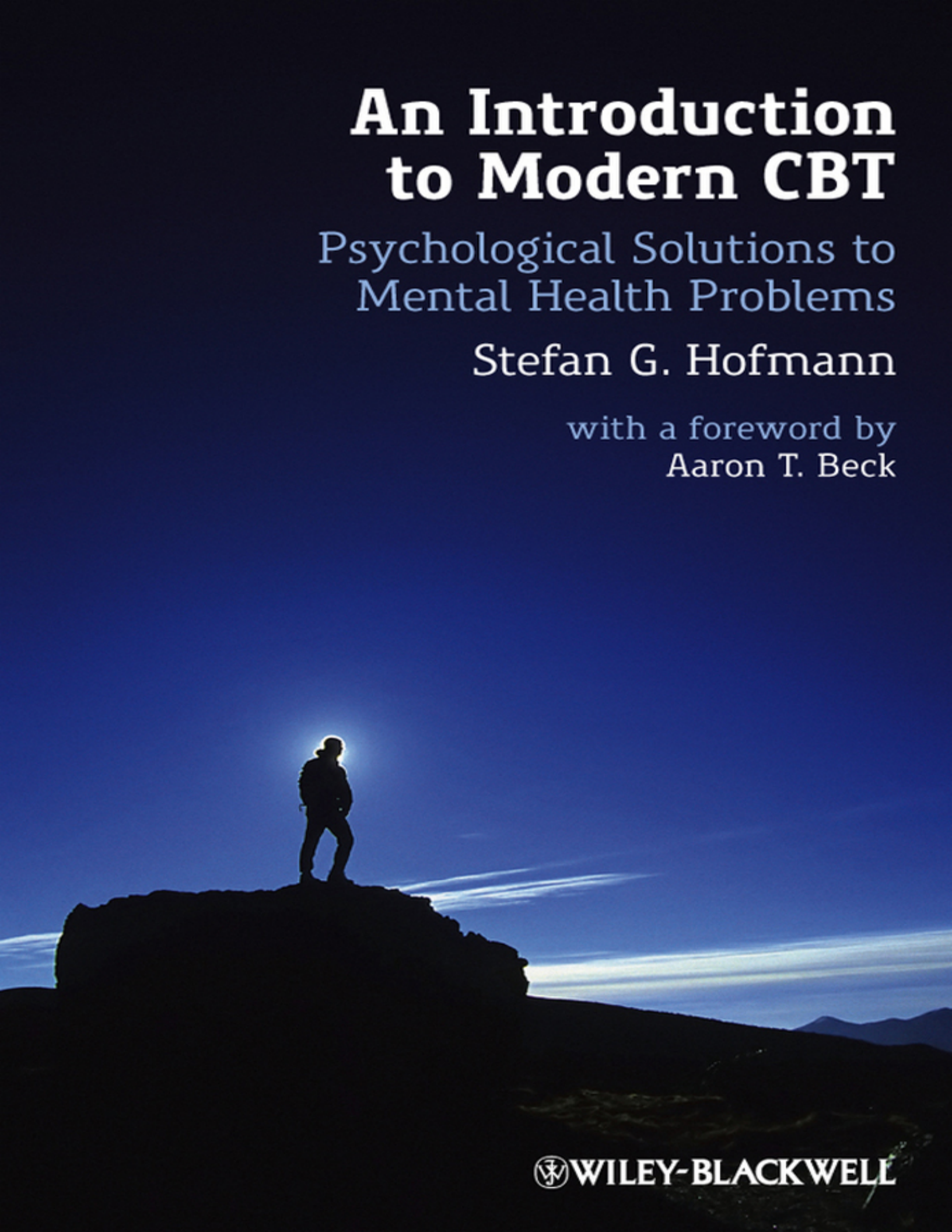
An Introduction to Modern CBT

Psychological Solutions to Mental Health Problems

Stefan G. Hofmann

with a foreword by
Aaron T. Beck



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Praise for An Introduction to Modern CBT

An Introduction to Modern CBT by internationally known researcher and clinical psychologist Stefan Hofmann is exactly the right book for the busy clinician who wants to know the latest research, how it is relevant to clinical practice, and what to do with patients who need help now. Written in a clear, compelling, and caring style, this book will be invaluable for graduate students interested in the application of empirically supported approaches— and for experienced clinicians who need to know the latest innovative CBT treatments.

