How CBT sees a case: case conceptualisation and session structure

How a CBT therapist builds a working hypothesis about a problem, how a 50-minute session is organised, and what the research says

DRAFT this text has not yet been approved by the author and may change.

19 chapters ~55 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **A diagnosis is a category; a conceptualisation is a hypothesis.** In CBT the therapist builds an individual explanation of why this person has these particular difficulties and what keeps them going. That explanation is tested and revised as the work goes on.
- **A case is described on three levels.** What is happening (thoughts, emotions, body, behaviour, life circumstances), why it isn't going away (vicious circles), and where it came from (history, beliefs, rules).
- **Treatment targets what maintains the problem now.** CBT doesn't ignore the past, but the first targets are the loops that recreate the problem every day.
- **Core beliefs are the most contested level.** When 115 practitioners independently formulated the same case, they agreed well on the problems and much less on core beliefs. Experts rated only 44% of the formulations as at least good enough.
- **Formulation has not yet been shown to improve outcomes.** A 2018 review of 24 studies concluded that its importance for CBT's effectiveness "has yet to be demonstrated". In a phobia study, standard treatment did as well as, and sometimes better than, tailored treatment.
- **A CBT session follows the same shape:** mood check → bridge → agenda → homework review → main work → new homework → summary and feedback. The agenda is set together.

- **Questions are asked out of curiosity, not to steer you to an answer.** In a depression study, sessions in which the therapist asked more Socratic questions were followed by larger drops in symptoms by the next session.
- **The relationship matters, but in a more complicated way than people think.** The alliance is linked to outcome in every kind of therapy, yet early in CBT for depression a strong alliance seems to follow early improvement more than it predicts it.
- **CBT is time-limited and ends to a plan.** It usually takes 5–15 sessions; in the UK's state service, high-intensity treatment averages about 8 sessions. Towards the end sessions are spaced out, client and therapist write a relapse prevention plan together, and booster sessions may follow the course.

Timeline

Key work on case conceptualisation and session structure. Details and sources are in the chapters below.

1979 Beck, Rush, Shaw and Emery, *Cognitive Therapy of Depression*: a structured, time-limited therapy
COGNITIVE LINE

1980 Young and Beck create the Cognitive Therapy Rating Scale (CTRS); its first item is the agenda
COGNITIVE LINE

1990 Padesky and Mooney describe the five-part model
COGNITIVE LINE

1993 Padesky: "Socratic questioning: changing minds or guiding discovery?"
COGNITIVE LINE

1997 Schulte: standardised phobia treatment is no worse than tailored treatment
EVIDENCE

2001 The revised therapist competence scale, CTS-R

COGNITIVE LINE

2005 Kuyken and colleagues: 115 practitioners formulate the same case

EVIDENCE

2006 Persons: 58 patients in private practice; Ghaderi: standard versus individualised CBT for bulimia

EVIDENCE

2008 Kuyken, Padesky and Dudley: the "crucible" model; Persons's book on case formulation

COGNITIVE LINE

2010 Moorey: the "vicious flower" of depression; Strunk and colleagues: alliance and early gains

EVIDENCE

2015 Braun and colleagues: Socratic questioning and symptom change

EVIDENCE

2018 Review of 24 case conceptualisation studies; alliance meta-analysis of 295 studies

EVIDENCE

2020 Third edition of Judith Beck's textbook: the "Action Plan" and the "best part of the week"

COGNITIVE LINE

2024 Sweden: therapists' competence scores are not linked to patient outcomes

EVIDENCE

Here "Cognitive line" means ideas and tools developed within cognitive therapy; "Evidence" means research testing whether those ideas work.

How to read these notes: evidence labels

Each claim carries a label in brackets, followed by its source. **Proven by research**: empirical studies, trials and meta-analyses (with their limits stated alongside). **Clinical consensus**: clinical guidelines (such as the UK's NICE) and professional training resources. **The author's own account**: the position or observation of a model's creator, not independently tested. **Interpretation**: a conclusion or reading of the data that is still debated. **Documented fact**: dates, publications, names. **Not verified**: we could not open the primary source. Where sources disagree, both versions are given. CBT stands for cognitive behavioural therapy. These notes stand on their own; related topics in the series are referred to as "Episode N".

> Important This is education, not therapy or diagnosis. The example in these notes is fictional. The chapter on assessment mentions, in one sentence, checking for suicide risk, a standard part of any clinical assessment. If you need support right now, see If you need help now.

Diagnosis versus conceptualisation

Two people with the same diagnosis may need different work. Conceptualisation explains why.

Picture two people with the same diagnosis: depression. One has barely left the house since a divorce. The other works fourteen-hour days, has just been promoted, and wakes at 4 a.m. thinking "I can't cope with this job". Same label. What keeps each of them stuck is a different story.

A diagnosis answers the question "what kind of condition is this?". It helps choose a model of the disorder and an evidence-based treatment protocol. It doesn't explain why things turned out this way for this particular person. For that, CBT uses **case conceptualisation**, also called **case formulation**. The two terms are used interchangeably in the literature **documented fact; Psychology Tools, "Case formulation"**.

A conceptualisation is an individual working hypothesis about how a person's difficulties arose, what keeps them going, and what that means for treatment **clinical consensus; Persons, 2008; Kuyken, Padesky & Dudley, 2009**. The key word is hypothesis. It isn't the final truth about someone; it is a guess that gets tested against session data, questionnaires and real-life experiments.

Kuyken, Padesky and Dudley note that leading commentators treat conceptualisation as "a first principle of CBT", and they call it a foundation of cognitive behavioural therapy (**the author's own account; Kuyken, Padesky & Dudley, 2008**). Back in 2003, Bieling and Kuyken called it "the heart of evidence-based practice" (**the author's own account; Bieling & Kuyken, 2003, quoted in Kuyken et al., 2008**). How well this high regard holds up against the data is a separate question, covered in "Does formulation help?".

Three well-known models

CBT has no single mandatory way to conceptualise a case. Three approaches are most widely used:

Model	Author(s)	Core idea
Cognitive Conceptualization Diagram	Judith Beck	A ladder from life history to beliefs, rules, strategies and specific situations
Case formulation approach	Jacqueline Persons	Problems, mechanisms, precipitants and origins; the formulation is tested with weekly measurement
The "crucible" of collaborative case conceptualisation	Willem Kuyken, Christine Padesky, Robert Dudley	The formulation grows in levels, is built with the client and includes strengths

The models don't compete; they look at a case from different angles. Below they are used together on one fictional example.

