Treatment Planning Reference Guide for CBT Clinicians

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Glossary of Terms

CBT Adaptations

CBT-E (Enhanced Cognitive Behavioral Therapy): Specifically designed for eating disorders, it focuses on issues such as overvaluation of body shape and weight.

CBT-T (Trauma-focused Cognitive Behavioral Therapy): Aimed at children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

CBT-I (Insomnia): A structured program that helps individuals overcome beliefs and attitudes that hinder sleep and establish good sleep habits.

CBT-P (Perinatal CBT): Tailored for women with mood disorders during the perinatal period (before and after childbirth), addressing specific issues such as prenatal depression and anxiety.

CBT-SP (Cognitive Behavioral Therapy – Schizophrenia and Psychosis): This is a form of therapy adapted for treating schizophrenia and other psychotic disorders.

CBT-CP (Chronic Pain): Helps patients understand the thoughts and feelings that affect pain, and teaches coping skills to manage the chronic pain.

CBT-CD (Childhood Disruptive Behaviors): Targets behavior problems in children, such as Oppositional Defiant Disorder or Conduct Disorder.

CBT-S (Substance Abuse): Focuses on teaching recovering addicts to find connections between their thoughts, feelings, and actions and increase awareness of how these things impact recovery.

CBT-AD (Adult ADHD): Helps adults with attention-deficit/hyperactivity disorder (ADHD) develop skills to manage symptoms and organizational challenges.

CBT-AR (Anger Resolution): Designed for individuals with anger management issues, focusing on identifying triggers and developing healthier responses.

CBT-BN (Bulimia Nervosa): Targets the cycle of bingeing and compensatory behaviors in bulimia nervosa.

CBT-BDD (Body Dysmorphic Disorder): Focuses on the distorted body image and maladaptive behaviors characteristic of BDD.

CBT-PI (Postpartum Insomnia): Specific for new mothers experiencing sleep disturbances.

CBT-PTSD (Post-Traumatic Stress Disorder): Involves processing traumatic events and reducing avoidance and hyperarousal.

CBT-OCD (Obsessive-Compulsive Disorder): Often includes Exposure and Response Prevention (ERP) to help manage obsessions and compulsive behaviors.

Cognitive Behavioural Therapies

Cognitive Behavioural Therapy: The original form of CBT that combines cognitive and behavioural techniques to change thoughts and behaviours.

Acceptance and Commitment Therapy (ACT): Uses acceptance and mindfulness strategies, together with commitment and behavior change strategies.

Cognitive Analytic Therapy (CAT) Combines cognitive therapy with analytic understanding to look at the way a person thinks, feels, and acts

Cognitive Behavioral Analysis System of Psychotherapy (CBASP): Specifically designed for chronic depression, combining elements of CBT with interpersonal psychotherapy.

Cognitive Therapy: Concentrates on changing internal thoughts and perceptions that lead to emotional distress and maladaptive behavior.

Dialectical Behaviour Therapy (DBT): Combines cognitive and behavioral techniques with mindfulness strategies; it was originally developed for Borderline Personality Disorder.

Mindfulness-Based Cognitive Therapy (MBCT): Integrates cognitive behavioral techniques with mindfulness strategies to help individuals suffering from chronic depression.

Multimodal Therapy: Proposes that therapists must address seven different but interconnected modalities (behavior, affect, sensation, imagery, cognition, interpersonal factors, and drug/biological considerations).

Rational Emotive Behavior Therapy (REBT): Focuses on identifying irrational beliefs, actively challenging these beliefs, and finally learning to recognize and change these thought patterns.

Concepts & Techniques

Action Plan: The step-by-step plan to implement the chosen solution.

Activating Event: The actual event or situation that triggers the thought process.

Activation Strategy: The plan for increasing engagement in positive activities.

Activity Scheduling: Planning specific activities that the client aims to complete, often used to combat depression.

Activity Scheduling: Planning specific activities to improve mood or increase the structure in one's day.

Assertiveness Training: Improving communication skills and the ability to set boundaries with others.

Behavioral Activation: A CBT technique to help clients engage more often in enjoyable activities to improve mood.

Behavioral Activation: Increasing engagement in positively reinforcing activities to improve mood and decrease depression.

Behavioral Experiment: A method of testing out the validity of negative beliefs by designing and carrying out an experiment.

Behavioral Goals: Specific targets for action or behavior change.

Beliefs: The automatic thoughts or interpretations that arise from the activating event.

Cognitive Restructuring or Reframing: Identifying and challenging harmful thoughts and replacing them with more constructive ones.

Commitment: The intention to carry out the scheduled activities.

Consequences: The emotional and behavioral responses that result from the beliefs.

Decision Making: Choosing the best solution from the options generated.

Exposure Hierarchy: A list of feared or avoided situations ranked by difficulty, used in exposure therapy.

Exposure Therapy: Gradually and systematically exposing the patient to feared objects or situations to lessen the emotional response.

Graded Exposure: Gradually exposing patients to more challenging situations to build up their tolerance.

Graduated Exposure: A step-by-step approach where clients confront their fears beginning with the least difficult situations.

Homework Assignments: Tasks given to clients to practice CBT techniques in real-world situations.

Hypothesis: An assumption made by the client that can be tested through a behavioral experiment.

Mindfulness: Focusing one's attention on the present moment while calmly acknowledging and accepting one's feelings and thoughts.

Outcome: The result of the experiment, used to confirm or disprove the hypothesis.

Prioritization: The process of determining which activities are most important or enjoyable to schedule.

Problem Definition: Clearly stating the problem to be solved.

Problem Solving Worksheet: A tool to identify solutions to specific problems and create a plan of action.

Problem-Solving Therapy: Teaching individuals to solve the problems that contribute to their emotional distress.

Relaxation Techniques: Methods such as deep breathing, progressive muscle relaxation, and guided imagery to reduce stress and anxiety.

Skill Training: Teaching skills to manage problematic behaviors and emotions effectively.

Socratic Questioning: A method of guided discovery in which therapists ask clients questions that lead to insight and change.

Solution Generation: Brainstorming possible ways to resolve the issue.

Systematic Desensitization: A technique used in which relaxation strategies are paired with the exposure hierarchy to reduce anxiety.

Thought Record: A tool used to track negative thoughts, feelings, and behaviors. Clients learn to identify and challenge unhelpful thoughts and replace them with more balanced, helpful ones.

Technique-Diagnostic Indication Quick Reference Chart

Technique	Diagnostic Indication
Anger Management	Oppositional defiance/conduct, antisocial personality, narcissistic personality
Assertiveness Training	Persistent depression/dysthymia, gender dysphoria, communication disorders, histrionic personality, narcissistic personality, dependent personality, substance use disorder
Behavioural Activation	Depression, particularly with inactivity
CAT (Cognitive Analytic Therapy)	Personality Disorders
CPT (Cognitive Processing Therapy)	PTSD, trauma-related disorders
DBT (Dialectical Behaviour Therapy)	Borderline Personality Disorder, self-harm
Emotion Regulation	Disruptive mood dysregulation, anti-social personality, borderline personality, histrionic personality, schizotypal personality
ERP (Exposure and Response Prevention)	OCD, OCPD, motor disorders (tic, Tourette's), kleptomania, gambling disorder, bulimia nervosa
Gradual Exposure	Phobias, OCD, body dysmorphic disorder, hoarding, avoidant personality, genito-pelvic pain/penetration disorder hypoactive sexual desire, illness anxiety,
Guided Imagery	Anxiety, stress, pain
Habit Reversal Training	Pica, rumination disorder, motor disorders, OCD, excoriation (skin-picking), trichotillomania (hair-pulling)
Mood Monitoring	Bipolar disorders, cyclothymic disorder, premenstrual dysphoric disorder
Motivational Interviewing	Hoarding disorder, factitious disorder, substance use disorder, gambling disorder
Parent Training	Separation anxiety, disruptive mood dysregulation, oppositional defiance, disinhibited social engagement disorder
Problem Solving Skills	General decision-making difficulties; plus Cyclothymic disorder, depressive disorders, disruptive and conduct disorders, intellectual disabilities, communication disorders, autism spectrum, learning disabilities, hoarding disorder, antisocial personality, dependent personality, adjustment disorders, substance use / relapse prevention, gambling disorder
Prolonged Exposure	PTSD, trauma, phobias

Technique	Diagnostic Indication
Reality Testing	Depersonalization/derealization, schizotypal personality, histrionic personality, delusional disorder
Relapse Prevention Planning	Binge eating disorder, OCD, schizophrenia, substance use and gambling disorders
Relaxation Techniques	Anxiety, stress
Sensate Focus	Delayed ejaculation, erectile difficulty, hypoactive sexual desire
Social Skills Training	Social anxiety, disruptive mood dysregulation, oppositional defiance/conduct disorder, binge-eating disorder, communication disorder, autism spectrum, schizophrenia, schizoid personality, schizotypal personality, histrionic personality, avoidant personality, disinhibited social engagement disorder, substance use disorders
Stimulus Control	Excoriation, trichotillomania, insomnia, hypersomnolence disorder, selective mutism
Systematic Desensitization	Phobias, anxiety disorders
Thought Record	Nearly every disorder where cognitive restructuring is suggested
Time Management	ADHD, OCPD

Critiques and Limitations of CBT

CBT is a widely researched and practiced form of psychotherapy known for its efficacy in treating a range of mental health issues, including anxiety disorders, depression, eating disorders, and more. However, like any therapeutic approach, it has its critiques and limitations. Here are some of the common ones:

- ⇒ **Overemphasis on Cognition:** Critics argue that CBT places too much emphasis on cognitive processes and may not address emotional or unconscious aspects sufficiently. It operates on the assumption that changing thought patterns can change feelings and behaviors, but some argue that this neglects the complexity of human emotions.
- ⇒ **One-Size-Fits-All Approach:** CBT is often criticized for being too manualized and structured, which may not account for the individual differences in patients' experiences or cultural backgrounds.
- ⇒ **Short-Term Focus:** The structured and time-limited nature of CBT is sometimes seen as a drawback because it may not address deeper or more chronic issues that require long-term treatment.
- ⇒ **Underestimates Environmental Factors:** CBT primarily focuses on individual thought and behavior patterns, which can lead to underestimating the impact of socio-economic and environmental factors on mental health.
- ⇒ **Research Bias:** Some argue that the research on CBT is biased due to the "file drawer problem," where studies with negative results are less likely to be published. Additionally, the effectiveness of CBT may be overestimated because it is often compared to waiting list controls in studies rather than other active therapies.
- ⇒ **Skill Acquisition vs. Insight:** CBT focuses on skills and techniques for dealing with problematic thoughts and behaviors, which may not necessarily lead to deeper insight into the underlying causes of psychological distress.
- ⇒ **Dependence on Patient's Motivation:** The success of CBT relies heavily on the patient's active participation in the process, including homework assignments. Those who are not motivated or are unwilling to put in the work outside of therapy sessions may not benefit as much from CBT.
- ⇒ **Simplistic View of Disorders:** Some critics believe CBT can oversimplify complex mental disorders by attributing them mainly to distorted thinking patterns without considering the interplay of biological and genetic factors.
- ⇒ **Efficacy Over Time:** While CBT is effective for many people, there is debate about the long-term durability of its effects, with some studies suggesting that other therapies may have better long-term outcomes for certain conditions.
- ⇒ **Therapist's Role:** CBT often requires therapists to be more directive and educative, which can sometimes limit the therapeutic relationship and the warmth and empathy felt by the client.
- ⇒ **Not Suitable for All Clients:** People with severe mental health issues, cognitive impairments, or those who have difficulty with introspection may not find CBT to be the best approach.
- ⇒ **Reliance on Client's Rationality:** CBT assumes that clients are capable of rational thinking and that they can identify and challenge their own irrational thoughts. However, this may not be possible for all individuals, especially during severe episodes of mental illness.

Integration for CBT-plus Therapy

CBT can be combined with various therapeutic approaches to enhance its effectiveness and address its limitations. Below is a brief overview of how CBT might be integrated with the therapies you mentioned:

Solution-Focused Brief Therapy (SFBT)

Integration: CBT can be blended with SFBT by focusing on building solutions rather than addressing the causes of problems. CBT techniques can help modify negative thought patterns, while SFBT can guide clients to envision and work towards desired outcomes.

Person-Centred Therapy

Integration: While CBT is more structured, combining it with the principles of person-centred therapy can enhance the therapeutic relationship. Therapists can use CBT techniques but also place a strong emphasis on empathy, unconditional positive regard, and congruence, key aspects of person-cantered therapy.