***Robert L. Leahy**, Director, American Institute of Cognitive Therapy, New York*

A world leader in the treatment of social phobia, Stefan Hofmann has written the ideal introductory guide to 21st century cognitive-behavior therapy. Lucid and accessible, *An Introduction to Modern CBT* will be especially valuable for students and for seasoned therapists keen to learn the latest evidence-based interventions for the most common problems therapists see today.

***Richard J. McNally**, Professor of Psychology, Harvard University, and author of "What is Mental Illness?"*

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Psychological Solutions to Mental Health Problems

Stefan G. Hofmann, Ph.D.

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To Aaron T. Beck for his ground-breaking work that has changed the field of psychotherapy forever. His therapy has helped countless of patients with debilitating mental disorders, and his theory has been an inspiration for generations of clinicians and researchers.

About the Author

Stefan G. Hofmann, Ph.D., is Professor of Psychology at the Department of Psychology at Boston University where he directs the Psychotherapy and Emotion Research Laboratory. His main research focuses on the mechanism of treatment change, translating discoveries from neuroscience into clinical applications, emotion regulation strategies, and cultural expressions of psychopathology. His primary area of research is on cognitive behavioral therapy and anxiety disorders. His research has been supported by the National Institute of Mental Health, the National Alliance for Research on Schizophrenia and Depression, pharmaceutical companies, and other private foundations. He has written more than 200 scientific publications and nine books. He is currently an associate editor of the *Journal of Consulting and Clinical Psychology,* the former editor of *Cognitive and Behavioral Practice*, a Board member of the Academy of Cognitive Therapy, and an advisor to the DSM-V Development Process. He also works as a psychotherapist using cognitive behavioral therapy. For more information, visit http://www.bostonanxiety.org/.

Foreword

Cognitive therapy is an evolving field. After an initially stormy adolescent period, it has now moved into the stage of maturity. Although pharmacotherapy has proven beneficial, it may have reached its limits, making it clearer that there will likely never be a “magic pill” for every psychiatric condition. Consequently, it has become apparent that psychotherapeutic interventions are needed to effectively treat the range of mental disorders.

A number of disorder-specific cognitive therapy protocols have been developed over the years. These treatments target many different problems, including pain, sleep disorders, sexual dysfunctions, depression, anxiety, and substance use, to name only a few. Despite the various specific symptom focus of these cognitive therapy protocols, they all share features that ground them within the same conceptual framework. The basic approach of cognitive therapy, which applies to virtually all mental disorders, can be separated into three parts: first, there are external triggers that activate maladaptive beliefs that subsequently lead to automatic, maladaptive thoughts; second, there is an attentional focus on these beliefs and thoughts; and third, there are maladaptive control mechanisms. For example, in the case of panic disorder, the external trigger may be feelings of heart palpitations. The person’s belief may be that the bodily symptoms are harmful and uncontrollable. In an attempt to control these feelings, the person may engage in avoidance behaviors that serve as maladaptive control mechanisms. These control mechanisms worsen the problem. As a result, the person is compelled to focus even more on the feared symptoms and engage in more avoidance behaviors that lead to the further maintenance of the problem.

A number of treatment techniques arise from the adoption of this triad in the conceptualization of mental dysfunction. For instance, the therapist can identify and evaluate maladaptive beliefs, target maladaptive control mechanisms, and address attentional focus by, for example, encouraging the person to focus his or her attention on to other, nonthreatening stimuli.

