, or diagnostic uncertainty exceeds competence.

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ADVANCED CLINICAL PRACTICE

CBT and Substance Use

Substance use assessment should be nonjudgmental, specific, and linked to function and risk.

Assessment

Ask what is used, amount, frequency, pattern, route, context, withdrawal, overdose, mixing, prescribed medication, consequences, motivation, previous change, and supports.

CBT approach

Map triggers, thoughts, craving, availability, use, short-term effect, and longer-term cost. Use functional analysis, coping skills, stimulus control, alternative actions, lapse planning, and motivational strategies.

- Distinguish lapse from full relapse.
- Plan for high-risk situations.
- Coordinate specialist and medical care.

Clinical application

Complete a chain analysis of one episode and identify an earlier point for a feasible alternative action.

Safety and scope

Possible severe withdrawal, overdose, intoxication, or medical instability requires urgent specialist or emergency care.

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ADVANCED CLINICAL PRACTICE

CBT and Eating Disorders

Eating-disorder work requires specialist assessment because medical risk can be present at any body size.

Assessment

Review eating pattern, restriction, bingeing, compensatory behavior, exercise, body-image concerns, weight and shape overvaluation, physical symptoms, medication, mood, trauma, and risk, with appropriate medical evaluation.

Treatment context

Evidence-based CBT protocols may address regular eating, monitoring, dietary restraint, overvaluation, checking, avoidance, and relapse prevention. Treatment should be coordinated with medical and nutritional professionals.

- Do not prescribe unsupervised weight-loss goals.
- Assess purging, fainting, dehydration, and cardiac symptoms.
- Use respectful, non-stigmatizing language.

Clinical application

Write a multidisciplinary referral question and identify the information that must be shared urgently.

Safety and scope

Suspected medical instability, severe restriction, frequent purging, syncope, chest symptoms, or acute risk requires urgent assessment.

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ADVANCED CLINICAL PRACTICE

CBT for Psychosis

CBT for psychosis is collaborative and distress-focused; it does not begin by arguing that experiences are false.

Assessment

Explore the person's description, meaning, conviction, distress, preoccupation, triggers, sleep, mood, trauma, substances, medication, functioning, command content, risk, and coping.

Intervention

Build safety and trust, normalize discussion, examine alternative explanations gently, reduce distress, improve coping and sleep, test low-risk predictions, and support valued activity alongside multidisciplinary care.

- Use curiosity rather than confrontation.
- Assess commands and perceived control.
- Coordinate with psychiatric services.

Clinical application

Develop a coping menu for one distressing experience without requiring the client to abandon their explanation.

Safety and scope

Acute risk, severe deterioration, inability to care for self, or dangerous command experiences require urgent psychiatric assessment.

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ADVANCED CLINICAL PRACTICE

CBT and Bipolar Disorder

CBT may support relapse prevention and functioning, but mood-state assessment and psychiatric coordination are essential.

Assessment

Review past and current elevated or irritable mood, reduced need for sleep, increased activity, impulsivity, grandiosity, psychosis, depression, medication, substance use, and early warning signs.

Intervention

Use psychoeducation, regular routines, sleep protection, mood monitoring, problem solving, medication adherence support, coping plans, and family work when appropriate. Cognitive work should match the current state.

- Develop personalized early-warning signs.
- Agree an escalation plan.
- Avoid activating sleep deprivation or overambitious goals.

Clinical application

Create a relapse signature with early signs, supports, prescriber contact, and actions for both elevated and depressed mood.

Safety and scope

Possible mania, severe mixed state, psychosis, or acute risk requires urgent specialist care.

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ADVANCED CLINICAL PRACTICE

Complex Trauma and Dissociation

Complex presentations require phased, formulation-led care rather than immediate intensive trauma processing.

Assessment

Review current safety, dissociation, memory gaps, affect regulation, relationships, shame, self-harm, substance use, sleep, somatic symptoms, ongoing threat, and resources.

Phased work

Prioritize engagement, safety, stabilization, grounding, emotion regulation, and daily functioning. Trauma processing is considered only with adequate readiness, consent, competence, monitoring, and recovery support.

- Use a window-of-tolerance formulation carefully.
- Track dissociation and post-session recovery.
- Avoid suggestive memory techniques.

Clinical application

Develop a grounding menu using orientation, sensory contact, movement, choice, and social support; test which options help.

Safety and scope

Severe dissociation, ongoing abuse, acute instability, or complex risk may require specialist trauma services.

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ADVANCED CLINICAL PRACTICE

Therapeutic Exercise Design

Every exercise should state purpose, suitability, contraindications, materials, steps, dose, measurement, and transfer.