The big picture

In CBT the process usually runs in a loop (**clinical consensus; Persons, 2008; Kuyken et al., 2008**):

1. **Assessment**: interview, questionnaires, problem list, goals, risks.
2. **Conceptualisation**: a three-level hypothesis about the case.
3. **Treatment plan**: which mechanisms to target, in what order, with which methods.
4. **Sessions** with a consistent structure.
5. **Monitoring**: questionnaires every week.
6. The data feed back into the conceptualisation, which is refined or dropped.

Sources: Kuyken, Padesky & Dudley, 2008 · Persons, 2008 · Kuyken, Padesky & Dudley, 2009 · Psychology Tools: Case formulation

Where it starts: assessment

Before explaining anything, the therapist gathers facts: what is happening, how severe it is, what the person wants and what they can draw on.

The first meeting (sometimes two) in CBT is a bit like a joint investigation. This is what is usually gathered clinical consensus; Persons, 2008; Weinstock, CDP:

- **A problem list.** Every difficulty in every area: mood, sleep, work, relationships, health, money, daily life. In Persons's approach the full problem list is the first component of the formulation the author's own account; Persons, 2008, as summarised by Wilson & Antony.
- **Diagnostic assessment.** A structured interview helps decide which disorder model and protocol may fit.
- **Questionnaires.** Standard depression and anxiety scales are filled in regularly, often every week, not just once.
- **Life history.** Important events, relationships, culture, previous treatment: the material for explaining "where it came from".
- **Goals in the client's own words**, as concrete as possible. Not "feel better" but "leave work before seven".
- **Strengths and resources.** In Kuyken, Padesky and Dudley's model this is one of three principles, not a nice extra the author's own account; Kuyken et al., 2008.
- **Risk assessment**, including thoughts of suicide and self-harm: a standard part of any clinical assessment clinical consensus.

Why measure every week

Persons built a whole method on measurement: if you don't measure, you can't tell whether what you're doing works. In her study, 58 outpatients with anxiety and depression received formulation-driven CBT with weekly monitoring; 40 of the 58 also received adjunctive treatment (including medication), chosen on the basis of the formulation and the monitoring data. Anxiety and depression improved in statistically and clinically meaningful ways, broadly in line with randomised trials of evidence-based therapies for single disorders proven by research; Persons et al., 2006. An important caveat: there was no control group, so this is a good sign, not proof that the formulation is what helped.

A fictional example: Alex

Example **Alex is a fictional composite for teaching, not a real person's story.** Alex is 34, a project manager at a tech company, promoted six months ago. For the past three months Alex has been sleeping badly and waking at 4 a.m. thinking about work; works late into the night yet still hands things in late; hardly goes out at weekends ("no energy");

snaps at their partner and then feels guilty. In Alex's words: "I probably just can't handle this job." No diagnosis is made here; for the example, "low mood and anxiety" is enough.

What a therapist might note after assessment:

What is gathered	For Alex
Problem list	Sleep, overwork and procrastination, fatigue, cancelling on friends, arguments with partner, self-criticism
Questionnaires	Depression and anxiety scales at the start and every week
Goals	"Leave work by 7 p.m.", "get Saturday meet-ups with friends back", "stop waking at 4 a.m."
Strengths	Conscientious, good sense of humour, used to run, learns quickly, has a close friend
Risks	Checked; no acute risk

Sources: Persons et al., 2006 · Wilson & Antony, Praxis CET · Weinstock, CDP · Kuyken et al., 2008

Level 1. What is happening: the five-part model

CBT's simplest map: one specific situation broken down into thoughts, emotions, body, behaviour and life circumstances.

Kuyken, Padesky and Dudley describe conceptualisation as growing level by level. The first level is **descriptive**: what is happening, in the language of the cognitive model **the author's own account; Kuyken et al., 2008**. The most popular tool for this is the five-part model.

Christine Padesky and Kathleen Mooney described it in 1990 in a short professional newsletter article, "Presenting the cognitive model to clients" **documented fact; Padesky & Mooney, 1990**. The model later appeared in Greenberger and Padesky's self-help book *Mind Over Mood*.

How it works

- **Thoughts**: what the person tells themselves about the situation.
- **Mood (emotions)**: anxiety, shame, sadness, anger.
- **Body**: physical reactions such as tension, a racing heart, sleeplessness.

- **Behaviour**: what the person does or doesn't do.
- **Environment (life)**: the surrounding circumstances: work, family, money, culture, past experience. It encircles the other four.

The four inner parts are linked by two-way arrows: a change in one affects all the others **the author's own account; Padesky & Mooney, 1990**. In 2020 Padesky stressed that the environment is central to the model, because it is how life events and sociocultural factors enter the conceptualisation **the author's own account; Padesky, 2020**. For more on how thoughts relate to emotions and what automatic thoughts are, see Episode 2 on the cognitive model.

Example **Tuesday, 10:40 p.m.** Alex opens an unfinished report for the director. **Environment:** new role, deadline on Wednesday, a week ago the director made a critical remark in a meeting. **Thoughts:** "This is weak again", "Tomorrow everyone will see I can't cope." **Emotions:** anxiety (80 out of 100), shame (60 out of 100). **Body:** tight chest, lump in the throat, can't fall asleep later. **Behaviour:** rewrites the same paragraphs until 2 a.m. and still doesn't send it.

How the model is shared with the client

Padesky and Mooney suggested doing this in the first or second session, after the interview **the author's own account; Padesky & Mooney, 1990**:

1. Use questions to fill in the model with an example from the client's life.
2. Show how a change in one area pulls the others along and builds up.
3. Give an example of how a small change in one area helps the rest.
4. Set homework: record behaviour and mood to test whether the model fits the client's life.

The authors observed that clients often find the model reassuring: scattered problems turn out to be connected, and the changes needed turn out to be small **the author's own account; Padesky & Mooney, 1990**. For Alex this is the first shift: not "I'm broken" but a set of connected things that can be influenced.

Myth vs fact **Myth:** "hot cross bun" is Padesky's own name for the model. **Fact:** the phrase does not appear in the 1990 article **documented fact; Padesky & Mooney, 1990**. It is a later nickname for the circular diagram: four circles crossed by arrows look like the Easter bun, and it is now the standard name (documented fact; Davies, Salkovskis & Laidlaw, 2025, *Cambridge Guide to CBT*, ch. 1: "commonly known as the hot cross bun model"). We could not find who coined it **not verified**.

Sources: Padesky & Mooney, 1990 · Padesky, 2020 · Kuyken et al., 2008

Level 2. Why it doesn't go away: maintenance cycles

A problem persists not because it once started, but because the ways we react to it recreate it every day.

The second level in Kuyken, Padesky and Dudley's model is **cross-sectional explanatory**: it looks for the triggers and the factors that keep the problem going now **the author's own account; Kuyken et al., 2008**. "Cross-sectional" means a slice of the present, as opposed to a "longitudinal" view of the past.

