Compare contrast and evaluate two psychotherapeutic approaches

Cognitive-behavioural therapy (CBT) and psychodynamic therapy are the most commonly used psychotherapeutic treatments of mental disorders in adults (Goisman et al., 1999). Both will be described as defined by their primary therapeutic aims, theoretical backgrounds and some of the more blatant differences that make them such conflicting approaches, after which they will be evaluated in terms of evidence for and against efficacy as found in recent studies. CBT will mainly be discussed in its traditional form, with reference to ways in which it is currently evolving to include aspects of constructivist- and narrative therapy, as well as mindfulness.

The modern roots of CBT can be traced to the development of behaviour therapy in the early 20th century, the development of cognitive therapy in the 1960's by Aaron Beck, and the merging of the two. CBT consists of a unique category of psychological interventions based on models of human behaviour, cognition, and emotion (Dobson, 2000). During CBT treatment, patients and therapists focus on the present by working together and trying to identify and understand problems in terms of the relationship between thoughts, feelings and behaviour, and personalized, time-limited goals are developed. The therapist assists the patient in becoming aware of maladaptive automatic thoughts that spring to mind and evoke negative personal meanings (e. g., " I'm in danger"). The CBT therapist then probes for patient meanings and stimulates for alternative viewpoints or ideas. Based on these alternatives, patients carry out behavioural experiments to test the accuracy of alternative behaviours, and adopt new and more realistic ways of perceiving and acting. CBT can be described as a therapy fundamentally very different from psychodynamic therapy, and as being "

forward-looking” and “ practical”, typically involving no more than 16 sessions, in comparison to psychodynamic therapy which is not time limited (Loewenthal, 2006). The “ cognitive revolution” which lead psychologists to recognize an inner world characterized by mental models and maps was partly responsible to CBT emerging as a therapy (Westen, 2005), but a dissatisfaction with particular aspects of psychodynamic therapy, the dominant psychological movement during the 1950’s and 1960’s, also played a role in this.

There is no single psychodynamic theory, and psychoanalysis has reproduced within itself many of the controversies of the entire field. The word psychodynamic is used as an umbrella term to include many theoretical approaches that remain connected to these psychoanalytic roots. Perhaps the core of the psychodynamic approach lies in its focus on psychological pain, and the way in which life is hard and our psyche develops to deal with this- i. e. developing ways of avoiding pain. Much of this takes place without our awareness (Johnstone & Dallos, 2006) and there is much focus on unconscious mental processes, as originally developed by Sigmund Freud, and also on dream analysis. These unconscious factors may become the source of distress, either in the form of recognizable symptoms or as troubling personality traits, difficulties in work and/or in love relationships, or as problems in mood and self-esteem. Psychodynamics attempt to reveal how these factors affect current relationships and behaviour by looking at the roots of problematic manifestations (Sandler, 1989). The role of insight in psychodynamic therapy is valued, and it is not only about what the therapist says, but the way he or she says it as well (Gabbard, 2003). In contrast, the

unconscious is dismissed by CBT practitioners, whose main focus lies in the present, and aims to target behaviour by focusing on thought processes rather than on underlying problems. Psychodynamics characterize CBT therapists as being “ oblivious to personal boundaries, insensitive to client disappointment and hostility, obsessed with questionable psychiatric diagnoses, form-filling, homework and handouts at the expense of spontaneity and emotional expression, and blind to the interpersonal difficulties of their clients, especially those that arise in the therapeutic relationship itself”. CBT focuses on the subject’s relation to him or herself, while psychodynamics focus on the self in relation to others Loewenthal & House, 2010).

Psychoanalytic therapy has been criticized by CBT practitioners for being costly and lengthy, as well as for an overvaluation of the unconscious as opposed to the conscious mind, and for lacking ways in which it can be scientifically evaluated. According to Loewenthal & House (2010) most CBT practitioners view psychodynamic therapists as being trapped in the past, as ineffective, as not collaborative in nature, as making patients do things that makes no sense, as having high drop-out rates, as mother-obsessed, and as basically absurd and an inferior type of therapy. In contrast to psychoanalysis, during CBT the client becomes an active player in the therapeutic process as an equal, and is informed about the process of working together with the therapist from the beginning. The aim is to preserve the client’s integrity as an adult, rather than to use the therapeutic relationship to “ invoke client regression into earlier developmental stages”. CBT assists the client in understanding, making sense of and gaining control

over experienced difficulties (Herbert, 2002). Pychodynamics, on the other hand, tend to dismiss CBT as a superficial, quick-fix, “ fast-food” therapy which, while it may temporarily relieve symptoms, is often followed by relapse. According to Sayles (2010) psychodynamic therapy is a space where unhappiness can be slowly unraveled, and not immediately or temporarily fixed, in contrast to CBT where therapy is time limited.

There are few studies that make direct comparisons between CBT and psychodynamic approaches. In cases where comparisons have been made, the most common outcome at this stage seems to be that CBT is doing a better job at a faster rate, but this could be due to a smaller number of trials, based on fewer patients in studies based on the efficacy of psychoanalytic therapy (Loewenthal & House, 2010). For some psychiatric disorders, no randomized controlled trials of psychodynamic psychotherapy exist at all (e. g. for OCD), and the results provided by the available studies can not be generalized to psychiatric disorders in general. A meta- analysis on CBT done by Chapman et al (2006) looked at the treatment outcomes of CBT for a wide range of psychiatric disorders. Large effect sizes for CBT was found in depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, posttraumatic stress disorder, and both childhood depressive and anxiety disorders. Moderate effect sizes were found for marital distress, anger, childhood somatic disorders and chronic pain. However, in a literature review study by Leichsenring (2006) which focused on randomized controlled trials and several meta-analyses on the effectiveness of CBT and psychodynamic psychotherapy, it was found that although CBT yields beneficial results in many mental disorders, the rates of

positive outcomes for treatment responders in specific disorders are not satisfactory, especially if long-term outcome is considered. This is true for depressive disorders (Davidson et al., 2004), and for some anxiety disorders, such as social phobia or generalized anxiety disorder (Davidson et al., 2004; Rodebaugh et al., 2004; Zaider & Heimberg, 2003).

