CBT for insomnia, eating disorders, addiction and psychosis

How CBT looks for the "engine" behind four very different problems, and what the evidence says about how much it helps

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

18 chapters ~60 min read

How solid is each fact

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

In short

- **Each problem has its own "engine".** CBT (cognitive behavioural therapy) does not apply one template to everything. For insomnia it looks for what keeps poor sleep going; for eating disorders, what self-worth rests on; for addiction, what happens after the first slip; for psychosis (a state in which contact with reality is disrupted, for example hearing voices), how a person makes sense of unusual experiences.
- **CBT for insomnia (CBT-I) has the strongest evidence.** American physicians (2016), American sleep specialists (2021) and the European guideline (2023) all call it the first-line treatment for chronic insomnia, meaning it is where treatment should start.
- **Sleep hygiene on its own does not treat insomnia.** Advice about coffee, curtains and phones is a useful background, but the American Academy of Sleep Medicine advises against using it as the only treatment, and the European guideline says that sleep hygiene by itself is not an evidence-based treatment.
- **CBT-I adds hardly any hours of sleep.** Its main effect lies elsewhere: people fall asleep faster, spend less time awake in the middle of the night and suffer less from insomnia. In one meta-analysis (a study pooling many trials) total sleep time rose by just 7.6 minutes, and even that was not statistically reliable.
- **Eating disorders are not about willpower or a number on the scales.** In Christopher Fairburn's model, the core is a sense of self-worth that rests mainly on shape, weight and control over eating. UK guidelines explicitly say not to decide whether to offer treatment on a single measure such as body mass index (a number calculated from height and weight).

- **A slip is not a relapse.** In Alan Marlatt's model, what happens next depends less on the slip itself than on how the person reads it: "a mistake, back to the plan" or "it's all over".
- **CBT for addiction works, but no better than other proven methods.** It clearly beats no treatment; against other specific treatments (also designed for addiction) there is no difference.
- **CBT for psychosis does not argue with voices.** Its aim is to reduce distress and help people live their lives, not to "talk them out of" their beliefs. The effect on symptoms is small, and its size is genuinely disputed. It is always part of care alongside a psychiatrist, never a substitute for medication.

Timeline

Key milestones of the four areas on one line. Details and sources are in the chapters below.

1952 — Beck's first psychiatric paper: a case of a patient with a delusion, treated psychoanalytically
ROOTS

1985 — Marlatt and Gordon publish "Relapse Prevention"
COGNITIVE LINE

1991–1994 — Kingdon and Turkington: CBT for schizophrenia with a "normalising rationale"
COGNITIVE LINE

1995 — Fowler, Garety and Kuipers: a manual of CBT for psychosis
COGNITIVE LINE

1999 — Meta-analysis of relapse prevention: 26 studies
EVIDENCE

2002 — NICE (the UK body for clinical guidelines) recommends CBT for psychosis for the first time
EVIDENCE

2003 — Fairburn, Cooper and Shafran: the transdiagnostic theory of eating disorders, one model for different eating disorders
COGNITIVE LINE

2009 — Trial of CBT-E in 154 patients with eating disorders
EVIDENCE

2009 — Pilot trial of mindfulness-based relapse prevention (MBRP)
THIRD WAVE

2014 — Jauhar and colleagues' meta-analysis: the effect of CBT in schizophrenia is small
EVIDENCE

2015 — Trauer and colleagues' meta-analysis: what CBT-I actually changes
EVIDENCE

2016 — American College of Physicians: CBT-I as the initial treatment for all adults
EVIDENCE

2017 — OASIS trial: treating insomnia reduces paranoid thinking in students
EVIDENCE

2021 — American Academy of Sleep Medicine: strong recommendation for CBT-I
EVIDENCE

2022 — NICE recommends a digital CBT-I programme in primary care (at the GP)
EVIDENCE

2023

European Insomnia Guideline: CBT-I first-line, in person or digital

EVIDENCE

What the lines mean. "Roots" is prehistory. "Cognitive line" covers models and protocols that work with thoughts, beliefs and behaviour. "Third wave" covers approaches where mindfulness and acceptance play a central role (more on the third wave in Episode 13). "Evidence" covers trials, meta-analyses and clinical guidelines.

How to read these notes: evidence labels

Every claim here carries a label that tells you how solid it is.

CBT stands for cognitive behavioural therapy. Every factual claim in the text carries a label in brackets, followed by its source.

Label	What it means
Proven by research	Randomised trials (participants are split into groups by chance and the results compared) or meta-analyses (studies that pool many trials)
Clinical consensus	Clinical guidelines, i.e. official advice to clinicians on what to treat with (for example from the UK's NICE), or positions of professional bodies
The author's own account	How the creator of a model describes it; not independently checked
Interpretation	A reading of the evidence, or a question still under debate
Documented fact	Dates, publications, regulatory decisions
Not verified	We could not open the primary source; treat with care

Where sources disagree, both versions are given.

We often cite the UK's NICE guidelines, not because they are the only right answer. They are public, built on reviews of the research and regularly updated, which makes them a convenient reference point; the way care is organised where you live may differ (interpretation).

Important

This is education, not therapy or diagnosis. The techniques below are described as they are used in therapy, not as a "do it yourself instead of treatment" guide. With eating disorders, physical dependence on alcohol or medication, psychosis and bipolar disorder, help always starts with a doctor. These notes mention suicidal thoughts. If you need support right now, see If you need help now.

One method, different engines

Why CBT has no single protocol "for everything", and what four very different topics have in common.

The basic idea of CBT (cognitive behavioural therapy) is the same for any problem: a situation triggers a thought, the thought shapes feelings and behaviour, and behaviour often keeps the problem going (the model is covered in Episode 2). But *what exactly* keeps a problem in place differs between disorders. That is why many disorders have their own protocols: detailed treatment programmes tested in research.

It helps to picture each problem as having its own "engine", a mechanism that keeps reproducing it. A protocol aims squarely at that engine (interpretation; our summary of the chapters below).

Problem	Protocol	What keeps it going	Aim of therapy
Chronic insomnia	CBT for insomnia (CBT-I)	The bed has become a place of struggle, natural "sleep pressure" is weakened, anxiety about sleep itself	Restore sleep as an automatic process
Eating disorders	Fairburn's enhanced CBT (CBT-E)	Self-worth rests mainly on shape, weight and control over eating	Break the cycle that maintains the disorder
Addiction	CBT and relapse prevention, with motivational interviewing and incentives	High-risk situations, the expectation that "this will help", the "it's all over" reaction after a slip	Reduce use and stop a slip turning into a relapse
Psychosis	CBT for psychosis (CBTp)	Frightening interpretations of unusual experiences, distress, behaviours that prevent fears from being tested	Reduce distress and improve everyday life

Key: CBT-I is CBT for insomnia, CBT-E is enhanced CBT for eating disorders, CBTp is CBT for psychosis. Motivational interviewing and incentives are described in the chapter on addiction.

All four topics share two things. First, CBT here works hand in hand with medicine: sleep physicians, psychiatrists, addiction specialists, GPs. Second, each topic has an area where a psychologist without clinical training should not work **clinical consensus; summarised from AASM, 2021; NICE NG69, 2017; NICE CG115, 2011; NICE CG178, 2014**. That is not a weakness of the method but a boundary of competence.