A core CBT idea is that treatment targets, first of all, what maintains a problem now rather than what originally caused it **clinical consensus; Kuyken et al., 2008; Persons, 2008**. These loops are called **maintenance cycles**: a person responds to a difficulty in a way that keeps it in place.

Common loops

Loop	How it works	Everyday example
Avoidance	Brings relief now but removes the chance to learn the fear was wrong	Not calling the doctor because "it'll be bad news"
Safety behaviours	The person credits their "rescue" to a ritual rather than to the fact that disaster wasn't going to happen	Holding on to a wall "so I don't faint"
Withdrawal and reduced activity	Less enjoyment, lower mood, less energy	Cancelling plans because of "no energy"
Rumination and self-criticism	Going over and over the problem deepens low mood	Spending hours on "why am I like this"
Overcompensation	Perfectionism and checking are exhausting and confirm the rule "only this way works"	Redoing a report late into the night
Interpersonal loops	Behaviour draws reactions from others that confirm the belief	Snapping at a partner, who is hurt: "I let everyone down"

Summarised from clinical sources **clinical consensus; Padesky & Mooney, 1990; Padesky, 2020; Moorey, 2010**.

Example **Alex's two loops.** Looking at several situations over a week, the therapist and Alex notice patterns. **Loop 1, perfectionism and procrastination:** "The report has to be flawless or everyone will see I can't cope" → anxiety rises → puts it off, then rewrites late into the night → hands it in late, with mistakes from lack of sleep → "See, I can't cope." **Loop 2, withdrawal:** tiredness → "no energy for friends" → cancels Saturday → weekend on the sofa with a laptop → less enjoyment and energy → the next meet-up gets cancelled too.

The "vicious flower"

British psychiatrist Stirling Moorey proposed a six-cycle maintenance model of depression, the "vicious flower" **documented fact; Moorey, 2010; Confer biography of S. Moorey**. At the centre is the depressed state, surrounded by six "petals", each feeding the centre and fed by it **the author's own account; Moorey, 2010**:

1. Negative automatic thoughts.
2. Rumination and self-attacks.
3. Mood and emotions.
4. Withdrawal and avoidance.
5. Unhelpful behaviours.
6. Motivation and physical symptoms.

The whole system sits within the environment. For Alex, three petals stand out: thoughts ("I can't cope"), withdrawal (the cancelled Saturday) and physical symptoms (sleep, fatigue). More on CBT for depression in Episode 7.

Testing a loop

In CBT a loop isn't just named; it is tested. The therapist might suggest an experiment: this week, send the report in a "good enough" version at 7 p.m. and write down the prediction ("the director will say it's sloppy") and what actually happened. This is a behavioural experiment, not persuasion **clinical consensus; Kuyken et al., 2008**. Behavioural experiments are covered in detail in Episode 6.

Sources: Moorey, 2010 · Kuyken et al., 2008 · Padesky & Mooney, 1990 · Persons, 2008

Level 3. Where it came from: beliefs, rules and strategies

CBT does work with the past: the deepest level of a formulation explains why a person has these particular thoughts.

The third level is **longitudinal explanatory**: it describes predisposing and protective factors over time (the author's own account; Kuyken et al., 2008). Kuyken and colleagues stress that conceptualisation grows during therapy: the longitudinal level is added in the middle and later stages, not at the first meeting.

Judith Beck's diagram

Judith Beck, daughter of cognitive therapy's founder Aaron Beck (see Episode 1), developed the Cognitive Conceptualization Diagram. Its fields, from top to bottom (documented fact; Beck Institute, adapted from J. Beck, 2020):

1. **Relevant life history and precipitants.**
2. **Core belief**: a basic, global idea about oneself, others or the world ("I'm not good enough").
3. **Intermediate beliefs**: rules, attitudes and "if..., then..." assumptions.
4. **Coping strategies**: behaviour that protects against the belief being "switched on". Earlier editions called them compensatory strategies.
5. **Three typical situations**, each with an automatic thought, what it means to the person, the emotion and the behaviour.

The lower part of the diagram shows the cognitive model at work in specific situations; the upper part explains why the person has these automatic thoughts. The "meaning of the automatic thought" field is the bridge between the two (the author's own account; Beck Institute, adapted from J. Beck, 2020). Core and intermediate beliefs are covered in detail in Episode 2.

Example **A hypothesis for Alex (offered as a question, not a verdict). History:** at home only top marks were valued; a lower grade was met with silence and a disappointed look. Precipitants: the promotion and the director's remark. **Core belief:** "I'm not good enough." **Rules:** "If I do it perfectly, I won't be found out", "If I ask for help, everyone will see I'm not coping", "Making a mistake means failing." **Strategies:** checking and rechecking, working longer than anyone, not delegating, not asking for help, putting things off if they can't be done perfectly. **Situations:** the report at 10:40 p.m. ("this is weak again" → anxiety → rewrites until late); a colleague offers help ("he thinks I can't cope" → shame → turns it down); their partner suggests the cinema ("I don't deserve a break until I've finished" → guilt, irritation → a curt no).

Alex's strategies aren't "stupid". Once they helped a child earn approval; now they keep the problem going. The point is not who is to blame but what the person learned.

Important **This is the most contested level.** Core beliefs and rules are exactly where practitioners agree least (proven by research; Kuyken et al., 2005), and some clients experience

being formulated as unpleasant **proven by research; Chadwick et al., 2003**. That's why longitudinal hypotheses are offered later, once there are enough observations and trust, and as a question: "Does this ring true for you?" Details in "Does formulation help?".

Myth vs fact **Myth:** CBT doesn't deal with the past. **Fact:** longitudinal conceptualisation explicitly includes childhood, personal history and where beliefs came from **documented fact; Beck Institute, adapted from J. Beck, 2020; Kuyken et al., 2008**. But treatment first targets what keeps the problem going now.

Sources: Beck Institute: Cognitive Conceptualization Diagram · Kuyken et al., 2008 · Kuyken et al., 2005 · Chadwick et al., 2003

From formulation to plan: Persons and the "crucible"

A formulation isn't an end in itself: it shows what to work on first. And it is built together with the client.

Persons's formulation

Jacqueline Persons describes a formulation in four components **the author's own account; Persons, 2008, as summarised by Wilson & Antony and Psychology Tools**:

- **Problems**: symptoms and difficulties in every area.
- **Mechanisms**: the psychological factors that cause or maintain the problems. These are the main treatment target.
- **Precipitants**: the immediate triggers, such as stress, an event or a bodily sensation.
- **Origins**: the distant causes that shaped the mechanisms.

