CBT and Psychodynamic Psychotherapy
A Comparison

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***Abstract*—All psychotherapies go back to the revolutionary concept of the 'talking cure' in the late nineteenth century, the use of communication as an instrument of healing. CBT and psychodynamic psychotherapy as descendants from the same concept should be viewed as complimentary rather than as substitutes. Technical approaches from both can be helpful in individual situations**

***Index Terms*—CBT, cognitive behavioral therapy, psychodynamic psychotherapy, psychoanalysis, communication, psychotherapy, psychiatry**

I. Introduction

COGNITVE BEHAVIORAL THERAPY (CBT) and PSYCHODYNAMIC PSYCHOTHERAPY, the less intensive form of psychoanalysis, are arguably the most prominent and well-researched schools of psychotherapy (see Lambert and Bergin, 1994), apart from interpersonal therapy (IPT) models.

Essentially all psychotherapies go back to the revolutionary concept of the 'talking cure' (Breuer at al, 2000) in the late nineteenth century, the use of communication as an instrument of healing. CBT and psychodynamic psychotherapy as descendants from the same concept should be viewed as complimentary rather than as substitutes. Technical approaches from both can be helpful in individual situations.

II. Philosophical Differences

The late nineteenth century with new discoveries in biological medicine and neurology and the emergence of Darwinian evolution provided the background for psychoanalysis. Psychoanalysis regards the mind as a complex yet structured system that produces and is affected by communication and meaningful information, not unlike individual cells in an organism. The patient's free associations are reflected upon by patient and analyst to explore and resolve intrapsychic conflicts and their defenses, which cause 'neurotic' symptoms, such as anxiety, OCD, depression. Symptoms contain not only hints of repressed feelings and emotions, but also information about the patient's authentic wishes and desires for individual growth. 'Organic' conditions, such as hysteria, disappeared when patients talked to Breuer in the 'talking cure' about their life events and the emotions associated with them in a kind of catharsis. Freud expanded this method later to build psychoanalysis.

CBT delivers a more action-oriented and problem-focused approach, in which treatment plans and goals are formulated without a prior analysis of the meaning of the symptoms. CBT goes back to a merger of the behaviorism based on studies on conditioning and learning[1] and studies into cognitive processes by students of Freud[2], who believed cognitive processes to be closer to consciousness than their mentor. CBT focuses on an understanding of the mechanisms of present thoughts and behaviors rather than their pathogenesis. Both, however, teach their patients to become experts in their respective skills. Also, the question whether a lasting change in thinking and behavior requires a modification of unconscious processes that influence or determine them would largely become irrelevant if the two therapies were integrated.

In psychodynamic theory, the development stages in childhood play an important role,[3] as do other past experiences, which are largely organized around interpersonal relations. In CBT, the focus is on conscious processes and the present. Psychoanalysis assumes that communication phenomena between therapist and patient allow insight into partly unconscious intrapsychic processes, which are organized in a structured system (such as the tri-partite model of ego, superego and id)[4]. Transference and counter-transference are two examples. For example, a patient may present with symptoms of intrusive aggressive thoughts,

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[1] The early pioneers were J.B. Watson, Ivan Pavlov, B.F. Skinner and others.

[2] Alfred Adler, Albert Ellis and Aaron T. Beck

[3] However, this is also reflected in newer CBT approaches to cognitive development and paediatric CBT.

[4] The intrapsychic information transfer between conscious awareness, pre-consciousness, unconsciousness and various stages of memory have largely been validated by research in neurobiology which can attribute the regulation of information transfers between them to certain morphological systems.

indecisiveness on his job and a deteriorating relationship to his son. In the therapeutic session, he experiences helplessness (transference) because he sees his violent father in any perceived authority figure, including the therapist (projection). Since he also loves and idealizes his father and has internalized him, he fears he could be violent towards his own son whom he loves. This conflict can lead to OCD-like thought intrusions and considerable difficulties in communicating emotionally with his don. If the therapist feels helpless and angry in his work with the patient (counter-transference), he can use this information to help the patient develop insight into the conflicting emotions and help him resolve it through insight into what he 'really' wants and desires. From a CBT perspective, distorted thought processes and maladaptive behaviours are direct causes of mental health symptoms (Hollon and Beck, 1994),[5] in psychodynamic theory they are 'only' symptoms and not to be confused with the underlying causes.[6] In CBT, logic, for example in the form of the Socratic dialogue, can be used to identify and discard false beliefs that cause unwanted thoughts and emotions (Beck at al, 1979). Psychodynamic therapy enables reason (the ego) to break down the defenses, which protect from underlying conflicts.

