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PSYCHOANALYSIS AND COGNITIVE BEHAVIOUR THERAPY—RIVAL PARADIGMS OR COMMON GROUND?[1]

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The author suggests that contemporary enthusiasm for cognitive-behavioural therapy reflects our longing for swift, rational help for psychological suffering. Competition for funding threatens the psychoanalytic presence in the public sector. The psychoanalytic and cognitive-behavioural models are contrasted, and the relative richness of the psychoanalytic paradigm outlined. The author suggests that a cognitive model is commonsensical, but less complex, with less potential explanatory and therapeutic power. She discusses how the analytic stance is always under pressure to 'collapse' into simpler modes, one of which resembles a cognitive one. This also occurs inevitably, she argues, when attempts are made to 'integrate' the two models. Cognitive and 'integrated' treatments nevertheless have the advantage that they are less intrusive and hence more acceptable to some patients. Selected empirical process and outcome research on cognitive and psychoanalytic therapies is discussed. Brief psychotherapies of either variety have a similar, modestly good outcome, and there is some evidence that this may be based more on 'dynamic' than 'cognitive' elements of treatment. Formal outcome studies of more typical psychoanalytic psychotherapy and of psychoanalysis itself begin to suggest that these long and complex treatments are effective in the more comprehensive ways predicted by the model.

INTRODUCTION

Cognitive behaviour therapy (CBT), relatively new to the psychotherapeutic scene, is hailed with great hope and enthusiasm as a means of rapidly alleviating mental distress. Its practice is seen in some quarters, for example the UK public sector, as providing an alternative to psychoanalytically orientated therapy that is more rational, quick and efficient, and regarded as of proven efficacy. This is similar to the early idealisation of psychoanalysis, and may prove relatively short-lived. However, psychoanalysts need to take careful heed of this phenomenon, and be prepared to engage in debate about it, as it appears to be linked with a serious devaluation and erosion of the psychoanalytic perspective in health-care services worldwide.

I will compare and contrast the two clinical paradigms, the psychoanalytic and the cognitive-behavioural. I will show how CBT practitioners are beginning to rediscover the same phenomena that psychoanalysts earlier faced, and are having to change and deepen both their theory and practice accordingly, and to modify their expectations. These rediscovered phenomena concern unconscious processes, the complexity of the internal world and the intrinsic difficulties of psychic change. The main

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originator of CBT, Aaron Beck, in his recent book about work with personality-disordered patients (Beck et al., 1990), talks at times in a way reminiscent of the early Freud. Early psychoanalysis was itself more 'cognitive', and had to evolve to meet the challenges encountered in the psyche. We may find that CBT technique continues to become more 'analytic' as time goes by, and that accompanying this the need for longer and more complex training of therapists, including substantial personal analysis, will be rediscovered. At least one major CBT training course in the UK in fact already recommends that trainees seek personal psychotherapy.

The stance of the therapist in CBT is a socially acceptable one, which makes immediate intuitive sense. The psychoanalytic stance is much harder to swallow, and is maintained against the resistance of both the analyst and the patient. I will suggest that there is a constant tendency for 'decomposition' or collapse into something simpler during psychoanalytic work. The analyst is pushed constantly from without and within either into being more 'cognitive' or into a simpler counselling stance—in such ways the analytic stance is frequently in danger of being lost and having to be refound. When it can be achieved, the advantage is that through the discomfort and tension of the striving for analytic neutrality and abstinence, more disturbance becomes available in the room, within the therapeutic relationship itself, to be worked with and potentially transformed. CBT is far less disturbing and intrusive. It is worth noting that although it forfeits potential therapeutic power, it may be acceptable to some patients in a way that psychoanalytic therapy is not, protecting privacy and defences that the individual has good reasons for wishing to preserve.

A second, related point is that 'integration' of analytic and cognitive methods in my view inevitably produces something more cognitive than analytic. Once cognitive or behavioural parameters are introduced by the therapist, I will argue that an analytic stance essentially ceases to exist, and the analytic paradigm and methodology again collapse into the cognitive one, with a loss of potential therapeutic power. This is worth exploring in view of the huge current enthusiasm for so-called 'integrated' treatments such as 'cognitive analytic therapy'.

One oft-quoted argument for offering CBT rather than psychoanalytic treatments to patients in the public sector is that there is so much more empirical research evidence for its efficacy. It also on the surface appears cheaper, as it is brief and needs less training to apply. It is worth noting first of all that where patients have freedom to choose, in the private sector, only a minority opt for CBT, most patients preferring dynamic therapies. The alleged superior efficacy of CBT is also questionable empirically, and I will look briefly at the outcome research field in this connection.

Comparing psychoanalytic and cognitive-behavioural therapy

History of the split from psychoanalysis

The biographical context for Freud's ideas is widely known, with important links between the ideas and Freud's personal experiences and his self-analysis. A similar context for Beck's ideas is less well-known and is worth outlining. Aaron T. Beck began as a psychoanalyst, graduating from the Philadelphia Psychoanalytic Institute in 1956. He became disillusioned and impatient with the psychoanalytic culture in which he found himself over the following decades—in his view unfocused, resting on dubious theoretical foundations and insufficiently located in the patient's current reality. Psychoanalysis was very much the dominant, authoritative culture in psychiatry (a situation radically different from that in the UK then or now). Beck, in opposition to this establishment model, founded first a 'cognitive theory' of depression, then derived a brief therapeutic approach. Perhaps, as is not uncommon, innovation arose through the combination of a particular personality and a rather rigid or too-

comfortable state of affairs in psychoanalysis at one place and time.