Persons draws hypotheses about mechanisms from evidence-based theories (of learning, cognition and emotion) and keeps testing them throughout treatment **the author's own account; Persons, 2008, publisher's description**.

Component	For Alex	What follows
Problems	Sleep, overwork, withdrawal, arguments, self-criticism	Track with questionnaires every week
Mechanisms (hypothesis)	Perfectionist rules, avoiding asking for help, giving up enjoyable things	Experiments with "good enough", asking for help, bringing back enjoyable activities
Precipitants	Promotion, the director's remark	Work through specific work situations
Origins	Approval that depended on results in childhood	Later, if needed, work on the belief "I'm not good enough"

A rough order for Alex (an illustration, not a protocol): first the five-part model, explaining the approach and setting goals; then rebuilding activity and the first experiments; then perfectionist rules, asking for help and sleep; and only after that, if still relevant, the core belief and relapse prevention.

Kuyken, Padesky and Dudley's "crucible"

Kuyken, Padesky and Dudley compare conceptualisation to a crucible: "a strong container in which different elements go through a process of substantive and lasting change" **the author's own account; Kuyken et al., 2008**. In the crucible, the client's experience is combined with CBT theory and research. The model has three principles **the author's own account; Kuyken et al., 2008**:

1. **Levels of conceptualisation.** From describing, to explaining what keeps the problem going, to explaining it through history, gradually over the course of therapy.
2. **Collaborative empiricism**, the "heat" of the crucible. The therapist brings knowledge of theory, the client brings knowledge of their own life; together they form hypotheses and test them against evidence. Put simply: two researchers, not an expert and a patient.
3. **Strengths and resilience**, at every stage. In the authors' view, a formulation that includes resources is less overwhelming for the client and helps suggest goals.

The first chapter of the authors' book is titled "The Procrustean Dilemma" **documented fact; Kuyken, Padesky & Dudley, 2009, table of contents**. Procrustes, in Greek myth, made travellers fit his bed by cutting off whatever stuck out. The dilemma is how to apply a general theory to a unique person without trimming them to fit the template.

Example **What keeps Alex afloat.** Conscientiousness, the same trait that feeds the perfectionism, can help with homework between sessions. Humour helps Alex look at their thoughts from a distance. Running experience is a resource for getting active again. A close friend means support. Being a quick learner means CBT skills are within reach.

Sources: Persons, 2008 · Wilson & Antony, Praxis CET · Kuyken et al., 2008 · Kuyken, Padesky & Dudley, 2009

Does formulation help? What the evidence says

Conceptualisation is called a foundation of CBT. Put to the test, two awkward findings emerge: practitioners often disagree, and the benefit for outcomes hasn't been shown.

115 practitioners, one case

In 2005 Willem Kuyken and colleagues gave 115 mental health practitioners attending training workshops the same case description and asked each to write a formulation using Judith Beck's diagram. The formulations were then compared with each other and with a benchmark formulation by Judith Beck herself **proven by research; Kuyken et al., 2005**.

- On the descriptive parts, practitioners largely agreed.
- On the parts that required theory-driven inference (core beliefs, rules), agreement fell.
- Quality ranged from very poor to good; only **44%** were rated at least good enough.
- Both agreement and quality were higher among more experienced and accredited practitioners.

What does this mean for a client? If a therapist confidently tells you in the third session, "your problem is that as a child you decided you weren't good enough", that may be true. Or it may be a coherent story that another practitioner would tell differently. Coherence isn't proof (interpretation; based on Kuyken et al., 2008).

Does formulation make therapy more effective?

- **A review of 24 studies** (Easden & Kazantzis, 2018): experienced therapists seem able to build some components of a formulation reliably, but its importance for CBT's effectiveness "has yet to be demonstrated" **proven by research; Easden & Kazantzis, 2018**. This is an absence of evidence of benefit, not evidence of no benefit.
- **Phobias.** German researcher Dietmar Schulte compared standard phobia treatment, chosen by diagnosis alone, with individually tailored treatment. Standard treatment was as good as, and sometimes better than, tailored treatment. Therapists formulated the problems of patients with the same diagnosis differently, but those different formulations

did not lead to different treatment strategies proven by research; Schulte, 1997. Schulte concluded that diagnosis and problem analysis should complement each other.

- **Bulimia.** Ata Ghaderi randomly assigned 50 patients to manual-based CBT or a broader, individualised CBT. Both groups improved; overall there was little difference, but the individualised version did better on three measures. Of the 10 people who did not respond, 8 were in the manual-based group. The author called the effects moderate and called for replication in larger samples proven by research; Ghaderi, 2006.
- **Psychosis.** In CBT for psychosis, therapists rated the therapeutic relationship as improved after formulation, but formulation made no meaningful difference to anxiety or depression. Six clients described it as at least partly a negative experience proven by research; Chadwick et al., 2003.

The proponents' reply

Kuyken, Padesky and Dudley argue that these studies tested formulations built largely by the therapist alone and handed to the client; collaborative, multi-level formulation that includes strengths has not yet been properly tested the author's own account; Kuyken et al., 2008. A second argument: protocols are designed for single disorders, while many people have several at once; choosing and combining protocols requires a formulation the author's own account; Dudley, Kuyken & Padesky, 2011; Persons et al., 2006.

The honest position is to keep both sides in mind. Whether CBT protocols work is a separate, well-researched question (covered in Episode 14). What is in dispute is the added value of an individual formulation over a standard protocol (interpretation; Easden & Kazantzis, 2018; Kuyken et al., 2008).

Myth vs fact **Myth:** a good formulation is a proven guarantee of successful therapy. **Fact:** there is no evidence yet that an individual formulation improves outcomes compared with a standard protocol proven by research; Easden & Kazantzis, 2018; Schulte, 1997. Its main supposed value is for people with several problems at once and for those a standard protocol hasn't helped the author's own account; Kuyken et al., 2008.

Protocol or flexibility

A **protocol** is a step-by-step treatment manual for a specific disorder. The "protocol versus tailoring" debate is often settled with a phrase from Philip Kendall's group: **flexibility within fidelity**. The manual is a framework, and clinical skill is needed to apply it moment to moment in the session. What can change is the delivery: shorter segments with breaks, simpler tasks, a choice of activities, or, for a child, a single portable coping thought such as "Be brave" instead of a set of thoughts. The principles stay: if a therapist skips exposures because they are "too difficult", that is no longer adherence to the protocol the author's own account; Beidas, Benjamin, Puleo, Edmunds & Kendall, 2010. The paper is about the

Coping Cat programme for anxious children, but the logic — change the form, keep the principle — applies more widely (interpretation). Another answer to the same problem is transdiagnostic protocols, one protocol for mechanisms shared by several disorders, such as Barlow's Unified Protocol (more in Episode 8).