Important

About my practice. Psychosis and bipolar disorder are outside my practice. I write about them as part of the history and science of CBT, so that it is clear what good care looks like and where to find it.

Insomnia: what keeps it going

Why insomnia that began with stress can last for years after the stress is gone.

What counts as chronic insomnia

Chronic insomnia means difficulty falling asleep, staying asleep or waking too early, with knock-on effects during the day: tiredness, irritability, poorer concentration. Under the ICD-11 classification of diseases, these problems must occur "at least several times per week for at least 3 months"; under the sleep disorders classification ICSD-3, at least three times a week for at least 3 months **documented fact; Riemann et al., 2023**. No fixed thresholds such as "it takes me over half an hour to fall asleep" are needed for the diagnosis.

It is common: up to 10% of adults in Europe have chronic insomnia **clinical consensus; Riemann et al., 2023**. The European guideline describes it as an independent risk factor for depression and anxiety disorders, as well as for a number of physical illnesses **clinical consensus; Riemann et al., 2023**.

Three motors of insomnia

Picture someone who went through a hard period at work six months ago and started sleeping badly. Work has long since settled down; sleep has not. What keeps insomnia going once the original cause has gone? Guidelines and reviews describe several maintaining processes **clinical consensus; Edinger et al., 2021, review; Riemann et al., 2023**. They can be grouped into three "motors" (interpretation; our summary).

1. **The bed has become a cue for wakefulness.** Months of lying in bed awake, tossing and worrying, teach the brain a link: "bed is where I struggle". This is a conditioned association, the same kind as in Pavlov's dogs (laws of learning are covered in Episode 1). Pavlov trained dogs to salivate at a signal that had previously come before food **documented fact; Pavlov, 1927**; in the same way, a bed can become a signal not for sleep but for the struggle to sleep. A familiar picture: someone nods off on the sofa in front of the TV, but in the bedroom sleep disappears.
2. **"Sleep pressure" is weakened.** Sleep pressure is the need for sleep that builds up while we are awake. Going to bed early "just in case", lying in late or napping during the day uses it up, and night-time sleep becomes broken and shallow.
3. **Anxiety about sleep itself.** Thoughts like "if I don't get eight hours, tomorrow will be a disaster" arouse the nervous system on their own. The harder someone tries to sleep, the worse it goes: sleep is not something you can achieve by effort.

The European guideline describes this as a vicious circle: heightened arousal, anticipatory anxiety, rumination at night and excess time in bed all feed one another **clinical consensus; Riemann et al., 2023**.

What about sleeping pills?

Sleeping pills help for a while, but, as the European guideline notes, symptoms frequently recur or even rebound after they are stopped, whereas the effect of CBT-I (cognitive behavioural therapy for insomnia) appears stable, with follow-ups of up to 10 years published

clinical consensus; Riemann et al., 2023. The American College of Physicians advises deciding about medication together with a doctor, weighing benefits, harms and costs, if CBT-I alone has not helped clinical consensus; Qaseem et al., 2016. Decisions about medication are a doctor's call, and stopping it on your own is not a good idea.

What CBT for insomnia is made of

CBT-I is not talking about your problems; it is a set of mostly behavioural techniques, each with its own target.

CBT for insomnia (CBT-I) is a multicomponent programme. According to the European guideline it includes psychoeducation, explaining how the problem works (including sleep hygiene), relaxation, sleep restriction, stimulus control and several cognitive strategies clinical consensus; Riemann et al., 2023. It can be delivered in person, one-to-one or in groups, by phone, through online programmes and self-help books clinical consensus; Qaseem et al., 2016.

Stimulus control: giving the bed back its meaning

The target is the first motor, the "bed equals wakefulness" link. The rules are: go to bed only when sleepy; if you can't fall asleep, get out of bed; use the bed only for sleep and sex; get up at the same time every day; avoid daytime naps clinical consensus; Edinger et al., 2021, review. Picture it: it is one in the morning, and you are lying there counting the hours until the alarm. The "get up" rule breaks exactly that scene. The method was described by psychologist Richard Bootzin in the early 1970s documented fact; per Penn Behavioral Sleep Medicine; the 1972 original was not opened.

"Can't sleep? Get up" has a cost. American sleep specialists warn of the risk of night-time falls in older adults, people taking sleeping pills and people with limited mobility; for them the protocol is adapted clinical consensus; Edinger et al., 2021, review.

Sleep restriction: less time in bed

The target is the second motor, sleep pressure. Using a sleep diary, the specialist looks at how long the person actually sleeps and temporarily limits time in bed to roughly that amount. Sleep becomes more consolidated, and then the "sleep window" is gradually widened clinical consensus; Edinger et al., 2021, review. It sounds paradoxical: treating insomnia starts with spending less time in bed. The method has notable side effects and contraindications, so it gets its own chapter below. It was first fully set out by Arthur Spielman, Paul Saskin and Michael Thorpy in 1987 (documented fact; Spielman et al., 1987, as cited in the systematic review by Maurer, Espie & Kyle, 2018).

Relaxation

Techniques that reduce bodily tension (breathing exercises, progressive muscle relaxation, autogenic training) and mental arousal (guided imagery, meditation) clinical consensus; Edinger et

al., 2021, review.

Cognitive techniques

The target is the third motor, anxiety about sleep. Therapist and client examine beliefs about sleep and "performance anxiety": the fear that without perfect sleep the next day is doomed. The tools are psychoeducation, Socratic dialogue (questions that help people reach conclusions themselves; see Episode 5), thought records and behavioural experiments clinical consensus; Edinger et al., 2021, review.

Example

A behavioural experiment. A client is sure: "If I sleep badly, I won't be able to work." With the therapist, they write down this prediction, and after a bad night they note what actually happened: which tasks got done, where it was hard. Often the day turns out harder than usual but not catastrophic. The prediction is tested against facts rather than argued with. The example is ours, for illustration; the technique itself is described in the review by the AASM, the American Academy of Sleep Medicine (Edinger et al., 2021).

Another cognitive strategy is **paradoxical intention**: the person is asked to lie in bed without trying to fall asleep, which takes the pressure of effort away. The European guideline lists it among CBT-I's cognitive strategies clinical consensus; Riemann et al., 2023.

Sleep hygiene, as a background

Sleep hygiene is general advice on lifestyle (caffeine, alcohol, exercise) and environment (light, noise, temperature) clinical consensus; Edinger et al., 2021, review. It is part of CBT-I, but as psychoeducation, not as treatment. The next chapter explains why.

Myth vs fact

Myth: CBT for insomnia means talking about what's bothering you. **Fact:** the main working components that received AASM recommendations are behavioural: stimulus control, sleep restriction, relaxation clinical consensus; Edinger et al., 2021. Cognitive work is part of the programme too, but on its own it has barely been studied.

What actually helps with sleep: the evidence

What guidelines and meta-analyses say, from strong evidence to weak.

First line: CBT for insomnia

First line means where treatment is recommended to start. CBT for insomnia is cognitive behavioural therapy for insomnia (CBT-I). Three major bodies reached the same conclusion.