Design

Link the exercise to the individualized formulation. Define the predicted learning, starting difficulty, therapist role, client choice, and observable outcome. Use the least burdensome activity likely to answer the clinical question.

Review

Record prediction, result, emotional and physical response, safety, new learning, and next step. A technique is changed or stopped when it is unsafe, unacceptable, or not producing relevant learning.

- Obtain informed agreement.
- Plan accessibility and cultural fit.
- Distinguish practice from a test of worth.

Clinical application

Rewrite one vague homework instruction into a complete exercise prescription.

Safety and scope

Do not use exposure, trauma processing, sleep restriction, or other high-intensity procedures without appropriate assessment and competence.

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ADVANCED CLINICAL PRACTICE

Exercise Behavioral Activation

Purpose: increase contact with reinforcement and reduce depression-maintaining withdrawal.

Suitable use

Use when reduced activity, avoidance, disrupted routine, or loss of reward is part of the formulation. Adapt for fatigue, pain, disability, caring duties, and environmental barriers.

Procedure

Monitor activity and mood; identify values and patterns; choose a small specific activity; schedule when, where, with whom, and duration; predict difficulty and benefit; complete; record actual outcome; problem-solve barriers; repeat or grade upward.

- Start below the level likely to trigger failure.
- Balance pleasure, mastery, connection, and self-care.
- Measure completion, mood, learning, and function.

Clinical application

Schedule one ten-minute activity and write a backup version requiring half the effort.

Safety and scope

Assess suicide risk, mania, medical limitations, and severe exhaustion; activation is not simply “keeping busy.”

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ADVANCED CLINICAL PRACTICE

Exercise Full Thought Record

Purpose: examine a specific interpretation and develop a credible, useful perspective.

Materials

Use situation, automatic thought or image, emotion and intensity, evidence supporting, evidence not supporting, alternative perspective, action, and outcome.

Procedure

Anchor the record to one moment. Capture the exact thought, not a broad topic. Validate why it felt convincing. Review evidence with curiosity, consider missing information and coping ability, then write an alternative that the client can genuinely believe.

- Do not force positive thinking.
- Rate belief before and after.
- End with a behavior that tests or applies the new perspective.

Clinical application

Complete one record using a real recent situation and identify what information remains unknown.

Safety and scope

Avoid intensive cognitive disputation during acute crisis, severe dissociation, or when practical action and safety are the priority.

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ADVANCED CLINICAL PRACTICE

Exercise Socratic Dialogue

Purpose: help the client examine meaning and discover a new perspective without therapist-led persuasion.

Procedure

Ask one question at a time: What happened? What did you predict? What supports that? What does not fit? Is there another explanation? What would you say to someone you respect? What action could give useful information? Summarize in the client's words.

Therapist discipline

Listen to the answer, allow silence, check understanding, and follow the client's reasoning. Avoid rapid questioning, hidden conclusions, debate, or using questions to invalidate emotion.

- Use plain language.
- Ask permission before challenging a sensitive belief.
- Convert insight into an observable next step.

Clinical application

Record a six-question dialogue and mark where the therapist could become leading or judgmental.

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ADVANCED CLINICAL PRACTICE

Exercise Behavioral Experiment

Purpose: test a specific prediction through safe, collaborative observation.

Plan

State the belief and percentage conviction; write a precise prediction; identify alternative outcomes; choose a safe task; define what will be observed; consider ethics and genuine risk; agree supports and stop criteria.

Do and review

Complete the task while reducing only formulation-relevant safety behaviors. Record what happened, what did not happen, unexpected information, belief change, and the next experiment. One result may not settle a complex belief.

- Separate an experiment from exposure for endurance.
- Avoid humiliating or deceptive tasks.
- Measure learning, not courage.

Clinical application

Design a low-risk experiment for “If I ask one question, everyone will think I am incompetent.”

Safety and scope

Do not test predictions involving illegal, medical, interpersonal, occupational, or physical danger.

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ADVANCED CLINICAL PRACTICE

Exercise Graded Exposure

Purpose: support new learning by approaching safe but feared situations while reducing avoidance.

Plan

Confirm the fear formulation and genuine safety. Build a flexible hierarchy using predicted fear and personal importance. Choose a manageable step, identify learning goals, agree duration and repetition, and decide which safety behaviors to reduce.

Review

Remain long enough to gather information rather than demanding anxiety reduction. Review expectancy violation, tolerance, coping, and what varied across trials. Repeat in multiple contexts and include relapse planning.

- Use consent and collaboration at every step.
- Vary stimuli after initial learning.
- Do not shame avoidance.

Clinical application

Plan three graded steps with prediction, learning target, safety limits, and review questions.

Safety and scope

Exposure is contraindicated when the feared situation is genuinely unsafe or when instability requires another intervention first.