Sources: Beidas et al., 2010 · Kuyken et al., 2005 · Easden & Kazantzis, 2018 · Schulte, 1997 · Ghaderi, 2006 · Chadwick et al., 2003 · Kuyken et al., 2008 · Dudley et al., 2011

How a CBT session is structured

Every session follows a consistent order. There is nothing secret about it, and it helps clients to know it.

Structure has been one of cognitive therapy's trademarks since Beck and colleagues' first manual (1979). A typical session lasts 45–50 minutes, with no more than two or three agenda items **clinical consensus; Weinstock, CDP**.

Part	What happens	Why	Common mistake
1. Mood check	A brief review since last time, often with a questionnaire	Track progress, spot deterioration and risk early	Letting the week's story take up half the session
2. Bridge	The main thing the client took from last session	Link sessions into one process	Every session starts from scratch
3. Agenda	Choose and order 2–3 topics together	Transparency, collaboration, focus on goals	The therapist decides alone; too many items
4. Homework review	What worked, what got in the way, what was learned	Carry skills into life; show homework matters	"Did it? Well done" with no conclusion
5. Agenda work	CBT methods linked to the conceptualisation; brief summaries	The main change	Chatting "about everything"; techniques unconnected to the formulation
6. New homework	Grows out of the session; obstacles discussed	Practice between sessions	Setting it in the last minute
7. Summary and feedback	The client sums up the key points; the therapist asks what helped and what didn't	Adjust the work, catch strains in the relationship early	Not asking, or asking for form's sake

The order and purpose of each part follow a training resource from the US Center for Deployment Psychology, which trains clinicians working with military personnel **clinical consensus; Weinstock, CDP**, and Judith Beck's demonstration session **documented fact; J. Beck, 2020, annotated transcript**. We found no experiments among the sources for these notes that test the effect of individual elements (bridge, agenda) on outcomes **not verified**. There is an indirect signal: in a study by Strunk and colleagues, of all the items on the competence scale, the agenda item had the strongest link with subsequent symptom improvement, r = 0.48 **proven by research; Strunk, Brotman, DeRubeis & Hollon, 2010b**. This is a correlation in one sample of 60 patients, not a test of cause.

What changed in Judith Beck's 2020 edition

In the third edition of Judith Beck's textbook, homework is called an **Action Plan**. In the demonstration second session with a client called Abe, the therapist asks about the **best part of the week** and helps draw conclusions from it; an annotation notes that this differs from the traditional CBT opening of asking what went wrong documented fact; J. Beck, 2020, annotated transcript. In the same session the client chooses which goal to start with, and items in the new Action Plan are simplified or made optional if the client rates them as too hard.

> Example **Session 4 with Alex (50 minutes; all fictional; timings are approximate). 0–3. Mood check.** "Your questionnaire shows sleep is a bit better and anxiety about the same. How would you describe the week?" "A bit easier. Two evenings I left work at eight." **3–5. Bridge.** "What did you take away last time?" "That the anxiety and rewriting until late is a loop, not laziness." **5–10. Agenda.** Alex wants to talk about the cancelled Saturday; the therapist suggests going over the report experiment. Alex chooses the order. **10–15. Homework review.** The prediction was "the director will say it's sloppy", confidence 85%. In reality the director asked for one extra chart. "What does that say about the rule 'if it isn't perfect, I'll be found out'?" "That it isn't that strict." Confidence in the prediction: 50%. **15–38. Agenda work.** First, questions about the experiment and a summary: "you expected to be torn apart and got one edit." Then the five-part model for the moment Alex cancelled; the thought "I don't deserve a break until I've finished" comes up. **38–45. New Action Plan.** Meet a friend on Saturday for one hour and rate mood before and after on a 0–10 scale; send another report at 7 p.m. with a prediction. "How likely is it to happen? What might get in the way?" "70%. I might start working in the morning." "What then?" "I'll set an alarm for 11 and close the laptop." **45–50. Summary and feedback.** Alex sums up the key points. "What was useful? Was anything unpleasant?" "The bit about Saturday felt a little like being told off." "Thank you for saying so. If you feel that again, stop me straight away."

How long CBT lasts

The short answer: usually between 5 and 15 sessions, depending on what a person is being treated for clinical consensus; NHS 111 Wales. UK patient information describes sessions as weekly or fortnightly, lasting 30–60 minutes, with exposure sessions often longer clinical consensus; Patient.info. A standard one-to-one CBT session lasts 45–50 minutes (see above). Therapist and client decide on the length of treatment together the author's own account; J. Beck, questions and answers about cognitive therapy.

Benchmarks from the UK's NICE guidelines and other professional bodies, by condition:

Condition	What is recommended, and how much	Session length and frequency	La
Depression, less severe	Options include guided self-help, usually 6–8 sessions; group CBT, usually 8 sessions; individual CBT, usually 8, sometimes more (with comorbid health problems, complex social needs or residual symptoms)	—	
Depression, more severe	Individual CBT, usually 16 sessions, alone or with an antidepressant	—	
Generalised anxiety disorder	Guided self-help, usually 5–7 sessions; CBT or applied relaxation, usually 12–15 sessions; fewer with early recovery, more if clinically needed	Self-help: 20–30 min, weekly or fortnightly; CBT: 1 hour, weekly	
Panic disorder	CBT totalling 7–14 hours, completed within 4 months	Usually weekly, 1–2 hours each	
Social anxiety, adults	Individual CBT based on the Clark and Wells model, up to 14 sessions over about 4 months	Up to 90 minutes	
Social anxiety, children and young people	Individual or group CBT, 8–12 sessions; parents may be involved	Individual: 45 min; group: 90 min	
OCD	Mild impairment: low-intensity treatment including exposure and response prevention (ERP), up to 10 therapist hours (brief individual work with self-help materials, by telephone, or in a group). Moderate: an SSRI or more intensive CBT with ERP, over 10 hours. Severe: an SSRI combined with CBT with ERP	—	

Condition	What is recommended, and how much	Session length and frequency	La
PTSD	Trauma-focused CBT, usually 8–12 sessions, more if clinically needed, for example after multiple traumas	—	
Health anxiety	5–10 sessions of CBT; after a year, twice as many people reached normal levels of health anxiety as with usual care, and the gains held at 2 years	—	
Chronic insomnia	CBT for insomnia, typically 4–8 sessions; in person, via telehealth or through an app	—	
Bulimia, adults	Guided self-help, 4–9 sessions; CBT, up to 20 sessions over 20 weeks, twice weekly at first	Self-help: about 20 min	
Binge eating disorder, adults	Guided self-help, 4–9 sessions; group CBT, 16 weekly sessions over 4 months	Self-help: about 20 min; group: about 90 min	
Anorexia, adults	CBT for up to 40 weeks (9–10 months), twice weekly for the first 2–3 weeks	Weekly	
Psychosis	Individual CBT, at least 16 sessions; family intervention, at least 10 sessions over 3 months to a year	—	