Gestalt Therapy

Integration: Gestalt therapy's focus on awareness and the present moment can be incorporated into CBT sessions to help clients understand and change their current thought and behavior patterns. Techniques from both therapies can help clients integrate fragmented aspects of self.

Narrative Therapy

Integration: Narrative therapy's approach to re-authoring one's personal narrative can complement CBT's focus on cognitive restructuring. Clients can use storytelling to create new meanings while using CBT techniques to challenge and reframe negative thoughts.

Psychoanalytic Therapy

Integration: Although CBT is more present-focused and psychoanalytic therapy delves into past experiences, therapists can use insights from psychoanalytic understanding to inform CBT interventions, particularly regarding unconscious conflicts that may affect current thought patterns.

Emotion-Focused Therapy (EFT)

Integration: CBT can incorporate EFT techniques to help clients become more aware of their emotional experiences and to use their emotions as information. This can lead to a more holistic approach that addresses both thoughts and emotions.

Attachment-Focused Therapy

Integration: This approach can be integrated into CBT by addressing attachment issues that underlie dysfunctional thought patterns. Therapists can help clients understand how their attachment history influences their thoughts and relationships.

Sex Therapy

Integration: CBT techniques can be useful in sex therapy by addressing cognitive distortions related to sexual function and satisfaction. Therapists can combine this with sex education and specific techniques to address sexual issues.

Couples Therapy

Integration: Within couples therapy, CBT can be used to help partners identify and modify dysfunctional patterns of thinking and behavior that lead to relationship issues. It can be combined with communication skills training and conflict resolution strategies typical in couples therapy.

Existential and Humanistic Therapies

Integration: These therapies' focus on self-awareness, freedom, and human potential can be incorporated with CBT to help clients find meaning and purpose, while also addressing how their thoughts and behaviors affect their existential choices.

Somatic Therapy

Integration: CBT can be combined with somatic approaches to help clients recognize the interplay between the body and mind. Techniques that focus on bodily sensations and movements can complement CBT's cognitive focus and help clients integrate their experiences.

Treatment Planning by DSM-5 Disorder

Anxiety disorders

Separation Anxiety Disorder

⇒ **Cognitive restructuring:** Helps to identify and challenge negative thoughts related to separation.

⇒ **Gradual exposure:** Gradually exposes the patient to the feared separation in a controlled way to reduce anxiety.

⇒ **Parental training:** Educates parents on how to respond to their child's anxiety to avoid reinforcing anxious behaviours.

⇒ **Relaxation techniques:** Teaches breathing exercises and muscle relaxation to manage physical symptoms of anxiety.

Selective Mutism

⇒ **Stimulus fading:** Gradually introducing new people into the child's environment while they are speaking.

⇒ **Desensitization:** Exposing the child to speaking in a non-threatening, gradual manner.

⇒ **Shaping:** Reinforcing progressive approximations of the desired behavior, such as making sounds, whispering, and eventually speaking.

⇒ **Self-modeling:** Using video and audio recordings to show the child successful speaking situations to increase confidence.

Specific Phobia

⇒ **Systematic desensitization:** Gradually exposing the individual to the feared object or situation while practicing relaxation techniques.

⇒ **In vivo exposure:** Directly facing the feared object or situation in real life in a controlled and systematic way.

⇒ **Virtual reality exposure**: Utilizing virtual reality environments to simulate exposure to the phobic stimulus.

⇒ **Flooding**: Intense and prolonged exposure to the feared object or situation without gradual steps

Social Anxiety Disorder (Social Phobia)

⇒ **Exposure therapy:** Facing feared social situations in a controlled way until anxiety decreases.

⇒ **Social skills training:** Enhancing social skills through role-playing and other exercises to improve confidence in social situations.

⇒ **Cognitive restructuring:** Identifying and challenging irrational beliefs about social interaction.

⇒ **Mindfulness training:** Developing a nonjudgmental awareness of the present moment to reduce overall anxiety in social situations.

Panic Disorder	⇒ **Interoceptive exposure:** Deliberately inducing physical sensations that are safe but may trigger panic (e.g., rapid breathing) to reduce fear of bodily sensations. ⇒ **Cognitive restructuring:** Addressing catastrophic thinking patterns associated with panic attacks. ⇒ **Relaxation and breathing techniques:** Learning to control breathing and muscle tension to manage acute symptoms. ⇒ **Panic control treatment:** Specific CBT protocol for panic that involves exposure, cognitive therapy, and relaxation training.
Panic Attack (Specifier; not a disorder on its own)	⇒ **Psychoeducation:** Understanding the nature of panic attacks and their physiological causes. ⇒ **Breathing retraining:** Learning deep breathing techniques to manage hyperventilation. ⇒ **Relaxation strategies:** Employing progressive muscle relaxation to reduce symptoms. ⇒ **Coping strategies:** Developing a list of coping mechanisms to use during a panic attack.
Agoraphobia	⇒ **In vivo exposure:** Gradual exposure to feared places or situations from which escape may be difficult. ⇒ **Virtual exposure:** Using computer simulations to safely confront feared environments. ⇒ **Cognitive restructuring:** Challenging and modifying negative thoughts about being in open or public places. ⇒ **Panic management skills:** If panic attacks are present, teaching skills to manage panic symptoms when in feared situations.

Examples, Templates, Process Steps

Relaxation techniques can to be taught and practiced in session; introducing them while recounting a stressful experience can be useful. Planning to implement them before/during anticipated anxiety-producing situations is needed.

- ⇒ Deep diaphragmatic breathing
- ⇒ Progressive muscle relaxation
- ⇒ Guided imagery/visualization
- ⇒ Mindfulness meditation

Worry exposure

Here are the general steps for implementing worry exposure:

Identify Worry Themes: Write down the major themes of your worries. For example, worries about health, finances, relationships, or work.

Choose One Worry to Focus On: Select one worry that is particularly prevalent or distressing to work on first.

Set a Time for Worry Exposure: Schedule a specific time of the day for the worry exposure practice. This should be a time when you can have 20-30 minutes undisturbed.

Rate the Worry: Before you begin exposure, rate the intensity of your worry on a scale from 0 to 100, with 100 being the most intense.

Vividly Imagine the Worry: Close your eyes and imagine the scenario you're worried about as vividly as possible. Think about what you fear will happen in great detail.

Stay with the Anxiety: Allow yourself to feel the anxiety without trying to push it away. Notice where in your body you feel the anxiety and what thoughts come to mind.

Rational Response: After you have maintained the focus on your worry for several minutes, begin to challenge the worry by considering the probability of the event happening and what you could do to cope if it did happen.

Create a Plan: Develop a plan of action for the worst-case scenario. This helps to reduce the feeling of helplessness that often accompanies anxiety.

Rate the Worry Again: After going through the exposure and rational response, rate the intensity of your worry again on the same 0 to 100 scale.

Repeat Regularly: Practice worry exposure regularly with the same worry theme until the intensity of the worry decreases significantly. Then, move on to another worry theme.

Reflect on the Experience: After the exercise, take some time to reflect on the experience. Did the worry decrease in intensity? What did you learn from the exercise?

*It's important to note that worry exposure can initially increase anxiety as you're facing your fears directly. However, with repeated practice, the anxiety should start to diminish.

Probability and Danger Overestimation Worksheet

Step 1: Identify the Feared Event

- ⇒ What is the specific situation or outcome you are worried about?

Step 2: Evidence Supporting Overestimation

- ⇒ What evidence do you have that this event is likely to occur?
- ⇒ What evidence supports the idea that the consequences will be as bad as you fear?

Step 3: Evidence Against Overestimation

- ⇒ What evidence do you have that this event might not happen?
- ⇒ What facts can you list that show the consequences might not be as severe as you expect?

Step 4: Probability Estimation

- ⇒ Based on the evidence, estimate the actual probability of the event occurring (e.g., 30% chance).
- ⇒ Are there statistics or factual data that can inform your estimation?

Step 5: Danger Assessment

- ⇒ Realistically, what is the worst that could happen if the feared event occurred?
- ⇒ How would you cope with it? What resources or supports could you use?

Step 6: Alternative Perspectives

- ⇒ Can you think of alternative outcomes or scenarios?
- ⇒ How might someone else view the probability or danger of this situation?

Step 7: Balanced Thought

- ⇒ Develop a balanced, rational thought that takes into account the actual probability and danger, rather than the overestimated ones.
- ⇒ For example: "Even though I'm worried about [event], the actual likelihood is low, and I have the resources to handle it if it does occur."

Step 8: Behaviour Experiment

- ⇒ Plan a small, safe experiment to test out your balanced thought.
- ⇒ Reflect on the outcome. Did the event occur? If so, was it as catastrophic as you initially feared?

Step 9: Reflection

- ⇒ What did you learn from this exercise?
- ⇒ How can this new understanding reduce your anxiety in future similar situations?

Step 10: Ongoing Practice

- ⇒ Continue to apply this template to new situations where you notice overestimation of probability or danger.

Phobia Thought Challenging Worksheet

Identify the Feared Object or Situation:

⇒ What specifically are you afraid of?

Describe the Phobic Thought:

⇒ What goes through your mind when you think about the feared object or situation?

Evidence Supporting the Phobic Thought:

⇒ What are the reasons you believe this object or situation could harm you?

Evidence Against the Phobic Thought:

⇒ Are there any experiences where you or others were not harmed by this object or situation?

⇒ What is the statistical likelihood of the feared harm actually occurring?

Challenge the Irrational Beliefs:

⇒ Are there any cognitive distortions (like overgeneralization, catastrophizing, etc.) present in your phobic thought?

⇒ Is there a discrepancy between the perceived danger and the actual danger?

⇒ How might someone else view this situation differently?

Develop Alternative Thoughts:

⇒ What are some more balanced thoughts about the feared object or situation?

⇒ What would you tell a friend who had the same fear?

Plan for Exposure:

⇒ How can you gradually expose yourself to the feared object or situation in a controlled and safe way?

Reflection on Past Experiences:

⇒ Recall a time when you faced a fear and it was less harmful than you expected. What did you learn from that experience?

Outcome Prediction:

⇒ What do you think would realistically happen if you were exposed to the fear?

⇒ What would you do? How would you cope?

New Perspective:

⇒ Write a rational and realistic statement about the feared object or situation.

Affirmation of Ability to Cope:

⇒ Remind yourself of your strengths and ability to handle challenging situations.

Hierarchy of Graded exposures

For a specific phobia, e.g. public speaking, develop the hierarchy of graded exposures with the client and then implement it over several sessions.

Level 1: Low Anxiety

- ⇒ Imagining giving a presentation.
- ⇒ Watching videos of people speaking in public.
- ⇒ Discussing public speaking with friends or a therapist.

Level 2: Mild Anxiety

- ⇒ Writing a brief speech or presentation.
- ⇒ Reading a speech alone out loud.
- ⇒ Practicing the speech in front of a mirror.

Level 3: Moderate Anxiety

- ⇒ Recording oneself giving a speech and watching it.
- ⇒ Giving a speech to a trusted person or a small, supportive group.
- ⇒ Attending a public speaking workshop or a Toastmasters meeting as an observer.

Level 4: Moderate-High Anxiety

- ⇒ Participating in a public speaking class by asking a question or making a comment.
- ⇒ Giving a short talk to friends or family.
- ⇒ Joining a Toastmasters meeting and participating in a table topic.

Level 5: High Anxiety

- ⇒ Giving a presentation to a small group of peers or colleagues.
- ⇒ Volunteering for opportunities to speak in front of a community group.
- ⇒ Conducting a small workshop or teaching a class.

Level 6: Very High Anxiety

- ⇒ Speaking at a larger meeting or a community event.
- ⇒ Giving a formal speech at a social event, such as a wedding or a club.
- ⇒ Hosting an event or acting as an MC.

Level 7: Severe Anxiety

- ⇒ Presenting at a professional or academic conference.
- ⇒ Public speaking in a large, formal setting with a significant audience.
- ⇒ Participating in a competitive speaking event.

CBT Thought Record

Situation: Describe the specific situation that is causing anxiety. Be as detailed as possible.

Emotions: Label the emotions you feel when thinking about the situation. Rate the intensity of the emotions on a scale from 0-100%.

Automatic Thoughts: Write down the immediate thoughts that come to mind when you imagine the situation. These are often negative or fear-based.

Evidence Supporting the Thought: List any facts or past experiences that seem to prove your automatic thought is true.