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ADVANCED CLINICAL PRACTICE

Exercise Exposure and Response Prevention

Purpose: weaken the OCD cycle by approaching triggers while refraining from compulsive responses.

Plan

Identify obsession, feared meaning, overt and covert rituals, avoidance, reassurance, accommodation, and genuine safety. Build a hierarchy and choose a step the client understands and accepts.

Practice

Contact the trigger; refrain from agreed rituals, including mental review and reassurance; notice urges without obeying them; remain until planned learning is possible; review what was learned about uncertainty, distress, and feared outcomes; repeat across contexts.

- Do not provide repeated reassurance.
- Reduce family accommodation collaboratively.
- Track rituals, avoidance, and valued functioning.

Clinical application

Write an ERP task for checking OCD that preserves one normal safety check but prevents repeated checking.

Safety and scope

ERP requires accurate OCD assessment and trained supervision; never block medically or legally necessary safety behavior.

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ADVANCED CLINICAL PRACTICE

Exercise Interoceptive Exposure

Purpose: reduce catastrophic fear of safe bodily sensations by deliberately and carefully testing them.

Assessment first

Clarify panic formulation, medical history, pregnancy, medication, fainting, respiratory, cardiac, neurological, vestibular, and other relevant conditions. Select only exercises judged safe within competence.

Practice

State the feared prediction, obtain agreement, induce a mild sensation using an appropriate task, observe without escape or reassurance, allow recovery, compare outcome with prediction, and repeat or vary only when safe.

- Examples require individualized screening.
- Measure fear, prediction, and learning.
- Stop for concerning symptoms.

Clinical application

Design the documentation for an exercise without prescribing a specific physical task.

Safety and scope

Do not use unscreened hyperventilation, spinning, breath restriction, or strenuous exercise. Medical uncertainty requires consultation.

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ADVANCED CLINICAL PRACTICE

Exercise Worry Postponement and Problem Solving

Purpose: distinguish hypothetical worry from problems that can be acted upon.

Worry postponement

Choose a consistent brief worry period. When worry appears, record a few words, redirect attention gently, and return to it at the planned time. Review whether the concern remains relevant.

Problem solving

Define one solvable problem, set a realistic goal, generate options, consider advantages and disadvantages, choose a step, specify when and where, act, and review.

- Do not use postponement to suppress urgent action.
- Keep the worry period away from bedtime.
- Measure time spent worrying and engagement in valued activity.

Clinical application

Sort six concerns into current problem, hypothetical worry, or urgent action, then apply the matching response.

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ADVANCED CLINICAL PRACTICE

Exercise Sleep Routine and Stimulus Control

Purpose: rebuild a consistent connection between bed, sleep, and a stable waking rhythm.

Procedure

Use the bed primarily for sleep, go to bed when sleepy, leave the bed for a quiet safe activity when prolonged wakefulness continues, return when sleepy, and keep a consistent rising time. Adapt for disability, caregiving, housing, culture, and safety.

Review

Use the sleep diary to examine patterns, daytime function, adherence barriers, and unintended effects. Coordinate treatment of pain, apnoea, medication effects, mood episodes, and other sleep disorders.

- Avoid clock watching.
- Plan a safe low-light activity.
- Review caffeine, naps, and evening stimulation without rigid blame.

Clinical application

Write a personalized night plan and morning plan with one realistic change each.

Safety and scope

Specialist assessment is needed for suspected sleep disorders or when behavioral sleep changes carry significant risk.

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ADVANCED CLINICAL PRACTICE

Exercise Structured Problem Solving

Purpose: convert an overwhelming concern into a specific, manageable action.

Steps

Describe the problem in observable terms; identify what is controllable; set a small goal; brainstorm options without immediate judgment; compare feasibility, benefit, cost, and risk; choose one; create an action plan; review outcome and revise.

Common errors

Avoid defining the problem as a personal defect, choosing a goal controlled by someone else, or treating an emotional reaction as something to eliminate before action.

- Use written or visual support.
- Include a backup plan.
- Celebrate information gained, not only success.

Clinical application

Apply the steps to one practical barrier preventing therapy attendance or homework completion.

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ADVANCED CLINICAL PRACTICE

Exercise Compassionate Balanced Belief

Purpose: build a believable alternative to harsh global self-judgment while maintaining responsibility.

Procedure

Identify the critical message, trigger, emotional effect, and intended protective function. Ask how a fair, wise, supportive person would describe the same situation. Include strengths, context, responsibility, limits, and the next constructive action.

Practice

Create a short balanced statement, test its credibility, pair it with a supportive behavior, and collect daily evidence for and against the old global belief.

