

Principles of Cognitive Behavioral Therapy: Formulation, Collaboration, and Change

Christian Jonathan Haverkamp

Narrative Clinical Review

Abstract—Cognitive behavioral therapy (CBT) is better understood as a family of formulation-guided methods than as a fixed sequence of techniques. Its central clinical task is to identify a plausible, testable account of how meanings, attention, emotion, physiology, behavior, and context sustain a patient's difficulty, and then to revise that account through collaborative observation and action. This narrative clinical review examines foundational principles, assessment and shared formulation, therapeutic communication, session structure, cognitive and behavioral methods, exposure, between-session practice, outcome monitoring, adaptation, relapse prevention, and safety. Evidence available through 30 August 2024 supports CBT across several depressive and anxiety presentations, while also showing that average efficacy does not identify which component helped a particular patient. Behavioral activation can be effective without elaborate cognitive restructuring, exposure depends on new learning rather than fear elimination alone, and alliance quality remains associated with outcome within CBT. These findings favor disciplined flexibility: interventions should follow the proposed maintaining mechanism, preserve the patient's agency, and be revised when predicted changes do not occur. The review proposes that a useful formulation is not merely explanatory; it specifies an observable sequence, an ethically acceptable experiment, and a meaningful outcome. CBT is most recognizably cognitive-behavioral when therapist and patient can say what they are testing, why it matters, what happened, and how the result changes the next step.

Index Terms—cognitive behavioral therapy, case formulation, therapeutic alliance, behavioral experiment, exposure, outcome monitoring

I. INTRODUCTION

Cognitive behavioral therapy is often introduced through visible procedures: thought records, activity schedules,

exposure exercises, or homework. Those procedures matter, but none by itself defines the approach. CBT is a way of organizing clinical inquiry. A therapist and patient develop a provisional account of how a difficulty is being maintained, choose an intervention that can test part of that account, observe what changes, and revise the formulation accordingly. The process is structured, but it is not mechanical. It depends on careful listening, shared language, and the patient's experience of the problem in ordinary life. Beck's retrospective account and later overview with Dozois describe a model that evolved through reciprocal exchange between clinical observation, testable theory, and outcome research (Beck, 2005; Beck & Dozois, 2011).

The label CBT covers related but nonidentical treatments. Protocols differ in their targets, assumptions, dose, and techniques; behavioral activation, exposure-based treatment, standard cognitive therapy, mindfulness-based cognitive therapy, and transdiagnostic protocols should not be treated as interchangeable. Reviews nevertheless show substantial evidence across common mental disorders, especially depression and anxiety, while comparative advantage over other bona fide psychotherapies is smaller and more variable than advantage over no treatment or weak controls (Butler et al., 2006; Hofmann et al., 2012; Tolin, 2010). A principles review should therefore explain both what travels across protocols and what must remain diagnosis- and mechanism-specific.

A practical claim runs through this review: CBT gains coherence from an explicit cycle of formulation, intervention, observation, and revision. Without that cycle, technique selection can become a collection of exercises, while formulation without behavioral testing can become an elegant story that cannot correct itself. The patient's priorities, social setting, bodily state, relationships, culture, and material constraints are not background variables; they shape what an event means, which responses are available, and whether a proposed task is safe or feasible. CBT does not ask the patient to think positively. It asks therapist and patient to examine predictions, expand workable action, and preserve uncertainty when the evidence remains incomplete.

Christian Jonathan Haverkamp, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkamp@gmail.com. Website: www.jonathanhaverkamp.com.
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II. SCOPE AND REVIEW METHOD

This narrative clinical review uses a literature-search cutoff of 30 August 2024, one calendar month before the nominal issue date of 30 September 2024. Sources were eligible only when a journal article, book, guideline, or stable public record was publicly available by that cutoff; a later issue assignment did not make an unavailable source eligible. Searches combined terms for cognitive therapy, cognitive behavioral therapy, behavioral activation, exposure, homework, case formulation, therapeutic alliance, treatment mechanism, depression, anxiety, randomized trial, meta-analysis, relapse, and clinical guidance. Reference lists of major reviews were checked for foundational trials and process studies. Priority was given to systematic reviews, randomized comparisons, influential component studies, process meta-analyses, and authoritative clinical guidance.