Evidence Against the Thought: Challenge your automatic thoughts by listing facts or reasons why the thought may not be true or could be an overestimation.

Alternative Thought: Based on the evidence against your automatic thoughts, come up with a more balanced and rational thought that reduces anxiety and is more positive.

Outcome: Reflect on how you feel after considering the alternative thought and what actions you can take based on this new perspective.

Bipolar and related disorders

Bipolar I Disorder

⇒ **Mood monitoring:** Keeping a daily record of mood changes to identify patterns and triggers.

⇒ **Cognitive restructuring:** Challenging and changing unhelpful beliefs and thoughts that can lead to mood swings.

⇒ **Psychoeducation:** Learning about the disorder and its management, including the importance of medication adherence.

⇒ **Relapse prevention planning:** Developing strategies to recognize early warning signs of both manic and depressive episodes.

Bipolar II Disorder

⇒ **Lifestyle regulation:** Establishing a regular routine for sleep, diet, and exercise to help stabilize mood.

⇒ **Interpersonal and social rhythm therapy (IPSRT):** Aiming to improve mood by increasing the regularity of daily rhythms.

⇒ **Cognitive techniques for depression:** Addressing depressive symptoms with traditional CBT techniques for depression.

⇒ **Stress management:** Implementing techniques such as relaxation training to manage stress, which can contribute to mood disturbances.

Cyclothymic Disorder

⇒ **Behavioral activation:** Encouraging engagement in regular activities to increase positive interactions and stabilize mood.

⇒ **Sleep hygiene:** Implementing practices that promote consistent, quality sleep to help regulate mood fluctuations.

⇒ **Mood monitoring and regulation:** Identifying and working with cyclical patterns to manage mood variations.

⇒ **Problem-solving therapy:** Enhancing problem-solving skills to deal with life challenges that could affect mood stability.

Examples, Templates, Process Steps

Mood monitoring for bipolar disorders involves tracking daily mood fluctuations, behaviours, sleep patterns, and potential triggers.

Mood Monitoring Chart

Day	Mood (1-10)	Sleep (hours)	Energy Levels	Medication Taken	Stressors/ Triggers	Thoughts	Behaviours
Monday	5	6	Moderate	Yes	Project deadline	"I can't handle this."	Procrastinated; sought help late
Tuesday	6	7	High	Yes	Argument with partner	"They're better off without me."	Withdrew socially; skipped meals
Wednesday	7	5	Very High	Yes	None	"I'm on top of the world."	Started many projects; impulsive spending
Thursday	4	3	Low	No	Missed medication	"I'm worthless."	Stayed in bed; ignored calls
Friday	5	7	Moderate	Yes	None	"I need to get my life together."	Made a to-do list; went for a walk
Saturday	6	8	High	Yes	Social outing	"I can manage things if I try."	Socialized; moderate alcohol consumption
Sunday	6	8	Moderate	Yes	Meal prep	"I'm preparing for a good week."	Cooked meals; relaxed at home

Key:

- ⇒ Mood Rating: A scale from 1 (most depressed) to 10 (most manic).
- ⇒ Sleep: Number of hours slept each night.
- ⇒ Energy Levels: Subjective assessment of energy throughout the day (Low, Moderate, High, Very High).
- ⇒ Medication Taken: Indicates whether daily medication was taken (Yes/No).
- ⇒ Stressors/Triggers: Any potential stressors or triggers that could impact mood.
- ⇒ Thoughts: Dominant thoughts or mental patterns noticed throughout the day.

⇒ Behaviours: Actions taken or behaviours exhibited, including coping strategies or risk behaviours.

Cognitive Restructuring

Self-Deprecating Thoughts:

⇒ "I am a failure in everything I do."
⇒ "I'm completely useless and can't do anything right."
⇒ "I don't deserve happiness."
⇒ "No one could ever love or care for someone as flawed as me."

Hopelessness:

⇒ "Nothing will ever get better."
⇒ "There's no point in trying because I know I'll fail."
⇒ "This pain is never going to end."
⇒ "I'll always feel this miserable."

Beliefs About Worthlessness:

⇒ "I am worthless and don't contribute anything to the world."
⇒ "I'm not good enough, not now, not ever."
⇒ "I have no talents or things to offer others."
⇒ "My life has no value or meaning."

Feelings of Helplessness:

⇒ "I'm powerless to change my situation."
⇒ "It's impossible for me to make things better."
⇒ "I can't manage even the simplest tasks."

Exaggerated Responsibility for Negative Events:

⇒ "It's all my fault that things have gone wrong."
⇒ "I'm to blame for everyone else's unhappiness."
⇒ "If I had done something differently, none of these bad things would have happened."
⇒ "Everything bad that happens is a result of my mistakes or inadequacy."

Manic Thinking Styles

Overgeneralization

⇒ Believing that a single positive event is a never-ending pattern of success.

Illusions of Grandeur

⇒ Holding an inflated belief in one's power, knowledge, or identity (e.g., thinking one has special connections with famous people).

Magical Thinking

⇒ Believing that one's thoughts or actions can control unrelated events.

Minimizing Consequences

⇒ Underestimating the negative consequences of one's actions.

Personalization

⇒ Believing that one is the cause of external events, especially those that are not realistically connected to the individual.

Depressive disorders

Disruptive Mood Dysregulation Disorder	⇒ **Behavioral interventions:** Teaching children and their parents about positive reinforcement strategies, and the use of consistent consequences for behavior. ⇒ **Emotion regulation skills:** Helping children to recognize and manage their emotional responses. ⇒ **Problem-solving skills:** Learning to identify problems and generate and implement solutions. ⇒ **Social skills training:** Enhancing the ability to interact positively with peers and adults.
Major Depressive Disorder, Single and Recurrent Episodes	⇒ **Activity scheduling and behavioral activation**: Encouraging engagement in pleasurable activities to improve mood and energy. ⇒ **Cognitive restructuring:** Identifying and challenging negative thought patterns and beliefs. ⇒ **Problem-solving therapy:** Learning to deal effectively with the day-to-day problems that can contribute to depression. ⇒ **Mindfulness and relaxation techniques:** Implementing practices to reduce stress and prevent rumination.
Premenstrual Dysphoric Disorder	⇒ **Mood monitoring:** Tracking mood symptoms in relation to the menstrual cycle. ⇒ **Cognitive restructuring:** Addressing negative thoughts that may be more prevalent during the premenstrual phase. ⇒ **Stress management:** Utilizing relaxation and stress reduction techniques to manage hormonal changes. ⇒ **Lifestyle modifications**: Focusing on diet, exercise, and sleep, which can all affect hormone levels and mood.
Persistent Depressive Disorder (Dysthymia)	⇒ **Cognitive restructuring:** Challenging chronic negative thinking patterns and promoting more adaptive thoughts. ⇒ **Behavioral activation:** Gradually increasing engagement in activities to counteract the low energy and motivation associated with dysthymia. ⇒ **Interpersonal effectiveness:** Working to improve communication and assertiveness skills in relationships. ⇒ **Goal setting:** Setting and working toward personal goals to create a sense of purpose and achievement.

Examples, Templates, Process Steps

Behavioural Activation for Depression

Behavioural activation: Help individuals understand how their behaviours influence their mood and then encourage them to actively engage in activities that are likely to improve their mood and decrease depression symptoms.

Objective: To increase engagement in positive and rewarding activities to improve mood.

Step 1: Monitor Your Activities and Mood

- ⇒ For one week, record your daily activities and rate your mood every couple of hours on a scale from 0 (very sad) to 10 (very happy).
- ⇒ Note any patterns between activities and mood.

Step 2: Identify Values and Goals

- ⇒ List your values in different areas of life (e.g., family, work, personal growth, health).
- ⇒ Set goals that align with your values. Goals should be specific, measurable, achievable, relevant, and time-bound (SMART).

Step 3: Create an Activity Menu

- ⇒ Make a list of activities that you enjoy or used to enjoy, including social activities, hobbies, self-care, and exercise.
- ⇒ Rate each activity based on how likely it is to improve your mood (from 0 - not at all, to 10 - very much).

Step 4: Schedule Activities

- ⇒ Use a weekly planner to schedule activities from your menu. Start with a few and gradually increase.
- ⇒ Consider the best times for these activities and try to balance them throughout the week.

Step 5: Identify Obstacles and Plan for Them

- ⇒ Consider what might prevent you from doing the activities and plan ways to overcome these barriers.

Step 6: Record Outcomes

- ⇒ After completing each activity, record what you did and rate your mood again.
- ⇒ Reflect on how these activities impact your mood.

Step 7: Review and Adjust

- ⇒ At the end of each week, review your planner. Reflect on what worked and what didn't.

Disruptive, impulse-control, and conduct disorders

Oppositional Defiant Disorder

- ⇒ **Parental training programs:** Teaching parents effective strategies for responding to behaviors.
- ⇒ **Problem-solving skills:** Helping children to identify problems and come up with constructive solutions.
- ⇒ **Anger management:** Teaching children how to recognize signs of anger and use strategies to control it.
- ⇒ **Social skills training**: Improving communication and interaction skills with peers and adults.

Intermittent Explosive Disorder

- ⇒ **Relaxation techniques:** Learning methods to calm down when feeling the urge to act out.
- ⇒ **Cognitive restructuring:** Identifying triggers and changing thought patterns that lead to explosive outbursts.
- ⇒ **Stress management:** Techniques for managing stress that can contribute to explosive behaviors.
- ⇒ **Communication skills training:** Learning how to express feelings and needs in a non-aggressive way.

Conduct Disorder

- ⇒ **Problem-solving skills:** Developing more effective coping strategies for dealing with frustrations or conflicts.
- ⇒ **Cognitive restructuring:** Modifying thoughts that justify antisocial behavior.
- ⇒ **Anger management**: Identifying anger triggers and learning to respond without aggression.
- ⇒ **Social skills training:** Fostering prosocial behaviors and improving interactions with others.

Antisocial Personality Disorder

- ⇒ **Cognitive restructuring:** Targeting antisocial thoughts and attitudes.
- ⇒ **Emotion regulation:** Helping individuals recognize and regulate their emotional responses.
- ⇒ **Moral reasoning training:** Working to develop a more mature and moral way to interpret and interact with the world.
- ⇒ **Interpersonal skills training:** Focusing on empathy development and understanding the impact of one's behavior on others.

Pyromania

- ⇒ **Impulse control training**: Developing strategies to resist the urge to set fires.
- ⇒ **Cognitive restructuring:** Challenging any beliefs or thoughts that contribute to fire-setting behaviors.

⇒ **Relaxation and stress management**: Learning alternative ways to cope with stress that do not involve fire-setting.

⇒ **Arousal modification**: Techniques to reduce the excitement or thrill associated with setting fires.

Kleptomania

⇒ **Impulse control training:** Techniques to help resist the urge to steal.

⇒ **Cognitive restructuring:** Identifying and challenging beliefs that contribute to the stealing behavior.

⇒ **Mood regulation:** Learning to manage emotions that might trigger stealing.

⇒ **Exposure and response prevention:** Gradually exposing the individual to triggers and preventing the impulsive behavior.

Examples, Templates, Process Steps

Cognitive Restructuring: General

Automatic Thoughts:

⇒ "I can't stand this frustration."
⇒ "They deserve it for what they did to me."
⇒ "I can't help it; I just explode."
⇒ "If I don't fight back, I'm weak."
⇒ "I need to take this to feel better."

Intermediary Beliefs:

⇒ "It's okay to break the rules if I can get away with it."
⇒ "People are out to get me, so I have to get them first."
⇒ "My needs are more important than others."
⇒ "If I show anger, people will take me seriously."
⇒ "Life is unfair, and acting out is the only way to deal with it."

Core Beliefs/Schemas:

⇒ "I am powerless unless I am in control or feared."
⇒ "People are not trustworthy and will betray or hurt me if given the chance."
⇒ "I am bad and deserve to be punished."
⇒ "To get what I want, I must take it."

Cognitive Restructuring: Kleptomania

Automatic Thoughts:

- ⇒ "I need to take this to feel better."
- ⇒ "No one will notice if I take just one small item."
- ⇒ "The urge is too strong; I can't resist it."
- ⇒ "I'll be able to return it later, so it's not really stealing."

Intermediary Beliefs:

- ⇒ "Stealing is the only way I can cope with my feelings."
- ⇒ "If I don't give in to the urge, the anxiety will be unbearable."
- ⇒ "I deserve this item more than the store or the person does."
- ⇒ "Taking things impulsively is part of who I am; I can't change it."