What this looks like in practice. Robinson, Kellett and Delgadillo analysed data from more than 100,000 patients of the UK's state-funded IAPT programme (now NHS Talking Therapies; more in Episode 6) from 2014–2017. On average patients had 3.7 low-intensity sessions (the middle half had 1–6) and 8.3 high-intensity sessions (4–12). Of those who achieved reliable and clinically significant improvement, 95% did so by session 7 of low-intensity or session 14 of high-intensity treatment. PTSD and OCD needed the most: 6–16 high-intensity sessions. The authors suggest reviewing the plan if there is no improvement by these points, and caution strongly against arbitrarily capping treatment for people who are already improving: extending it up to 24 sessions may be warranted **proven by research; Robinson, Kellett & Delgadillo, 2020**. These are observational data from one

system, not an experiment. The programme's own manual also says the number of sessions should never be restricted arbitrarily **clinical consensus; NHS Talking Therapies Manual, 2024**.

Important These figures are benchmarks from the UK's state system, not a promise. The number of sessions depends on severity, other problems and how quickly things improve. Asking roughly how many sessions you'll need, and how you'll both know therapy is helping, is a perfectly reasonable question for a first appointment.

What is known about "dose":

- In a meta-regression of 70 studies of psychotherapy for depression (92 comparisons, 5,403 patients), the total number of sessions was only weakly linked to effect size, and the link disappeared once other study characteristics were accounted for. Frequency, however, mattered: moving from one to two sessions a week with the same total number of sessions raised the effect by g = 0.45 **proven by research; Cuijpers et al., 2013**. This compares studies rather than testing frequency experimentally, and the authors call for confirmation.
- The good-enough level model suggests that people change at different speeds and stop therapy when they feel well enough. In a meta-analysis of 15 studies, the overall link between therapy length and outcome was not significant, with very high heterogeneity **proven by research; Bone, Delgadillo & Barkham, 2021**.

Myth vs fact **Myth:** structure makes CBT cold and mechanical. **Fact:** the structure includes a jointly set agenda and feedback at the end of every session **clinical consensus; Weinstock, CDP**, and in Judith Beck's 2020 textbook the session opens with the best part of the week **documented fact; J. Beck, 2020**.

Sources: Weinstock, CDP · J. Beck, 2020, annotated transcript of session 2 · Kendrick et al., 2022 · NICE CG113 · Warnock-Parkes et al., 2020 · Cuijpers et al., 2013 · Bone et al., 2021 · NHS 111 Wales · Patient.info · NICE CG113, recommendations · NICE CG113, panic · NICE CG159, children · OCD-UK on NICE CG31 · GPnotebook on NICE NG116 · Beck Institute on CHAMP · AASM, 2021 · NICE NG69 · NICE CG178 · Robinson et al., 2020

The client's journey: from first appointment to last

CBT is time-limited from the start. That is why its ending is planned as carefully as its beginning, and why it helps the client to know the whole route in advance.

The first appointment and informed consent

The first appointment is usually an assessment (see "Where it starts: assessment"): the therapist asks about the difficulties, their history and the person's goals, and often asks them to fill in questionnaires. This is also where the client gives **informed consent**, agreeing to the work while understanding what they are agreeing to. The American Psychological Association's ethics code puts it this way: as early as is feasible, tell the client about the nature and anticipated course of therapy, fees, involvement of third parties and the limits of confidentiality, and give them sufficient opportunity to ask questions and receive answers (**documented fact; APA, Ethical Principles, standard 10.01**). Codes differ in detail from country to country, but this list of topics is a good guide for a client anywhere (interpretation).

Formulation, goals and the active phase

In the first sessions the client and therapist build the case formulation together (see the chapters above) and agree on goals: what needs to change in the person's life for therapy to count as a success. Then comes the active phase: usually weekly sessions, each with the structure described in the session chapter and a short questionnaire. If there is no improvement for a long time, that is a reason to review the plan together; in UK service data, almost everyone who was helped had improved markedly by session 7 of low-intensity or session 14 of high-intensity treatment (**proven by research; Robinson, Kellett & Delgadillo, 2020**).

Spacing sessions out

As things improve, sessions are spaced out: first every two weeks, then every three. This lets the client practise the skills on their own while still in therapy (**the author's own account; J. Beck, questions and answers about cognitive therapy**).

The last session and the relapse prevention plan

Ending is a topic in its own right in CBT: Judith Beck's 2020 textbook has a chapter called "Termination and Relapse Prevention" (**documented fact; J. Beck, 2020, table of contents**). The UK competence framework for CBT (UCL, Roth & Pilling) lists a specific ability to end therapy in a planned way and to plan how gains will be maintained afterwards; ending includes reviewing progress and planning for the risk of relapse. The framework's authors stress that leaving therapy is often as significant as engaging in it (**clinical consensus; Roth & Pilling, UCL CORE**). For depression, NICE suggests that people whose remission followed psychological therapy consider continuing the same therapy, adapted for relapse prevention (**clinical consensus; NICE NG222, "Preventing relapse" visual summary**).

Booster sessions

Booster sessions are separate appointments after the course has ended. Judith Beck recommends them three, six and twelve months after therapy finishes

the author's own account; J. Beck, questions and answers about cognitive therapy. They check whether gains are holding and work through difficulties that have come up in the meantime.

Example **Alex's relapse prevention plan (fictional, one page).** *What helped:* the five-part model for hard moments; experiments instead of "I'll make it perfect"; work-free Saturdays. *Early warning signs:* sending reports after midnight again, cancelling plans with friends, under six hours' sleep three nights running. *What I do:* go back to a weekly activity schedule, set up one experiment, reread my session notes. *When I contact a professional:* if I've been worse for two weeks in a row despite the plan. *Booster sessions:* at 3, 6 and 12 months. A setback isn't failure; it's exactly what the plan is for.

Questions instead of answers: guided discovery

Socratic questions in CBT aren't a way of steering someone to the "right" answer; they help the person notice something for themselves.