The review is narrative rather than systematic. It does not estimate a pooled effect and cannot settle comparative efficacy for every diagnosis or delivery format. Broad reviews combine populations, comparators, therapist expertise, outcomes, and follow-up intervals that may not be commensurable. Older trials also used different diagnostic systems and standards of reporting. Accordingly, statements about efficacy are separated from statements about mechanism: improvement after a CBT package does not establish that every named component was necessary, and correlation between process and outcome does not by itself establish causal mediation. The clinical synthesis asks what the evidence can reasonably support at the level of a treatment decision.

III. A WORKING MODEL OF MAINTENANCE AND CHANGE

A CBT formulation usually links a situation with rapid appraisals, images or memories, emotion, bodily arousal, attention, and action. The clinical value lies less in filling boxes than in showing a sequence. A person who interprets a racing heart as imminent collapse may scan the body, escape, seek reassurance, and avoid exertion. Relief follows, but the feared prediction remains untested and future sensations become more salient. In depression, withdrawal may reduce immediate effort or disappointment while also removing reinforcement, mastery, contact, and corrective experience. In both examples, a response that is understandable in the short term can carry a longer-term cost. The formulation must describe that trade-off without recasting coping as irrationality.

Cognitions in CBT include more than sentences. Images, autobiographical meanings, attentional rules, conditional assumptions, and felt predictions may organize behavior before a patient can state them. Conversely, change need not begin with verbal belief revision. Component and dismantling studies in depression showed that behavioral activation alone

could produce outcomes comparable with more elaborate cognitive packages in the studied samples (Jacobson et al., 1996; Dimidjian et al., 2006). Longmore and Worrell's review similarly questioned whether direct disputation of thoughts is universally necessary (Longmore & Worrell, 2007). These findings do not make cognition irrelevant. They suggest that action can generate information that changes meaning, and that the route of change should be investigated rather than assumed.

A good formulation operates at the right scale. Too broad—'low self-esteem causes avoidance'—and it gives little direction. Too narrow—'the patient checked the door three times at 08:10'—and it may not generalize. A useful middle level identifies repeatable conditions, predictions, responses, immediate consequences, and delayed consequences. It also names protective factors and exceptions. When does the pattern not occur? Which relationship makes disclosure easier? What activity produces absorption rather than rumination? Exceptions are not incidental; they are naturally occurring tests of the model and may reveal resources that treatment can amplify.

Formulation complements rather than replaces diagnosis and protocol knowledge. Diagnosis summarizes a recognizable syndrome and connects the patient to an evidence base; formulation asks why this presentation persists in this life now. The empirically supported treatment movement made intervention claims more accountable while also prompting debate about how research categories transfer to complex clinical cases (Chambless & Ollendick, 2001). A disciplined clinician uses both levels. The protocol supplies tested possibilities and contraindications, while the individualized model decides which possibility is currently relevant. When the levels conflict, the conflict is documented as uncertainty and examined through additional assessment, consultation, or a cautious test rather than concealed by confident terminology.

A formulation becomes more informative when it contains a plausible rival. Repeated reassurance after bodily sensations might be maintained by catastrophic misinterpretation, by insufficient explanation from fragmented medical care, or by both. Withdrawal after conflict might protect against feared rejection, genuine escalation by a partner, or exhaustion that has been mistaken for avoidance. Each account predicts something different and implies a different intervention. The therapist can state which evidence favors one account, which observation would favor another, and what cannot yet be distinguished safely. This comparative method makes revision concrete: a formulation changes because a rival better explains the result, not simply because the patient failed to respond. It also prevents contextual realities from being absorbed into a preferred intrapsychic mechanism.

Table 1. From formulation to a testable clinical question

Element	Question	Example
Trigger	What happened, internally or externally?	A bodily sensation during exercise
Prediction or meaning	What seemed likely or personally significant?	The sensation means danger
Maintaining response	What reduced distress now but preserved the problem?	Stopping, scanning, reassurance
Experiment	What safe action would distinguish competing accounts?	Graded exertion with reduced checking
Outcome	What observation would matter to this patient?	Recovery, confidence, resumed activity

IV. ASSESSMENT BEFORE INTERVENTION

Assessment begins with the problem the patient wants help with, not with a protocol title. The clinician establishes symptom form, duration, severity, functional impact, course, previous treatment, physical health, medication and substance use, sleep, trauma, developmental history, relationships, work, and current stressors. The same behavior can have different functions: staying home may reflect fear, exhaustion, pain, shame, caregiving demands, coercive control, or realistic danger. A formulation that ignores function can prescribe exposure to a hazard, activation beyond medical capacity, or assertiveness where disclosure would increase risk. Diagnosis helps organize evidence, but it should not replace a timeline and functional analysis.