The present book has adapted these fundamental principles of cognitive therapy to a wide range of mental disorders. Although the specific treatment techniques are very specific and tailored to a particular problem and patient, all techniques are grounded on the same basic treatment model. I believe this text will be a valuable resource for therapists in training and a handy reference tool for the practicing clinician.

Aaron T. Beck, M.D.

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Acknowledgment

It is impossible to thank everybody who has helped me develop this book. Therefore, the list of people that follows is necessarily incomplete and arbitrary. First and foremost, I would like to thank my wife Dr. Rosemary Toomey and my sons Benjamin and Lukas for their support and love. Next, I want to thank my patients for their courage, trust, insight, and willingness to share their personal suffering, and for making me part of the healing experience. Personally witnessing the power of healing teaches more than any lecture or textbook can do, including this one. I also want to thank my teachers, friends, and collaborators who are the giants upon whose shoulders I have been standing while writing this book. These include Drs. Aaron T. Beck, Leslie Sokol, Anke Ehlers, Walton T. Roth, C. Barr Taylor, David H. Barlow, Michael W. Otto, and Richard J. McNally. Your ideas have made this world a better place. Finally, I want to thank my current students and collaborators for proofreading parts of this book, including (in alphabetical order) Dr. Idan Aderka, Anu Asnaani, Hans-Jakob Boer, Jacqueline Bullis, Michelle Capozzoli, Angela Fang, Cassidy Gutner, Dr. Angela Nickerson, and Alice (Ty) Sawyer. I am fully aware of how lucky I am for having had the privilege to work with these wonderful friends, superb mentors, excellent students, and remarkable patients.

Preface

Mind over Matter: If you don't have a mind, what does it matter?

—Benjamin Franklin Impersonator, Boston, Massachusetts

Psychiatric disorders are common and cause a high degree of personal suffering and financial burden on society. Psychotropic drugs are common treatments for these problems. These medications are among the most successful products of a highly profitable industry.

Psychological treatments, and in particular cognitive behavioral therapy (CBT), are highly effective alternatives to drug treatments. CBT is a very simple, intuitive, and transparent treatment. It encompasses a family of interventions that share the same basic idea, namely that cognitions profoundly and causally influence emotions and behaviors and, thereby, contribute to the maintenance of psychiatric problems. The specific model and treatment techniques depend on the disorder that is targeted, and the techniques change as more is known about the targeted problem. This book will give an introduction to the modern CBT approach for some common psychiatric problems. Although CBT has become well known, there are still many misconceptions and "cognitive errors" (no pun intended) regarding this treatment, which is well on its way to becoming the dominant treatment for psychiatric disorders. My intention is to summarize the established empirically supported and efficacious CBT strategies, as well as modern and developing CBT approaches that still require validation from well-controlled clinical trials and laboratory tests.

The main message of this text is simple: CBT is a coherent model, but it is not one single approach. Because CBT is evolving and changing as more knowledge is accumulating, it is more accurate to view it as a maturing scientific discipline rather than as an assembly of specific treatment

techniques. The reason for this is the strong commitment to the scientific enterprise and openness to translating and integrating new empirical findings about the psychopathology of a disorder into a working CBT model of the disorder. This is an ongoing and iterative process; for example, CBT for anxiety disorders 10 years ago looked very different from CBT for such disorders today. Although the core assumption of CBT remains the same—changes in cognitions causally predict changes in psychopathology—the specific treatment techniques have certainly changed and will continue to change as basic research on psychopathology progresses.

My hope is that this book will facilitate dissemination of CBT. Studies comparing CBT and pharmacotherapy consistently demonstrate that CBT is at least as effective as pharmacotherapy, and in many instances, CBT proves even better than the most effective medications, especially when considering the long-term effects. In addition, CBT is much better tolerated, less expensive, and associated with fewer complications than pharmacotherapy. Nevertheless, pharmacotherapy remains the standard treatment for common psychiatric problems.

