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The Dynamic Perspective versus the Cognitive-Behavioral Perspective in Counselling

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Abstract: Dynamic psychotherapy originates in psychoanalysis, from which it borrows a series of theories and principles of understanding the mind and its functioning, but using a series of specific techniques and procedures that involve a face-to-face approach between the psychotherapist and the client. Cognitive-behavioral therapy (CBT) is a type of psychotherapy based on identifying and modifying destructive or disruptive thought patterns that have a negative influence on behavior and emotions. This article aims to determine, starting from the characteristics of each of these two types of therapy, what are the common and divergent aspects between the two forms of psychotherapy.

Keywords: *dynamic psychotherapy, cognitive-behavioral psychotherapy, psychoanalysis, neurolinguistic programming.*

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1. Introduction

Dynamic psychotherapy originates in psychoanalysis, from which it borrows a series of theories and principles of understanding the mind and its functioning, but using a series of specific techniques and procedures that involve a face-to-face approach between the psychotherapist and the client – unlike the classic psychoanalytic approach, in which the patient was lying on the couch -, and the treatment that takes place is an interactive process between the therapist and the client, during which the therapist is engaging a dialogue with the client - as opposed to the psychoanalyst, who has the role of a listener.

Cognitive-behavioral therapy (CBT) is a type of psychotherapy based on identifying and modifying destructive or disruptive thought patterns that have a negative influence on behavior and emotions.

2. Peculiarities of dynamic psychotherapy

During dynamic psychotherapy, the unconscious motivations underlying the patient's behavior are explored, including the identification of unconscious connections with childhood emotional traumas and also dysfunctional cognitive patterns. As a therapeutic techniques, we mention that the interpretation of dreams is often used - which psychotherapists perform either in a manner inspired by Freud or, less often, inspired by Jung - and the method of free associations, in which case the client is taught relaxation techniques and sometimes even meditation (Richmond, 2020a).

There are a number of common elements between psychoanalysis and dynamic psychotherapy, as follows:

- therapeutic neutrality, which is based on a therapeutic distancing that the psychologist adopts concerning the client, while the psychotherapist is creating an intentional therapeutic alliance in order to facilitate the therapeutic process, detaching as much as possible from their own emotions and intentions. The entire relationship between the therapist and the client is maintained at a "strictly therapeutic" level, and the therapist is prohibited from personalizing the relationship with the client.

- transfer and counter-transfer, which means the development of feelings on the part of the client towards the therapist (Richmond, 2020b). Jacques Lacan (1985, p. 169) considers that the usual feelings that appear outside the therapeutic act are not qualitatively different from those that represent a transfer reaction between the patient and the psychoanalyst. The love and hate that appear in the therapeutic process is similar to those that usually arise, but the therapist must discourage these feelings - otherwise the

therapeutic process fails (Lacarn, 1985, p. 129). In turn, the counter-transfer represents the feelings that the psychotherapist develops towards the client in the therapeutic process. Neither the transference, nor the counter-transference phenomenon are negative phenomena per se, but they require special attention from the therapist so that they do not divert the therapeutic process (Richmond, 2020b).

- free associations, which are a common therapeutic practice at the crossroads between psychoanalysis and dynamic psychotherapy, representing a mental process when a word or an image makes other words or images appear in the client's mind. The method of free association can lead the patient to the original experience of the trauma or the unpleasant feelings. In general, these traumas derive from childhood and have led to the emergence of defense mechanisms in the person's subconscious, which block healthy communication processes.

- resistance represents, in Freud's opinion (2010, p. 517), that set of elements that interrupt the analytical process. For Freud (2010, p. 517), these elements can be manifested in the form of therapeutic withdrawal and the refusal to express feelings during the therapeutic process or even to address a particular problem (Freud, 2010, p. 517). Resistance to therapy is generally determined by the fear that appears when the patient is facing their own subconscious. Also, anger that appears for the patient who has experienced trauma can block the therapeutic process. On the other hand, J. Lacan (1977, p. 129) points out that resistance is often confused with defense mechanisms. These defenses represent mechanisms of defense that the client has against emotions they felt, when confronted with the dark side of their subconscious, and therefore, in the view of J. Lacan (1977, p. 129), the therapeutic attitude of encouragement is particularly important for the client, without forcing the process of confrontation with the subconscious.