- **American College of Physicians (ACP, 2016):** all adults with chronic insomnia should receive CBT-I as the initial treatment; strong recommendation, moderate-quality evidence clinical consensus; Qaseem et al., 2016.
- **American Academy of Sleep Medicine (AASM, 2021):** strong recommendation for multicomponent CBT-I clinical consensus; Edinger et al., 2021.
- **European Insomnia Guideline (2023):** CBT-I is recommended as the first-line treatment for chronic insomnia, in person or digitally, at the highest grade, A clinical consensus; Riemann et al., 2023.

Components by strength of recommendation

What	AASM recommendation, 2021
Multicomponent CBT-I	Strong, for
Brief behavioural therapy for insomnia (a shortened version)	Conditional, for
Stimulus control alone	Conditional, for
Sleep restriction alone	Conditional, for
Relaxation alone	Conditional, for
Sleep hygiene as the only treatment	Conditional, against

clinical consensus; Edinger et al., 2021. "Conditional" means the experts judged that benefits outweigh harms for most people, but the decision depends on the person and circumstances. For cognitive therapy as a stand-alone treatment, no study met the AASM review's inclusion criteria, so there was nothing to grade documented fact; Edinger et al., 2021, review. That does not mean "it doesn't work": it means it has barely been studied on its own, while cognitive techniques are used within CBT-I.

Why sleep hygiene isn't enough

The AASM review states that sleep hygiene alone "was not identified as an effective single-component therapy" in any of the earlier reports proven by research; Edinger et al., 2021, review. The European guideline says that sleep hygiene on its own is not an evidence-based treatment for insomnia, and that sleep hygiene advice given alone is not recommended for chronic insomnia clinical consensus; Riemann et al., 2023.

A likely explanation: hygiene removes external disturbances but does not touch the three motors of insomnia. Many people with long-standing insomnia have long since tried the blackout curtains and skipping the evening coffee (interpretation; our reading, not a direct research finding).

Myth vs fact

Myth: follow good sleep hygiene and your insomnia will go away. **Fact:** for chronic insomnia, sleep hygiene alone is not a treatment; the AASM advises against using it as the only one **clinical consensus; Edinger et al., 2021; Riemann et al., 2023**. As a background it is useful.

What actually changes

This is the most surprising finding. Trauer and colleagues' meta-analysis (2015), a study pooling many others, combined 20 randomised trials (in which participants are assigned to groups by chance) with 1,162 adults with chronic insomnia. After CBT-I **proven by research; Trauer et al., 2015**:

Measure	Change
Time to fall asleep	about 19 minutes faster
Time awake in the middle of the night	about 26 minutes less
Sleep efficiency (share of time in bed actually spent asleep)	almost 10 percentage points higher
Total sleep time	+7.6 minutes, with a confidence interval (the range where the true value most likely lies) that includes zero, so the gain is not statistically reliable

The Dutch meta-analysis by van Straten and colleagues (2018), 87 randomised trials, showed the same picture in effect sizes. An effect size (g) is a standard measure: around 0.2 is considered small, around 0.5 medium, 0.8 and above large. The largest effect was on insomnia severity on the ISI, the Insomnia Severity Index questionnaire (g = 0.98), followed by sleep efficiency (0.71), night-time waking (0.63) and time to fall asleep (0.57); the smallest was on total sleep time (0.16) **proven by research; van Straten et al., 2018**. In the same meta-analysis, face-to-face programmes of four or more sessions looked more effective than self-help and shorter formats.

So CBT-I does not so much add hours as make sleep more solid and end the exhausting nightly battle. What this means for you: if your goal is "sleep a couple of hours longer", therapy

may disappoint; if it is "fall asleep quickly and stop lying awake at night", that is its strength (interpretation; reading of Trauer et al., 2015; van Straten et al., 2018).

Myth vs fact

Myth: insomnia therapy will give you a couple of extra hours of sleep. **Fact:** total sleep time is exactly what CBT-I changes least; it changes insomnia severity, time to fall asleep and night-time waking the most **proven by research; Trauer et al., 2015; van Straten et al., 2018**.

Does the effect last?

A meta-analysis of 30 trials with long-term follow-up found that the effect on insomnia severity fades over time, g = 0.64 at 3 months, 0.40 at 6 months and 0.25 at a year, so from medium to small, but remains significant **proven by research; van der Zweerde et al., 2019**. The European guideline adds that booster sessions help **clinical consensus; Riemann et al., 2023**.

Can an app treat insomnia?

It can, and this is one of the most studied areas of digital psychotherapy. The European guideline gives digital CBT-I the same grade A as in-person treatment **clinical consensus; Riemann et al., 2023**.

- **Sleepio.** In a randomised trial of 1,711 adults, digital CBT-I was compared with sleep hygiene education. At 24 weeks, participants in the digital programme had better functional health, psychological well-being and sleep-related quality of life; improvement in insomnia accounted for 45.5% to 84% of these effects **proven by research; Espie et al., 2019**. A limitation: 77.7% of participants were women and 91.1% were White, so the findings transfer less well to other groups **documented fact; Espie et al., 2019**. In 2022 NICE (the UK body that writes guidance for clinicians) recommended Sleepio in UK primary care (at the GP) as a cost-saving option for people who would otherwise be offered sleep hygiene advice or sleeping pills; people at higher risk of other sleep disorders (for example during pregnancy or with other conditions) should have a medical assessment first **clinical consensus; NICE MTG70, 2022, moved unchanged to HTG624 in 2025**. In 2024 a prescription version received clearance from the US regulator, the FDA, the agency that authorises medicines and medical products **documented fact; AASM, 2024**.
- **SHUTi.** In a trial of 303 adults, a fully automated online programme was compared with a website of sleep information; after a year, about 70% of programme participants reported significant improvement and 56.6% were in the "no insomnia" range, versus 43% and 27.3% in the control group (proven by research; Ritterband et al., 2017; figures checked against a commentary in Annals of Translational Medicine, 2017; the full paper was not opened). A prescription digital therapeutic based on it received FDA clearance in 2020 **documented fact; AASM, 2020**.

Programme names here are examples of studied programmes, not advertising; we have not checked availability in different countries. And there is a catch: fully automated programmes have drop-out rates above 50%, which is why European experts prefer versions with support from a professional **clinical consensus; Riemann et al., 2023**.

Sleep restriction: a powerful method with a price

Why the strongest component of CBT-I is done only with a specialist.

Sleep restriction is one of the key components of CBT-I (cognitive behavioural therapy for insomnia). But it has a price, and that price is rarely mentioned.

What happens in the first weeks

In a small study by Kyle and colleagues (2014), 16 adults with insomnia underwent sleep restriction while their sleep was measured objectively in a sleep lab. On the first night of therapy, sleep fell by about 91 minutes compared with baseline, by 78 minutes on night 8 and 69 minutes on night 22. In the first weeks, daytime sleepiness increased and alertness and reaction times got worse. By three months these measures were back to baseline, and insomnia severity had improved **proven by research; Kyle et al., 2014**. An important caveat: the study had no control group (a comparison group without this treatment) and a very small sample.

American sleep specialists write that patients should be regularly warned about the dangers of daytime sleepiness, including when driving **clinical consensus; Edinger et al., 2021, review**.

What this means for you: if a specialist suggests sleep restriction, the first weeks will probably feel harder than before treatment. That is an expected part of the method, not a sign it "isn't working", but it is exactly why it is done under supervision.

