Ingrid Söchting

Cognitive Behavioral Group Therapy

Challenges and Opportunities

WILEY Blackwell

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This edition first published 2014

Registered Office
John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
350 Main Street, Malden, MA 02148-5020, USA
9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication Data

Söchting, Ingrid.
Cognitive behavioral group therapy : challenges and opportunities / Ingrid Söchting.
pages cm
Includes bibliographical references and index.
ISBN 978-1-118-51035-3 (cloth) – ISBN 978-1-118-51034-6 (pbk.) 1. Cognitive therapy.
2. Group psychotherapy. I. Title.
RC489.C63S63 2014
616.89′1425–dc23
2014005687

A catalogue record for this book is available from the British Library.

Cover image: Diana Ong, Masked emotion, 2006. © Diana Ong / SuperStock

Set in 10.5/13pt Minion by SPi Publisher Services, Pondicherry, India

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Dedication

For my group therapy colleagues

Contents

About the Author

Ingrid Söchting is chief clinical psychologist in an outpatient mental health program and clinical assistant professor in the Department of Psychiatry at the University of British Columbia. Over the past 20 years, she has been instrumental in developing cognitive behavioral group therapy (CBGT) programs for depression, obsessive-compulsive disorder, generalized anxiety disorder, panic disorder, social anxiety disorder, and posttraumatic stress disorder, as well as interpersonal therapy (IPT) groups for later life depression. She supervises and teaches CBGT and IPT to psychology and psychiatry residents and is the codirector of the Richmond Psychotherapy Training Program. She has received several teaching excellence awards. She lectures and consults nationally and internationally. She is involved in group psychotherapy research and has published over 25 peer-reviewed journal articles and book chapters. She received her PhD in clinical psychology at Simon Fraser University, Vancouver, Canada, and trained at the University of British Columbia as an intern and postdoctoral fellow from 1994 to 1997 to become a CBT therapist. She is a Canadian certified CBT therapist and a Certified Group Therapist of the American Group Psychotherapy Association.

Acknowledgments

This book is the sum of many people's work. I have benefited from their teaching, supervision, consultation, group cofacilitation, research collaboration, and collegial inspiration.

This book is also written in gratitude to the hundreds, if not thousands, of group members in our program who trusted their facilitators and were therefore able to engage in challenging exposures and revisions of their previously held self-denigrating beliefs.

First and foremost, thanks to my team of exceptionally skilled and supportive outpatient mental health group program colleagues. They are, in alphabetical order: Ellen Abrams, clinical counselor; psychiatrist Jaswant Bhopal; Veronica Clifton, social worker; Lorna Clutterham, psychiatric nurse; Denise Coles, clinical counselor; Abi Dahi, psychiatrist; Heather Donaldson, psychiatrist; Maureen Edgar, counseling psychologist; Rosemary Messmer, clinical counselor; Jamal Mirmiran, psychiatrist; Erica O'Neal, psychiatrist; Sue Paul, rehabilitation assistant; Nicola Piggott, nurse; Dan Ring, recreational therapist; Petra Rutten, recreational therapist; Shelagh Smith, occupational therapist; Betty Third, occupational therapist; Darren Thompson, psychiatrist; and Tova Wolinsky, social worker. I also extend my appreciation to psychiatrists Harry Karlinsky, Raj Katta, Carolyn Steinberg, David Cohen and psychologists Timothy Crowell, Ingrid Fedoroff, and Suja Srikameswaran for their collegiality and cheerful support for this book.

Going back to an earlier era, I offer thanks to my graduate school supervisors and mentors James Marcia and Robert Ley, who provided rich teachings in psychodynamic theory, Erik Erikson's psychosocial developmental stages, and Carl Rogers's psychotherapy principles. Thanks to my first cognitive behavioral therapy (CBT) practicum supervisor, Georgia Nemetz, who continues to be a role model, and to my internship and postdoctoral CBT supervisors for their commitment to excellent supervision, teaching, and thoughtful applications of CBT: William Koch, the late Peter McLean, Randy Paterson, Charles Brasfield, and Lynn Alden.