There are many reasons why CBT is still struggling to be the first-line treatment, or at least the first-line alternative, for a variety of psychiatric problems. Drug companies have a vested interest in promoting and selling their medication, because a great deal of money can be made by treating people with medication, and a large number of people earn a great deal of money by developing and selling drugs: researchers who develop the drugs, researchers and sales people who work for the pharmaceutical industry, and the doctors and nurses who prescribe the drugs. In contrast, CBT is considerably less lucrative. These treatments are typically developed by psychologists as part of their research projects. If the researcher is lucky, he or she may

receive a grant from the National Institute of Mental Health to test the effectiveness of the treatment. However, these grants are scarce and extremely difficult to obtain. Furthermore, the funding that is provided for those trials is a far cry from the profits of the billion dollar drug industry. My hope is that this book can help to disseminate CBT to an educated public.

Pharmacological treatments are often preferred over psychological interventions due to the stigma associated with psychotherapy. Taking a pill for a problem implies that the problem is linked to a medical condition. This also shifts the presumed reason for a problem from the patient's behavior or maladaptive thinking to the biochemical imbalance and thereby relieves the patient from responsibility. Tying psychiatric problems to biochemical dysregulations is also consistent with the general medical model of human suffering and gives the appearance that the medication treats the root cause of the problem. Mental health care specialists know that this is far from the truth, as psychological models provide an equally (and sometimes more) plausible and scientifically validated explanation for psychiatric problems. This book will provide the readers with these contemporary psychological models.

Finally, the preference for pharmacotherapy over psychological treatments appears to be related to the erroneous assumption that pharmacotherapy has a superior scientific foundation compared with psychological treatments. Psychiatric medications undergo years and sometimes decades of research to establish safety and efficacy. These tests typically begin with animal research and later examine the effects of the drug in humans. In contrast, the process of psychological treatment development is largely unknown to the public. In this book, I aim to clarify this process and to summarize the empirical basis of psychological treatment development.

This book is primarily for the students and clinicians in training, as well as the policymakers and consumers who want to learn about effective psychological treatment options. My intention was not to write yet another self-help book. Instead, my goal was to provide a one-step practical treatment guide for some of the most common and debilitating psychiatric conditions to those who wish to learn about psychological treatment alternatives for common mental disorders. The choice of disorders covered in this text was arbitrary and many important disorders were not included, such as eating disorders, personality disorders, and psychotic disorders. Moreover, I have not compiled an exhaustive review of the CBT literature, but rather, provide the reader with snapshots of some established and developing CBT models and approaches. The book is intended to present a coherent introduction that is practically oriented and that captures some of the established as well as newer, evolving techniques of CBT. Personally, I will use this text when training and supervising clinicians and as a way to refresh my own knowledge of CBT for a particular disorder. I hope you, the reader, will do the same.

Stefan G. Hofmann, Ph.D.

Boston, Massachusetts

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The Basic Idea

Joe

Joe is a 45-year-old car salesman. He and his wife Mary live in a suburban home just outside Boston. They have two children, ages 9 and 12. The family had been doing well financially until Joe was laid off 3 months ago. Mary had been working part-time as a receptionist for a dentist and was able to upgrade this to a full-time job once her husband was out of work. Her income is enough to make ends meet, at least for now.

Since Joe was laid off, he has been staying home. He helps to get the kids ready for school, but then goes back to bed and stays there until 1 or sometimes 2 in the afternoon. He watches TV until his kids and wife come home. Sometimes, he doesn't even have the energy to do that. He feels worthless and believes he will never find a job again. Mary cares deeply for Joe. Although his lack of motivation has created some conflict around doing household chores and cooking, she does whatever she can to make him feel better. However, the added responsibilities are at times burdensome for Mary.