Differential assessment is especially important when symptoms change abruptly, are episodic, or do not fit the proposed model. Depression-like slowing may accompany medication effects, substance withdrawal, sleep disorders, endocrine or neurological disease, psychosis, bipolar depression, bereavement, or severe environmental depletion. Anxiety-like arousal may reflect cardiopulmonary, endocrine, neurological, medication-related, or substance-related causes. Cognitive difficulties may arise from sleep loss, trauma, ADHD, depression, delirium, or neurological disease. CBT can be adapted for many comorbidities, but the therapist must know when psychological treatment is adjunctive and when urgent medical or psychiatric evaluation takes priority.

Baseline measurement should serve a decision. A diagnosis-specific scale can estimate symptom severity, but change in a total score is not identical to restored function or reduced risk. The assessment should identify one or more observable outcomes meaningful to the patient: returning to a lecture, sleeping in the bedroom, completing a work task, speaking with a partner without repeated reassurance, or remaining in a feared situation long enough to learn. Measures should be named because an interview, questionnaire, behavioral record,

and administrative outcome answer different questions. A small average trial effect may be important for one patient, while a statistically reliable symptom change may leave the central disability untouched.

Assessment is already an intervention because its questions direct attention and establish what kinds of explanation will be taken seriously. A narrowly intrapsychic interview may miss that symptoms peak after conflict, discrimination, caregiving strain, or contact with a particular service. A purely contextual account may miss a repeatable appraisal-and-avoidance loop. The clinician can summarize both: 'This pattern intensifies when you expect criticism, and leaving quickly protects you from shame but prevents you from discovering whether repair is possible.' The patient is then asked what fits, what does not, and what evidence would alter the account. This exchange makes formulation a shared act of communication rather than a private conclusion written after the session.

Temporal sampling often improves the accuracy of that account. Global questions such as 'How anxious are you?' invite an average reconstructed through current mood, whereas two recent episodes can reveal different triggers, predictions, and consequences. One episode may involve internal arousal and escape; another may follow a partner's ambiguous message and end in reassurance seeking. The therapist can compare these sequences before deciding that one mechanism explains both. Brief records between sessions then test whether the sampled episodes were representative. This approach respects the patient's narrative while reducing the risk that a memorable crisis, or the therapist's preferred model, becomes the whole case.

V. COLLABORATION, LANGUAGE, AND THE THERAPEUTIC ALLIANCE

Collaborative empiricism is sometimes reduced to asking a series of Socratic questions. Its deeper purpose is to distribute epistemic authority appropriately. The patient knows the private meaning, history, and consequences of an experience; the therapist contributes knowledge of patterns, methods, and evidence. Neither has complete access to the answer in advance. The pair therefore frame hypotheses in language the patient recognizes and test them against lived experience. A therapist who silently decides the 'distortion' and then guides the patient toward it is conducting persuasion, not collaboration. Genuine collaboration allows the patient's observation to disconfirm the therapist's preferred formulation.

The alliance is not dispensable because CBT is structured. Meta-analytic work across therapies shows a reliable association between alliance and outcome, and a CBT-specific review in adult depression found the same broad relationship (Horvath et al., 2011; Flückiger et al., 2018; Cameron et al., 2018). Causal interpretation remains difficult because early improvement can strengthen alliance and better alliance can

facilitate engagement. Clinically, the distinction does not justify neglect. Agreement on goals and tasks, a credible rationale, emotional safety, and a relationship in which disagreement can be expressed are conditions under which demanding behavioral work becomes possible.

Communication should make structure useful rather than controlling. An agenda is negotiated, not imposed; a formulation is offered as a draft, not delivered as a verdict; and feedback is invited in ways that make criticism safe. 'What did I miss?' is often more productive than 'Does that make sense?' The therapist can explain why a question is being asked, acknowledge when evidence is mixed, and distinguish validation of distress from endorsement of a feared conclusion. When a partner or family member is involved, consent, role, confidentiality, and the risk of becoming a reassurance provider or covert monitor should be explicit. Relationships can support experiments and valued action, but treatment should not turn them into surveillance systems.

Alliance strain often appears in technically meaningful form. A patient who agrees to an exposure but repeatedly changes the subject may be signaling fear, shame, disagreement about the target, or concern that refusal will disappoint the therapist. A therapist who responds by restating the rationale more forcefully may reproduce the patient's expectation that authority will not listen. Naming the process permits a new test: can disagreement be expressed and still leave the relationship intact? The answer may correct an interpersonal prediction while improving task design. Thus rupture repair is not a departure from CBT; it is collaborative hypothesis testing applied to the therapeutic interaction, with the additional ethical duty to protect the patient's freedom to decline.

