

PSYCHODYNAMIC THERAPY AND COGNITIVE-BEHAVIORAL THERAPY: INTEGRATION IN THE TRENCHES

Lisa W. Cross, Ph.D.

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Introduction

Why the acrimony of the debate between these two schools of thought?

Implicit vs. explicit theory

The importance of not creating straw men

Contrasting tone and metaphors of theoretical language

Lack of familiarity on each side with other field's recent clinical and theoretical evolution

Healthy countertransferential function of "home theory" as a holding environment in the face of patients' uncertainty and despair

Contrasting harsh supervisory super-egos of psychoanalysis vs. CBT: asceticism vs. tough pragmatism

I Differences in View of Human Nature

Psychodynamic view: Ambivalence/Conflict is basic.

Irrational forces in the mind are problematic, yet give power and meaning to life. Emphasis on complexity and levels of consciousness. Somewhat pessimistic.

Developmental. "Tragic" and "Ironic" view of life and the self (Messer, [1992])

CBT: Prosaic; emphasizes rationality. Emphasizes deficit rather than conflict. Fewer levels of consciousness. More

optimistic. Fairly a developmental . “Comic” view of life and the self (Messer [1992])

II Differences in Scientific Method

Psychodynamic view: What is real is what is hard to know. Schafer: “criteria of intelligibility, cohesiveness, and economy of explanation”. N of 1 case study approach.

“The truth of psychoanalysis [has], from the time of Freud’s work on, usually been misconstrued as that of an actual or potential behavioral science.” (Schafer)

CBT: What is real is what can be directly observed. Parsimony as key criterion of good theory. Standard methodological criteria of hard science. Occam’s razor; fairly atheoretical

III Differences in Goals of Treatment

Psychodynamic view: Schafer (1973): “deal more effectively with inescapable, objective miseries of experience”; “reduction of radical discontinuities, both cross-sectional and longitudinal, in one’s knowledge and tolerance of oneself”

- hope, fortitude, endurance, humility, humor
- increased sense of one’s own active contribution to one’s problems, rather than being a passive victim
- increased sense of curiosity, tolerance, authenticity, empathy for others and oneself
- personal past and present seem less chaotic yet more complex; see one’s actions as having meaning and function

-- wider range of affects and higher level of defenses; sublimation

CBT: Decrease of cognitive and behavioral (discrete and measurable) symptoms. Increased interpersonal and intrapersonal skills. Less black and white, rigid, thinking; more adaptive cognitive schemas.

IV Differences in Method of Treatment

Psychodynamic view: Therapist very active, but in a less manifest way. Therapist's "benevolent but tough-minded curiosity" (Schafer). Somewhat more emphasis on the past.

- interpretation: defense, genetic, transference ("distillate of essential problems"; "learn in the medium of a relationship") (Schafer/Loewald)
- free association
- countertransference
- therapeutic alliance intertwined with resistance and transference issues; a focus throughout treatment
- guided regression
- unconscious vs. preconscious
- fantasy
- metaphor
- transformative power of termination work

"Language, in its most specific function in analysis, as interpretation, is thus a creative act similar to that in poetry, where language is found for phenomena, contexts, connections, experiences not previously known and speakable." (Loewald)

CBT: Emphasis on present and future. Guided discovery—“collaborative empiricism”. Therapist works in structured ways; sometimes didactic; quite active.

- case formulation
 - modeling; role-playing
 - psychoeducation
 - homework--diaries
 - chain analysis
 - stimulus control
 - contingency management
 - desensitization and response prevention
 - evaluation of automatic thoughts and core beliefs
 - hypothesis testing
 - skills development
 - therapeutic alliance: seen as a prerequisite to treatment, which may need to be tuned up occasionally.
- Very little focus on resistance
- relapse prevention/termination

V Differences in Types of Clinical Problem Addressed

Psychodynamic: Symptoms seen in context of more important generalized difficulties.

CBT: Focus on specific, discrete symptoms.

VI Differences in Temperament and Cognitive Style of Therapist

Psychodynamic: Less action-oriented; drawn to complexity; distrust of charisma; comfortable with effacing him or herself; has a horror of giving advice; not good administrator.