Several people have kindly donated their time and mental energy to read some or all chapters. I am deeply thankful to psychiatry residents Margaret Wong,

John Tavares, and Alan Bates, who offered valuable feedback from their novice CBGT perspectives, as well as to experienced group therapists who read chapters related to their expertise. A profound thank you to psychologist Colleen Allison, who read the entire manuscript, for her keen attention to where the reader "stumbles," for alerting me to new research findings, and for her insightful and sharp perspective; to psychiatrist George Hadjipavlou, who read several chapters and offered substantial comments on content and style; to psychologist Rosalind Catchpole for sharing in enthusiasm and research updates on groups for children; to doctoral students in clinical psychology Alison Welsted and Kirstie Kellman-McFarlane for their clinical and research experience with compulsive hoarding; to psychologist Heather Fulton for her ability to effectively teach and disseminate CBT for addictions; and to psychologist Mahesh Menon for his encouraging and helpful comments on the psychosis chapter.

A special thanks to Shannon Long, the librarian who for years has helped with literature searches and supplied articles for various group programming needs, to formatting wizard Suzanne Daigle for help with the appendices, and to Kjartan Jaccard for his careful attention and diligence in producing the author index.

A number of other colleagues—too many to name—have played a large role in supporting and influencing my CBT work over the years. Some have played a more direct role in this book. Thanks to psychologists Theo De Gagné and Christopher Wilson for our collaboration on a chapter in the *Oxford Guide to Low Intensity CBT* (2010), which provided some of the "bare bones" for this book; to psychologist Mark Lau for the Oxford Guide chapter opportunity and other collaborations as well as his detailed comments on the mindfulness section; and to professor John Ogrodniczuk for his mentoring in my development as a clinician-researcher.

Thanks to my manager Jo-Anne Kirk for granting me a leave of absence to complete this book.

A huge thank you to the Wiley Blackwell team: senior editors Darren Reed and Karen Shield, editorial assistants Olivia Wells and Amy Minshull, copyeditor Kumudhavalli Narasiman, account manager Revathy Kaliyamoorthy and production project manager Radjan Lourde Selvanadin. Your encouragement, reasonableness, and excellent communication have made this project more enjoyable. Also a heartfelt thank you to the four reviewers of the initial proposal for this book. They were not only enthusiastic about the need for it, but also offered constructive feedback and suggestions.

Thanks to my family without whom my stamina would quickly have been depleted. I am especially grateful to my patient partner, journalist Douglas Todd, who read the entire manuscript more than once and offered excellent suggestions for giving this book a livelier tone. I particularly value and learn from Douglas's genuine interest in psychology and psychotherapy. A hearty thank you to my adult children—Ingram, Kjartan, Torsten, and Sigbrit—your expressions of support, each in your own way, make a big and meaningful difference. I treasure your sibling group cohesion.

"Tak" to my Danish family for their moral support from afar: my mother Karin Michelsen, her partner Martin Daugaard-Hansen, my sister, psychiatrist Astrid Söchting, and last, but not least, my loving and bookish late father, Robert Söchting.

Thank you to all who have directly or indirectly shaped this book. Any mistakes, unclear writing, misunderstandings, or misrepresentations are solely my responsibility.

Introduction: The Depth and Breadth of Cognitive Behavior Group Therapy

As a graduate student in the 1980s in a psychology department known for its focus on individual psychodynamic therapy, I did not imagine eventually writing a book in which I shared my enthusiasm for cognitive behavioral group therapy (CBGT).

While I'm grateful for my psychodynamic training, I have come to appreciate the many benefits of cognitive behavioral therapy (CBT) including its shorter term duration making it more affordable, if individuals are paying themselves. Individual CBT and group CBT (CBGT) both offer specific interventions for specific problems, especially problems with mood and anxiety. Clinicians typically present CBT as a symptom or problem-focused psychological treatment with an emphasis on personal change in behaviors and patterns of thinking about oneself, other people, and one's day to day living environment. CBT clinicians focus more on what maintains problems or disorders than on what causes them, and they help clients understand and problem solve barriers to living their lives more fully. CBT always conveys deep respect and empathy for clients' goals, needs, and unique personal histories. Indeed, CBT is credited with coining terms such as *client-centred* and *client collaboration*.

CBGT at its finest has much to offer. Not only are clients offered effective help for their fear of, let's say, becoming contaminated and seriously ill by taking public transit. They also get to experience that they are not alone in their fears and, perhaps most importantly, that they are perceived by others as a wholesome human being and not just as an "OCD patient." To witness clients undergo this transformation is one of the many benefits of CBGT for clients and therapists alike. Unlike individual CBT, CBGT gives clients an opportunity to connect meaningfully with society, however small the slice. It is an undisputed psychological fact that human beings benefit—they feel and

Cognitive Behavioral Group Therapy: Challenges and Opportunities, First Edition. Ingrid Söchting.

do better—when connected to a larger community. With increased levels of social isolation in many Western societies, in-person group CBT may indeed offer individuals far more than symptom relief.