- Compassion is not excuse-making.
- Use the client's cultural and spiritual language when invited.
- Avoid phrases the client experiences as false.

Clinical application

Rewrite "I am a complete failure" as a specific, accountable, and compassionate statement followed by one action.

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Exercise Relapse Prevention Rehearsal

Purpose: help the client recognize early warning signs and respond before a lapse becomes a full return to the old cycle.

Plan

Summarize the formulation, useful skills, remaining vulnerabilities, warning signs, high-risk situations, support network, medication plan, and steps for self-help, routine review, and professional contact.

Rehearse

Use an imagined future setback. Ask the client to notice warning signs, choose a response, predict obstacles, contact support, and review. Make the plan short enough to use under stress.

- Normalize lapses.
- Schedule booster or follow-up where appropriate.
- Include crisis and emergency contacts.

Clinical application

Write a one-page relapse plan and rehearse one scenario in session.

Safety and scope

A relapse plan does not replace active risk management or urgent care.

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ADVANCED CLINICAL PRACTICE

Final Comprehensive CBT Assessment

A defensible CBT assessment explains the problem, context, risk, maintaining cycle, strengths, treatment options, and limits of current knowledge.

Required domains

Referral question; consent; access; presenting problems; onset and course; diagnosis and differential considerations; mental state; medical and medication factors; substance use; trauma; development; relationships; culture and spirituality; function; risk; strengths; goals; measures; previous treatment; and client preferences.

Clinical synthesis

State what is observed, reported, measured, inferred, and uncertain. Link the proposed intervention to a formulation and evidence source. Document alternatives, referrals, supervision, and review date.

- Include risk and safeguarding.
- Check treatment readiness and practical access.
- Share the formulation in understandable language.

Clinical application

Complete the assessment headings for one book case and identify five missing facts before treatment selection.

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ADVANCED CLINICAL PRACTICE

Final Treatment Evaluation

Evaluation asks whether therapy produced meaningful, safe, and sustainable change and what contributed to the outcome.

Outcome domains

Review symptoms, individualized goals, functioning, participation, quality of life, risk, medication or service changes, skill use, therapeutic alliance, adverse effects, and client-defined value.

Decision rules

Continue when relevant improvement is occurring; modify when progress is absent or overly cue-dependent; step up or refer when risk or complexity requires it; consolidate when skills generalize; end collaboratively when goals are met, benefit is limited, or another care pathway is more appropriate.

- Use baseline and repeated data.
- Invite negative feedback and unintended effects.
- Plan follow-up and relapse response.

Clinical application

Write a final evaluation separating outcome, mechanism, client perspective, limitations, and recommendation.

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ADVANCED CLINICAL PRACTICE

Final Therapeutic Exercise Bank

The exercise bank supports supervised selection; the formulation determines which exercise is appropriate.

Cognitive exercises

Moment analysis; thought record; image re-scripting only with appropriate training; continuum; responsibility pie; probability and coping review; compassionate letter; alternative perspective; core-belief evidence portfolio.

Behavioral exercises

Activity scheduling; graded task; behavioral experiment; exposure; response prevention; problem solving; assertiveness rehearsal; attention training; sleep routine; relapse rehearsal. Each requires a prediction, safe procedure, measurement, review, and transfer.

- Choose one target only.
- State contraindications and stop criteria.
- Record dose, cueing, response, and learning.
- Agree home practice rather than assigning it automatically.

Clinical application

Select one cognitive and one behavioral exercise for the same formulation. Explain why one should come first.

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ADVANCED CLINICAL PRACTICE

Model Answers and Evidence Base

Strong clinical answers connect evidence, uncertainty, safety, formulation, intervention, measurement, and the client's priorities.

Model answer structure

State the main problem and functional effect; identify immediate risk; summarize the maintaining cycle; name missing assessment information; propose a collaborative goal; select one intervention and explain why; specify measurement; identify contraindications, referral, or supervision; and state the review point.

Core sources

Consult current guidance from NICE, the American Psychological Association, the World Health Organization mhGAP program, and the U.S. Department of Veterans Affairs National Center for PTSD. Foundational clinical texts include Beck, Cognitive Behavior Therapy Basics and Beyond; Bennett-Levy and colleagues, Oxford Guide to Behavioral Experiments in Cognitive Therapy; Clark and Beck, Cognitive Therapy of Anxiety Disorders; Kuyken and colleagues, Collaborative Case Conceptualization; and Martell and colleagues, Behavioral Activation for Depression.

- Use current editions and official manuals.
- Verify local law, crisis pathways, licensing, and measure permissions.
- Update references before each new edition.

Clinical application

Answer one case using the nine-part model structure, then ask a supervisor to challenge the formulation and safety plan.

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