Socratic questioning is a sequence of questions that helps a person reach a conclusion on their own. In 1993 Christine Padesky gave a keynote at the European Congress of Behavioural and Cognitive Therapies in London titled "Socratic questioning: Changing minds or guiding discovery?" documented fact; Padesky, 1993. She distinguishes two ways of asking questions the author's own account; Padesky, 1993:

- **Changing minds.** The therapist already has the answer and uses questions to lead the client to it, like a lawyer with a witness.
- **Guiding discovery.** The therapist asks out of genuine curiosity, without knowing in advance where the conversation will go. The conclusion belongs to the client.

Padesky argues for the second. In her words documented fact, verbatim quote; Padesky, 1993, p. 6:

> "If you are not truly curious to know the answer, don't ask the question."

Four stages

Padesky describes guided discovery in four stages the author's own account; Padesky, 1993:

1. **Informational questions**: ones the person can answer: "What exactly did the director say?"
2. **Listening**: closely, paying attention to the client's particular words, images and emotional reactions.
3. **Summarising**: every few minutes, so both can check their understanding: "So you expected to be torn apart and got one edit."

4. **Synthesising (analytical) questions**: how the new information fits the original thought: "How does that fit with the rule 'making a mistake means failing'?"

What the data show

In a study by Braun and colleagues, 55 adults with depression received cognitive therapy; observers rated recordings of the first three sessions on a 0–6 Socratic questioning scale. When a therapist asked more Socratic questions than usual for that client in a given session, depressive symptoms fell more by the next session: about 1.5 points on the Beck Depression Inventory (BDI-II) per standard deviation. The effect held after controlling for the quality of the alliance **proven by research; Braun et al., 2015**.

Limits: this is one correlational study, covering only early sessions and only depression. The authors themselves say a causal link can't be established without an experiment. Average levels of Socratic questioning were modest: 1.16 to 2.68 out of 6 **proven by research; Braun et al., 2015**.

Socratic dialogue and the thought record are covered in detail in Episode 5.

Myth vs fact **Myth:** Socratic dialogue means the therapist uses questions to lead the client to the correct answer. **Fact:** Padesky explicitly separates "changing minds" from "guiding discovery" and argues for the latter **the author's own account; Padesky, 1993**.

Sources: Padesky, 1993 · Braun et al., 2015

Homework, or the Action Plan

Almost all of a client's life happens between sessions. Homework carries what was found in the session into that life.

In CBT, tasks between sessions are part of the method, not a formality. Typical tasks during conceptualisation: recording one or two situations a week in the five-part model; keeping a behaviour–mood diary to test the model **the author's own account; Padesky & Mooney, 1990**; listing what went well during the day **the author's own account; J. Beck, 2020, transcript**; running a behavioural experiment that tests one hypothesis from the formulation **clinical consensus; Kuyken et al., 2008**.

What the data say

- A meta-analysis by Kazantzis and colleagues (17 studies, 2,312 clients) found that both the quantity of homework completed and the quality of completion were linked to better CBT outcomes. At post-treatment: quantity g = 0.79 (15 studies), quality g = 0.78 (3 studies); the

link persisted at follow-up **proven by research; Kazantzis et al., 2016**. g is a measure of effect size; values around 0.8 are usually considered large. Data on quality are thin, only three studies, so that finding is preliminary.

- Kazantzis suggests talking about client engagement rather than "compliance", and links completion to how well homework fits the content of the session **the author's own account; Kazantzis, 2021**.

Why the homework review shouldn't be skipped

If homework isn't reviewed, clients quickly learn it doesn't matter and stop doing it **clinical consensus; Weinstock, CDP**. A good review isn't "did it? well done" but "what follows from this?". In Alex's example, the conclusion from the experiment lowered confidence in the gloomy prediction from 85% to 50%.

Myth vs fact **Myth:** CBT homework is a box-ticking formality. **Fact:** completing homework is linked to therapy outcomes **proven by research; Kazantzis et al., 2016**, and in clinical experience a skipped review teaches clients not to do it **clinical consensus; Weinstock, CDP**.

Sources: Kazantzis et al., 2016 · Kazantzis, 2021, Beck Institute · Weinstock, CDP · Padesky & Mooney, 1990

The relationship and the therapist's skill

Do the relationship with the therapist and the therapist's skill matter in CBT? The data say yes, but less straightforwardly than one might hope.

The alliance: linked to outcome in every therapy

The **therapeutic alliance** is the agreement between client and therapist on the goals and tasks of the work, plus the emotional bond between them. A meta-analysis by Flückiger and colleagues pooled 295 independent studies (published 1978–2017, more than 30,000 patients). The alliance–outcome correlation in face-to-face therapy was r = .278 (95% confidence interval .256–.299), roughly d = 0.58; in internet-based therapy, r = .275 (23 studies). For CBT, a separate adjusted estimate was r = .20 (72 studies); types of therapy did not differ significantly **proven by research; Flückiger et al., 2018**.

Chicken or egg

But within CBT for depression there is a twist. Strunk, Brotman and DeRubeis looked at the first five sessions of 60 patients with moderate to severe depression **proven by research; Strunk, Brotman & DeRubeis, 2010a**:

- the alliance did not predict improvement by the next session (r = .15, not significant);
- improvement that had already happened did predict a stronger alliance (r = .34);
- the therapist's cognitive methods (r = .44) and session structuring (r = .38) predicted improvement even after controlling for the alliance.

How do these fit together? Both are true at once: the alliance is linked to outcome across approaches, and early in CBT for depression a good relationship partly grows out of early progress. Correlational data can't tell which is cause and which is effect (interpretation; Flückiger et al., 2018; Strunk et al., 2010a).

Myth vs fact **Myth:** in CBT the relationship doesn't matter; only techniques do. **Fact:** the alliance is linked to outcome across approaches, CBT included **proven by research; Flückiger et al., 2018**; in CBT for depression it partly follows early improvement **proven by research; Strunk et al., 2010a**.

How therapist skill is rated

CBT has scales that an expert uses to rate a session recording:

Scale	What it rates	Format
CTRS (Young & Beck, 1980)	A cognitive therapy session	11 items scored 0–6, including agenda, feedback, collaboration, pacing, guided discovery and homework
CTS-R (Blackburn et al., 2001)	The same, revised	12 items in the current manual, scored 0–6 from "incompetent" to "expert"; items include agenda, feedback, collaboration, eliciting emotion, guided discovery, conceptual integration and homework
CCC-RS (Kuyken et al., 2015)	Competence in collaborative case conceptualisation	14 items scored 0–3; preliminary testing, link to outcome not studied

Based on the scale manuals and papers **documented fact; Young & Beck, 1980; Blackburn et al., 2001; Kuyken et al., 2015**. On the CTS-R's psychometrics: internal consistency was high, but the reliability of individual items varied considerably between pairs of raters **proven by research; Blackburn et al., 2001**. The scale forms are copyrighted; the CTS-R may be used free of charge in routine clinical and supervision practice, but reproducing it requires the copyright holder's permission **documented fact; CTS-R manual**.