Core Beliefs/Schemas:

- ⇒ "I am powerless over my impulses."
- ⇒ "I am a bad person because I steal."
- ⇒ "I cannot manage stress or negative emotions without stealing."
- ⇒ "My needs are not met unless I take what I want."

Dissociative disorders

Dissociative Identity Disorder	⇒ **Cognitive restructuring:** Working to reframe distorted beliefs and perceptions related to different identities or states. ⇒ **Grounding techniques:** Exercises that help individuals stay connected to the present moment and reduce dissociation. ⇒ **Trauma-focused therapy:** Addressing the traumatic memories and experiences that may be at the root of the dissociative symptoms. ⇒ **Relapse prevention**: Developing strategies to manage triggers and stressors to prevent dissociative episodes.
Dissociative Amnesia	⇒ **Cognitive restructuring:** Challenging any false beliefs about the self or situation that may be maintaining the amnesia. ⇒ **Memory techniques:** Exercises and practices that may help in the retrieval of memories and the re-establishment of identity. ⇒ **Stress reduction techniques:** Methods such as mindfulness and relaxation to manage stress that can exacerbate amnesic symptoms. ⇒ **Psychoeducation:** Learning about the condition to understand and normalize the experience of amnesia.
Depersonalization/Derealization Disorder	⇒ **Grounding techniques:** Activities that help reconnect the person with their body and surroundings, such as mindfulness and sensory exercises. ⇒ **Cognitive restructuring:** Identifying and modifying thoughts that contribute to feelings of unreality. ⇒ **Stress and anxiety management:** Techniques to reduce overall levels of stress and anxiety which can trigger or worsen symptoms. ⇒ **Reality testing:** Exercises to help distinguish between subjective feelings of unreality and objective reality.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

- ⇒ "I am losing control of my mind."
- ⇒ "I can't trust my own memory."
- ⇒ "I don’t know who I am anymore."
- ⇒ "I feel like I'm watching myself from the outside."
- ⇒ "I must be going crazy."

Intermediary Beliefs:

- ⇒ "If I start to feel emotions, I will become overwhelmed by them."
- ⇒ "I can only cope by disconnecting from my experiences."
- ⇒ "People will think I’m seeking attention if I talk about my dissociation."
- ⇒ "My thoughts and feelings are dangerous."

Core Beliefs/Schemas:

- ⇒ "I am fundamentally different from other people."
- ⇒ "I am broken and can never be whole."
- ⇒ "The world is a dangerous place, and I must disconnect to survive."
- ⇒ "I am powerless to control my mind and my life."

Elimination disorders

Enuresis

⇒ **Bladder training exercises:** Teaching children techniques to increase bladder capacity and control.

⇒ **Urination control training:** Establishing regular bathroom schedules and encouraging children to delay urination to strengthen control.

⇒ **Positive reinforcement:** Using reward systems to encourage the child to wake up dry or use the toilet.

⇒ **Psychoeducation:** Educating the child and family about enuresis to reduce any shame or guilt and improve coping strategies.

Encopresis

⇒ **Bowel habit training:** Establishing a routine and encouraging regular bowel movements through scheduled sits.

⇒ **Relaxation techniques:** Teaching the child how to relax the pelvic muscles to facilitate bowel movements.

⇒ **Dietary changes:** Incorporating dietary advice within CBT to ensure adequate fiber and fluid intake for healthy bowel movements.

⇒ **Cognitive restructuring:** Addressing any negative thoughts or feelings associated with bowel movements and the stigma of soiling.

Feeding and eating disorders

Pica	⇒ **Psychoeducation:** Educating about the harmful consequences of eating non-nutritive substances. ⇒ **Behavioral interventions:** Using strategies such as reinforcement, aversion therapy, or habit reversal to decrease the undesirable behavior. ⇒ **Environmental alteration:** Modifying the environment to reduce access to non-food items. ⇒ **Stress reduction:** Techniques such as mindfulness and relaxation to manage the stress that may trigger pica behavior.
Rumination Disorder	⇒ **Diaphragmatic breathing:** Learning and practicing breathing techniques to reduce the likelihood of regurgitation. ⇒ **Behavioral modification:** Changing the circumstances around eating, such as posture or eating speed, to prevent rumination. ⇒ **Habit reversal training:** Recognizing the urge to ruminate and substituting another action in its place. ⇒ **Psychoeducation:** Understanding the disorder and the impact of behaviors associated with it.
Avoidant/ Restrictive Food Intake Disorder	⇒ **Exposure therapy:** Gradual exposure to feared or avoided foods to reduce anxiety and increase dietary variety. ⇒ **Cognitive restructuring:** Identifying and challenging negative thoughts related to food and eating. ⇒ **Psychoeducation:** Information about nutritional needs and the consequences of restricted intake. ⇒ **Family-based therapy:** Involving the family to support changes in eating behaviors and attitudes toward food.
Anorexia Nervosa	⇒ **Cognitive restructuring:** Addressing distorted beliefs about body image, weight, and dieting. ⇒ **Weight restoration:** Establishing a structured eating plan to normalize weight. ⇒ **Exposure therapy:** Confronting feared foods and situations to reduce avoidance. ⇒ **Body image interventions:** Working on acceptance and appreciation of the body.
Bulimia Nervosa	⇒ **Cognitive restructuring:** Challenging irrational beliefs about food, weight, and self-worth.

⇒ **Eating pattern regulation:** Establishing regular, non-binge meals to stabilize eating patterns.

⇒ **Exposure with response prevention (ERP):** Exposing to binge triggers while preventing the purging response.

⇒ **Stress management:** Developing healthy coping strategies for stress and emotional dysregulation.

Binge-Eating Disorder

⇒ **Cognitive restructuring:** Addressing dysfunctional thoughts related to binge eating, body shape, and weight.

⇒ **Mindfulness-based interventions:** Enhancing awareness and control over eating behaviors.

⇒ **Interpersonal effectiveness skills:** Improving relationships and social skills to reduce emotional eating.

⇒ **Relapse prevention planning:** Identifying high-risk situations and developing strategies to maintain progress.

Examples, Templates, Process Steps

Cognitive Restructuring: Challenge distorted thoughts about body image, weight, and food.

All-or-Nothing Thinking:

"If I eat any dessert, I've blown my diet completely."

"I must adhere strictly to my diet, or I'm a total failure."

Catastrophizing:

"If I gain a pound, it will be the start of gaining uncontrollably."

"Eating this high-calorie food will make me fat instantly."

Overgeneralization:

"I ate poorly this weekend, so I'll never be able to eat healthily."

"I've always been overweight, which means I will never be thin."

Emotional Reasoning:

"I feel fat (regardless of the person's actual size), so I must be fat."

"I feel guilty after eating, so I must have done something wrong."

Mind Reading:

"Everyone is judging me for what I'm eating."

"People think I'm lazy because of my weight."

Labelling:

Assigning labels to oneself based on eating behaviour or body shape, such as "disgusting" or "worthless."

Musts and Shoulds:

"I must always eat clean."

"I should never have cravings."

Discounting Positives:

"It doesn't matter that I lost some weight; I'm still not thin enough."

"Even though I ate well today, it's not enough because I didn't work out."

Magnification of Importance of Appearance:

"How I look is the most important thing about me."

"My self-worth is entirely dependent on my weight and size."

Perfectionism:

"I must have a perfect body to be happy."

"I will only be loved if I'm thin."

Examine Personal Rules

Address rules around eating and beliefs about the implications of eating certain foods or breaking dietary rules.

- ⇒ "I must avoid all high-fat foods."
- ⇒ "I can never eat sweets because they are bad."
- ⇒ "I should only eat at specific times, regardless of whether I'm hungry."
- ⇒ "I must not eat after a certain time at night."
- ⇒ "My meals must be smaller than other people's to not gain weight."
- ⇒ "I can only eat a specific amount of calories per meal/day."
- ⇒ "I can only eat foods that are 'clean' and organic."
- ⇒ "Processed foods are toxic and should never be eaten."
- ⇒ "If I eat something I consider 'bad', I have to compensate by skipping the next meal or exercising excessively."
- ⇒ "I have to earn my meals by working out."
- ⇒ "My diet must be followed perfectly, or it's completely ruined."
- ⇒ "I cannot afford a single slip; if I do, I have failed."
- ⇒ "This food is completely good, while this one is entirely bad."
- ⇒ "If I indulge in any 'bad' food, I've lost all control."
- ⇒ "If I break my diet rules, I will immediately gain weight."
- ⇒ "Eating forbidden foods will make me fat."
- ⇒ "I can't eat in public or when people are watching."
- ⇒ "I must eat less than others to not be judged."
- ⇒ "I have to eat foods in a particular order."

⇒ "I must cut my food into tiny pieces to control my intake."

Date & Time	Food & Drink (Predicted)	Food & Drink (Actual)	Hunger Level Before (0-10)	Hunger Level After (0-10)	Urges (0-10)				Emotions/ Thoughts Before & After	Skills/ Coping Strategies Used
					Restrict	Binge	Purge	Exercise		
Example: 11/06/23 8:00 AM	Oatmeal with fruit (planned)	Oatmeal, skipped fruit	4	6	Restrict: 2, Binge: 0, Purge: 0, Exercise: 0				Before: Anxious, After: Satisfied	Mindfulness, distress tolerance skills

Food Diary Chart for Eating Disorder Management

Gender dysphoria

⇒ **Psychoeducation:** Educating the individual about gender identity, gender dysphoria, and the options for gender expression and transition if desired.

⇒ **Cognitive restructuring**: Identifying and challenging negative thought patterns related to one's gender identity and developing more affirming and accurate ways of thinking about oneself.

⇒ **Anxiety management:** Teaching relaxation techniques, such as deep breathing, progressive muscle relaxation, or mindfulness, to manage the anxiety that can accompany gender dysphoria.

⇒ **Social support:** Working on building a support system, which may include finding transgender support groups or communities, to provide a network of understanding and support.

⇒ **Assertiveness training:** Helping individuals develop the skills to assert their gender identity in various social situations, which includes setting boundaries and advocating for oneself in personal relationships and public settings.

⇒ **Coping skills development:** Building a repertoire of coping strategies to handle dysphoria and the stress of potential discrimination, rejection, or violence.

⇒ **Body image work:** Addressing issues of body image and helping individuals develop a more positive relationship with their body, which might include support around living with gender dysphoria without seeking medical interventions or supporting decisions around transitioning.

⇒ **Exploration of gender expression:** Assisting individuals in safely exploring their gender expression, which can include experimenting with clothing, pronouns, and names.

⇒ **Goal setting:** Assisting the individual in setting goals related to their gender identity, which may include social, legal, or medical transition goals.

It's important to note that while CBT can help manage some of the distress associated with gender dysphoria, it is not used to change one's gender identity, as such attempts are unethical and harmful. CBT for gender dysphoria is about affirming one's gender identity and finding ways to live comfortably with that identity. For some individuals, CBT may be a part of a multidisciplinary approach that includes medical interventions such as hormone therapy or surgery, depending on the individual's needs and desires.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

- ⇒ "I will never be seen as my true gender."
- ⇒ "My body is wrong, and I will never be comfortable in it."
- ⇒ "I am deceiving people by presenting in my experienced gender."
- ⇒ "I will always be rejected by society."
- ⇒ "No one will ever love me for who I truly am."

Intermediary Beliefs:

- ⇒ "If I express my true gender, I will be ostracized."
- ⇒ "People are constantly judging me for not conforming to gender norms."
- ⇒ "Being misgendered means I am failing at my gender expression."
- ⇒ "I must have a perfect body that aligns with my gender identity to be valid."

Core Beliefs/Schemas:

- ⇒ "I am not worthy of acceptance because of my gender identity."
- ⇒ "I am fundamentally different and will never belong anywhere."
- ⇒ "My gender identity is a burden to myself and others."

Neurodevelopmental disorders

Intellectual Disabilities

⇒ **Simplification of Cognitive Techniques:** Breaking down complex tasks into smaller, more manageable steps.

⇒ **Use of Concrete and Visual Aids:** Implementing visual schedules, cue cards, or other visual supports to facilitate understanding.

⇒ **Behavioral Rehearsals:** Practicing social and adaptive skills in structured settings.

⇒ **Role-Playing:** To improve social interaction and problem-solving skills.

⇒ **Positive Reinforcement**: Providing rewards for desired behaviors to increase their frequency.