Who it may not suit

According to the AASM, the American Academy of Sleep Medicine (2021), sleep restriction may be contraindicated for people in high-risk occupations (drivers, operators of heavy machinery), people prone to mania or hypomania (periods of unusually elevated mood and energy), people with poorly controlled seizure disorders and people with excessive daytime sleepiness **clinical consensus; Edinger et al., 2021**. The European guideline lists any kind of epilepsy and conditions that might be aggravated by sleep loss as contraindications for stimulus control and sleep restriction **clinical consensus; Riemann et al., 2023**. For insomnia alongside bipolar disorder, European experts judge the evidence insufficient **clinical consensus; Riemann et al., 2023**.

In addition, other sleep disorders, such as apnoea (pauses in breathing during sleep), need to be ruled out before treatment starts **clinical consensus; NICE MTG70, 2022; Riemann et al., 2023**.

Myth vs fact

Myth: sleep restriction just means "sleep less". **Fact:** it is a protocol with a sleep diary, a gradually widening sleep window, screening for contraindications and monitoring of sleepiness **clinical consensus; Edinger et al., 2021; Riemann et al., 2023**. That is why a specialist sets it up after an assessment. We deliberately do not give protocol numbers here.

Sleep myths, and when to see a specialist

A quick check of popular advice, and the signs that make insomnia a reason to see a doctor. CBT-I is cognitive behavioural therapy for insomnia; NICE is the UK body for clinical guidelines; the FDA is the US regulator of medicines and medical products.

Sleep myths

Myth	Fact	Label
"Can't sleep? Just lie there, at least you're resting"	With chronic insomnia, lying awake for long periods keeps the problem going; stimulus control means getting up	**Clinical consensus (Edinger et al., 2021, review)**
"Good sleep hygiene will cure insomnia"	Sleep hygiene alone does not treat chronic insomnia	**Clinical consensus (Edinger et al., 2021; Riemann et al., 2023)**
"A pill is the most reliable solution"	Symptoms often return after stopping; the effect of CBT-I is more stable	**Clinical consensus (Riemann et al., 2023)**
"CBT-I isn't for me, I have depression or an illness"	The European guideline recommends CBT-I alongside other mental and physical conditions too	**Clinical consensus (Riemann et al., 2023)**
"Therapy will add hours of sleep"	Total sleep time is what changes least	**Proven by research (Trauer et al., 2015; van Straten et al., 2018)**
"An app can't be serious"	Some programmes have randomised trials and NICE and FDA decisions behind them, but more than half of people drop out of fully automated ones	**Proven by research / clinical consensus (Espie et al., 2019; NICE MTG70, 2022; Riemann et al., 2023)**
"You have to try hard to fall asleep"	Effort and anxiety about sleep get in the way; cognitive techniques and paradoxical intention target this	**Clinical consensus (Riemann et al., 2023)**

Example

The "morning card". Every form of CBT-I starts with self-monitoring: the foundation of treatment is a sleep diary **clinical consensus; Edinger et al., 2021, review; Riemann et al., 2023**. The simplest version: each morning, in the first minutes after getting up, write down three things: when you went to bed; when you think you fell asleep and how long you were awake at night; when you got up. Within a week you can see how much time you spend in bed awake. This is observation, not treatment. If your insomnia has lasted more than three months, show your notes to a specialist.

When to see a specialist, and whom

- Insomnia on three or more nights a week for more than three months (ICSD-3 criteria, from the international classification of sleep disorders; Riemann et al., 2023): a CBT-I specialist or a sleep physician.
- Loud snoring, pauses in breathing during sleep, severe daytime sleepiness, falling asleep at the wheel: a doctor, to rule out apnoea **clinical consensus; NICE MTG70, 2022**.
- Sleep got worse together with low mood, loss of interest, a sense of pointlessness: a psychotherapist or psychiatrist (depression is covered in Episode 7). If you have suicidal thoughts, get urgent help; see If you need help now.
- Someone barely sleeps yet is full of energy, talks fast and takes lots of risks: a psychiatrist, as this can be mania (interpretation; per AASM, 2021, sleep loss is treated as a risk factor in bipolar disorder).
- Insomnia linked to medication, alcohol or illness: a doctor.

Eating disorders: why it isn't about food

How Fairburn's model explains what different eating disorders have in common.

> Important
>
> This chapter and the next contain no weight or eating figures, no descriptions of behaviours and no dietary advice: such details can harm someone who is struggling right now. They cover only how therapy works and what the evidence says. Eating disorders are serious conditions with real medical risk. If you recognise yourself or someone close to you, start with a doctor.

Who Fairburn is and what he noticed

Eating disorders are a group of conditions that includes anorexia nervosa, bulimia nervosa and binge eating disorder. Most people would say they are a problem with food or weight. British psychiatrist Christopher Fairburn of Oxford, with Zafra Cooper and Roz Shafran, suggested looking deeper. In 2003 they published a "transdiagnostic" theory and treatment of eating disorders **documented fact; Fairburn, Cooper & Shafran, 2003**.

"Transdiagnostic" means "across diagnoses". The model starts from the observation that people often move from one eating disorder category to another over time: the label changes, the mechanism stays. So the shared mechanism itself can be treated **the author's own account;** **description of the model per Psychology Tools**.

The core: what self-worth rests on

According to the model, at the heart of eating disorders lies a particular way of judging oneself: a person's worth in their own eyes is built mainly on eating, shape, weight and the sense of being able to control them **the author's own account; description of Fairburn et al., 2003, per Psychology Tools**. For most people, self-worth rests on many things: work, relationships, interests, character. In an eating disorder, one support crowds out the rest.

This produces a cycle that keeps the disorder going. Described only in general terms: rigid rules → inevitable breaking of the rules → a sense of failure → even more rigid rules (interpretation; simplified description, without behavioural detail). The circle closes, and the issue is no longer food but what self-worth rests on.

Example

Self-worth on one leg. Picture a table on a single leg: any movement is risky, and all your attention goes into keeping it upright. Self-worth that rests almost entirely on control is like that table. That is why therapy works not only on the disorder itself but also on gradually restoring other supports. The image is ours, for illustration.

Four additional mechanisms

The model was later extended. For some people, four more processes stand in the way of recovery: clinical perfectionism (rigid, exhausting demands on oneself), core low self-esteem, mood intolerance and interpersonal difficulties **the author's own account; Fairburn et al., 2009; description per Psychology Tools**. They were added because many people did not fully recover with standard treatment.

Myth vs fact

Myth: eating disorders are about willpower, or about food. **Fact:** in the transdiagnostic model, the core of an eating disorder is self-worth built on shape, weight and control **the author's own account; per Psychology Tools**. And UK guidelines state plainly: do not use single measures such as BMI (body mass index, a number calculated from height and weight) or duration of illness to decide whether to offer treatment **clinical consensus; NICE NG69, 2017, rec. 1.2.8**. A disorder is not defined by a number on the scales.

CBT-E: how the therapy works and what the evidence says

What is known about the results of enhanced CBT, how adolescents are treated, and why this is always teamwork.