Collaboration is tested most clearly when patient and therapist prefer different next steps. The therapist may judge exposure to have the strongest evidence, while the patient wants first to address sleep, relationship conflict, or the fear of being overwhelmed. Shared decision-making does not require the clinician to describe all options as equivalent, nor the patient to accept the statistically favored one. Each can state priorities, expected benefits, burdens, and conditions for reconsideration. A brief, safe preparatory target may increase capacity for later exposure; it may also become avoidance if review is indefinitely postponed. Naming both possibilities and agreeing a review point preserves clinical direction without turning evidence into leverage. The quality of collaboration is shown by whether disagreement produces a clearer plan, not by how quickly preference converges.

VI. STRUCTURE, GOALS, AND BETWEEN-SESSION LEARNING

CBT sessions commonly include a brief review, agreement on priorities, focused work, summary, and a plan for

observation or practice. Structure protects time for change and makes the reasoning visible. It should remain proportionate. A patient disclosing acute risk, coercion, medication toxicity, or a major loss does not need the agenda defended against reality. Conversely, repeated crisis-driven drift can prevent work on the pattern that generates crises. The therapist's task is to hold both the immediate need and the longer arc, explaining transitions rather than making the patient guess why the conversation has moved.

Goals are strongest when they link personal value to observable action. 'Reduce anxiety' gives little guidance; 'attend the weekly meeting and speak once even when anxious' identifies context, behavior, and purpose. Goals also need a burden test. A plan that requires unavailable transport, privacy, money, energy, digital access, or family cooperation is not a test of motivation. Treatment planning should distinguish inability, ambivalence, uncertainty, and disagreement. Motivational work may be appropriate when the costs of change are real, but it should not reframe structural constraints as resistance.

Between-session tasks extend learning into the setting where the problem occurs. Meta-analysis supports an association between homework processes and outcome, but assignment alone is not the active ingredient (Kazantzis et al., 2010). A useful task has a shared rationale, manageable dose, specified prediction, method of observation, and planned review. Completion is not a moral score. If a task was not attempted, the therapist asks what happened: Was it forgotten, too vague, too difficult, unsafe, embarrassing, or based on a formulation the patient did not believe? That review may provide more clinically valuable information than nominal completion. A 2023 systematic review of 25 studies found mixed-to-neutral immediate findings but positive intermediate outcomes when therapists integrated between-session work through a convincing rationale, collaborative design, and review; because the literature was mostly CBT and exposure based, this supports deliberate integration rather than a universal causal recipe (Ryum et al., 2023).

The opening and closing minutes of a session carry disproportionate informational value. At the beginning, patient and therapist can compare current priorities with the agreed treatment arc; at the end, each states the emerging learning and any unresolved concern. Divergent summaries are useful data. If the therapist heard 'anxiety is tolerable' while the patient heard 'I must ignore danger,' the discrepancy must be repaired before a task is attempted. This brief check reduces the chance that professional language hides different meanings. It also models a broader interpersonal skill: important conversations are more reliable when partners make their interpretations visible rather than assuming that the same words produced the same understanding.

A rationale should remain short enough to be used and specific enough to be questioned. Explaining that exposure 'reduces anxiety' can create a hidden performance rule; explaining that a task will test whether anxiety, uncertainty, and valued action can coexist identifies a different outcome. The patient should be able to state the rationale in their own words and say what would make it unconvincing. That test is especially important when the therapist recommends a demanding exercise. Shared understanding does not require enthusiasm, but it does require that consent rests on the actual purpose, foreseeable burden, and available alternatives rather than on deference to professional authority.

VII. COGNITIVE METHODS AS INQUIRY

Cognitive work begins by slowing a significant episode enough to recover the appraisal that organized emotion and action. The therapist may ask what went through the patient's mind, what image appeared, what seemed about to happen, or what the event meant about self, others, or the future. The aim is precision, not extraction of a required 'negative thought.' Some patients first notice bodily states or impulses; others report a conclusion without accessible words. Imagery, role reconstruction, or attention to a recent interaction may reveal meaning more accurately than repeated abstract questioning.