Across mental health training in the Western world, we are seeing a renewed interest in promoting individuals' well-being, resilience, and sense of purpose and meaning—the so-called *positive psychology* approach. Positive psychology proponents led by psychologist Martin Seligman and psychiatrist George Vailliant, among others, argue that psychology and psychiatry have for too long been too confined to working with all the negatives that come with pejorative diagnostic labels and debilitating symptoms, instead of taking a more holistic, strength-based view of our clients. I argue throughout this book that CBGT offers *both* effective symptom relief *and* promotion of positive individual resources, which are harder to bring about in individual therapy. CBGT also moves therapy from a concern with the individual to the societal and even global arena. CBGT embodies a democratic and communitarian feel given its vast opportunities for people struggling with mental health problems to break the isolation and stigma as they interact with and feel supported by peers in addition to mental health professionals.

In the earlier text, I deliberately used the phrase "group CBT at its finest" to imply that those moments are not the norm. The rewarding times are of course what keep us going as group therapists, but they also challenge us to ask why we do not experience them more often. As with any craft, some solid basic skills are imperative for the CBGT therapist, but equally important is openness to revisions and trying new ways without losing one's foothold in and fidelity to CBT theory and principles. A helpful analogy may be a musical one where practicing scales is tedious but necessary for later improvising and playing with others in the same key—and in tune, including with one's group cofacilitator!

I have written this book to help CBGT facilitators become more confident in leading their groups and more appreciative of the many ways groups can be strengthened and become even more effective. My own journey as a CBT group therapist has come a long way since conducting a first panic disorder group as an intern in 1994. Thinking back on this group, I feel embarrassed when remembering how we did the homework review go-round in the traditional CBT fashion dealing with one person at the time: "Thanks, next!" It's sad to think of how much was lost by not tapping into the collective experience of the group on the difficulty of completing home practice and ways to overcome this common problem. I believe this introduction to group therapy installed some inflated self-confidence because, for some baffling reason, we did not have any dropouts. (I hasten to say that panic disorder may be a problem that requires the least process attention, thus it is a good "starter" group for CBGT novice therapists.) Our success made it seem so obvious that trapping eight people with anxiety in the same room for 2 hours during 8 weeks was the way to go in terms of human and financial efficiency. I was "converted" and have co-conducted four to six CBT groups weekly since.

This guide is meant as a conversation with both beginner and experienced CBGT therapists. I find it helpful to think of myself as a conduit. I aim to share much of what we already know about CBGT based on academic and clinical research in addition to my experience over the past 20 years with developing, running, training, and evaluating CBT groups—and always talking to and learning from other group therapists. Unlike individual therapy, there is usually at least one other professional being a witness—and critic—to our work, something that took me a little while to get used to given how intensely private the individual therapy room feels. But CBGT presents a wonderful opportunity for peer feedback and consultation, something many individual therapists often miss after their training is completed. The term "we" thus refers to my colleagues and trainees, primarily psychology and psychiatry students, but also students from occupational therapy, counseling, social work, and nursing. This book is similar to other books on this topic in that it covers most of the disorders for which CBGT has been shown to be especially helpful, namely the so-called *common mental health problems* of mood and anxiety disorders. It is different in that it also offers more discussion on how to troubleshoot problems in implementing and running CBT groups. In addition, it shows how to apply CBGT to problems and populations where the clinical research is limited but promising.

Readers will notice my bias for emphasizing the "B" in CBT when it comes to CBGT. In individual therapy, I tend to be more balanced in including both cognitive and behavioral interventions. My experience has unequivocally been that the more *doing*, in form of exposures and group activities, the better the cohesion in CBT groups becomes, which in turn positively influences motivation and outcomes for everyone. In addition to underlining behavioral interventions, three other themes recur throughout this book.

The first theme I emphasize is that CBGT offers a unique opportunity to promote the *common good* by offering access to high-quality, cost-attractive mental health care for the most prevalent mental ailments. Second, CBGT must take group process variables more seriously in order to become even more effective. Third, while it does not necessarily require several university degrees to be a CBGT leader, it does necessitate a thoughtful approach to training, to the nature of cofacilitation, and to ongoing professional development in order to achieve and maintain basic and advanced skills.