In addition to these therapeutic approaches inherited from psychoanalysis, the therapist who uses dynamic psychotherapy uses their own experience as a therapeutic tool, thus presenting themselves to the client as a trusted person, therefore generating a transformation of the transference phenomena into a real therapeutic alliance. Axiological neutrality replaces cognitive neutrality; the psychotherapist does not try to impose their own values on the patient, but expresses their own cognitions - especially those generated by their own life experience, which become subjected to the patient's cognitive analysis, without being imposing to the patient as life wisdom or as advice to be followed. Also, this approach distances itself from psychoanalysis, placing the patient on an equal position with the therapist, highlighted by the face-to-face placement of the two

interlocutors – a positioning that must be completed with the appropriate attitude of equal positioning, both physically and inter- relational. Hence, the idea of an expert patient - regarding his own life and his own needs, which balances the position of power that the therapist holds, as an expert in psychotherapeutic practices.

The patient-expert approach and therapeutic alliance have now expanded to other areas where the therapist-patient relationship is involved, such as the care of chronic patients, where the approach is known as the chronic care model (Davy et al., 2015). Through the idea of therapeutic alliance (Öner, n.d.), the paternalism specific to the Freudian approach is practically rejected.

3. Cognitive-behavioral psychotherapy

Cognitive-behavioral therapy (CBT) is a form of "problem-oriented" and "action-oriented" therapy, which means that it is used to treat specific problems related to a diagnosed mental disorder. The role of the therapist is to assist the client in finding and practical effective strategies to address the identified goals and reduce the symptoms of the disorder (Schacter et al., 2010). This type of therapy has, on the one hand, philosophical roots in Stoic thinking and, on the other hand, it draws its peculiarities from previous forms of psychotherapy, such as behavioral therapy (Wilson, 2008, pp. 63–106). Cognitive therapy itself is another source from which the development of CBT started (Ellis, 2008).

Cognitive-behavioral therapy focuses on changing negative thoughts and automatic negative responses that contribute to worsening emotional difficulties, including depression and anxiety. Spontaneous pesimistic thoughts negatively influence a person's mood, accentuating their behavior in a generally self-destructive manner. Through CBT, these thoughts are identified, challenged, and replaced with more objective, realistic thoughts (Hofmann et al., 2012). CBT means more than identifying negative thought patterns, this therapy is focused on using strategies to help clients overcome these negative thoughts. As strategies, one can use journaling - creating a journal -, role play, relaxation techniques and mental distractions (Tsitsas & Paschali, 2014).

CBT is based on the combination of basic principles taken from behavioral and cognitive psychology (Beck, 2011, pp. 19–20). Practitioners of cognitive-behavioral therapy generally favor the following approaches to this form of psychotherapy:

• cognitive therapy focuses on identifying and changing inaccurate thinking patterns, emotional responses, and exaggerated or distorted behaviors (Rnic et al., 2016);

• dialectical behavior therapy (DBT) addresses thoughts and behaviors based on strategies such as emotional regulation and focusing attention on the present;

• multimodal therapy suggests that psychological problems should be treated by interconnecting seven different modalities, which are: behavior, affect, sensation, imagery, knowledge, interpersonal factors and drug treatment (Lazarus & Abramovitz, 2004);

• emotional rational therapy (ERT) involves identifying irrational beliefs and challenging the client to activate these beliefs - to bring them to the surface from the subconscious -, in order to be able to recognize them and exchange these thought patterns with more productive and ecological ones (Cherry , 2017).

The common feature of these therapeutic models is to address the thought patterns that contribute to mental suffering, and to replace them with others (Apostu, 2016) that prove to be ecological for the client. By becoming aware of negative and often unrealistic thoughts that inhibit their feelings and moods, people are able to begin engaging in healthier thinking patterns (Hofmann et al., 2012).

The main techniques used in most CBT approaches are:

• identification of negative thoughts – it starts with introspection, the client seeks to be as aware as possible of the moments when negative thoughts appear, and moves on to self-discovery, based on revelatory moments (insights) (Lincoln et al., 2017) ;

• practicing new skills - consists in learning new ways to approach a situation, which once again become internalized behaviors. It is important to continuously train these skills to replace the subject's automatic response with the new response based on newly built skills;

• goal setting - helps the client to develop a behavioral change plan, starting from personal development goals and objectives. The role of the therapist is to help the client set goals that will help them exchange their undesirable behaviors with others, appropriate and ecological for both themselves and those around them. Objectives must be SMART (specific, measurable, affordable, achievable, time-frameable);

• problem solving - involves learning new skills to identify and solve problems that occur due to life stressors, both large and small, and reduce the negative impact of psychological and physical illness. Problem solving in CBT often involves five steps: identifying a problem, generating a list of

possible solutions, evaluating the strengths and weaknesses of each possible solution, choosing to implement a solution, and implementing the solution (Sburlati et al., 2014).