Two versions of one therapy

Fairburn's protocol is called CBT-E, for "enhanced" CBT (cognitive behavioural therapy) for eating disorders. It is described in detail in a 2008 manual **documented fact; Fairburn, 2008; we did not open the book**. It comes in two versions **the author's own account; Fairburn et al., 2009**:

- the **focused** version works only on the eating disorder itself;
- the **broad** version also addresses the four mechanisms: perfectionism, low self-esteem, mood intolerance and interpersonal difficulties.

We have not checked the detailed stages and procedures against the 2008 manual, so we do not describe them.

The key trial (2009)

Fairburn's group ran a randomised trial (participants are assigned to groups by chance) at two centres in England with 154 outpatients (treated outside hospital) with eating disorders who were not significantly underweight. Some received one of the two versions of CBT-E over 20 weeks; others first waited 8 weeks (a so-called waiting list). Outcomes were assessed by clinicians who did not know who was in which group. Follow-up lasted 60 weeks after treatment **proven by research; Fairburn et al., 2009**.

Findings **proven by research; Fairburn et al., 2009**:

- while people waited, symptoms barely changed; both treatment groups improved substantially and similarly, and the improvement held throughout follow-up;
- at 60 weeks, 51.3% of participants had eating disorder symptom levels within one standard deviation of the population average, roughly the level usual for people without an eating disorder;
- the outcome did not depend on the diagnosis, an argument for the transdiagnostic idea;
- people with marked perfectionism, low self-esteem, mood intolerance or interpersonal difficulties did better with the broad version; the others did better with the focused one. The authors call the focused version the default.

Why this matters: about half of participants were close to the level of people without an eating disorder 60 weeks after treatment, and the other half were not, which is also worth knowing in advance (our reading of the 51.3% figure). A fair caveat: the trial was run by the method's own developers, a known source of possible bias (interpretation).

What UK guidelines say

The eating disorder guideline (NG69) from NICE, the UK government body that writes guidance for clinicians, suggests different first steps for different disorders (clinical consensus; NICE NG69, 2017, as updated in 2020, recs 1.3.4, 1.3.10, 1.3.15, 1.4.2, 1.4.4, 1.5.2, 1.5.4, 1.5.6, 1.5.9):

Disorder	Adults	Children and young people
Bulimia nervosa	Guided self-help focused on bulimia; if unsuitable or not working, individual CBT for eating disorders	Family therapy focused on bulimia; if unsuitable, individual CBT for eating disorders
Binge eating disorder	Guided self-help; if unsuitable or not working, group CBT for eating disorders	—
Anorexia nervosa	One of three options: individual CBT for eating disorders, MANTRA or specialist supportive clinical management (SSCM)	Family therapy focused on anorexia; if unsuitable, individual CBT for eating disorders or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN)

MANTRA (Maudsley Anorexia Nervosa Treatment for Adults) is a model for treating anorexia in adults, named after London's Maudsley Hospital. "Guided self-help" is not reading a book alone, but a self-help programme with regular sessions with a professional.

Hofmann and colleagues' review of meta-analyses (studies pooling many trials) (2012) sums up: for bulimia, CBT has a medium-sized effect and better remission rates (remission meaning symptoms have largely gone) than other psychotherapies; for binge eating disorder, psychotherapy and structured self-help show large effects **proven by research; Hofmann et al., 2012**. For anorexia in adults the evidence is more modest and mixed; we did not open the systematic review of CBT-E for eating disorders by Atwood and Friedman (2020) **not verified**.

Adolescents: family at the centre

For children and young people with anorexia, NICE puts family therapy first, with parents playing a key role **clinical consensus; NICE NG69, 2017, rec. 1.3.10**. Individual CBT is an option if family therapy is not suitable (rec. 1.3.15).

In 2022 Le Grange and colleagues compared the two approaches in 97 adolescents with eating disorders at one US centre: 51 received family-based treatment (FBT) and 46 received CBT-E. Families chose the treatment themselves, so this was not a randomised trial **proven by research, with limitations; Le Grange et al., 2022**. What they found:

- FBT restored weight faster by the end of treatment, but at 6 and 12 months there was no longer a difference;
- on eating disorder symptoms themselves, the approaches did not differ at end of treatment or later;

- the authors consider CBT-E a viable alternative and say that which approach is stronger should be settled by a properly powered randomised trial.

The limitations are serious: the groups differed (adolescents in the CBT-E group were older and more severely ill), assessors knew who received which treatment, and there was only one centre **documented fact; Le Grange et al., 2022**. And the absence of a significant difference does not prove the approaches are equivalent (interpretation).

Medical risk: why it takes a team

Eating disorders carry real medical risk. According to a meta-analysis of 36 studies, the risk of death in anorexia is roughly six times higher than in the general population **proven by research; Arcelus et al., 2011: standardised mortality ratio 5.86**. That is why care for eating disorders is a team effort: doctor, psychiatrist, eating disorder specialist and, for adolescents, the family. NICE guidance also provides for inpatient care when physical health is seriously compromised **clinical consensus; NICE NG69, 2017, rec. 1.11.1**.

If you suspect an eating disorder in yourself or someone close to you, start with a doctor. With fainting, an irregular heartbeat or severe weakness, see a doctor urgently **clinical consensus**.

Important

Why there are no tests here. Questionnaires for assessing eating disorders are copyrighted and intended for clinicians and research **documented fact; CREDO Oxford on the EDE-Q**. Their items can also be unsafe for vulnerable readers. Assessment is done by a professional.

Addiction: why a slip is not a relapse

Alan Marlatt's model: what matters is less the slip itself than how the person explains it to themselves.

Important

With physical dependence on alcohol or certain sedatives, stopping abruptly can be life-threatening. UK guidelines from NICE (the body that writes guidance for clinicians) provide for medically supported withdrawal, and in severe dependence this happens in hospital **clinical consensus; NICE CG115, 2011, rec. 1.3.4.5**. So the first step is an addiction specialist or psychiatrist.

Relapse prevention

In 1985 American psychologist Alan Marlatt and Judith Gordon published the book "Relapse Prevention" (documented fact; Marlatt & Gordon, 1985; we did not open the book, the model is described from a later paper by Marlatt and colleagues, 2005). The model draws attention to a moment that is often overlooked: what happens after the first slip.

How the relapse model works

It all starts with a **high-risk situation**, circumstances that make use more likely: stress, conflict, a crowd where everyone is drinking **the author's own account; Witkiewitz, Marlatt & Walker, 2005**.

- If the person has an effective way of coping, their **self-efficacy** grows, the confidence that they can cope (a concept introduced by psychologist Albert Bandura). The risk of use falls.
- If they have no way of coping, confidence drops and **positive expectations about the substance** ("this will make it better") grow. The likelihood of use rises.

Then comes the first use, a **lapse**. Here the road forks **the author's own account; Witkiewitz, Marlatt & Walker, 2005**:

- if the person sees the lapse as a mistake and a chance to learn, a return to their goal is more likely;
- if they see it as proof of total failure and personal hopelessness, continued use, that is a **relapse** (a return to the old pattern, the usual way of using), is more likely.

Marlatt called the "it's all over" reaction the **abstinence violation effect**: seeing a lapse as an irreparable failure, which itself pushes towards further use **the author's own account; Witkiewitz, Marlatt & Walker, 2005**.