Joe is depressed. He often struggles with his mood, motivation, and energy. But this time, his depression is more severe than usual. Getting laid off from his job apparently triggered the onset of a major depression. Anyone would be upset and sad after being laid off. But in Joe's case, the level and duration of the sadness are clearly outside the normal range. This is not the first time Joe has felt like this. Shortly after the birth of his second son, he slipped into a period of severe depression that lasted for almost a year. There was no clear trigger, aside from having a second child. He was so depressed that he even thought about suicide by hanging himself. Fortunately, he did not act on these thoughts. He has tried various medications for his depression, but he did not find them to be helpful and did not like the side effects they caused.

Mary recently read about a form of talk therapy in a magazine. The therapy is called *cognitive behavioral therapy* (CBT). She was very excited and decided that Joe should try it. When she came home that day, she asked Joe to read the article in the magazine. Joe did not think

that it could help him. The couple got into an unusually heated argument, and Mary made Joe promise that he would try this treatment. Mary arranged for an appointment with a psychologist in Boston who specializes in CBT.

During the course of sixteen 1-hour CBT sessions, Joe's depression lifted. By the end of treatment, it had virtually disappeared. He developed a positive outlook on his life and a positive attitude toward himself. His relationship with his wife and children improved dramatically, and he started a new job as a car salesman within weeks after starting therapy.

Joe's recovery after treatment is not at all unusual. The treatment that he received, cognitive behavioral therapy (CBT), is a highly effective, short-term form of psychotherapy for a wide range of serious psychological problems, including depression, anxiety disorders, alcohol problems, pain, and sleep problems, among many other conditions. The CBT strategies that target some of these common disorders are described in detail in the following chapters. The current chapter will review the guiding principles on which these disorder-specific strategies are based.

The Founding Fathers

Aaron T. Beck and Albert Ellis independently developed the therapy that later became known as CBT. Beck was trained in Freudian psychoanalysis and became dissatisfied with the lack of empirical support for Freudian ideas. In his work with depressed patients, Beck found that people who were depressed reported streams of negative thoughts that seemed to appear spontaneously. Beck called these cognitions *automatic thoughts*. These thoughts are based on general, overarching core beliefs, called *schemas (or schemata*) that the person has about oneself, the world, and the future. These schemas determine how a person may interpret a specific situation and thereby give rise to specific

automatic thoughts. These specific automatic thoughts contribute to the maladaptive cognitive appraisal of the situation or event, leading to an emotional response. Based on this general model, Beck developed a treatment method to help patients identify and evaluate these thoughts and higher-order beliefs in order to encourage patients to think more realistically, to behave more functionally, and to feel better psychologically.

Like Beck, Ellis was trained in Freudian psychoanalysis, but later became influenced by the neo-Freudian Karen Horney. Similarly to Beck's, Ellis's treatment approach emphasizes the importance of cognitive processes and is an active and directive form of psychotherapy. Therapists help patients realize that their own beliefs contribute greatly to, maintain, and even cause their psychological problems. This approach leads patients to realize the irrationality and rigidity of their thinking and encourages them to actively change self-defeating beliefs and behaviors. Ellis initially named the treatment Rational Therapy, then Rational-Emotive Therapy, and finally Rational-Emotive Behavior Therapy to stress the interrelated importance of cognition, behavior, and emotion. Beck prefers the term *maladaptive* or *dysfunctional,* rather than *irrational,* to describe the nature of the distorted cognitions, since thoughts do not have to be irrational in order to be maladaptive. For example, some people with depression might have a more realistic assessment of the potential danger in life. However, this "depressive realism" is maladaptive because it interferes with normal life.