⇒ **Emotion Regulation Training:** Teaching the identification and appropriate expression of emotions.

Communication Disorders

⇒ **Social Skills Training:** Enhancing effective communication through role-play and modeling.

⇒ **Relaxation Techniques:** To reduce anxiety that may hinder communication.

⇒ **Assertiveness Training:** Helping individuals express themselves more effectively.

⇒ **Exposure Therapy:** Gradually exposing the individual to more challenging communication situations to build confidence and skill.

⇒ **Problem-Solving Skills:** Developing strategies for dealing with communication challenges.

Autism Spectrum

⇒ **Structured Learning:** Using schedules and routines to create predictability.

⇒ **Social Skills Groups:** Providing opportunities for practice and reinforcement of social skills in a group setting.

⇒ **Emotion Recognition Training:** Teaching individuals to identify and respond to their own and others' emotions.

⇒ **Behavioral Interventions:** To reduce problematic behaviors and increase prosocial behaviors.

⇒ **Joint Attention Intervention:** Encouraging the individual to share focus on an object or event with another person.

Attention-Deficit/Hyperactivity Disorder

⇒ **Skills Training**: Such as time management, organizational skills, and planning.

⇒ **Behavior Modification**: Implementing reward systems to increase desirable behaviors and decrease impulsivity.

	⇒ **Mindfulness**: To improve focus and reduce hyperactivity. ⇒ **Self-Monitoring Techniques**: Helping individuals to become more aware of their behaviors and the situations in which they occur. ⇒ **Homework Assignments:** Structured tasks to practice self-regulation and planning outside of therapy sessions.
Specific Learning Disorder	⇒ **Academic Skills Training:** Specific strategies to address areas of difficulty, such as reading or math skills. ⇒ **Cognitive Enhancement Techniques:** Such as memory aids or techniques for improving attention and processing. ⇒ **Self-Esteem Building:** Addressing feelings of inadequacy or frustration related to learning difficulties. ⇒ **Goal Setting:** Helping individuals to set and achieve realistic academic goals. ⇒ **Problem-Solving Skills**: To help manage tasks and academic challenges.
Motor Disorders (Tic, Tourette's)	⇒ **Habit Reversal Training (HRT):** Teaching awareness of tic behaviors and training in a competing response. ⇒ **Exposure and Response Prevention (ERP):** To reduce the severity of tics through tolerance of the urge to tic. ⇒ **Relaxation Techniques:** Such as deep breathing or progressive muscle relaxation to control the urge to tic. ⇒ **Psychoeducation:** Teaching the individual and family about the disorder and how to manage symptoms. ⇒ **Comprehensive Behavioral Interventions for Tics (CBIT):** Including elements of HRT and ERP along with other strategies.

Examples, Templates, Process Steps

Behavioural Activation for ADHD

Step 1: Activity Monitoring

Keep track of your daily tasks and how much time you spend on each activity.

Note when you feel most and least focused.

Step 2: Set Clear and Achievable Goals

Define specific areas of your life you want to improve (e.g., work, education, personal hobbies).

Break goals down into achievable tasks.

Step 3: Prioritize Tasks

Prioritize tasks based on urgency and importance.

Use color-coding or labelling to distinguish between high and low-priority tasks.

Step 4: Break Down Tasks

Break larger tasks into smaller, more manageable steps.

Estimate how much time each step will take.

Step 5: Create an Activity Schedule

Use a planner or digital calendar to schedule your tasks.

Schedule tasks for when you tend to be most focused.

Step 6: Incorporate Breaks and Rewards

Schedule short breaks to prevent burnout.

Use rewards to reinforce completion of tasks.

Step 7: Develop Strategies to Deal With Distractions

Identify common distractions and plan strategies to minimize them.

Set up a dedicated workspace with minimal distractions.

Step 8: Use Reminders and Alerts

Set alarms or notifications to remind you of task start times and deadlines.

Step 9: Reflect and Adjust

At the end of each day or week, review what you accomplished.

Adjust your plan as needed to be more effective.

Step 10: Accountability

Share your goals and progress with someone who can help keep you accountable.

Cognitive Restructuring

Modify thoughts of incompetence or anticipated failure, especially in social or academic performance. Challenge beliefs that perpetuate inattention or impulsivity.

Disqualifying the Positive: "Even when I pay attention, I don't get things right, so there's no point in trying to focus."

Overgeneralization: "I've never been good at following through on tasks, so I won't be able to manage this one either."

Catastrophizing: If I can't concentrate on this, everything else will fall apart."

All-or-Nothing Thinking: If I can't do this perfectly, I might as well not do it at all."

Emotional Reasoning: "I feel overwhelmed, so this must be impossible to complete."

Personalization and Blame: "It's just the way I am, I can't help being impulsive."

Mind Reading and Fortune Telling: "I'm sure others think I'm incompetent because I can't stay on task."

"Should" Statements: "I should be able to multitask; other people do it all the time."

Labelling: "I'm just a scatterbrain."

Alternatives to Uncertainty: "I don't know how this will turn out, so I better do something else I know I can do."

Weekly Activity Planner for ADHD

Day/Time	Task	Priority	Est Time	Actual Time	Focus (1-10)	Notes

Obsessive-compulsive and related disorders

Obsessive-Compulsive Disorder

⇒ **Exposure and Response Prevention (ERP):** Gradually exposing the person to feared objects or ideas (exposure) and teaching them to resist the urge to perform compulsions (response prevention).

⇒ **Cognitive Restructuring:** Helping individuals challenge and change their maladaptive beliefs related to obsessions.

⇒ **Mindfulness Training:** Encouraging awareness of obsessive thoughts without engaging with them.

⇒ **Relaxation Techniques:** Such as deep breathing or progressive muscle relaxation to manage anxiety.

⇒ **Habit Reversal Training:** This is sometimes used for OCD-related tic symptoms.

Body Dysmorphic Disorder

⇒ **Mirror Re-training:** Teaching individuals to reduce the time spent checking in the mirror and to view their body as a whole rather than focusing on specific perceived flaws.

⇒ **Perceptual Mirror Exposure:** Gradual exposure to one's reflection to reduce avoidance and distress.

⇒ **Cognitive Restructuring:** Identifying and modifying distorted beliefs about one's appearance.

⇒ **Mindfulness and Acceptance Strategies:** Focusing on present experiences with acceptance rather than judgment.

⇒ **Exposure Therapy:** To confront body-related avoidance behaviors in a controlled and gradual way.

Hoarding Disorder

⇒ **Exposure Therapy:** Gradual exposure to discarding items and managing the distress that follows.

⇒ **Organizational Training:** Skills development to categorize and organize possessions.

⇒ **Motivational Interviewing:** Enhancing motivation to declutter and maintain organization.

⇒ **Problem-Solving Training:** Developing strategies to decide what to discard and how to prevent accumulation of new items.

⇒ **Cognitive Restructuring:** Addressing beliefs about the need to save items and fear of discarding them.

Excoriation (Skin-Picking) Disorder

⇒ **Habit Reversal Training (HRT):** Learning to recognize situations where skin-picking occurs and to substitute a competing, incompatible action.

⇒ **Stimulus Control:** Changing the environment to reduce cues that trigger skin-picking.

	⇒ **Cognitive Restructuring:** Challenging distorted thoughts that contribute to the urge to pick. ⇒ **Mindfulness-Based CBT**: Fostering awareness of the triggers, urges, and practices surrounding skin-picking. ⇒ **Self-Monitoring:** Increasing awareness of skin-picking behaviors and their antecedents.
Trichotillomania (Hair-Pulling Disorder)	⇒ **Habit Reversal Training (HRT):** Identifying triggers for hair-pulling and learning a competing response that is physically incompatible with pulling hair. ⇒ **Stimulus Control:** Implementing changes in the environment to reduce triggers for hair-pulling. ⇒ **Cognitive Restructuring:** Working to change distorted beliefs about hair-pulling. ⇒ **Mindfulness Techniques:** Recognizing the urge to pull without automatically acting on it. ⇒ **Acceptance and Commitment Therapy (ACT):** Sometimes incorporated into CBT, focusing on accepting thoughts and feelings without hair-pulling.

Examples, Templates, Process Steps

Obsessive-Compulsive Disorder (OCD) can manifest in various forms based on the nature of the obsessions and compulsions.

OCD Expressions & Manifestations

⇒ Contamination Obsessions with Cleaning Compulsions
⇒ Symmetry Obsessions with Ordering/Arranging Compulsions
⇒ Harm Obsessions with Checking Compulsions
⇒ Obsessions about Unwanted Sexual Thoughts
⇒ Religious Obsessions (Scrupulosity)
⇒ Hoarding
⇒ Obsessions with a Need for Exactness
⇒ Obsessions without Visible Compulsions

Relationship OCD

Common Relationship OCD obsessions:

⇒ Fear that you're not good enough for your partner.
⇒ Constantly second guessing your love for your partner.

⇒ Constantly wondering if you're with the right person.

Common Relationship OCD compulsions:

⇒ Obsessive questioning: You're preoccupied with very small details that make you question everything about your relationship.

⇒ Research: Constantly reading articles that define what a "successful" relationship looks like.

⇒ Comparisons: Speaking to friends about their relationships and comparing it to yours.

⇒ Endless reflection: Always questioning and thinking about your partner's qualities.

⇒ Seeking passion: Becoming upset during moments of sexual intimacy because you're desperate to find passion with your partner.

⇒ Always looking for love: An endless quest for the "perfect" kind of love. This obsession keeps you from actually experiencing it.

⇒ Creating rules for your partner: When they don't uphold them, you think the relationship isn't worth it.

Exposure Response Prevention - Template

Education:

⇒ Understand the nature of OCD and how ERP works to weaken the connection between obsessions and compulsions.

Identification:

⇒ List obsessions and compulsions.

⇒ Identify the situations, thoughts, or images that trigger the OCD.

Fear Hierarchy Construction:

⇒ Create a list of triggers ranked from least to most anxiety-provoking.

Exposure Planning:

⇒ Plan systematic exposure to triggers starting from the less distressing ones, moving up the hierarchy as tolerability increases.

Response Prevention Planning:

⇒ Decide on the steps to resist performing compulsive behaviours after exposure.

Exposure Practice:

⇒ Engage with the triggers (through real-life interactions, imaginal exposure, or virtual reality) without performing the compulsive responses.

Self-Monitoring:

⇒ Keep a log of exposures, anxiety levels, and details of response prevention efforts.

Anxiety Management:

⇒ Learn and apply anxiety management techniques such as deep breathing, mindfulness, or progressive muscle relaxation.

Homework Assignments:

⇒ Complete planned exposures between therapy sessions.

Relapse Prevention:

⇒ Develop a plan for coping with future stressors and potential triggers.

Consistent Review:

⇒ Regularly review progress with a therapist and make adjustments to the exposure tasks as needed.

Personality disorders

Cluster A Personality Disorders

Paranoid Personality Disorder

⇒ **Cognitive Restructuring:** Addressing and challenging the maladaptive beliefs and assumptions about trust, betrayal, and malice.

⇒ **Developing Coping Skills:** Learning how to manage stress and anxiety, which often exacerbate paranoid thoughts.

⇒ **Interpersonal Skills Training:** Improving communication and social interaction to reduce isolation and misinterpretation of others' actions.

⇒ **Relaxation and Stress Management Techniques:** To reduce overall levels of arousal and vigilance.

⇒ **Gradual Exposure:** To social situations to decrease hypersensitivity to potential criticism or threat.

Schizoid Personality Disorder

⇒ **Social Skills Training:** Focusing on enhancing social skills and increasing the range of emotions the person can express and understand.

⇒ **Cognitive Restructuring:** Addressing beliefs about the lack of enjoyment in social relationships.

⇒ **Behavior Activation:** Encouraging engagement in activities to increase positive interactions with others.

⇒ **Empathy Training:** Helping individuals understand and respond to their own and others' emotions.

⇒ **Increasing Awareness of Personal Values:** Supporting the individual in recognizing the importance of social relationships and the potential benefits they can bring.

Schizotypal Personality Disorder

⇒ **Social Skills Training:** Like in schizoid personality disorder, but also addressing more unusual behaviors and thoughts.

⇒ **Cognitive Restructuring:** Challenging odd beliefs and magical thinking, while acknowledging the person's unique perception of the world.

⇒ **Reality Testing:** Helping individuals check their interpretations of events and perceptions against reality.

⇒ **Managing Paranoia:** Learning strategies to manage suspicious thoughts.