Evaluation of an appraisal is broader than listing evidence for and against it. The pair can examine probability, cost, coping, alternative explanations, source quality, base rates, and the effects of holding the belief as certain. They can distinguish a possibility from the prediction that is driving behavior. Balanced reappraisal should not promise safety that no one can guarantee. For a patient fearing rejection, the alternative may be not 'everyone will like me' but 'some discomfort is likely, I cannot know the other person's view in advance, and I can remain in the conversation long enough to learn.' Such an appraisal supports action without requiring false reassurance.

Behavioral experiments give cognitive work traction. An experiment specifies competing predictions and chooses an ethically acceptable observation capable of changing confidence. It differs from simply doing something difficult. If a patient predicts that a pause in conversation will lead a partner to leave, the experiment might involve naming the need for a short pause and observing the response, not withholding communication without explanation. Results are reviewed for what occurred, what was learned, what remains uncertain, and whether safety behaviors obscured the test. Unexpected results should update the therapist's model as readily as the patient's.

Interpersonal appraisals deserve the same precision as solitary fears. 'My partner does not care' may refer to a delayed reply, an expression, a history of broken promises, or a current act of coercion; these are not equivalent targets for

reappraisal. The therapist first clarifies the observable event, the inferred intention, the patient's emotional and bodily response, and the ensuing communication. Where the relationship is safe, an experiment may involve a direct request, reflective listening, or checking an interpretation. Where it is unsafe, encouraging disclosure can increase harm. CBT's commitment to testing beliefs never requires a patient to suspend sound judgment about power, consent, or credible threat.

VIII. BEHAVIORAL ACTIVATION, EXPOSURE, AND NEW LEARNING

Behavioral activation targets patterns in which avoidance, withdrawal, or routine loss reduces access to reinforcement and increases passivity, rumination, or hopelessness. Activity is selected for function and value rather than for generic pleasantness. A short walk may offer mastery for one patient, unwanted exposure to harassment for another, and medical overexertion for a third. Monitoring can identify links among situation, activity, mood, mastery, connection, and delayed consequence. The evidence that behavioral activation can perform comparably with full cognitive therapy in some depression trials supports its status as a substantive intervention, not merely preparation for 'real' cognitive work (Jacobson et al., 1996; Dimidjian et al., 2006).

Exposure is similarly more than endurance. Traditional accounts emphasized habituation; inhibitory-learning accounts emphasize building retrievable associations that compete with threat expectations (Craske et al., 2008; Craske et al., 2014). Fear need not fall within a session for useful learning to occur. An exposure should identify what catastrophe is expected, vary contexts where appropriate, reduce safety behaviors selectively, and review expectancy violation. The goal is flexible approach in the presence of uncertainty, not proof that anxiety or danger can never occur. Exposure to genuine hazards, abusive relationships, or medical contraindications is not a therapeutic test; trauma-focused exposure requires an appropriate protocol, informed consent, and assessment of current safety.

Both activation and exposure work through action that generates information and restores choice. Their apparent simplicity makes formulation more, not less, important. Repeated tasks can become rituals if the patient uses them to guarantee safety; an activity schedule can become another standard for self-criticism; exposure can become coercive if refusal is treated as pathology. Therapist and patient should monitor immediate relief, longer-term function, and unintended effects. The clinically relevant question is not whether the patient complied, but whether the action changed the proposed maintaining process and expanded life in a direction the patient values.

Generalization should be designed rather than hoped for. Learning achieved with one therapist, in one room, or at one point on a hierarchy may remain tied to that context. Varying cues, settings, emotional states, and the presence or absence of support can test whether a new response is portable. At the same time, variability must be paced so that the patient can identify what produced the result. A partner may sometimes participate by responding differently to reassurance or accompanying an early approach task, but should then step back where independence is the aim. The relational question is whether support increases learning and agency, not simply whether it lowers anxiety during the exercise.

Table 2. Mechanism-matched interventions and common errors

Maintaining process	Possible intervention	Error to avoid
Withdrawal and reinforcement loss	Graded, values-linked activation	Prescribing generic busyness
Catastrophic prediction plus avoidance	Exposure with prediction tracking	Using fear reduction as the only outcome
Checking or reassurance	Response prevention and uncertainty practice	Withholding necessary medical care
Rigid appraisal	Guided discovery and behavioral experiment	Debating the patient into agreement
Rumination	Attention shift, activity, and process-focused experiment	Treating every thought as content to dispute

IX. EVIDENCE, COMPARATORS, AND WHAT EFFICACY DOES NOT PROVE

Broad reviews support CBT for many anxiety and depressive disorders, but the size and meaning of benefit depend on the comparator. Advantages over waiting list often exceed advantages over credible psychological treatment. Tolin found comparative benefits concentrated in anxiety and depression and also identified researcher allegiance as relevant to apparent differences (Tolin, 2010). Direct-comparison meta-analysis found psychotherapy and pharmacotherapy broadly comparable across depression and anxiety at the group level, with heterogeneity that limits simple ranking (Cuijpers et al., 2013). Placebo-controlled anxiety trials continue to support acute CBT efficacy, but they do not establish a universal protocol or response for every patient (Carpenter et al., 2018).