Example

One glass. Someone hasn't drunk for several months. A party, tension, and they have a glass. Two paths follow. One: "I slipped. It's one episode. What led me to it? Tomorrow I'm back on the plan." The other: "That's it, I'm hopeless, I've blown it anyway, so what's the difference." In Marlatt's model, it is largely the interpretation, not the glass, that decides whether a lapse becomes a relapse. The example is ours, for illustration.

The reasoning is not only about substances. The same "I broke the rule, so it's all over" logic is familiar to many people who have tried to change any habit (interpretation).

What happens in therapy

Relapse prevention is a cognitive behavioural treatment focused on responding to high-risk situations; it combines skills training with cognitive work **clinical consensus; Bowen et al., 2009**. In practice this means knowing your high-risk situations in advance, having a plan for them, and

having a plan for what to do if a lapse happens anyway. The model also stresses lifestyle balance: activities that give pleasure and restore you matter. Marlatt called them "positive addictions", such as exercise, reading and meditation **the author's own account; Witkiewitz, Marlatt & Walker, 2005**.

Another technique is **urge surfing**: the craving is observed like a wave that rises, peaks and subsides if you neither fight it nor give in to it. It combines imagery and relaxation **the author's own account; Witkiewitz, Marlatt & Walker, 2005**.

Myth vs fact

Myth: one relapse means it was all for nothing. **Fact:** Marlatt's model distinguishes a lapse from a relapse; the outcome depends largely on how the lapse is interpreted, and the "it's all over" reaction is one of the targets of therapy **the author's own account; Witkiewitz, Marlatt & Walker, 2005**.

What helps with addiction, and how much

CBT, motivational interviewing, incentives for abstinence and mindfulness, with honest numbers for each.

CBT: it works, but no better than other proven methods

A reminder of the effect size scale (g or d): around 0.2 is small, 0.5 medium, 0.8 large. A meta-analysis pools many studies; a controlled study is one with a comparison group.

- **Magill and Ray's meta-analysis (2009):** 53 controlled studies, 9,308 participants with alcohol and drug use disorders. The overall effect of CBT (cognitive behavioural therapy) was small but significant (g = 0.15, below even the "small" mark). It was largest for cannabis (g = 0.51, 6 studies). CBT combined with another psychosocial treatment had a larger effect (0.31) than CBT alone (0.17). The effect faded over time: at 12 months g = 0.10 **proven by research; Magill & Ray, 2009**.
- **Magill and colleagues' meta-analysis (2019):** 30 randomised trials (participants assigned to groups by chance). Against minimal intervention, CBT clearly reduced frequency of use (g = 0.58 at 1–6 months and 0.44 later). Against non-specific therapy (general support not designed for addiction), a small effect in the first months (0.18), not significant later. Against another specific treatment, no difference **proven by research; Magill et al., 2019**. The authors conclude that CBT outperforms no treatment, minimal treatment and non-specific controls, but not other specific treatments.

That is not bad news. It means people have a choice of several proven approaches (interpretation). Why "the most researched therapy" does not mean "the most effective" is

covered in Episode 14.

According to Hofmann and colleagues' review (2012), CBT is more effective for cannabis and nicotine and less so for opioids and alcohol; for opioids and alcohol, medication-based maintenance treatment shows larger effects **proven by research; Hofmann et al., 2012**.

What about Alcoholics Anonymous?

The best-known help for alcohol problems is Alcoholics Anonymous (AA) and other "12-step" programmes: mutual-help groups where people support each other in staying sober. A 2020 Cochrane review (Cochrane is an international network that produces rigorous research summaries) pooled 27 studies with 10,565 people. Clinical programmes that help people engage with AA led to complete abstinence more often than other treatments, including CBT: a year later, about 42% were fully abstinent versus 35% **proven by research; Kelly, Humphreys & Ferri, 2020, per press release**. On reducing how much people drank, they performed about as well as other treatments **proven by research; Kelly, Humphreys & Ferri, 2020**. For the reader, this is one more reason to see a choice here: CBT and AA are not rivals but different tested routes (interpretation).

Myth vs fact

Myth: "Rat Park" proved that addiction is caused by the environment alone. **Fact:** in the late 1970s, Bruce Alexander and colleagues in Canada compared rats kept alone in cages with rats in a spacious "park" with other rats and toys: the caged rats drank morphine solution far more readily **documented fact; Alexander et al., 1981**. But the samples were small, and a direct repeat of the experiment in 1996 did not reproduce the original result **documented fact; Petrie, 1996, as summarised in Wikipedia: Rat Park**. Environment matters, but it is not the only cause of addiction, and popular retellings overstate this experiment (interpretation; Gage & Sumnall, 2019).

Relapse prevention: the evidence

Irvin and colleagues' meta-analysis (1999) pooled 26 studies with 9,504 participants. The overall effect of relapse prevention was modest ($r = 0.14$); it was most noticeable for alcohol ($r = 0.37$), and relapse prevention had its largest effect on people's overall psychosocial functioning ($r = 0.48$) **proven by research; Irvin et al., 1999; figures as reported by Witkiewitz, Marlatt & Walker, 2005**. The coefficient r is another measure of the strength of an association: around 0.1 is small, around 0.3 medium, 0.5 large.

Mindfulness: MBRP

Mindfulness is the skill of noticing what is happening inside and around you without judging it or reacting on autopilot. Later, Marlatt's students and colleagues added mindfulness practices to relapse prevention (the third wave of CBT is covered in Episode 13). In a pilot (first, small-

scale) trial of MBRP (mindfulness-based relapse prevention), 168 adults who had completed intensive treatment received either 8 weekly two-hour sessions or usual care. Immediately after the programme and at 2 months, MBRP participants had fewer days of use and a greater drop in craving; but at 4 months the difference from usual care was no longer significant proven by research; Bowen et al., 2009. Limitations: short follow-up, and substance use was self-reported, without lab tests.

Motivational interviewing

Motivational interviewing (MI), developed by William Miller and Stephen Rollnick, often works alongside CBT. It does not persuade or pressure; it helps people work through their own ambivalence: "I want to stop, and I don't." UK guidelines from NICE (the body that writes guidance for clinicians) suggest that people with limited contact with services be offered brief interventions of one or two sessions focused on motivation, with empathy, exploration of ambivalence and non-judgemental feedback clinical consensus; NICE CG51, 2007, as summarised by Pilling et al., 2007. We did not open meta-analyses of MI for these notes not verified.

Incentives for abstinence

There is a method few people have heard of, although its evidence is strong. **Contingency management** gives people small incentives, such as vouchers, for periods without the substance confirmed by tests clinical consensus; Pilling et al., 2007. It sounds too simple, but Prendergast and colleagues' meta-analysis (2006) found a medium effect (d = 0.42), higher for opiates (0.65) and cocaine (0.66); the effect decreased after the programme ended. The authors call it one of the most effective approaches for maintaining abstinence proven by research; Prendergast et al., 2006. A meta-analysis of 74 trials in people receiving medication for opioid use disorder linked contingency management with abstinence from stimulants, illicit opioids and cigarettes, and with better treatment adherence, meaning how well people stick with treatment proven by research; Bolívar et al., 2021; from a brief summary, effect sizes not checked.

UK guidelines recommend considering it for people who misuse stimulants clinical consensus; NICE CG51, 2007, per Pilling et al., 2007.