Sadly, Dr. Ellis passed away on July 24, 2007. Dr. Beck, now well into his 90s, is still an active practitioner and scientist with an insatiable thirst for knowledge. Beck and Ellis, who developed their two therapy approaches in the 1960s, have had an enormous influence on contemporary clinical psychology and psychiatry. In the face of the overwhelming dominance of psychoanalytic thinking, these

two pioneers began to question some fundamental assumptions of psychiatry. Driven by their intuition that human problems are best solved by human solutions, Beck and Ellis began to use empirical methods to treat psychological problems and to critically study uncomfortable questions in psychiatry. Ellis, a practicing psychologist, set up his clinic in downtown Manhattan. Like many other places at that time, New York was heavily dominated by psychoanalysis. Similarly, Beck, an academic psychiatrist at the University of Pennsylvania, continued to pursue his quest in the face of strong resistance by the general psychiatric community, which was dominated by Freudian ideas. When he applied for research grants to test his ideas and was rejected, he assembled friends and colleagues to conduct his studies without financial support from the government or other funding agencies. When his papers were rejected by academic journals, he convinced open-minded editors to publish his writing in the form of books.

In recognition of his influence, Beck received the Lasker Award in 2006, a highly prestigious medical prize that is often bestowed on individuals who later win the Nobel Prize. The chairman of the Lasker jury noted that “cognitive therapy is one of the most important advances—if not the most important advance—in the treatment of mental diseases in the last 50 years” (Altman, 2006).

Despite the clear influence of the approach and the effectiveness of the treatment, the majority of people with psychological problems do not have easy access to CBT services. Unlike that involved with psychiatric medications, there is no sizable industry promoting CBT. In an attempt to increase the availability of CBT, politicians in some countries have decided to not let the fate of mental health care be ruled by the financial interest of drug companies and have taken matters into their own hands. In October 2007, the

Health Secretary of the United Kingdom announced a plan to spend £300 million ($600 million) to initiate a six-year program with the goal of training an army of therapists to provide the British people with CBT for psychological problems. This change in health care delivery was based on economic data showing that provision of CBT for common mental disorders is overall less expensive than pharmacotherapy or psychoanalysis. Similarly, in 1996 the Australian government recommended the provision of CBT and introduced a plan to provide better access to these services.

A Simple and Powerful Idea

Although Beck and Ellis are rightly credited for their pioneering work, the basic idea that gave rise to the new approach to psychotherapy is certainly not new. It could even be argued that it is simply common sense turned into practice. Perhaps the earliest expression of the CBT idea dates back to Epictetus, a Greek stoic philosopher who lived from AD 55 to 134. He has been credited with saying, “Men are not moved by things, but by the view they take of them.” Later, Marcus Aurelius (AD 121–180) wrote in his Meditations, “If thou are pained by any external thing, it is not this thing that disturbs thee, but thine own judgment about it. And it is in thy power to wipe out this judgment now.” And William Shakespeare wrote in Hamlet, “There is nothing either good or bad, but thinking makes it so.” Other philosophers, artists, and poets have expressed similar ideas throughout history.

The central notion of CBT is simple. It is the idea that our behavioral and emotional responses are strongly influenced by our cognitions (i.e., thoughts), which determine how we perceive things. That is, we are only anxious, angry, or sad if we think that we have reason to be anxious, angry, or sad.

In other words, it is not the situation per se, but rather our perceptions, expectations, and interpretations (i.e., the cognitive appraisal) of events that are responsible for our emotions. This might be best explained by the following example provided by Beck (1976):

The housewife (Beck, 1976, pp. 234 – 235)

A housewife hears a door slam. Several hypotheses occur to her: “It may be Sally returning from school.” “It might be a burglar.” “It might be the wind that blew the door shut.” The favored hypothesis should depend on her taking into account all the relevant circumstances. The logical process of hypothesis testing may be disrupted, however, by the housewife’s psychological set. If her thinking is dominated by the concept of danger, she might jump to the conclusion that it is a burglar. She makes an arbitrary inference. Although such an inference is not necessarily incorrect, it is based primarily on internal cognitive processes rather than actual information. If she then runs and hides, she postpones or forfeits the opportunity to disprove (or confirm) the hypothesis.