Individual trials illustrate both promise and limits. Cognitive therapy performed comparably with antidepressant medication in a trial of moderate-to-severe depression delivered by experienced clinicians, while behavioral activation also showed acute effects in a separate trial (DeRubeis et al., 2005; Dimidjian et al., 2006). A transdiagnostic Unified Protocol was noninferior to diagnosis-specific protocols for principal anxiety outcomes in one randomized trial, suggesting that shared emotional processes

can sometimes be treated without abandoning diagnostic knowledge (Barlow et al., 2017). Mindfulness-based cognitive therapy reduces relapse risk for recurrent depression in selected populations, but prevention evidence should not be generalized to acute crisis treatment (Kuyken et al., 2016).

These findings support disciplined pluralism. They do not mean that all therapies are equivalent, that components are interchangeable, or that an average effect predicts a particular patient's outcome. Treatment fidelity protects against calling any supportive conversation CBT, yet competence includes responsive adaptation. Research reports should specify population, comparator, therapist training, treatment integrity, missing data, adverse events, and outcome domain. Clinicians should state which evidence they are borrowing and where transfer is uncertain—for example, from specialist trials to routine care, from a single diagnosis to multimorbidity, or from symptom reduction to relational and occupational recovery.

Evidence hierarchies answer different questions. A randomized trial can estimate average causal effects under its conditions, a component study can challenge assumptions about necessity, and process research can identify candidate pathways without proving them. Case-level monitoring then tests whether those pathways are changing for this patient, but cannot recreate randomization. The useful synthesis is cumulative rather than competitive: group evidence constrains plausible choices; diagnosis and context define the transfer problem; collaborative observation supplies local feedback. This framework avoids two symmetrical errors—treating a manual as a prediction for every individual and treating clinical intuition as exempt from evidence because every individual is unique.

Average effects also conceal clinically different trajectories. Two patients can contribute the same endpoint change when one improves steadily and another deteriorates before recovering; a third may achieve important functional gains while a symptom scale barely moves. Trials and reviews support offering CBT, but they do not supply a stopping rule for an individual course (Butler et al., 2006; Carpenter et al., 2018). Clinicians therefore need planned review thresholds: what early change is expected, how much worsening is acceptable during a difficult but safe task, and when persistence becomes unjustified. Such thresholds make evidence actionable without pretending that an average response curve is a forecast.

X. ADAPTATION WITHOUT LOSING THE MODEL

Adaptation begins with access and meaning. Language, literacy, disability, neurodivergence, age, culture, faith, migration, poverty, discrimination, and caregiving responsibilities can alter both presentation and feasibility. A standard thought record may be inaccessible to a patient who

processes experience visually, while audio notes, diagrams, objects, or in-session rehearsal may work. Direct eye contact or assertive disclosure may carry different meanings across cultures and relationships. Adaptation is not a reduction in rigor if the therapist preserves the hypothesis, intervention target, and method of learning while changing delivery.

Comorbidity requires sequencing. A patient with panic, depression, chronic pain, and relationship conflict may not need four simultaneous protocols. The formulation can identify which process is currently central, which risks require immediate attention, and which improvement would unlock others. Sleep stabilization, medication review, safeguarding, or practical support may precede demanding experiments. Where cognitive impairment or severe distress limits reflection, sessions may be shorter, repetition greater, and behavioral observation more prominent. Where psychosis or bipolar disorder is present, CBT may be adjunctive and should be integrated with appropriate medical care rather than presented as a substitute.

Digital and low-intensity delivery can improve reach, but contact is not a trivial wrapper. Guidance may help a patient interpret exercises, titrate difficulty, disclose adverse effects, and recover after noncompletion. The absence of in-person cues makes explicit communication more important. Clinicians should agree how risk will be assessed, what messaging can and cannot provide, how privacy is protected, and what happens if contact is lost. A scalable intervention that systematically excludes patients with unstable housing, limited data, sensory impairment, or language barriers may be efficient for its users while widening inequity at service level.