In CBT, unhelpful thought patterns are made clear in the beginning (assessment phase), which, however, requires a norm[7] of 'helpful thinking' (Fancher, 1995). In psychodynamic psychotherapy, what is 'helpful' depends on the individual and should be worked out in the exploratory process.

Both therapeutic approaches are growing organically, though unfortunately with less than optimal cross fertilization. Emotional, motivational and relational aspects have been added to CBT.8 Neural networks and neural computation models are used in psychodynamic research (Peled, 2008), as well as in the cognitive sciences which underlie CBT. The neurosciences[9], infant research[10], neurobiology[11], attachment psychology and other fields have contributed significantly to psychodynamic theory.

III. Practical Differences

Treatment in CBT is usually shorter, often below twenty sessions, and with longer inter-session intervals. [12] There is an evidence-based short-term psychodynamic psychotherapy (STPP) which, however, has in a meta-analysis shown to be "significantly" less effective than the longer version (LTPP) (Leichsenring and Rabung (2008).

Both therapies transfer skills. In CBT the therapist is "very active" (Hofmann, 2011) and the approach is highly structured (Gatchel, 2008)[13], often with homework and including an initial assessment, education on the course of therapy (Hofmann, 2011), a reconceptualization of the problem, skills acquisition, skills training, generalization and maintenance, and another assessment. In psychodynamic psychotherapy, patients learn in the therapist-patient interaction to gain insight into their unconscious dynamics and to become their own analysts.

Since CBT assigns lower priority to the specific thought content and the communication dynamics between patient and therapist and defines problems more narrowly, psychoeducation and 'manualization'[14] are easier to integrate, particularly in clearly defined situations, such as drug addiction (Carroll, 1998)[15]. CBT also lends itself better to conduct therapy over a distance (Weiss et al, 2012; Himle et al., 2006)16, including the use of e-mail therapy (Vernmark et al, 2010). Computer programs (CCBT) can make therapy available to millions of previously underserved populations.[17]

Both, CBT and psychodynamic psychotherapy have proven their effectiveness in numerous studies and large meta-

[5] The strict cause-effect relationship may pose a conflict with the concept of free (see Slife and William, 1995).

[6] CBT may, for example, regard negative thoughts in depression as both symptoms and causes. Psychodynamic theory makes a clear distinction between the two. The same phenomenon (the negative thought) cannot be both, a cause and a symptom, as this would lead to circularity.

[7] This 'norm' pauses philosophical problems, in that it may again contradict the concept of 'free will' which underlies much of the reason for psychotherapy.

[8] To the original models, often cognitive and behavioural exposure and response (ERP) therapies, a number of techniques or therapies have been added, such as dialectical behaviour therapy (DBT) used in borderline disorder, mindfulness CBT (MCBT) acceptance and commitment therapy (ACT), often used in anxiety disorders, OCD or even psychosis, cognitive processing therapy and cognitive emotional behavioural therapy (CEBT) with its focus on understanding and accepting of one's emotions. CEBT is used in used in obsessive compulsive disorder (OCD), anxiety, post-traumatic stress disorder (PTSD), depression and other conditions where the emotions are an obvious part of the condition. Psychodynamic psychotherapy does not distinguish, because it sees emotional dynamics and conflicts underlying virtually all mental health disorders.

[9] such as memory or consciousness (see for example, Westen, 2006)

[10] Daniel Stern (2009) and many other researchers

[11] His research into memory earned psychoanalyst Eric Kandel the Nobel Prize in 2000.

[12] In psychodynamic psychotherapy, the frequency is often one or two sessions per week, in classical psychoanalysis three or four sessions a week.

[13] This article focuses on the therapy of back pain. However, the therapy structure is generally the same for many CBT approaches.

[14] Specific manuals are used in psychodynamic psychotherapy, albeit much less frequently than in CBT, such as for generalised anxiety disorder (Luborsky, 1984; see also Driessen at al, 2013) and various other condition. Vinnars et al (2005) demonstrated the effectiveness of manualised psychodynamic therapy, as long as it was practiced by experienced clinicians.