Thus, the same initial event (hearing the slamming of the door) elicits very different emotions, depending on how she interprets the situational context. The door slam itself does not elicit any emotions one way or the other. But when the housewife believes that the door slam suggests that there is a burglar in the house, she experiences fear. She might jump to this conclusion more readily if she is somehow primed after having read about burglaries in the paper, or if she has the core belief (schema) that the world is a dangerous place and that it is only a matter of time until a burglar will enter her house. Her behavior, of course, would be very different if she felt fear than if she thought that the event had no significant meaning. This is what Epictetus meant when he said that “men are not moved by things, but by the view they take of them.” Using more modern terminology, we can say that it is the cognitive appraisal of

the situation or event which determines our response to it, including behaviors, physiological symptoms, and subjective experience.

Beck calls these assumptions about events and situations *automatic thoughts,* because the thoughts arise without much prior reflection or reasoning (1976). Ellis refers to these assumptions as *self-statements,* because they are ideas that the person tells him- or herself (1962). These self-statements interpret the events in the external world and trigger the emotional and behavioral responses to these events. This relationship is illustrated in Ellis's ABC model, in which A stands for the antecedent event (the door slam), B stands for belief ("it must be a burglar"), and C stands for consequence (fear). B may also stand for *blank* because the thought can occur so quickly and automatically that the person acts almost reflexively to the activating event, without critical reflection. If the cognition is not in the center of the person's awareness, it can be difficult to identify it, which is the reason why Beck refers to this as an *automatic* thought. In this case, the person has to carefully observe the sequence of events and the response to them, and then explore the underlying belief system. Therefore, CBT often requires the patient to act as a detective or a scientist who is trying to find the missing pieces of the puzzle (i.e., to fill in the blanks).

Despite differences in the terminology they used, Beck and Ellis independently developed very similar treatment approaches. The idea underlying their methods is that distorted cognitions are at the center of psychological problems. These cognitions are considered distorted because they are misperceptions and misinterpretations of situations and events, typically do not reflect reality, are maladaptive, and lead to emotional distress, behavior problems, and physiological arousal. The specific patterns of physiological symptoms, emotional distress, and

dysfunctional behaviors that result from this process are interpreted as syndromes of mental disorders.

Initiating Versus Maintaining Factors

The reason a psychological problem develops in the first place is usually not the same as the reason the problem is maintained. It may be interesting to know why a problem developed in the first place, but this information is relatively unimportant for treatment in the context of CBT. Knowing the initiating factors provides neither necessary nor sufficient information for treatment. A simple medical example may illustrate this point: there are many ways to break an arm. One may fall down the stairs in one's house, get into a skiing accident, or get hit by a car. When we see a doctor, he or she may ask how it happened out of curiosity, but the information is rather unimportant for selecting the appropriate treatment—putting the arm in a cast.

Obviously, psychological problems are considerably more complex than a broken arm. In Joe's case, for example, more than one single reason led to his depression. He apparently had a tendency to be depressed. When he got laid off from work, he was unable to deal with the stress. However, many people get laid off from work, but only a minority develops depression. Others do not develop depression, but experience substance use problems, anxiety disorders, or sexual problems. In other words, the same stressor can have vastly different effects on different people. Most people cope with it without experiencing any long-lasting consequences. In only a minority of people does the stressor lead to psychological problems, and when it does, the same stressor is rarely associated with a specific psychological problem. A notable exception is post-traumatic stress

disorder (PTSD), in which case a horrific event outside of everyday human experiences—such as a psychological trauma caused by a rape, war experience, or an accident—is specifically linked to the development of a characteristic syndrome of psychological problems. However, even in those extreme cases, only a minority of people will experience PTSD. In most cases, stressors have rather unspecific effects on psychological disturbances, if they have any effect at all.