Relapse planning is another test of whether adaptation has preserved the model. Patient and therapist identify early changes in mood, avoidance, sleep, checking, or communication; distinguish a lapse from a full return of the old cycle; and write the smallest useful first steps. The plan includes circumstances that require professional or medical review rather than self-directed CBT. It also records which explanations and exercises felt respectful enough to reuse. Prevention evidence for mindfulness-based cognitive therapy in recurrent depression shows that maintenance interventions can alter relapse risk in selected patients, but the principle is broader than that protocol: durable care leaves the patient with a comprehensible method for noticing and responding, not only memories of techniques (Kuyken et al., 2016). An earlier JPPC review of mindfulness in psychotherapy similarly emphasizes that program identity, selection, teacher competence, burden, and adverse effects remain part of the intervention rather than optional context (Haverkamp, 2014).

A formulation is more durable when it can travel with the patient across clinicians and settings. At discharge or transfer, a concise handover can record the maintaining sequence, interventions tested, evidence that changed confidence, safety

boundaries, early warning signs, the patient's preferred language, and questions treatment did not answer. This is more useful than a diagnostic label and a list of completed worksheets: a new clinician can see why a task mattered, while the patient can correct an outdated account. With consent, a partner or relevant professional may know the agreed response to early difficulty without becoming a monitor. Used this way, formulation becomes a continuity tool: it reduces unnecessary restarting, preserves learning, prevents a partial success from hardening into a complete explanation, names who will review remaining uncertainty and what change would prompt reassessment, and leaves the next clinician and patient free to revise the model as context changes.

XI. MONITORING, FEEDBACK, AND FORMULATION REVISION

Monitoring should answer three questions: Is the patient safer, is the maintaining process changing, and is life becoming more workable? Symptom scales contribute but cannot answer all three. Process measures might include checking frequency, time spent ruminating, avoidance, sleep opportunity, or willingness to approach a valued task. Functional measures might include attendance, self-care, relationship participation, study, caregiving, or medical adherence. The interval must fit the expected mechanism; measuring depression hour by hour can create noise, while reviewing risk only at planned endpoints can miss rapid deterioration.

Before an intervention, therapist and patient should predict what would change if the formulation is correct. If graded exposure reduces avoidance but panic remains unchanged, the result may still represent useful approach learning; if neither approach nor expectancy changes, the dose, safety behavior, target, or model may be wrong. If activation increases activity but deepens exhaustion, medical burden, sleep, perfectionism, and task selection deserve review. A null result is not evidence that the patient failed. It is evidence about the current experiment, interpreted with adherence, context, and measurement quality.

Feedback becomes clinically active only when it changes the next decision. Persistent worsening should prompt review of diagnosis, risk, treatment fit, alliance, adverse effects, implementation, and external conditions. The therapist should ask directly about disappointment or pressure within therapy. A patient may report improvement to protect a therapist, or conceal noncompletion to avoid shame. Normalizing correction—'we need the model to fit your experience, not your experience to fit the model'—turns communication into a safety mechanism as well as an alliance practice.

Measurement can itself alter the process being measured. Detailed mood monitoring may reveal contingencies, but for a

patient prone to checking it can intensify self-surveillance; frequent partner ratings can turn a relationship into a treatment instrument. The solution is not to abandon data but to choose the lightest measure that answers the decision and to review whether collection is helping. A useful dashboard combines a standardized outcome with one mechanism indicator and one life-level goal. When those indicators diverge, conversation comes before arithmetic: patient and therapist examine what each measure captured, what it missed, and which decision the discrepancy should inform.

Table 3. A compact outcome dashboard

Domain	Possible indicator	Decision if unchanged or worse
Safety	Suicidality, self-neglect, violence, medical warning signs	Escalate assessment or level of care
Symptoms	Validated diagnosis-specific measure	Review diagnosis, dose, and adverse effects
Process	Avoidance, checking, rumination, sleep	Revisit the maintaining hypothesis
Function	Work, study, care, relationships, daily living	Change target or address practical barriers
Alliance	Goal/task agreement and session feedback	Repair misunderstanding or renegotiate treatment

XII. SAFETY, ETHICS, AND LIMITS OF SELF-APPLICATION

CBT is not a diagnostic shortcut or a reason to psychologize unexplained symptoms. New focal neurological signs, delirium, catatonia, collapse, severe chest pain or breathing difficulty, rapidly changing behavior, intoxication or withdrawal, severe self-neglect, mania, psychosis, and marked medical deterioration require appropriate urgent assessment. The threshold for escalation depends on context and professional role. A psychological formulation can coexist with medical illness, and prior anxiety does not make a new symptom benign. Collaborative care and clear communication between clinicians reduce both repeated uncoordinated testing and premature diagnostic closure.