⇒ **Behavioral Experiments:** Testing out beliefs in social situations to provide real-world feedback.

Cluster B Personality Disorders

Antisocial Personality Disorder

⇒ **Cognitive Restructuring:** Addressing patterns of thought that lead to harmful behaviors and disregarding the rights of others.

⇒ **Problem-Solving Skills:** Developing more effective ways to handle interpersonal and situational difficulties without resorting to manipulation or violation of norms.

⇒ **Anger Management:** Techniques to control impulsive and aggressive behaviors.

⇒ Moral Reasoning Development: To enhance the individual's moral understanding and concern for societal rules and norms.

⇒ **Empathy Training:** Fostering the ability to understand and share the feelings of others.

Borderline Personality Disorder

⇒ **Dialectical Behavior Therapy (DBT):** A specific form of CBT designed for BPD that combines cognitive-behavioral techniques with concepts of distress tolerance, acceptance, and mindful awareness.

⇒ **Emotion Regulation**: Learning how to change emotions that one wants to change.

⇒ **Interpersonal Effectiveness:** Skills to allow individuals to be more effective in relationships, balancing needs with demands, and maintaining self-respect.

⇒ **Distress Tolerance:** Building resilience and learning how to tolerate pain in difficult situations, not change it.

⇒ **Mindfulness:** Learning to be fully present in the moment, and more aware of oneself and others.

Histrionic Personality Disorder

⇒ **Cognitive Restructuring:** Challenging beliefs about self-esteem that are dependent on the approval of others.

⇒ **Emotion Regulation:** Teaching how to identify and manage the intensity of emotional experiences.

⇒ **Assertiveness Training:** Encouraging a more balanced expression of needs and desires.

⇒ **Reality Testing:** Working on the assessment of situations without over-dramatization or seeking attention.

⇒ **Social Skills Training:** Focusing on genuine connections with others rather than seeking attention.

Narcissistic Personality Disorder

⇒ **Cognitive Restructuring:** Addressing distorted self-images and expectations of superiority.

⇒ **Empathy Training:** Enhancing the ability to recognize and empathize with others' feelings and perspectives.

⇒ **Self-Esteem Regulation:** Helping the individual to understand and regulate their self-esteem without requiring external admiration.

⇒ **Assertiveness Training:** Encouraging respect for others' boundaries while maintaining personal boundaries.

⇒ **Anger Management:** Strategies to manage anger stemming from perceived slights or criticism.

Cluster C Personality Disorders

Avoidant Personality Disorder

⇒ **Cognitive Restructuring:** Challenging and altering negative beliefs about oneself and assumptions of rejection.

⇒ **Social Skills Training:** Enhancing social skills to improve interactions and reduce fears of rejection.

⇒ **Exposure Therapy:** Gradual exposure to social situations to decrease sensitivity to potential rejection and increase confidence.

⇒ **Anxiety Management Techniques:** Teaching relaxation and coping strategies to manage anxiety in social situations.

⇒ **Self-Esteem Building:** Working on increasing feelings of self-worth and self-compassion.

Dependent Personality Disorder

⇒ **Assertiveness Training:** Learning to express one's own needs and desires more effectively.

⇒ **Cognitive Restructuring:** Addressing thoughts related to incompetence and helplessness.

⇒ **Developing Autonomy:** Building skills to become more self-reliant and independent in decision-making.

⇒ **Problem-Solving Skills**: Improving the ability to solve problems independently.

⇒ **Graduated Task Assignments**: Structured activities that encourage independence and build confidence in one's abilities.

Obsessive-Compulsive Personality Disorder

⇒ **Cognitive Restructuring:** Challenging beliefs related to perfectionism, control, and orderliness.

⇒ **Relaxation Training:** Techniques such as deep breathing and progressive muscle relaxation to decrease the tension associated with the need for control.

⇒ **Prioritization and Time Management:** Helping individuals to prioritize tasks and manage time effectively, reducing the need for over-perfectionism in less important areas.

⇒ **Mindfulness and Acceptance:** Promoting present moment awareness and acceptance of thoughts without judgment to reduce rigidity.

⇒ **Exposure and Response Prevention (ERP):** Exposing individuals to their feared consequences of not following their rules or routines and preventing them from engaging in their usual compulsive behaviors.

Examples, Templates, Process Steps

Dialectical Behaviour Therapy

Teach and practice DBT skills. Create behavioural experiments that foster use of DBT skills.

1. Mindfulness:
   The practice of being fully aware and present in the moment.

   Skills include observing, describing, and participating in the current experience without judgment.
2. Distress Tolerance:
   Increasing the ability to tolerate pain in difficult situations, not change it.

   Skills involve accepting, finding meaning for, and tolerating distress. This includes techniques like distraction, self-soothing, and improving the moment.
3. Emotion Regulation:
   Learning to properly identify and label current emotions.

   Strategies include understanding the function of emotions, decreasing emotional vulnerability, and decreasing emotional suffering through changing emotions that are not helpful.
4. Interpersonal Effectiveness:
   Techniques that enable clients to attend to relationships, balance priorities versus demands, balance the 'wants' and 'shoulds', and build a sense of mastery and self-respect.

Skills taught include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict.

Cognitive Triad of Core Beliefs: Self, Others, World

Create awareness of core beliefs, situations that activate those beliefs and then engage in cognitive restructuring. Address long-standing negative beliefs about the self and others, often rooted in early life experiences.

Cluster A (Odd, Eccentric)

Paranoid Personality Disorder:

Beliefs about self: "I cannot trust myself to distinguish between true friends and enemies."

Beliefs about others: "Others are deceitful, malicious, and cannot be trusted."

Beliefs about the world: "The world is a dangerous place."

Schizoid Personality Disorder:

Beliefs about self: "I am a loner."

Beliefs about others: "Relationships are messy and undesirable."

Beliefs about the world: "The world is intrusive and overwhelming."

Schizotypal Personality Disorder:

Beliefs about self: "I am different or odd."

Beliefs about others: "Others will not understand or accept me."

Beliefs about the world: "The world is confusing and disordered."

Cluster B (Dramatic, Emotional, Erratic)

Antisocial Personality Disorder:

Beliefs about self: "I am entitled and superior to others."

Beliefs about others: "Others are targets or opportunities for manipulation."

Beliefs about the world: "The world is a game where the strongest and smartest prevail."

Borderline Personality Disorder:

Beliefs about self: "I am flawed and deserving of punishment."

Beliefs about others: "Others are going to abandon me; they can't be trusted."

Beliefs about the world: "The world is dangerous and unpredictable."

Histrionic Personality Disorder:

Beliefs about self: "I am not good enough if I'm not the center of attention."

Beliefs about others: "Others must find me entertaining and respond to me."

Beliefs about the world: "The world only values people who are attractive and fun."

Narcissistic Personality Disorder:

Beliefs about self: "I am superior and deserve special treatment."

Beliefs about others: "Others should admire me and cater to my needs."

Beliefs about the world: "The world should recognize my specialness."

Cluster C (Anxious, Fearful)

Avoidant Personality Disorder:

Beliefs about self: "I am inadequate and inferior to others."

Beliefs about others: "Others will judge and reject me."

Beliefs about the world: "The world is critical and rejecting."

Dependent Personality Disorder:

Beliefs about self: "I am helpless and incapable of taking care of myself."

Beliefs about others: "Others are competent and I need them to survive."

Beliefs about the world: "The world is a place where I can't function without support from others."

Obsessive-Compulsive Personality Disorder
(not to be confused with OCD):

Beliefs about self: "I must be perfect and in control at all times."

Beliefs about others: "Others are inefficient and too lax in their standards."

Beliefs about the world: "The world is chaotic and undisciplined."

Schizophrenia spectrum and other psychotic disorders

Schizotypal (Personality) Disorder	⇒ **Cognitive Restructuring:** Targeting odd beliefs and magical thinking without confrontation, to gradually reshape thought patterns. ⇒ **Social Skills Training:** Improving social interaction skills and reducing social anxiety. ⇒ **Emotion Regulation:** Helping to identify and manage intense emotions and mood swings. ⇒ **Behavioral Experiments:** Testing out the beliefs in safe environments to check their validity.
Delusional Disorder	⇒ **Reality Testing:** Collaboratively examining the evidence for and against delusional beliefs. ⇒ **Cognitive Restructuring:** Gently challenging the delusions and developing alternative, less distressing beliefs. ⇒ **Stress Management:** Teaching coping skills to manage stress that may exacerbate delusional thinking.
Brief Psychotic Disorder	⇒ **Psychoeducation:** Educating the individual about the disorder and the transient nature of symptoms. ⇒ **Stress Reduction Techniques:** Managing triggers that may induce or worsen psychotic symptoms. ⇒ **Symptom Management**: Providing strategies to cope with acute symptoms such as hallucinations or delusions.
Schizophreniform Disorder	⇒ **CBT for Psychosis:** Specific strategies targeting psychotic symptoms, such as hallucinations or delusions. ⇒ **Psychoeducation**: On the nature of the disorder and the importance of medication and therapy. ⇒ **Coping Strategy Enhancement:** Helping to develop and enhance personal coping strategies for dealing with symptoms.
Schizophrenia	⇒ **CBTsp:** Challenging distressing thoughts and perceptions, promoting alternative explanations. ⇒ **Enhancing Medication Adherence:** Using cognitive-behavioral strategies to improve adherence to antipsychotic medication. ⇒ **Social Skills Training:** Encouraging social engagement and improving social functioning. ⇒ **Relapse Prevention:** Identifying early warning signs and developing action plans to prevent relapse.

Schizoaffective Disorder	⇒ **Mood Regulation Strategies:** For managing the mood component, whether depressive or manic. ⇒ **CBTsp:** As with schizophrenia, to manage psychotic symptoms. ⇒ **Integrated Treatment:** Combining CBT strategies for psychosis with those for mood regulation, tailored to whether the mood disorder component is depressive or bipolar type.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

⇒ "People are talking about me."
⇒ "I must be on a special mission because I hear voices."
⇒ "My thoughts are being broadcasted aloud."
⇒ "I feel anxious in public because I know I'm being watched."

Intermediary Beliefs:

⇒ "I can't trust my senses; they always deceive me."
⇒ "If I'm hearing voices, I must be a bad or dangerous person."
⇒ "Others can hear my thoughts; I have no privacy."
⇒ "I am fundamentally different from everyone else."

Core Beliefs/Schemas:

⇒ "I am powerless against my mind."
⇒ "The world is a threatening and confusing place."
⇒ "I am alone in my experience; no one else can understand."
⇒ "I will never be able to function like a normal person."

For clients who experience a non-consensus (or different) reality, the following interventions and process steps can be useful:

Socratic Questioning:
Ask gentle, probing questions that encourage the individual to consider the evidence for their belief and to think about alternative explanations in a non-confrontational way.

Reality Testing:
Collaboratively examine the evidence for and against the delusional belief, encouraging the person to test the reality of their beliefs in a supportive manner.

Collaborative Empirical Investigation:
Work together to look at the facts and evidence surrounding their beliefs, treating the delusions as a hypothesis rather than a fact to be disproved.

Developing a Shared Understanding:
Acknowledge the person's emotional experience and explore the meaning and personal significance of the delusional belief.

Use of Metaphor:
Use metaphors to create parallels with the individual's belief, which can gently suggest alternative perspectives without direct confrontation.

Focus on Feelings Rather Than Content:
Concentrate on the feelings that arise from the beliefs rather than the factual content, which can reduce defensiveness.

Externalizing the Belief:
Talk about the delusion as if it is separate from the person, which can help reduce the threat to the person's identity when questioning the belief.

Exploring Consequences:
Gently discuss how the delusions impact their life and whether the outcomes are positive or negative.

Promoting a Sense of Agency:
Empower the individual to feel they have control over their response to their beliefs, even if the belief itself remains unchanged.