[15] One such manual "addresses several tasks essential to successful drug treatment, including motivation for abstinence, coping skills, reinforcement contingencies, management of painful feelings, and improved interpersonal functioning and social supports" (Carroll, 1998).

[16] Weiss et al. (2012) showed the effectiveness of CBT in a series of telephone conferences with patients suffering from ADHD. Himle et al (2006) showed the effectiveness of therapy by videoconferencing. However, many psychodynamic psychotherapists nowadays offer sessions over Skype, or even the telephone.

[17] The interactive computer program "Stressbusters", based on a face-to-face protocol, lowered depression scores in a number of adolescents with mild to medium depression (Abeles et al, 2009). A web-based CBT treatment for depression "reduced diabetes-specific emotional distress in depressed patients" (Van Bastelaar, 2011).

analyses. The effectiveness of CBT has been demonstrated its effectiveness in meta-analyses and larger controlled and follow-up studies in depression (Butler, 2006), anxiety (Stewart, 2009), OCD (Olatunji, 2013; Eddy, 2004), smoking and psychosis (Hofmann, 2012) and many other mental health conditions, including, as have its further developments, such as Acceptance and Commitment Therapy (ACT) in anxiety disorders (Arch et al, 2012) and MCBT (Teasdale, 2000; Woohlhouse et al, 2012). The effectiveness of psychodynamic psychotherapy has been demonstrated in meta-analyses of clinical studies (for example, de Maat et al, 2013; Leichsenring et al, 2013; Shedler, 2012; Leichsenring, 2005; Leichsenring and Rabung, 2011).

However, direct comparisons of the effectiveness of CBT and psychodynamic psychotherapy can be flawed by design if the two therapies are complementary and conceptually related. Bram and Björgvinsson (2004), for example, have successfully integrated exposure-response prevention into their psychodynamic therapies. Measuring success in completed therapy phases seems equally problematic, but is still often used. Measuring stepwise progress, however, is possible even in psychodynamic psychotherapy. Bond and Perry (2004) in their study used psychodynamic parameters, such as questionnaire on defence styles together with measures of symptoms and functioning over 3–5 years. It turned out, that symptoms improved as defence styles improved, which is an important result from a psychodynamic perspective.

CBT is likely to deliver quicker results in motivated patients with clearly defined symptoms, low resistance levels and relatively intact personality structures (with the exception of borderline personality disorder and DBT). Psychodynamic psychotherapy may have advantages in dealing directly with personality disorders, which are traditionally derived from psychodynamic models. Virtually all models of personality disorders, from narcissistic to compulsive and hysteric personality dynamics were elaborated first from within the psychoanalytic model. The psychoanalyst Otto Kernberg coined the term 'borderline personality' because he saw patients' personality structures and functioning located on the 'border' between the psychodynamic neurotic and psychotic modes of functioning.

Leichsenring and Leibling (2003) demonstrated in a meta-analysis a better long-time effectiveness of psychodynamic psychotherapy than CBT, while CBT on its own has shown to prevent relapses in the long-run (Driessen et al, 2013). Much of the apparent diversity in opinion may depend on the specific diagnosis in question.

CBT may have higher drop-out rates (Cuijpers et al, 2008; Whittal et al, 1999). Motivation seems more external in CBT (see Haddock et al, 2012) than in psychodynamic psychotherapy with its emphasis on the therapeutic relationship[18] and the integration of the more recent motivational systems research (see Lichtenberg at al, 2016). Adding these psychodynamic elements in CBT therapies may lead to better outcomes.