Risk assessment should be direct when clinically indicated: suicidal thoughts, self-harm, violence, exploitation, abuse, access to lethal means, inability to meet basic needs, and capacity to remain safe. A worksheet or routine exposure task is not an adequate response to acute risk. Safety planning should identify warning signs, internal strategies, supportive contacts, professional pathways, and emergency options appropriate to the setting. Partners or family may help only with consent and after considering whether involvement is safe. Where coercive control or abuse is present, conjoint tasks and disclosure can increase danger.

Self-help CBT can be valuable for mild or circumscribed problems, and stepped-care guidance supports lower-intensity options for some anxiety presentations (National Institute for Health and Care Excellence, 2011). It cannot determine diagnosis, medical fitness, medication management, or level of care. Unsupervised exposure should not involve genuine danger, medical contraindication, illegal conduct, or trauma work beyond the person's capacity to remain oriented and safe. The ethical standard is not maximal discomfort; it is a proportionate, consented test whose likely learning value exceeds foreseeable burden.

Pause routine CBT and reassess when

- risk, mental state, or physical health is deteriorating rapidly
- the proposed task could expose the patient or another person to genuine danger
- noncompletion may reflect coercion, disability, poverty, cognitive impairment, or treatment misunderstanding
- symptoms suggest mania, psychosis, delirium, withdrawal, neurological disease, or another urgent differential
- the alliance has ruptured and the patient no longer feels able to disagree or disclose adverse effects

XIII. LIMITATIONS AND RESEARCH PRIORITIES

The CBT evidence base is large but uneven. Trial populations may exclude severe comorbidity, acute risk, unstable living conditions, or patients unable to attend regular sessions. Therapist expertise in research clinics can exceed routine service conditions. Outcomes emphasize symptom totals more often than participation, relationship quality, adverse effects, or patient-defined change. Publication bias, allegiance, treatment fidelity, and comparator credibility complicate synthesis. Broad labels also obscure whether a study tested cognitive therapy, exposure, behavioral activation, mindfulness-based work, or a multicomponent protocol.

Mechanism research should move beyond demonstrating that a mediator changed during successful treatment. Temporal ordering, experimental manipulation, within-person measurement, and replication are needed to show that the proposed process actually drove improvement. Component findings should be interpreted with humility: failure to show an added average benefit does not prove that a component is useless for every patient. Research should also test how alliance repair, formulation agreement, cultural adaptation, partner involvement, digital contact, and structural access affect both benefit and burden.

A particularly useful research unit is the prediction–action–outcome sequence. Studies can ask whether explicitly tracking predictions improves learning, whether changes generalize across contexts, and which patients benefit from more cognitive, behavioral, relational, or transdiagnostic emphasis. Adverse events and deterioration should be reported

consistently. The field will be more clinically informative when it can say not only that a package works on average, but what process changed, for whom, under what conditions, at what cost, and with what effect on a life the patient values.

Communication deserves the same mechanistic precision as cognition and behavior. Agreement on a formulation may increase task engagement, but apparent agreement may also reflect compliance; partner involvement may support approach, but may also preserve reassurance. Future studies should specify the communicative act, its timing, the response it elicited, and the proposed pathway to outcome. Session recordings, sequential coding, and within-person designs could test whether clarification or rupture repair precedes renewed learning rather than merely accompanies improvement. This would make the human relationship empirically examinable without reducing it to a generic common factor or claiming that alliance substitutes for a mechanism-focused intervention.

XIV. CONCLUSION

The durable principle of CBT is not that thoughts cause all distress or that every problem yields to a worksheet. It is that clinically important patterns can often be described precisely enough to test, and that action can generate information unavailable through explanation alone. A formulation links meaning, emotion, physiology, behavior, context, and consequence; an intervention targets a specified maintaining process; monitoring asks whether that process and the patient's life changed; and revision protects against false certainty.

The human relationship is integral to this method. Collaboration determines whose question is being tested, communication makes uncertainty and rationale visible, and alliance permits demanding work without turning structure into coercion. Evidence supports CBT across several common disorders, while cautioning against attributing package effects to every component or assuming that average results identify an individual's best route. Credible practice is structured yet corrigible: therapist and patient agree on a meaningful aim, test a safe hypothesis, attend together to what happens, and allow the result—especially an unexpected one—to shape the next step.

XV. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

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