What UK guidelines say about alcohol

For harmful drinking and mild alcohol dependence, NICE recommends a psychological intervention: CBT, behavioural therapies or therapies that draw on the person's social network and environment; CBT typically runs as one hour a week for 12 weeks. For moderate and severe dependence, after withdrawal, medication combined with psychological support clinical consensus; NICE CG115, 2011, recs 1.3.3.1, 1.3.3.3, 1.3.6.1.

Method	What it does	What the evidence says
CBT	Works on thoughts, high-risk situations, coping skills	Small effect; better than no treatment, no better than other specific treatments (Magill et al., 2019)
Relapse prevention	A plan for high-risk situations and for a lapse	Modest overall effect, larger for alcohol and for overall functioning (Irvin et al., 1999)
MBRP	Mindfulness and urge surfing	Pilot trial: effect over the first 2 months, not significant at 4 (Bowen et al., 2009)
Motivational interviewing	Works with "I want to and I don't" ambivalence	Recommended by NICE for brief interventions; meta-analyses not checked
Contingency management	Incentives for confirmed abstinence	Medium effect, higher for opiates and cocaine (Prendergast et al., 2006)

Psychosis: from Beck's case to normalising

How CBT reached its most difficult territory, and why work here begins with normalising.

Important

Psychosis is a state in which a person partly loses touch with reality: hallucinations (such as hearing voices) and delusions (firm beliefs that do not yield to evidence) may appear. This is the domain of psychiatry. What follows describes how CBT for psychosis works, not self-help. If you notice signs of psychosis in yourself or someone close to you, see a psychiatrist.

A 1952 case that is often retold wrongly

The first psychiatric paper by Aaron Beck, founder of cognitive therapy (see Episode 1), came out in 1952, when Beck was 31 **documented fact; Padesky, 2004**. Its title is "Successful outpatient (non-hospital) psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt" **documented fact; Beck, 1952**.

According to historian Guillermo Korman (2013), the patient was a 28-year-old Second World War veteran diagnosed with chronic schizophrenia. He was convinced he was being watched by FBI agents. Therapy took 30 weekly outpatient sessions, and the patient improved considerably **documented fact; Korman, 2013**.

But the treatment was psychoanalytic, meaning it looked for hidden unconscious conflicts behind symptoms. Beck was then working as a psychoanalyst and interpreted the delusion through a hidden conflict: in his reading, the patient identified with his father and took on his father's dishonest act as his own guilt, hence "borrowed guilt" **documented fact; Korman, 2013**. Korman presents the case as an example of brief psychoanalytic, not cognitive, treatment (interpretation; Korman, 2013). Fifty years later the case was republished and discussed within the framework of cognitive therapy for schizophrenia **documented fact; Padesky, 2004**.

Myth vs fact

Myth: Beck started out with cognitive therapy for psychosis. **Fact:** his first psychiatric paper (1952) was about a patient with a delusion, but the treatment was psychoanalytic; a cognitive reading of the case came only half a century later **documented fact; Korman, 2013; Padesky, 2004**.

The British school

CBT (cognitive behavioural therapy) for psychosis was developed systematically in the UK. In 1991 David Kingdon and Douglas Turkington described using CBT with a "normalising rationale" in schizophrenia, and in 1994 they published "Cognitive-Behavioral Therapy of Schizophrenia" **documented fact; Dudley et al., 2007**. In 1995 David Fowler, Philippa Garety and Elizabeth Kuipers published a manual of CBT for psychosis, and NICE, the UK body that writes guidance for clinicians, first recommended CBT for psychosis in 2002 **documented fact; King's College London, 2014**. In 2001 Garety and colleagues proposed a cognitive model of how the positive symptoms of psychosis arise and persist, taking social factors into account too **documented fact; Garety et al., 2001**. "Positive" symptoms are those that are "added" to ordinary experience: voices, delusions.

Beck himself returned to the topic in the 2000s: with colleagues he published a book on the cognitive theory and therapy of schizophrenia (2009), and later a book on recovery-oriented cognitive therapy (2020), which builds on a person's goals and values **documented fact; Beck Institute, publication list**.

Normalising: the key idea

Normalising does not claim that psychotic experiences are a sign of health. It is the idea that distressing experiences lie within the range of ordinary human experience and need not lead to distress and disability. The difference between frightening and non-frightening experiences depends largely on the meaning a person gives them **the author's own account; Dudley et al., 2007**.

An example for illustration: imagine that after two sleepless nights you think you hear someone call your name. If the explanation is "I'm exhausted", it is unpleasant but not frightening. If it is "someone is watching me", fear grows, and the experience itself feels more and more threatening.

The authors' examples: sleep deprivation can cause illusions, hallucinations and paranoid ideas; prolonged isolation and sensory deprivation (too little input to the senses) are linked to psychotic experiences; similar experiences are relatively common in people without a diagnosis **the author's own account; Dudley et al., 2007**.

The tasks at this stage are to build trust, reduce shame and the sense of catastrophe around symptoms and diagnosis, and to create together with the person a less threatening explanation, which is then tested **the author's own account; Dudley et al., 2007**.

Myth vs fact

Myth: schizophrenia means a split personality. **Fact:** no. The word "schizophrenia" (Greek for "split mind") was introduced by the Swiss psychiatrist Eugen Bleuler in 1908; he meant a splitting of mental functions, a disconnect between thinking, feeling and perception **documented fact; Fusar-Poli & Politi, 2008**. "Several personalities in one person" is something else, a dissociative disorder. People with schizophrenia say they still hear both the "split personality" myth and the myth that they are a danger to others **documented fact; Rethink Mental Illness, accounts of people with schizophrenia**.

Fact

Sleep and paranoia. The OASIS trial (Freeman and colleagues, 2017) connects two topics of these notes. 3,755 students with insomnia were randomly assigned to digital CBT-I or usual care. At 10 weeks insomnia had fallen much more (d = 1.11, a very large effect: 0.8 already counts as large), and with it paranoid thoughts (d = 0.19) and hallucinatory experiences (d = 0.24) fell slightly. Analysis showed these changes ran through improved sleep; no adverse events were reported **proven by research; Freeman et al., 2017**. Limitations: these were students, not people diagnosed with psychosis, and the effects on paranoia were small. This is not a treatment for psychosis, but an argument that sleep influences such experiences (interpretation).

CBT for psychosis: aims and the debate over evidence

What CBT for psychosis tries to achieve, and why researchers still argue about the size of its effect.

The aim is not to "talk people out of it"

The aim surprises many: not to remove voices and not to change someone's mind. The UK quality standard from NICE (the body that writes guidance for clinicians) describes CBT for psychosis as at least 16 planned one-to-one sessions following a manual, in which the person learns to see links between their thoughts, feelings or actions and their symptoms; re-evaluates, with the therapist, perceptions, beliefs or reasoning related to the symptoms; and

does at least one of the following: monitors their own experiences, finds alternative ways of coping, reduces distress, improves everyday functioning **clinical consensus; NICE QS80, based on CG178, 2014**.

NICE recommends offering CBT to all adults with psychosis or schizophrenia, alongside antipsychotic medication (drugs that treat psychosis) or on its own if the person declines medication **clinical consensus; NICE QS80; CG178, 2014**.