The book is organized into three parts. Part 1 offers an introduction to basic principles, research, and theory related to CBGT. This part ends with two highly practical chapters on how to implement CBGT for depression, the most common mental health problem. In reading Part 1 experienced clinicians may enjoy having their CBGT skills validated and getting a new perspective or idea for consideration in their practice.

Part 2 tackles practical, or how-to, questions facing clinicians and mental health program managers interested in developing and conducting viable CBGT programs. We will look at questions such as *How much training is necessary in order to take the*

lead in a CBT group? How homogeneous do groups need to be in order to be effective? How to prepare people for CBGT? How to prevent dropouts? And *How to develop individual exposure hierarchies in a group?* Part 2 discusses several challenges for successful implementation of CBGT as well as suggestions for solutions. In addition to drawing on my own experience, I refer to the literature when relevant. This is especially the case for Chapter 7 where I present a literature review of transdiagnostic approaches to CBGT before offering practical examples.

Part 3 explores opportunities for CBGT in populations that have received less attention in the group therapy literature. These populations are included because they are likely to be new health care priorities, certainly within the public system. CBT, whether individual or in group, has traditionally been limited to a fairly narrow age range and presenting problems, usually anxiety and depression for people between the ages of 18 and 65. Part 3 shows how CBGT is an effective intervention for older adults, children, and cultural and language minorities, as well as for people with compulsive hoarding, addictions, and psychosis. Each chapter in this section will describe the population presented, including diagnostic criteria following the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) approach, review the existing literature, as well as present an example of a CBGT protocol. I seek to strike a balance between literature reviews and practical examples. The reviews are meant to aid busy clinicians with getting a sense of the latest developments within the CBGT areas chosen for this book.

This guide is for clinicians running groups for people whose stress and symptoms have already reached a threshold of clinical significance—or just below, but who do not require hospitalization or day treatment. The CBGT programs described could be considered a secondary level of care. Typical clients will be referred by primary care level family physicians or community mental health clinic case managers, who recognize that more specialized treatment is needed. Clients referred to CBGT may have tried less intensive treatment such as self-help books, DVDs, or interactive mental health web sites, but found these insufficient. The focus of the book may seem mostly on groups run in outpatient community mental health settings, but the information applies equally to groups in private mental health care.

All clinical examples and dialogues presented in this book have been modified to protect client privacy and confidentiality. Therefore, illustrations are disguised to eliminate identifying information, or they represent composite descriptions, combining aspects and material from several clients. I use the terms group therapist and group facilitator entirely interchangeably. References in the chapters are listed at the end of each chapter with some listed under the heading "Recommended Readings for Clinicians."

I hope this book will inspire everyone interested in group CBT to go further with this powerful intervention for common mental health problems.

Part 1

The Basics of Cognitive Behavioral Group Therapy

The first three chapters in Part 1 explain basic principles, research, and theory related to cognitive behavioral group therapy (CBGT). These opening chapters are sprinkled with clinical examples to illustrate how the principles of CBGT work in practice. Chapter 1 makes a case for extending individual cognitive behavioral therapy (CBT) to groups. Chapter 2 discusses why group CBT becomes more effective when clinicians are familiar with and actively engage with group process factors. Chapter 3 reviews research findings on CBGT for all the disorders covered in this book. This background information will provide a context for the last two more practical chapters of Part 1, which detail how to implement CBGT for depression.

Cognitive Behavioral Group Therapy: Challenges and Opportunities, First Edition. Ingrid Söchting.

1

Extending CBT to Groups

Cognitive behavioral group therapy (CBGT) can play an important role in making effective therapy for mental health problems more accessible and less costly—whether paid for by individual clients or governments. Within governmental mental health systems, CBGT offers significant cost savings and efficiencies without compromising effectiveness (Bennett-Levy, Richards, & Farrand, 2010). Groups run out of private offices or agencies are less expensive for clients because private group therapists do not charge the equivalent of an individual fee when they treat more than one person at the same time. This chapter provides an overview of how individual cognitive behavioral therapy (CBT) has gained momentum and why a group format is a logical extension of this success. Adapting an individual CBT protocol to a group setting is, however, not straightforward. A panic disorder group example illustrates some of these challenges. The chapter closes with a discussion of the unique therapeutic benefits offered by CBGT compared to individual CBT and how to be off to a good start with a CBT group.