IV. Example: Obsessive-Compulsive Disorder (OCD)

Both, CBT (Roshanaei-Moghaddam et al, 2011) and psychodynamic psychotherapy have demonstrated mixed effectiveness in treating patients with OCD. In psychodynamic theory, the anxiety underlying OCD is a result of conflicting dynamics (including emotions), often with a strong relationship component. A conflict may arise in an unstable relationship to an important other, such as a primary caretaker in early childhood, as the feelings of love for the idealized mental representation of the other (longing for attachment) and the frustration, sadness and/or abandonment about the reality of this person's unpredictability or unreliability cannot be resolved by the child.[19] Higher levels of aggression and distrust in other people have indeed been found in OCD (Moritz, 2011), and infant research has demonstrated how the interaction between primary caretaker and child can affect the child's evolving sense of self and feeling of secure attachment. A meaningful relationship means there is a two-way communication between child and primary caregiver that furthers the development of both. When the primary caregiver mirrors the emotions the infant is experiencing in his or her non-verbal and verbal communication, the infant learns about the effect of her own emotions on her environment and herself. This then furthers her evolving sense self and provides her with more resilient personality structures.

Obsessive thoughts and compulsive rituals are aimed at temporary relief from the heightened anxiety in present situations which trigger the situational and associated emotional memory systems of previous situations[20]. Awareness of the underlying emotional conflict, which manifests through the symptoms, helps the patient to recognize, identify the 'free-floating' anxiety in the past experience, which reduces the anxiety from experienced emotional uncertainty and the OCD symptoms in the present.

The cognitive-affective schemata of newer developments in psychodynamic theory[21] have considerable overlap with CBT

[18] The flip side is that high individualisation of psychoanalytic psychotherapy can mean that the therapist's personality style may lead to the use of different treatment techniques (see Waldinger, 1987), which increase flexibility but also make operationalisation more difficult.

[19] Since the sense of self is built early on in relations with others in various ways, such as by emotional mirroring, this can lead to a deficient sense of self, resulting in narcissistic personality traits.

[20] There is a considerable interest in neurobiological and psychodynamic research in how our memory stores emotional information and how it is activated if linked to sensoric memory.

[21] Psychodynamic research has shifted in its explanation of the emotional conflict in OCD towards a more cognitive focus on the ambivalence in mental representations of individuals in a relationship (object-relations theories) and the dynamics of cognitive-affective schemata (Kempke, 2007).

concepts of the effect of learned cognitive schemata. From a CBT perspective, obsessive thoughts are otherwise 'normal'[22] negative thoughts which may be misinterpreted as personally significant (Rachman, 1997) or as a potentially dangerous situation for which the patient feels responsible (Salkovskis, 1985), response patterns which are largely learned (Taylor and Jang, 2011). Compulsive rituals are efforts to control these intrusive thoughts. After performing the rituals, individuals usually report a temporary decrease in their obsessional distress (Rachman and Hodgson, 1980), which negatively reinforces these behaviors, a mechanism similar to CBT models on addiction.

Exposure and Response Prevention (ERP)[23] tries to break this cycle of negative reinforcement, in which the patient is repeatedly exposed to an anxiety-provoking thought or situation stimulus, but the self-calming ritual is reduced or suppressed. The anxiety may increase in the beginning, but then reach a peak and fade away.[24] Exposure necessarily leads to an involvement of the patient's emotional memory and an emotional processing of the anxiety (Foa and Kozak, 1986), which seems a point where CBT and psychodynamic psychotherapy again intersect. Basically, both approaches try to give patients a greater sense of positive control over their lives.

V. Example: Depression

Freud considered the internalization of object loss as a normal part of life, and depression as a reaction formation in the face of a particularly severe super-ego[25], which holds in check our basic desires and wishes (the 'id') with the help of conscious cognitive functions (reason, the 'ego'). In CBT, the super-ego could be compared to the messages we learn over time and the believes we construct of how we 'should' live our lives. And similar to the concept of limited cognitive resources in CBT, the rational 'ego' function in psychodynamic theory may get overwhelmed in stressful and traumatic situations and become unable to reconcile the super-ego and the id, leaving an unresolved emotional conflict,[26] which the ego (reason) needs to defend against. Loss and the emotions associated with this conflict (such as anger, sadness or helplessness) are important themes. Anxiety and avoidance have been shown to be greater in people with more insecure attachment (Bateman & Fonagy, 2012), who are often more dependent and self-criticizing, eliciting responses from others that confirm their fears of rejection and abandonment (see Blatt, 1974; Blatt, 1992). Our relations, particularly our first ones in life, determine how we judge ourselves in relation the world, and thus how confident we are in pursuing what is important to us. However, this sense of self can be affected at any stage in life, such as in a therapeutic relationship, whether CBT or psychodynamic. This is why empathy and compassion can bring forth more empathy and compassion. The negative emotions then lead to a 'withdrawal' from one's own emotions (repression), reminiscent of learned helplessness in CBT. Awareness of the underlying dynamics and their origin in the past, helps the patient to understand and integrate them in the present.