There has also been some debate about the suitability of CBT as treatment for severe depression and the American Psychiatric Association Clinical Practice Guidelines advised against it based on the results of one large randomized controlled trial (Elkin, 1989; American Psychiatric Association, 2000). However, more recent guidelines do recommend CBT as suitable for severe depression and this is supported by more recent analyses of trials that show that CBT is as- if not more effective- than antidepressant medication (DeRubeis, 1999; Haby, 2006). In a meta-analysis of CBT for depression, panic disorder and generalized anxiety disorder Haby et al. (2006) conclude that CBT is an effective treatment for all these disorders, with a moderate to large effect size of 0. 68. Another meta-analyses of studies focusing on the efficacy of CBT for schizophrenia by Gregory (2010) also found considerable empirical support, for both non-experimental (Bradshaw, 1997) and experimental studies (Bradshaw, 1996, 2003; Bradshaw & Roseborough, 2004). However, most studies looked at used psychologists as providers and more studies are needed to determine its efficacy in other professional groups.

There are a number of studies which proof psychoanalytic psychotherapy’s effectiveness in a wide range of conditions, including mild to moderate depression (Shapiro et al., 1994), personality disorders (Bateman and

Fonagy, 2004, 2008; Abbass et al., 2008), panic disorder (Milrod et al., 2007), somatization disorders (Guthrie et al., 1991) and eating disorders (Dare et al., 2001). Evidence suggests that short-term psychotherapy (STPP) is sufficiently effective for most individuals experiencing acute distress, but also indicates that STPP is insufficient for a considerable proportion of patients with complex mental disorders (Kopta et al., 1994, Leichsenring, 2008). In a study by Leichsenring (2008) which did an analysis of trials on the outcome of long-term psychodynamic psychotherapy (LTPP) it was found that LTPP showed significantly higher outcomes in overall effectiveness, target problems, and personality functioning than shorter forms of psychotherapy.

CBT in its traditional form is not focused on the emotional roots of problems, and has been criticized for being a superficial “ quick fix” therapy. However, different classes of therapy orient themselves towards CBT and it is fast evolving and beginning to also incorporate constructivist therapeutic approaches, which has a close affinity with narrative and discourse approaches to psychology. Constructivist approaches see humans as creating meaning within social contexts because it is believed either that reality is essentially without meaning, or that its true meaning is beyond us (Ridgway, 2007). A key feature of treatment involves identifying preferences in behaviour and understanding how meaning is attached to personal experience. Like CBT, there is less focus on the content of thoughts, and more focus on making meaningful connections between experiences. Consequently, therapy is less focused on correcting thought processes, and more on facilitating the process of thinking, and of generating meaning.

From an extreme perspective the constructivist therapist would see reality as only existing in the individual's mind, and concepts like mental health lose their meaning, which is where the gap widens when compared to CBT. However, many CBT therapists do use aspects of this approach and this has the potential to enrich CBT as a therapy. (Dobson, 2010). Narrative therapy sees problems in life as occurring when the stories people have available about themselves do not accord with their actual lived experiences. It places emphasis on respectfulness and non-blame, and assumes that the routes available to people are not always visible to them. In fact, these alternative routes can be made invisible by the influence of dominant narratives and power in society. Narrative therapy does not view the therapist as an expert, but relies on clients to provide the narratives to their own stories. Thus, therapists see their work as a process of ongoing collaborative sense-making rather than by developing objective descriptions of the cause of problems, and formulate a structured story of why things are the way they are, and what needs to be changed (Johnstone & Dallos, 2006). More recent cognitive approaches to CBT also includes mindfulness (Hayes, 2006). Mindfulness-based Cognitive Behavioural Therapy (MCBT) integrates the practice of mindfulness with the principles of CBT. While mindfulness is rooted in many spiritual disciplines, notably Buddhism, it can be applied in its own right without involvement in any religion. CBT encourages clients to become aware of their thoughts, and to focus on thinking patterns. Mindfulness, as a kind of meditation, helps to clear the mind, making it easier not to be distracted by negative or unwanted thoughts and to focus on the here and now.

In conclusion, the available randomized controlled trials provided some evidence that psychodynamic psychotherapy and CBT may in fact be equally effective in the treatment of specific mental disorders (Leichsenring et al., 2004), and it is extremely difficult to proof which approach is the most effective based purely on evidence generated by trials. However, as the impact of CBT increases, the question of which therapy is the most effective remains because we do not know whether alternative approaches work, purely because they have not been tested. On the other hand, it could be argued that CBT is fast evolving and incorporating constructivist- and narrative approaches to therapy, as well as mindfulness. Psychoanalysis, on the other hand, does seem rooted in the past to a great extend and its efficacy has been proved difficult to evaluate. This does not, however, proof that psychoanalysis is any less effective than CBT, merely that it is more problematic to test its efficacy due to lack of trials, and the varying lengths of time, often years, that clients spend in therapy. Considering the average 16 weeks that CBT involves, a comparison is problematic.