Why CBT Is Increasingly Used for Common Mental Health Problems

The number of individuals who suffer from mental health problems is steadily increasing. Depression and anxiety disorders account for the majority of these mental health problems, with North American lifetime prevalence rates estimated at 16% for adult depression and 28% for anxiety disorders (Kessler, Chiu, Demler, & Walters, 2005). There are several reasons for this upward trend. Some likely reflect increased awareness of mental health problems and treatment options. However,

Cognitive Behavioral Group Therapy: Challenges and Opportunities, First Edition. Ingrid Söchting.

even after taking better public education into consideration, rates of anxiety and depression are still on the rise. Larger socioeconomic trends may be operating, leading some health researchers to argue convincingly for a strong association between higher rates of mental illness and socioeconomic inequality. Rates for almost all mental health problems, but especially anxiety disorders, increase as socioeconomic status decreases, making poor mental health both a cause and consequence of poverty and inequality (White, 2010). Interestingly, inequality may also hurt the more affluent. In countries where the gap between rich and poor is large and widening, such as the United States (US), we see higher rates of depression and anxiety even among the financially comfortable members. Conversely, Japan has a relatively narrow income gap, and rates of mental illness across socioeconomic status are lower (Wilkinson & Pickett, 2010). Over and above socioeconomic factors, having a well-integrated family, friendship, and community network may be even more critical than previously thought for the psychological well-being of both men and women (Cable, Bartley, Chandola, & Sacker, 2013); conversely, any breakdown of family and community structure and support has been linked to increases in mental health problems (Alexander, 2010).

Medication can be helpful for many kinds of anxiety and depression and is usually the first treatment offered when a person talks to their family doctor about feeling anxious or depressed. For depression, the advent of the selective serotonin reuptake inhibitors (SSRIs) antidepressant medication in the 1980s was welcomed by family physicians because of their milder side effects compared to the "older" types of antidepressants, the tricyclics, such as imipramine. SSRIs are also routinely prescribed for anxiety. Research suggests that CBT and medication may be roughly equally effective for treating the acute phase of depression (DeRubeis, Siegle, & Hollon, 2008) but that CBT is more likely to help people stay free of depression after discontinuing treatment, whereas ceasing medication has a higher likelihood of relapse (Hollon, Stewart, & Strunk, 2006). A combination of medication and CBT may be especially helpful for depression. A recent randomized controlled trial involving 469 United Kingdom (UK) patients treated for depression with medication by their family physicians showed that only when CBT was added to their usual care did patients begin to improve. At 6 months follow-up, 46% in the CBT group had responded well to treatment compared to only 22% in the care as usual. The treatment gains were maintained at 12 months follow-up (Wiles et al., 2013). It is our experience that people with more severe depression, who respond to antidepressant treatment, are in a better position to commit to regular group attendance. In particular, we notice that those group members benefit from better sleep regulation and increased levels of energy after starting medication and are therefore less likely to miss group sessions due to inertia and low motivation.

Still, regardless of effectiveness, many people prefer not to take medications for various reasons. For depressed people, antidepressants often include side effects such as weight gain and diminished sexual interest, which can lead to a further decrease in social and interpersonal confidence and well-being. For older people with depression, lower rates of metabolism create a necessity for lower dosages which may

not even be therapeutic. Others simply prefer to learn sustainable self-help skills rather than relying on external agents such as medication, which can also be costly (Cooper et al., 2007; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). For people who prefer to take a more active role in their own health, CBT is an attractive option. Clinicians present CBT as a symptom- or problem-focused psychological treatment with an emphasis on personal change in behaviors and patterns of thinking about oneself, other people, and one's day-to-day living environment. Clients are informed that CBT is a shorter-term treatment, typically 8–16 weeks, and that a commitment to practice new skills between sessions is necessary if treatment gains are to be sustained over time.

CBT is available in most Western countries and increasingly also in other parts of the world such as China. Indeed, clinical guidelines in Canada, outlined by the Canadian Network for Mood and Anxiety Treatments (CANMAT), recommend CBT as a first-line treatment for both depression (Ravindran et al., 2009) and anxiety (Swinson et al., 2006) due to the steadily growing body of evidence supporting the effectiveness of CBT. In the United Kingdom the National Institute for Health and Clinical Excellence (NICE, 2009) also recommends CBT for anxiety and depression, including for people who may not meet all diagnostic criteria, that is, minor or sub threshold depression. Not only is CBT helping individuals enjoy a better quality of life, but it is also cost-effective. Before highlighting the cost-effectiveness of CBT, I briefly summarize what CBT is.