Sexual dysfunctions

Delayed Ejaculation	⇒ **Education and Behavioral Training:** Educate about the normal sexual response cycle and provide training in techniques such as the "start-stop" method. ⇒ **Anxiety Reduction Techniques:** Use relaxation exercises and stress reduction techniques to decrease performance anxiety. ⇒ **Cognitive Restructuring:** Challenge and modify negative beliefs about sex, performance, and pleasure. ⇒ **Sensate Focus Exercises:** These involve non-demand mutual pleasuring without the pressure of causing ejaculation. ⇒ **Masturbation Training:** In some cases, masturbation exercises are recommended to help the individual learn about their own sexual response and what might lead to orgasm.
Erectile Disorder	⇒ **Psychoeducation:** Understanding the physiological process of erection and the influence of psychological factors. ⇒ **Sensate Focus and Sexual Skills Training:** Reducing performance anxiety by focusing on pleasure rather than erection. ⇒ **Lifestyle Modification:** Addressing factors like smoking, alcohol, and obesity that can contribute to erectile problems. ⇒ **Cognitive Restructuring:** Challenging negative thoughts about performance or masculinity.
Female Orgasmic Disorder	⇒ **Psychoeducation:** Educating about the sexual response cycle and factors that influence orgasm. ⇒ **Directed Masturbation Training:** Helping women understand their own sexual response and what stimulates them. ⇒ **Communication Skills Training:** Encouraging open communication with partners about sexual preferences and needs. ⇒ **Cognitive Restructuring:** Addressing feelings of guilt or shame that may be associated with sex.
Female Sexual Interest/Arousal Disorder	⇒ **Mindfulness-Based Interventions:** Focusing on present sensations and feelings to increase sexual awareness and arousal. ⇒ **Cognitive Behavioral Couples Therapy**: Addressing relationship factors that may contribute to disinterest or arousal issues. ⇒ **Hormonal Considerations:** Though not a direct CBT intervention, addressing potential hormonal influences may be part of a comprehensive treatment plan.

	⇒ Cognitive Restructuring: Targeting thoughts that inhibit sexual interest or arousal.
Genito-Pelvic Pain/Penetration Disorder	⇒ Pain Education: Understanding the cycle of pain and its psychological components. ⇒ Relaxation Training: Learning techniques to reduce muscle tension and anxiety, such as progressive muscle relaxation. ⇒ Dilator Use: Gradual desensitization with the use of vaginal dilators to reduce fear of penetration. ⇒ Couples Therapy: Involving partners in treatment to improve communication and increase support.
Male Hypoactive Sexual Desire Disorder	⇒ Psychoeducation: Exploring potential causes and normalizing the experience. ⇒ Sensate Focus Exercises: Encouraging non-sexual and then gradually sexual touch to enhance desire. ⇒ Cognitive Restructuring: Challenging beliefs and attitudes about sex and masculinity that might contribute to low desire. ⇒ Lifestyle Modification: Addressing factors such as stress, fatigue, and physical health.
Early Ejaculation	⇒ Psychoeducation: Understanding the mechanisms of ejaculation. ⇒ The Stop-Start or Squeeze Technique: Exercises to help men gain control over the timing of ejaculation. ⇒ Behavioral Strategies: Including the use of condoms to reduce sensitivity, or different sexual positions that may help delay ejaculation. ⇒ Cognitive Restructuring: Addressing anxiety and self-focused attention during sex.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

- ⇒ "I won't be able to satisfy my partner."
- ⇒ "If I lose my erection, it means I'm not a real man."
- ⇒ "I'm not sexually attractive enough, and that's why I can't get aroused."
- ⇒ "Sex is always supposed to be perfect and spontaneous."
- ⇒ "I must have an orgasm every time to enjoy sex."

Intermediary Beliefs:

- ⇒ "Being sexually competent is essential to being a good partner."
- ⇒ "A sexual encounter without an orgasm is a failure."
- ⇒ "My worth is tied to my sexual performance."
- ⇒ "If I experience pain during sex, it will always be this way."
- ⇒ "My partner will leave me if I can't perform sexually."

Core Beliefs/Schemas:

- ⇒ "I am inadequate as a sexual partner."
- ⇒ "I am not man/woman enough."
- ⇒ "My body is defective."
- ⇒ "Sexuality is dangerous because it leads to rejection and humiliation."

Sleep–wake disorders

Insomnia Disorder	⇒ **Stimulus Control Therapy:** Creating a strong association between the bed and sleep by limiting the types of activities done in bed. ⇒ **Sleep Restriction Therapy:** Limiting the amount of time spent in bed to the actual sleep time, thereby increasing sleep efficiency. ⇒ **Sleep Hygiene Education:** Promoting habits that support good sleep, like reducing caffeine and creating a bedtime routine. ⇒ **Cognitive Therapy:** Identifying and challenging beliefs and attitudes about sleep that may maintain insomnia. ⇒ **Relaxation Techniques:** Including progressive muscle relaxation, deep breathing exercises, and meditation to reduce arousal and stress.
Hypersomnolence Disorder	⇒ **Sleep Schedule Management:** Establishing a consistent wake-up time to help regulate the sleep-wake cycle. ⇒ **Stimulus Control:** Encouraging activities that signal the brain for wakefulness during the day and calmness during the night. ⇒ **Napping Strategies:** Structuring naps to avoid disrupting night time sleep while reducing excessive daytime sleepiness. ⇒ **Cognitive Interventions:** Addressing worries about sleepiness and its impact, which may exacerbate the condition.
Narcolepsy	⇒ **Scheduled Napping:** Planning short, regular naps throughout the day to control sleepiness and maintain alertness. ⇒ **Sleep Hygiene:** Maintaining a regular sleep schedule and good sleep practices to ensure the quality of nighttime sleep. ⇒ **Cognitive Interventions:** Working on coping strategies to manage the psychological impact of narcolepsy and reduce any associated stigma. ⇒ **Behavioral Strategies:** Implementing strategies to maintain safety, such as avoiding certain activities at times when sleepiness is likely.

Examples, Templates, Process Steps

Stimulus Control Techniques

- ⇒ Use the Bed for Sleep Only
- ⇒ Go to Bed Only When Sleepy
- ⇒ Avoid Naps
- ⇒ Reserve the Bed for Sleep
- ⇒ Get Out of Bed When Unable to Sleep - If unable to fall asleep or return to sleep after 20 minutes, the person should get out of bed and engage in a relaxing activity until feeling sleepy again. This prevents the bed from becoming a cue for wakefulness.
- ⇒ Maintain a Regular Wake-Up Time - Regardless of how much sleep was achieved during the night, it's recommended to wake up at the same time every day to help set the body's internal clock.

Cognitive Restructuring

Identify and modify beliefs that contribute to sleep anxiety and unhelpful sleep-related behaviours. Work on catastrophic thinking related to the consequences of not sleeping.

Catastrophic Thinking: "If I don't get at least 8 hours of sleep, I will not be able to function at all tomorrow."

Overgeneralization: "I always sleep poorly before big events. It's going to be another terrible night."

Selective Abstraction / Filtering: "I only slept well for 4 hours last night; it was a bad night."

Fortune Telling: "I know I'm going to have a horrible night's sleep."

Personalization: "When I don't sleep well, it ruins everyone's day, not just mine."

"Should" Statements: "I should fall asleep within 20 minutes of going to bed."

Mind Reading: "My boss must think I'm lazy because I look so tired."

All-or-Nothing Thinking: "Unless I get a full night's sleep, there's no point in even trying to sleep."

Emotional Reasoning: "I feel anxious, so something must be wrong with my sleep."

Magnification of Consequences: "Every time I have a bad night's sleep, everything goes wrong."

Somatic symptom and related disorders

Somatic Symptom Disorder	⇒ **Cognitive Restructuring:** Identifying and challenging unhelpful thinking patterns related to the perception of bodily symptoms. ⇒ **Behavioral Experiments:** Testing out beliefs about symptoms through safe and structured activities to build more adaptive behaviors. ⇒ **Stress Management and Relaxation Techniques**: Techniques such as deep breathing, progressive muscle relaxation, and meditation to help manage physical tension and stress. ⇒ **Psychoeducation:** Educating the individual about the disorder to reduce worry about symptoms and to increase understanding of the mind-body connection.
Illness Anxiety Disorder	⇒ **Exposure Therapy:** Gradual and repeated exposure to health-related information or activities that provoke anxiety, with the aim of reducing the fear response. ⇒ **Health Anxiety Cognitive Behavioral Techniques**: Techniques specifically tailored to challenge and change the patterns of thinking that contribute to health anxiety. ⇒ **Mindfulness-Based CBT:** Developing awareness of the present moment to help individuals disengage from hyper-attention to bodily sensations or obsessive thoughts about health. ⇒ **Relaxation Training:** To help decrease general anxiety and stress, which can amplify preoccupations with health.
Conversion Disorder	⇒ **Symptom-Focused CBT:** Addressing the individual's symptoms and building specific behavioral techniques to manage and potentially alleviate them. ⇒ **Physical Therapy:** Incorporating physical rehabilitation strategies to improve motor or sensory function as part of a holistic CBT approach. ⇒ **Psychoeducation:** Helping the individual understand the nature of conversion symptoms and the absence of neurological damage. ⇒ **Stress Management:** Identifying and managing sources of stress that may be linked to the onset or exacerbation of symptoms.
Factitious Disorder	⇒ **Long-term Psychotherapy:** Building a trusting therapeutic relationship where underlying psychological needs can be addressed. ⇒ **Motivational Interviewing:** Helping the individual to find intrinsic motivation to change behaviors and to explore the underlying reasons for their deception.

⇒ **Cognitive-Behavioral Techniques:** These may be used to address any comorbid conditions, such as depression or personality disorders, that often accompany factitious disorder.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

⇒ "This headache must be a sign of a brain tumor."
⇒ "If my chest feels tight, I'm probably having a heart attack."
⇒ "No one understands how much pain I'm in."
⇒ "My body feels weird; I must be sick."
⇒ "I feel dizzy; something serious must be wrong with me."

Intermediary Beliefs:

⇒ "I must be vigilant about my health at all times."
⇒ "Doctors are missing something; they just aren't finding the real illness."
⇒ "It's not safe to exercise; it will make my symptoms worse."
⇒ "If I ignore my symptoms, they will get out of control."

Core Beliefs/Schemas:

⇒ "I am weak and my body is fragile."
⇒ "Being in good health means feeling no physical discomfort."
⇒ "My body is failing me."
⇒ "I cannot function unless I am completely symptom-free."

Trauma- and stressor-related disorders

Reactive Attachment Disorder	⇒ **Attachment-Based Therapy:** This is not strictly CBT, but may incorporate elements of CBT. It focuses on building a healthy attachment between the child and caregivers. ⇒ **Parent-Child Interaction Therapy (PCIT):** Aims to improve the quality of the parent-child relationship and change interaction patterns. ⇒ **Psychoeducation:** Teaching caregivers about attachment issues and providing strategies to handle behaviors associated with RAD. ⇒ **Structured Environment:** Providing a consistent and nurturing environment to help the child develop a sense of safety and attachment.
Disinhibited Social Engagement Disorder	⇒ **Behavioral Interventions:** Establishing clear rules and consistent consequences for behavior, while also teaching appropriate social boundaries. ⇒ **Parent Training:** Educators and therapists work with parents or caregivers to help them respond effectively to the child's needs and behaviors. ⇒ b Helping the child to understand and practice appropriate social interactions.
Posttraumatic Stress Disorder	⇒ **Cognitive Processing Therapy (CPT):** A type of CBT that helps patients learn how to challenge and modify unhelpful beliefs related to the trauma. ⇒ **Prolonged Exposure Therapy:** Involves having the patient repeatedly relive the frightening experience under controlled conditions to help him or her work through the trauma. ⇒ **Eye Movement Desensitization and Reprocessing (EMDR):** Though not a classic CBT technique, EMDR is often used to process and integrate traumatic memories. ⇒ **Stress Inoculation Training:** Teaching coping skills to manage stress and anxiety.
Acute Stress Disorder	⇒ **Cognitive Restructuring:** Changing patterns of negative thoughts about the traumatic event. ⇒ **Exposure-Based Techniques:** Encouraging individuals to confront the memories and feelings they may be avoiding. ⇒ **Relaxation and Anxiety Management:** Techniques to manage the physiological symptoms of stress. ⇒ **Psychoeducation:** Information about symptoms, explanations of common reactions to trauma, and the course of recovery.

Adjustment Disorders	⇒ **Problem-Solving Therapy:** Helping individuals develop skills to effectively cope with the stressor causing the adjustment issue. ⇒ **Cognitive Restructuring:** Addressing maladaptive thoughts that may arise in response to life changes. ⇒ **Relaxation Training:** Techniques to manage overall stress levels, which can help in adjusting to new life circumstances. ⇒ **Behavioral Activation:** Encouraging engagement in pleasurable or meaningful activities to counteract withdrawal and depression.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

- ⇒ "The world is a completely dangerous place."
- ⇒ "I can't trust anyone; they will hurt me."
- ⇒ "I should have done something to prevent what happened."
- ⇒ "If I let my guard down, something bad will happen."
- ⇒ "I can't handle this feeling; it's too much."