In CBT, thoughts, behaviors and feelings are directly interrelated, which can lead to a circularity that is in psychodynamic theory 'impossible'. Negative thoughts can lead to depressed feelings, which again lead to negative thoughts and 'depressed' behavior, such as social withdrawal, reinforcing the depression. Maladaptive cognitive patterns, such as negative thinking about oneself and one's experiences (McGinn, 2000), increase the vulnerability for depression.[27] In learned helplessness, for example, the sense of low self-efficacy brings about behavior that just reaffirms the low self-efficacy.[28]

In the cognitive aspect of CBT, a person learns to recognize and turn negative automatic thoughts into realistic[29] beliefs. More realistic beliefs lead to more adaptive thoughts and less depressed feelings. Patients are taught to deconstruct problems into the actual situation, and the thoughts, feelings and behaviors that occur before, during and after the situation, an external correlate to the internal deconstructive process in psychodynamic psychotherapy. In Mindfulness CBT (MCBT)[30] the emphasis is on experiencing one's thoughts as mental events rather than interpreting them as representations of oneself or reality. This detachment from negative thoughts and feelings is also useful in preventing relapse (Teasdale, 1999).[31]

[22] See the possible criticism regarding the definition of what is a 'normal' thought above.

[23] In the case of ticks, a similar technique, Habit Reversal Training (HRT), is used. Alternative behaviours are developed and practiced that are incompatible with the ticks.

[24] This is not unlike the build-up and decrease in anxiety (or other emotions), when a patient in psychodynamic psychotherapy is confronted with an unconscious conflict. The patient becomes aware of underlying issues that provoke an emotional reaction, before the resolution reduces the anxiety by integrating the emotions in oneself.

[25] In *Mourning and Melancholia* (1917), Freud suggested that while many cases of depression would be due to biological factors, some cases of depression could be linked to loss or rejection by a parent, not unlike the loss of an important relationship.

[26] This is reminiscent of some assumptions in Rational Emotive Therapy (RET).

[27] This definition helps us identify the existence of a maladaptive cognitive pattern, but not its origin.

[28] A.T. Beck (1970, 2005) considered negative thoughts about oneself, the word and the future as the three key elements in a negative belief system ('negative triad'), which is reminiscent of a deficient self-concept in psychodynamic self-psychology.

[29] Beck emphasized realistic rather than positive beliefs.

[30] MCBT is a combination of techniques from the mindfulness-based stress reduction program (MBSR) developed by Kabat-Zinn and others (see Kabat-Zinn, 1990) with CBT.

[31] In psychodynamic therapy, this 'detachment' comes from awareness about the origin of the negative thoughts and emotions.

VI. Conclusion

The aim of psychotherapy is not merely to eliminate suffering (WHO, 1946), but to help patients develop as humans. The primary tool is communication, in CBT to provide information that generates change and in psychodynamic psychotherapy to reveal the information that brings about change. There are synergistic effects from using both. Zipfel et al (2014) showed in a large sample of anorexic patients, that CBT was associated with weight gain, while psychodynamic psychotherapy with lower relapse rates at the 12-month follow-up. McFall and Wollersheim (1979) in an early study successfully used a combination of CBT and psychodynamic psychotherapy in anxiety[32]. Given the widely-perceived need for multimodal approaches[33], it is difficult to comprehend that this should not apply to the most important therapeutic models we have. In ancient Greece, knowing oneself (γνῶθι σεαυτόν, "know thyself") and the process of the Socratic dialogue were inextricably linked. Psychodynamic psychotherapy and CBT should be viewed as complementary rather than substitutes.

VII. References

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[32] The objective was to "modify their unrealistic cognitive appraisals of threat" (cognitive), "test the validity of their fears" (behavioural), and "realize resources … for coping with uncertainty and anxiety" (psychodynamic).

[33] A multimodal approach with intensive psychotherapy, medication, and psychosocial rehabilitation has repeatedly been shown to yield superior outcomes (see, for example, Saxena et al, 2002, Greist et al, 2003).

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