What the work looks like

The general sequence: trust and alliance → normalising → a shared formulation, a joint "map" of what is going on (case conceptualisation is covered in Episode 4) → working on interpretations of voices and beliefs: alternative explanations, behavioural experiments, ways of coping → associated anxiety, depression and self-esteem → relapse prevention, that is, preventing a new episode **clinical consensus; per NICE QS80 and Dudley et al., 2007**. In a British study reported by King's College London, the strongest predictor that therapy would help was a person's willingness to consider alternative explanations for their beliefs (the authors' own account; King's College London, 2014).

Example

Explore rather than argue. A person is sure the neighbours are discussing him through the wall. The therapist neither says "that's not true" nor agrees. Instead they ask: when is it loudest? What do you feel at that moment? What other explanations are possible, and how could we test them? Is it stronger after a sleepless night? The example is ours, for illustration; the principle of jointly testing explanations is described by Dudley et al. (2007).

Myth vs fact

Myth: CBT for psychosis is an attempt to talk people out of their beliefs. **Fact:** the aims are to see links between thoughts and symptoms, find ways of coping, reduce distress and improve life; it rests on normalising and a shared formulation **clinical consensus; NICE QS80; the author's own account; Dudley et al., 2007**.

The debate over effect size

Does it work? Here there is a genuine scientific debate. The figures below are effect sizes: around 0.2 is small, 0.5 medium, 0.8 large.

The critics. In 2014 Jauhar and colleagues pooled 52 studies in a meta-analysis. The overall effect of CBT on symptoms of schizophrenia was small (−0.33); on positive symptoms −0.25, on negative symptoms (apathy, reduced speech and emotion) −0.13. The key point: in studies where assessors knew who had received therapy, the effect was noticeably larger than where they did not. In masked studies (where assessors did not know) the effect on positive symptoms all but disappeared (−0.08, not significant). The authors concluded that the effect of

CBT on symptoms of schizophrenia is small and shrinks further when sources of bias (features of study design that can inflate results) are taken into account proven by research; Jauhar et al., 2014. A minus sign here means a reduction in symptoms.

The supporters' replies. In letters to the journal, Birchwood and colleagues argued that a small effect is not zero and broadly agrees with UK guidance, and that variation between results (studies differing a lot from each other) may point to groups of people whom CBT helps; Byrne noted that long-term follow-up data had not been considered (interpretation; positions as summarised in the authors' reply, McKenna et al., 2014; we did not open the letters themselves). The meta-analysis authors replied that the variation reflects the difference between rigorous and less rigorous studies (interpretation; McKenna et al., 2014). In 2019 the critics restated their view: the effect on positive symptoms is small, on negative symptoms small or absent, and CBT does not prevent relapse (interpretation; Jauhar, Laws & McKenna, 2019).

Other meta-analyses.

- Turner and colleagues (2014), 48 studies: against other psychological interventions, CBT had a small but robust advantage on positive symptoms (g = 0.16) proven by research; Turner et al., 2014.
- Bighelli and colleagues (2018), a network meta-analysis (comparing many treatments at once) of 53 trials with 4,068 participants, all on antipsychotics: CBT against usual care had a small effect on positive symptoms (−0.30, moderate certainty). Conclusion: CBT appears to help with positive symptoms in moderately ill people, with small to medium effects proven by research; Bighelli et al., 2018.
- According to Hofmann and colleagues' review (2012), CBT has little effect on relapse and hospitalisation compared with family interventions proven by research; Hofmann et al., 2012.

Source	Comparison	Result
Jauhar et al., 2014	CBT vs control, 52 studies	Positive symptoms −0.25; in masked studies −0.08 (not significant)
Turner et al., 2014	CBT vs other psychological interventions	g = 0.16 in favour of CBT
Bighelli et al., 2018	CBT vs usual care, all on antipsychotics	−0.30, small effect

The conclusion we think is fair: there is an effect, it is small, and its size is still debated. Guidelines include CBT as part of comprehensive care, with the emphasis on distress and everyday life, not as a substitute for medication (interpretation).

Myth vs fact

Myth: CBT can cure schizophrenia without medication. **Fact:** CBT for psychosis is an addition to psychiatric care, and its effect on symptoms is modest **proven by research; Hofmann et al., 2012; Jauhar et al., 2014**.

Bipolar disorder: a separate boundary

According to Hofmann and colleagues' review (2012), CBT effects in bipolar disorder are small to medium, there is little evidence on CBT without medication, and there is some evidence it helps delay relapse **proven by research; Hofmann et al., 2012**. Sleep loss can trigger mania (a period of unusually elevated mood and energy), which is why sleep restriction calls for particular caution in people prone to mania **clinical consensus; Edinger et al., 2021**. If someone barely sleeps yet is full of energy, talks fast and takes lots of risks, that is a reason to see a psychiatrist.

Test yourself

Five questions on the essentials, with short answers. CBT is cognitive behavioural therapy; AASM is the American Academy of Sleep Medicine.

1. **What is a problem's "engine" in CBT, and why look for it?** It is the mechanism that keeps the problem going. Protocols for different disorders are designed to target it: in insomnia, for example, the "bed equals wakefulness" link; in eating disorders, self-worth built on control.
2. **Why doesn't sleep hygiene alone treat chronic insomnia?** It removes external disturbances but does not touch what maintains insomnia. The AASM advises against using it as the only treatment.
3. **What does CBT-I change most?** Insomnia severity, time to fall asleep and night-time waking. Total sleep time changes least.
4. **How does a lapse differ from a relapse in Marlatt's model?** A lapse is a single episode of use; a relapse is a return to the old pattern. Much depends on how the lapse is interpreted: the "it's all over" reaction (the abstinence violation effect) raises the risk of relapse.
5. **What is the aim of CBT for psychosis, and what does the evidence say?** To reduce distress and improve everyday life, not to change someone's mind. The effect on symptoms is small and its size is disputed; CBT is part of care alongside a psychiatrist.

Key takeaways

The essentials in one table, plus a few lines to remember. ACP is the American College of Physicians, AASM the American Academy of Sleep Medicine, CBT-E enhanced CBT (cognitive behavioural therapy) for eating disorders.

Topic	Strength of evidence	Main point
Chronic insomnia	High; first line for ACP, AASM and the European guideline	Treated through behaviour and work on sleep anxiety, not sleep hygiene alone
Bulimia, binge eating disorder	High	CBT-E works regardless of diagnosis; guidelines start with guided self-help or CBT
Anorexia	Moderate, mixed	For adolescents, family therapy comes first; a team including a doctor is always needed
Addiction	Small effect of CBT; strong evidence for incentives for abstinence	CBT beats no treatment but not other proven methods
Psychosis	Small and disputed in size	The aim is distress and functioning; only alongside a psychiatrist

- CBT looks for the mechanism that keeps a problem going and matches the protocol to it.
- For insomnia, less time in bed and "can't sleep? get up" work better than blackout curtains and skipping coffee. But sleep restriction is for doing with a specialist.
- An eating disorder is defined not by a number on the scales but by what self-worth rests on.
- One slip is not a relapse: much depends on how a person explains it to themselves.
- CBT for psychosis doesn't argue with voices; it helps people live with them.
- In all four areas, CBT works hand in hand with medicine.

The next topic in the series is borderline personality disorder and Marsha Linehan's dialectical behaviour therapy (Episode 11).

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