• self-monitoring - also known as the activity of keeping a self-monitoring log, is an important part of CBT, which involves tracking behaviors, symptoms or experiences over time and sharing them with the therapist. Self-monitoring can help the therapist provide the client with the information needed for self-transformation, thus providing the best treatment. In the case of nutritional disorders, by self-monitoring eating habits but also the thoughts and feelings that accompany food consumption, appropriate eating programs can be established, replacing undesirable eating behaviors, such as those related to bulimia or anorexia (Lindgreen et al. ., 2018).

• gradual progress of therapy - therapy is based on approaching a series of steps that the client takes gradually in order to increase behavioral change. For example, in the case of a sociophobia or a social anxiety, patients can go through a stage when they only needs to imagine themselves in social situations that confront their own anxiety, and then to place themselves in more and more complex real situations, when they need to overcome the problematic behavior. In this regard, at first, they could engage in conversations with people they feels comfortable with and then, gradually, with people who show a certain degree of hostility, and finally, if it is also an agoraphobia, to develop public speaking skills.

The techniques listed above have been synthesized from the work ”What Is Cognitive Behavioral Therapy (CBT)?”, authored by Kendra Cherry (2020), educational consultant and psychotherapist.

Cognitive-behavioral therapy generally approaches a therapeutic process in 6 stages:

• Evaluation;
• Reconceptualization;
• Acquisition of skills;
• Strengthening of skills;
• Generalization and maintenance of new skills;
• Post-therapeutic evaluation (Kaplan & Saccuzzo, 2017, p. 415).

CBT therapies may include a range of intervention modalities based on self-directed patient instructions, including self-motivational speech and self-suggestion, relaxation and biofeedback techniques, adaptive and coping strategies, minimizing negative thoughts, changing maladaptive beliefs, increasing self-motivation for success etc.

4. Common aspects of the two therapeutic approaches

Between the two types of therapy, we can identify a series of points of convergence, out of which the most important we consider to be:

• both forms of psychotherapy are dialogical, based on various forms of therapeutic interview;

• both forms of psychotherapy are face-to-face, aiming to eliminate power disparities between the therapist and the client;

• both forms of psychotherapy seek, to some extent, the rationalization of behaviors and their verbalization, whether we are talking about the verbalization of emotional traumas recalled in dynamic psychotherapy, or we are talking about the rationalization of automatic behaviors, in the case of cognitive-behavioral therapy;

• in both forms of psychotherapy, when applied in a clinical, medical context, they may be accompanied or even may accompany drug therapy;

• both cognitive-behavioral and dynamic therapy have emotions as a starting point, but in the first case they are approached in a manner based on rationalization, and in the second in a manner based on awareness of the traumas that generate emotions.

5. Divergent approaches between the two forms of psychotherapy

There are a number of differences between the two types of therapy regarding their approach when put into practice, as follows:

• In the case of dynamic psychotherapy, the therapist is a vector of change, sometimes acting as a resource person, while cognitive-behavioral therapy focuses more on the client, and the therapist rather has a guiding role that accompanies the client-explorer in search of their own cognitive maladaptations;

• Dynamic psychotherapy focuses on the emotional response - both of the patient and of the therapist - and therefore transfer and counter-transfer phenomena similar to those described in psychoanalysis may occur, while cognitive-behavioral therapy is logo-centric, and the elements of emotional relaxation, biofeedback, etc. are only adjuvants to the therapeutic act;

• When approaching a harmful behavior, both types of approach start by creating awareness, but the psychodynamic approach emphasizes the emotion underlying the behavior (identifying it, exploring the emotion and the behavior it generates and other related psychological manifestations etc.), while cognitive-behavioral approach aims at the visible manifestations of the behavior and the replacement of the inappropriate response with

another one, which is more ecological for the client and for their social environment;

• The psychodynamic approach correlates the behavior with the emotions that deform the cognition, while the cognitive-behavioral approach analyzes the way in which the cognition reinterprets the emotion in the process of adapting the behavioral response. For the first approach, behavior is a response to environmental triggers - especially those of an emotional nature, a response that is filtered through the client's previous experience -, while in the second case, the behavior is learned in situations when the behavior was effective and is later used in situations that seem similar or are interpreted by the subconscious as being similar.

6. Conclusions

The two approaches were later partially reunited into neurolinguistic programming (Hall & Bodenhamer, 2012), in the form of a metamodel, starting from the NLP axiom according to which the map is not the same as the territory, following therapeutic practices such as timeline tracking, phobia therapy, NLP modeling etc.).

The two forms of psychotherapy have proven their therapeutic utility both in the clinical approach, in the case of pathologies with various degrees of severity, and in the case of non-clinical therapy, becoming forms of humanistic psychological counseling (Moise, 2019).

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