Intermediary Beliefs:

- ⇒ "People are generally malevolent and out to harm me."
- ⇒ "Vulnerability is a sign of weakness."
- ⇒ "Being constantly on alert is the only way to stay safe."
- ⇒ "I must control all my emotions, or I will fall apart."
- ⇒ "Avoiding anything that reminds me of the trauma is necessary to keep me safe."

Core Beliefs/Schemas:

- ⇒ "I am fundamentally damaged or broken."
- ⇒ "The world is an inherently threatening place."
- ⇒ "I am powerless to affect my life or safety."
- ⇒ "Others cannot be relied upon for support or safety."
- ⇒ "If something feels threatening, it must be threatening."

CBT Prolonged Exposure Exercise for Trauma

Education: Begin by educating the client about the nature of exposure therapy, the rationale behind confronting rather than avoiding the traumatic memory, and the role of habituation in reducing symptoms.

Developing the Trauma Narrative: Work with the client to create a detailed narrative of their traumatic experience. This narrative will be used during imaginal exposure sessions.

Breathing Retraining: Teach the client breathing techniques to manage immediate distress during exposure exercises.

Imaginal Exposure Process:

Preparation: Establish safety and ensure the client is ready for the exposure exercise. Choose a quiet, private space without interruptions.

Imaginal Exposure: Have the client close their eyes and recount the traumatic event out loud in the present tense, including details of what they saw, heard, thought, felt, and smelled during the event.

Duration: The exposure should last for a specific amount of time (typically 30-45 minutes) and will be repeated across several therapy sessions.

Processing: After the exposure, process the experience with the client. Discuss any new insights, thoughts, and feelings about the memory.

Homework: Assign the client to listen to a recording of their narrative daily to reinforce the exposure process.

In Vivo Exposure Assignments:

Identification of Triggers: Work with the client to identify real-world situations that trigger trauma symptoms but are objectively safe.

Hierarchical Approach: Develop a hierarchy of triggers, starting with less distressing situations and gradually moving to more challenging ones.

Confrontation: Assign the client to gradually confront these situations between sessions to reinforce learning and reduce avoidance.

Monitoring and Support:

Subjective Units of Distress Scale (SUDS): Use SUDS to rate the client's anxiety before, during, and after the exposure. This helps track progress and the process of habituation.

Safety Planning: Ensure that there are procedures in place for the client to manage increased distress, including crisis support if necessary.

Client Homework Example:

Daily Listening: Listen to your recorded narrative every day.

In Vivo Exposure: Visit the park where you feel slightly uneasy but which is safe, and remain there for an agreed-upon time.

Note: The PE therapy process should always be tailored to the individual client by a trained therapist.

Cognitive processing therapy

CPT usually involves a set number of sessions, around 12 to 16, and is comprised of several key components:

1. Education:
   - ⇒ Educating the client about PTSD symptoms and providing a rationale for the treatment.
   - ⇒ Explaining how thoughts and feelings are interconnected with behaviour.
2. Becoming Aware of Thoughts and Feelings:
   - ⇒ Identifying and understanding how thoughts about the traumatic event can lead to feelings.
   - ⇒ Learning about the impact of the event on beliefs about oneself, others, and the world.
3. Learning Skills:
   - ⇒ Teaching clients to recognize problematic thoughts (e.g., overgeneralization, catastrophizing).
   - ⇒ Introducing the skill of more balanced thinking.
4. Processing the Trauma:
   - ⇒ Clients write a detailed account of the traumatic event(s), which is read in session and as homework.
   - ⇒ Discussing the traumatic event helps the client process the trauma and reduce avoidance.
5. Challenging Beliefs:
   - ⇒ Identifying 'stuck points', or thoughts that keep the client from recovering.
   - ⇒ Challenging these stuck points and developing more balanced and accurate thoughts.
6. Understanding Changes in Beliefs:
   - ⇒ Examining pre-trauma, post-trauma, and currently held beliefs in various areas such as safety, trust, power/control, esteem, and intimacy.
   - ⇒ Learning to identify and modify extreme or unhelpful beliefs related to the trauma.
7. Skill Consolidation and Application:
   - ⇒ Clients write an impact statement about the meaning of the event and how it has affected their beliefs.
   - ⇒ Clients use the skills learned in CPT to address other areas of life and future challenges.
8. Final Sessions:
   - ⇒ Reviewing skills learned throughout therapy.
   - ⇒ Discussing progress, reviewing treatment gains, and planning for the future.

Substance use disorders

Cognitive Interventions

- ⇒ Cognitive Restructuring: Identifying and challenging harmful beliefs and thoughts that contribute to substance abuse.
- ⇒ Recognition of Drug-Use Triggers: Learning to recognize situations that trigger substance use and developing strategies to avoid or cope with them.

Behavioral Interventions

- ⇒ Coping Skills Training: Developing and practicing skills to cope with triggers and cravings without using substances.
- ⇒ Drug Refusal Training: Learning and practicing how to refuse substances when offered.
- ⇒ Contingency Management: Providing tangible rewards for positive behaviors such as maintaining sobriety.

Affective Interventions

- ⇒ Mood Management: Techniques to manage negative emotions that might lead to substance use.
- ⇒ Stress Reduction Techniques: Methods such as relaxation, mindfulness, and stress management to reduce the emotional triggers for substance use.

Interpersonal Interventions

- ⇒ Assertiveness Training: Building skills to communicate effectively and assertively without resorting to passive or aggressive behaviors.
- ⇒ Social Skills Training: Enhancing skills for building and maintaining healthy relationships that do not revolve around substance use.

Relapse Prevention

- ⇒ Relapse Prevention Planning: Developing a plan to prevent relapse which includes identifying early warning signs and coping strategies.
- ⇒ Lifestyle Modification: Encouraging the development of new, healthy routines and activities to replace those associated with substance use.

Motivational Interventions

- ⇒ Motivational Interviewing (MI): A client-centered approach that helps increase motivation to change by resolving ambivalence.

Self-Monitoring and Goal Setting

- ⇒ Self-Monitoring: Keeping track of substance use to understand patterns and triggers.
- ⇒ Goal Setting: Establishing clear and achievable goals regarding substance use reduction or abstinence.

Examples, Templates, Process Steps

Relapse Prevention Planning

Identify and Manage Triggers: Recognize the external cues (people, places, things, situations) and internal states (emotions, thoughts) that prompt cravings and develop strategies to avoid or manage them.

Develop Coping Skills: Learn and practice stress management techniques such as deep breathing, meditation, and mindfulness to deal with stress without resorting to substances.

Improve Problem-Solving Skills: Work on effective strategies to solve daily problems that could potentially lead to relapse.

Challenge Unhelpful Thoughts: Use cognitive restructuring to identify and dispute irrational or harmful beliefs that may lead to substance abuse.

Lifestyle Modifications: Make changes in daily routines to support recovery, such as engaging in regular exercise, maintaining a healthy diet, and getting adequate sleep.

Build a Supportive Network: Establish a strong support system of family, friends, or others in recovery who can provide encouragement and understanding.

Engage in Sober Activities: Find new hobbies or rekindle interests in activities that do not involve alcohol or drugs to fill the time that was previously spent on substance use.

Medication-Assisted Treatment: For some, medications can help to manage withdrawal symptoms, cravings, and maintain sobriety.

Have a Relapse Prevention Plan: Create a detailed plan for how to prevent a lapse and what to do if a lapse occurs, to prevent a relapse.

Practice Self-Care: Prioritize self-care to handle emotional and physical well-being, which can reduce the likelihood of relapse.

Learn to Refuse Substances Politely but Firmly: Practice ways to say no to alcohol or drugs in social situations.

Celebrate Sobriety and Harm Reduction Milestones: Recognize and reward achievements in sobriety to reinforce the positive aspects of recovery.

Emergency Planning: Have a plan for who to call and what to do if you feel a relapse might be imminent.

Cognitive Restructuring

Challenge beliefs that contribute to problematic substance use.

Self-Medication Beliefs:
"I need alcohol/drugs to cope with stress or emotions."
"Substances help me deal with depression/anxiety."

Enhancement Beliefs:
"Drugs make me more fun at parties."
"I can't enjoy myself without using."

Social Beliefs:
"Everyone I know drinks/uses, so it must be okay."
"I can only socialize or be social when I'm using."

Denial of Problems:
"I don't use that much, so it's not a problem."
"I can stop whenever I want."

Perceived Benefits:
"Using substances is the only way I can relax."
"Drugs make me feel confident."

Minimization of Consequences:
"I've never been arrested for DUI, so my drinking isn't that bad."
"I still have a job, so my drug use isn't a problem."

Fatalistic Beliefs:
"My life is already ruined, so I might as well keep using."
"I have an addictive personality; it's in my genes."

Entitlement Beliefs:
"I work hard, and I deserve to have fun."
"I've had a tough life, and drugs give me a break."

Lack of Alternative Solutions:
"There's no other way to deal with my problems."
"Nothing else works for me."

Infallibility Beliefs:
"I can handle my substance use; it won't get out of control."
"I know how to manage my use so it doesn't affect my health."

Comparative Rationalization:
"I'm not as bad as other people I know."
"At least I'm not using [more intense substance]."

Gambling Disorder

Cognitive Interventions

- ⇒ **Cognitive Restructuring**: Identifying and challenging irrational and harmful beliefs about gambling, such as the odds of winning, superstitions, and the ability to recoup losses ("chasing" losses).
- ⇒ **Reframing Gambling Outcomes:** Learning to understand the randomness of gambling outcomes and the independence of events in games of chance.

Behavioral Interventions

- ⇒ **Self-Monitoring:** Tracking gambling behaviors, triggers, and the consequences of gambling to increase self-awareness.
- ⇒ **Exposure with Response Prevention (ERP):** Gradually exposing the patient to gambling-related stimuli while teaching them to resist the urge to gamble.
- ⇒ **Behavioral Activation:** Encouraging engagement in alternative, non-gambling activities that are enjoyable and fulfilling.

Financial Interventions

- ⇒ **Money Management:** Establishing financial controls and budgeting skills to manage finances effectively and reduce the opportunity and means to gamble.
- ⇒ **Debt Management:** Learning strategies to deal with debt caused by gambling.

Problem-Solving Skills

- ⇒ **Developing Problem-Solving Strategies:** Teaching techniques to solve personal and interpersonal problems, thereby reducing the need to escape these problems through gambling.

Relapse Prevention

- ⇒ **Relapse Prevention Planning:** Developing strategies to cope with high-risk situations and the desire to gamble.
- ⇒ **Lifestyle Modification:** Encouraging the development of new, constructive habits to replace gambling.

Emotional Regulation

- ⇒ **Stress Management Techniques**: Implementing relaxation methods and stress reduction strategies to manage the emotional triggers that may lead to gambling.

Social Skills Training

- ⇒ **Improving Social Skills:** Enhancing skills for building and maintaining relationships, communicating effectively, and asserting oneself appropriately.

Motivational Interventions

- ⇒ **Motivational Interviewing (MI):** Enhancing motivation to change by exploring and resolving ambivalence about stopping gambling.

Psychoeducation

- ⇒ **Education about Gambling Disorder:** Understanding the nature of gambling disorder, its progression, and consequences.

Examples, Templates, Process Steps

Cognitive Restructuring

Automatic Thoughts:

- ⇒ "I'm feeling lucky today; I'm sure I'll win."
- ⇒ "I've lost three times in a row, so I'm due for a big win now."
- ⇒ "I just need one more bet to recoup my losses."
- ⇒ "I can't leave now; my luck is about to change."
- ⇒ "If I keep gambling, I'll eventually figure out a system to beat the odds."

Intermediary Beliefs:

- ⇒ "Winning money is a sign of success."
- ⇒ "Gambling is the only thing that makes me feel alive."
- ⇒ "If I don't gamble, I'll miss out on the chance to win big."
- ⇒ "I'm a better gambler than most people, so I'm more likely to win."
- ⇒ "Gambling losses are just the price for a future win."

Core Beliefs/Schemas:

- ⇒ "I am a loser, and the only way to be a winner is to hit the jackpot."
- ⇒ "I am worthless if I can't provide quick financial wins."
- ⇒ "The world is unfair, and gambling gives me a chance to level the playing field."
- ⇒ "My value is determined by my financial success."
- ⇒ "Without risk, there's no reward."