Are therapist scores linked to client outcomes?

Here the data are awkward:

- A meta-analysis by Webb, DeRubeis and Barber of 36 studies found that neither adherence (whether the therapist does what the method prescribes) nor competence (how well they do it) was meaningfully linked to patient outcomes; the average estimates were close to zero **proven by research; Webb, DeRubeis & Barber, 2010, via secondary sources**. The exact coefficients differ between summaries (sources disagree; Owen & Hilsenroth, 2014, give r = .07 for adherence, while a White Rose thesis gives r = .02 for adherence and r = .07 for competence). In studies that did not control for the alliance, the competence–outcome link was larger **the author's own account; as summarised by Scott Miller**.
- In routine psychiatric care in Stockholm (29 therapists, 85 patients with depression and anxiety disorders), the mean CTS-R score was 40.5 and 76% of therapists were at or above the competence threshold of 36; patients improved significantly (d = 0.80–1.36), but neither adherence nor competence was linked to outcome **proven by research; Bergvall et al., 2024**.
- There is evidence pointing the other way. In another paper by Strunk and colleagues (60 patients with moderate to severe depression, six therapists), therapist competence in the first four sessions predicted symptom improvement by the next session (r = 0.28) and lower scores on the Hamilton depression scale at the end of treatment (r = 0.33); on the Beck Depression Inventory (BDI-II) there was only a non-significant trend. When the researchers accounted for how "difficult" a patient was rated, the link with early improvement weakened to a trend. Competence mattered more for patients with higher anxiety and an earlier onset of depression; the authors describe this analysis as exploratory **proven by research; Strunk, Brotman, DeRubeis & Hollon, 2010b**.

How to read this? Perhaps therapists in these studies are all trained to a similar standard, leaving little variation in skill to show up. Perhaps the scales don't measure what matters most. It is an open question, and it doesn't mean therapist skill is unimportant (interpretation). A systematic review of methods for assessing CBT competence found no consensus on how to measure it **proven by research; Muse & McManus, 2013**.

Sources: Flückiger et al., 2018 · Strunk et al., 2010a · Strunk et al., 2010b · Young & Beck, 1980, CTRS · Blackburn et al., 2001 · CTS-R manual · Kuyken et al., 2015 · Owen & Hilsenroth, 2014 · Miller on Webb et al. · Bergvall et al., 2024 · Muse & McManus, 2013

Myths: a quick check

All the myths from these notes in one table.

Myth	What the sources say	Label
CBT is template techniques; the person doesn't matter	CBT has a well-developed tradition of individual conceptualisation: models by J. Beck, Persons, and Kuyken, Padesky and Dudley	**Documented fact**
CBT doesn't deal with the past	The longitudinal level of a formulation includes history and the origins of beliefs; but what maintains the problem now is treated first	**Documented fact**
A good formulation guarantees success	The added value of formulation over a standard protocol hasn't been shown	**Proven by research**
Any experienced therapist will see the same thing in a case	Agreement is good on description, worse on core beliefs; 44% of formulations were good enough	**Proven by research**
"Hot cross bun" is Padesky's term	The phrase isn't in the 1990 article	**Documented fact**
Structure makes CBT cold	The agenda is shared, feedback closes each session; in J. Beck's 2020 edition sessions open with the best part of the week	**Clinical consensus**
The relationship doesn't matter in CBT	The alliance is linked to outcome across approaches; early in CBT for depression it partly follows improvement	**Proven by research**
The longer the therapy, the better	Total number of sessions is weakly linked to outcome; in depression, frequency seems to matter more	**Proven by research**
Socratic dialogue leads you to the right answer	Padesky argues for questions asked out of curiosity, with no answer decided in advance	**The author's own account**
Homework is a formality	Completing homework is linked to outcome	**Proven by research**

Try this: four circles

A one-minute exercise. It's a first step in self-observation, not therapy or diagnosis.

Example **Four circles in a minute** (based on Padesky & Mooney, 1990).

1. Think of a recent situation that felt hard.
2. Draw four circles: thoughts, emotions, body, behaviour. Write one line in each.
3. Around the circles, note what was going on in your life at the time.
4. Look at the connections and ask yourself: what one small change in behaviour might pull the others along?

This is how the five-part model is used in therapy in the first sessions: to see that difficulties are connected, and therefore workable **the author's own account; Padesky & Mooney, 1990**. Don't use the exercise to diagnose yourself or people close to you, let alone to "work out" someone's core beliefs: the data show this is hard even for professionals. If a difficult state lasts for weeks, gets in the way of life or frightens you, that's a reason to see a professional.

Wrap-up: check yourself and key takeaways

Check yourself

1. **How does a conceptualisation differ from a diagnosis?** A diagnosis is a category of condition. A conceptualisation is an individual hypothesis about how a person's difficulties arose and what keeps them going; it guides treatment and is tested against data.
2. **What three levels of conceptualisation do Kuyken, Padesky and Dudley describe?** Descriptive ("what is happening"), cross-sectional explanatory ("why it isn't going away") and longitudinal ("where it came from").
3. **What are the parts of the five-part model?** Thoughts, emotions, body, behaviour, and the environment surrounding them.
4. **What did the study of 115 practitioners find?** Good agreement on the problems, worse on core beliefs; 44% of formulations were good enough; experienced and accredited practitioners did better.
5. **Has formulation been shown to improve CBT outcomes?** No: according to a review of 24 studies, its importance for effectiveness "has yet to be demonstrated"; in a phobia study, standard treatment was no worse than a tailored approach.
6. **What is the order of a session?** Mood check → bridge → agenda → homework review → main work → new homework → summary and feedback.

7. **How does "guiding discovery" differ from "changing minds"?** The therapist has no answer ready in advance, asks out of curiosity, and the client draws the conclusion.

Key takeaways

- In CBT a conceptualisation is a hypothesis, not a verdict; it is built with the client and tested.
- First describe, then explain what keeps the problem going now, and only then turn to history.
- Core beliefs are the least reliable part of a formulation; they are offered as a question.
- The added value of an individual formulation over a standard protocol hasn't been shown; whether CBT protocols themselves work is a separate question.
- A CBT session is transparent: shared agenda, homework review, feedback.
- Homework and Socratic questioning are linked to outcome, but these are correlations, not proof of cause.
- The alliance matters in every therapy; early in CBT for depression it partly grows out of early improvement.
- How long therapy lasts depends on the problem and the pace of improvement; the ending is planned in advance: sessions spaced out, a relapse prevention plan, booster sessions.

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