Whether a stressor leads to a particular psychological problem is determined by the vulnerability of the person to developing this problem. This vulnerability, in turn, is primarily determined by one's genetic predisposition for developing a specific problem. This so-called diathesis-stress model of psychopathology is a generally recognized theory of how psychological problems develop in the first place. However, determining which of the more than 20,000 protein-coding genes predispose some individuals to psychological problems is a task for future generations of researchers. Even if we knew the identity and combinations of those genes, it would be very difficult to predict who will and will not develop a psychological problem; in addition to the person's genetic makeup, we would need to know if or when the person will be exposed to certain stressors and whether or not the individual will be able to deal with the stressors. To complicate the matter even further, the evolving field of epigenetics suggests that environmental experiences can lead to the expression or deactivation of certain genes, and these changes not only lead to long-term changes in traits within an individual, but it might also be transmitted to later generations. This highlights the importance of learning and experience, the process that occurs in CBT, for psychopathology within and between generations.

In most cases of psychological problems, initiating and maintaining factors are very different, because the reason a problem developed in the first place is often unrelated, or only tangentially related, to the reason the problem persists. In Joe's case, for example, the depression was to a great extent maintained by his self-deprecating thoughts, his inactivity, and his excessive sleeping. Note that psychiatrists generally consider self-deprecating thoughts, inactivity, and excessive sleeping to be symptoms of his depression, whereas CBT therapists believe that these factors are partly responsible for his depression, and that Joe has the power to change them.

CBT in Psychiatry

CBT is a highly effective strategy for dealing with many psychological problems. In fact, CBT is at least as effective as medication for the problems that will be discussed in this book. Furthermore, CBT is not associated with any side effects, and can be practiced without any risks for an unlimited period of time. The goal of CBT is to change maladaptive ways of thinking and acting in order to improve psychological well-being. In this context, it is important to explain the term *maladaptive.* This goes to the heart of the definition of mental disorders. Psychiatrists and psychologists alike have been engaged in a long, heated, and still ongoing battle over the way to best define a mental disorder. Jerome Wakefield (1992) offered a popular contemporary definition of mental disorder. He defines it as a *harmful dysfunction*. It is harmful because the problem has negative consequences for the person and also because the dysfunction is negatively viewed by society. It is a dysfunction because having the problem means that the person cannot perform a natural function as designed by evolution (for a critical discussion, see McNally, 2011).

Some of the most extreme positions in this debate question whether mental disorders even exist. One of the earliest and most vocal proponents of this position was Thomas Szasz (1961). Szasz views psychiatric disorders as essentially arbitrary and manmade constructions formed by society with no clear empirical basis. He argues that psychological problems, such as depression, panic disorder, and schizophrenia, are simply labels attached to normal human experiences by society. The same experiences that are labeled as a disease in one culture or at one point in history may be considered normal or even desirable in another culture or at another point in history.

Proponents of CBT acknowledge that culture contributes to the expression of a disorder, but they disagree with the view that human suffering is simply a made-up construction by society. Instead, CBT conceptualizes psychiatric disorders as real human problems that can be treated with real human solutions. At the same time, CBT is critical of the excessive medicalization of human experiences. In CBT, it is not important whether or not a psychological problem that interferes with normal functioning is labeled as a psychiatric disease. The names of mental disorders come and go, and the criteria used to define a specific mental disorder are arbitrary and manmade. But human suffering, emotional distress, behavioral problems, and cognitive distortions are real. Regardless of what the name for the human suffering is—or whether there is even a name for it—CBT helps the affected person to understand and alleviate the suffering.

On the other extreme is the view that mental disorders are distinct medical entities. Psychoanalytically oriented clinicians believe that these disorders are rooted in deep-seated conflicts. Based on Freudian thinking, these conflicts are typically considered to result from repression (e.g., suppression) of unwanted thoughts, desires, impulses, feelings, or wishes. For example, the conflict in Joe might be