CBT: Comfortable with being authoritative; organized; decisive; results- and action-oriented. Discomfort with ambiguity. Cheerleading and chattiness are acceptable. Interpersonally “transparent”.

(See Andrews, [2000])

VII Caricatures

Psychodynamic Therapist: Stiff, faceless, unresponsive. Denies importance of real, present events. Assaultive interpretations of primitive fantasy. Denies any fundamental changes in personality after early childhood. Pathologizing, Uses the concept of the transference as a “nihilistic cliché” (Wachtel). Theory making as “rearranging deck chairs on the Titanic” (Benjamin)

CBT: Plodding, theoretically shallow. Resorts to simple-minded, self-evident truths. Cannot capture or recognize what it is to be human. Fragmented, piecemeal view of the self; symptoms not seen in larger context of personality or relationships to others. “Bloodless syllogisms” of formal logic (Wachtel)

VIII Parallels Underlying Differences in Terminology and Approaches to Integration

A) Recent changes in both theories’ technique and underlying theory of mind:

--Relational Psychoanalysis’ emphasis on the “here and now” and on interpersonal behavior

-- Wachtel’s cyclical psychodynamics: accomplices; changes in action can cause changes in insight, and vice

versa; critique of “woolly mammoth” notion of the “real” self

--empirically supported, increasingly manualized psychodynamic treatments (Kernberg/Clarkin/ Ken Levy; Bateman/Fonagy)

--CBT’s recent interest in the therapeutic relationship: Safran on therapeutic ruptures; Leahy on resistance; motivational interviewing; APA taskforce on empirically supported therapy relationships; Beutler, Norcross: the variance in treatment outcome explained by technique is less than variance explained by treatment relationship variable. Therapeutic relationship particularly important for CBT of psychosis

--CBT’s increased emphasis on acceptance-based therapies (Hayes; Z. Segal; Williams)

--Beck’s second, “schema-based, “relapse-prevention”, phase of treatment (Judith Beck calls it “psychodynamic-like”) More interest in patient’s past and evoking direct affective experience. See also Young’s schema therapy.

-- More CBT interest in personality disorders

--“Constructivist” critiques of CBT’s information processing view of the mind: Coyne; Mahoney; Joiner.

B) Parallels between terms and techniques

-- core schemas, underlying irrational assumptions~ unconscious fantasy

-- black and white thinking~ primitive defenses of projection, denial, splitting

-- dialectical thinking (Linehan)~ recognition of conflict; transcendence of ambivalence

-- covert modelling~ reparative experience, internalization of therapist

--reinforcement~ secondary gain

-- extinction, exposure~ working through

--chain analysis~ free association

C) Types of integration: eclectic, common factors, theoretical.

D) Different points of entry

IX What do you need to ask yourself when you feel a need to change technique?

--Am I giving in to transference pressure to blur boundaries?

--Do I need to feel active in the face of hopelessness?

--Do I want to do this just so the patient will like me more?

--Is there something wrong with the CBT treatment plan?

--Have I stopped believing in CBT?

--Do I resent being told what to do by a manual?

--Do I feel like a punitive teacher?

--Do I temperamentally feel uncomfortable with being this authoritative?

--What will the effect of this change in technique be on the patient?

X Choice Points and Opportunities for Integration of Clinical Approaches

- overly rigid adherence to or rebellion against homework
- over-idealization (or devaluation) of the therapist by the patient
- suicidality or parasuicidality
- patient asks therapist a personal question
- patient says something funny
 - client gives therapist a gift
 - “don’t just do something; sit there”
 - “the most effective reinforcer is a subtle change in attention and warmth” (Swenson)
- client asks for advice
- the importance of tact: timing, tone, word choice
- poor therapeutic alliance; patient and therapist can’t agree on goals of treatment
- client verbally attacks therapist
- client is in a real-life crisis
- diagnostic considerations

How does the therapist introduce a change in technique?

XI Conclusion

Avoid shallow eclecticism-- rag-bag of disparate techniques and concepts.

Develop instead an integrated eclecticism—algorithms are useful.

Avoid reinventing the wheel; feel free to be open to other paradigms.

New findings from neurology, cognitive and social/personality psychology, attachment theory, and psychobiology are helpful.

Be light on your feet!

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