Principles of CBT

CBT as we know it today has evolved from the original behavioral therapies developed in the 1960s as a result of the experiments by B.F. Skinner, Joseph Wolpe, Hans Eysenck, and I.P. Pavlov among several other physiologists and medical scientists. These early behaviorists conceptualized psychopathology as simple learning processes either involving *classical* or *operant* conditioning (Hawton, Salkovskis, Kirk, & Clark, 1989). They reacted to the notion in psychodynamic theory, as formulated by Sigmund Freud and his followers, of psychopathology being the result of unresolved intrapsychic conflict caused during the first 5 years of life. Instead of focusing on mind phenomena such as dreams, memories, and free associations, the early behavioral therapists focused exclusively on environmental determinants of behavior. They demonstrated that environmental factors lead to two basic forms of learning, classical conditioning and operant conditioning. We are all familiar with the classical conditioning of Pavlov's dogs.

Initially, the dogs exhibited an unconditioned response of salivation to the smell of food (unconditioned stimulus). However, over time, the presentation of food was systematically paired with a bell. Simply hearing the sound of the bell therefore led the dogs to salivate even though no food was present. The bell (conditioned stimulus) had thus produced a conditioned response. We see other versions of classical conditioning in the modern CBT office. A woman may show a strong anxiety

reaction to, and avoidance of, cats. She is puzzled because she is not afraid of cats per se. It becomes apparent that she had a first panic attack in a friend's home where there were several cats around. Seeing a cat becomes a conditioned stimulus because of its association with the extreme unpleasantness of a panic attack. Avoiding cats as much as possible becomes the conditioned response. Treatment would in part involve exposure to cats and other places associated with panic attacks. Operant conditioning involves manipulation of environmental factors in order to shape a person's behavior. For example, as will be reviewed in Chapter 17, people who receive treatment for an addiction may agree to receive vouchers that can be used to purchase goods as rewards for decreased engagement with their addictions. The presence of a reward thus serves to positively reinforce the desired behavior.

By the 1970s, behavioral therapy working within the paradigm of classical and operant conditioning was widely used for treating a number of problems, mostly anxiety and specific phobias. However, observations from the cognitive sciences challenged the strict behavioral models of learning. CBT psychotherapist pioneers such as Albert Ellis (psychologist) and Aaron Beck (psychiatrist) emphasized the role of mediating cognitive factors. They found that specific thoughts or interpretations of a stimulus influenced the person's behavioral response (Hawton et al., 1989). For example, the woman who avoids cats fearing she will have a panic attack in their presence will likely have powerful thoughts increasing her fear, thoughts such as "I cannot cope with a panic attack" or "having a panic attack means I'm going crazy." For people with depression, the importance of self-critical and exaggerated thoughts in maintaining symptoms of depression (e.g., "everyone else is so smart, and I have nothing to say") became a major focus for Beck. His groundbreaking cognitive theory of depression continues to inform CBT for depression (Beck, Rush, Shaw, & Emery, 1979).

Most CBT practitioners vary their relative focus between environmental and cognitive determinants of behaviors. As we will see throughout this book, some mental health problems call for more behavioral interventions, others for more cognitive, and most for a mix of both. The key treatment principle in behavioral therapy is *exposure* (facing one's fears), which always aims to extinguish the conditioned fear response through *systematic desensitization*. Central to cognitive therapy is *cognitive restructuring* (changing one's thoughts and interpretations). Cognitive restructuring involves gently helping clients become more flexible in their thinking and not lock in to "the first" interpretation or understanding of what is happening around them (e.g., "I'm convinced my boss wants to fire me") or within their bodies (e.g., "my racing heart means I'm having a heart attack").

More recently, CBT has undergone another transformation often referred to as the *third wave* after the initial behavioral wave and, secondly, the cognitive. Mindfulness training and acceptance and commitment therapy (ACT) characterize this newest branch on the CBT tree. Mindfulness training can be described as a continual practice of *awakening* to the present-moment experience (Bishop et al., 2004). Mindfulness-based cognitive therapy (MBCT) differs from traditional CBT in that it is less concerned with the kinds of thoughts people have but more with the