Beck's biographer (Weishaar, 1993) notes that Beck is open about having developed his theory and technique not just through his clinical work, but, like Freud, through introspection and analysis of his own neurotic problems. Born in 1921, the youngest of a sibship of five, Beck was according to family mythology the one who had 'cured' his mother by being born. Elizabeth Beck had been depressed since the loss of her first child, a son, in infancy, followed later by the death of a young daughter in the 1919 influenza epidemic. Described as a powerful matriarchal figure, overshadowing the quieter father, she remained an explosive person, whose unpredictable and irrational moods the young Aaron found troubling. She is described as having been 'overprotective' of her youngest son, who spent months in hospital with a life-threatening illness at the age of 8.

Beck describes the way he systematically desensitised himself to a serious 'blood/injury phobia' during his medical training, treating his fears of heights, tunnels, public speaking and 'abandonment' with similar sorts of behavioural and cognitive strategies. He also described curing himself of 'moderate depression'. He is lukewarm about the effects of his training analysis. Weishaar quotes a colleague, Ruth Greenberg, as referring to Beck's restive rebelliousness about the psychoanalytic establishment. Greenberg suggests that being his own authority and being in control of himself were of overriding importance to Beck, and would have made the analytic training very problematic for him.

In the decade following his qualification as an analyst, Weishaar relates how Beck carried out empirical research into depression. Through examining the dreams of his depressed patients, he came to the conclusion that hypothesising wish-fulfilment and hidden motivation was unnecessary, and indeed in time he came to dispense with the idea of an unconscious in Freud's sense at all. He also used more standard experimental psychology procedures in his research. One experiment involved a card-sorting test. The fact that depressed subjects did not react negatively to success in the task showed, Beck thought, that they did not have a need to suffer, and thus went towards disproving the psychoanalytic theory that depression was due to 'inverted hostility'. Many psychoanalysts might question this as a research paradigm for psychoanalytic concepts, isolated as it is from the context of a close interpersonal relationship. However I think it illustrates how great the conceptual differences sometimes are between practitioners of the two treatments, which can lead to major difficulties in communication.

Beck began to develop a cognitive theory, and from that a cognitive therapy (CT) of depression. He was influenced by Kelly's (1955) personal construct theory and by the idea that the patient could become his or her own 'scientist' of the mind. He was also influenced by the ideas of Adler, Horney and Stack-Sullivan. Beck communicated with Albert Ellis who was independently developing Rational-Emotive therapy, which shares some but not all of its features with cognitive therapy (Ellis, 1980). Beck, together with Ellis and Donald Meichenbaum (see e.g. Meichenbaum, 1985), is regarded as one of the 'founding fathers' of cognitive behavioural therapy (CBT), an umbrella term which covers this broad therapeutic approach, and which, in the UK at least, is now used more or less synonymously with CT. 'Behavioural' acknowledges the contribution of learning theory and classical behaviour therapy. I will continue to use the term CBT in this paper.

Early theories underpinning CBT were relatively simple, with little emphasis on the precise mechanism of symptom causality, simply that things had been 'mis-learnt' through childhood experience. The emphasis was rather on the way symptoms were currently maintained and underpinned by 'negative cognitions', which were in turn generated by maladaptive internal 'schemas'—deep cognitive structures organising experience and behaviour. (In recent years 'schemas' are seen in increasingly complex ways). Beck believed that discovering

and challenging negative cognitions was a simpler, shorter path to change than psychoanalysis, and made more theoretical sense. He saw himself as shifting away from the 'motivational' psychoanalytic model to an 'information processing' one—he directed attention away from 'why' on to 'how' distressed psychological functioning operates.

The cognitive behavioural paradigm

In its classical form (Beck, 1979; Hawton et al., 1989; Moorey, 1991) CBT is a short-term, structured, problem-solving method by which a patient is trained to recognise and modify the maladaptive, conscious thinking and beliefs that are, it is argued, maintaining his or her problems and distress. This treatment/training is done first by educating the patient in the cognitive model of emotion, often with the help of written material. The patient is then helped to recognise negative automatic thoughts, then encouraged to use a process of logical challenging and reality-testing of thoughts, both in the session and in the form of between-session homework.

A vital feature of CBT is the sympathetic, collaborative therapeutic relationship, in which the therapist tries to be an inspiring and imaginative trainer in self-help skills. The patient is encouraged to become a scientific observer of himself and his or her thoughts, and to start to question the logical basis on which beliefs—for example, beliefs about being unlovable, or a failure—are held. Sessions are structured and directive, with the patient and therapist focusing general complaints down on to specific negative cognitions which can then give rise to experimental tasks to be carried out, and the outcome monitored. Thus a depressed patient is found, for example, to have core beliefs that no one is interested in her, and that everyone else is having a better life. These core beliefs are found to generate day-to-day thoughts like 'no one talks to me at parties', and 'other people have much more interesting jobs'. Such beliefs can be specifically tested out both during discussion in sessions (often through a sort of Socratic dialogue) and then through carefully planned homework involving observations and possibly behavioural tasks. This hypothetical patient will be referred to again later.

The usual practice is to offer between ten and twenty sessions of treatment, with follow-up refresher sessions. Training required for the therapist is relatively brief, not requiring, for example, any personal therapy. Beck, however, stresses that it is far from enough for the therapist simply to learn a set of techniques—he/she needs to have an overall 'cognitive conceptualisation', and to have well-developed interpersonal skills and sensitivity. Weishaar notes that Beck's treatment manual for depression fails to capture the heart of his own empathic therapeutic style, as seen on videotapes. This observation will be returned to later, when discussing what factors may really be therapeutic in CBT.

Comparing the psychoanalytic paradigm

Contemporary psychoanalytic conceptualisation and clinical technique mostly differs from that of 1950s Philadelphia. Beck, who was sceptical about classical drive theory, and the strong emphasis his psychoanalytic colleagues then placed on childhood reconstructions, might (or might not) have found a relatively active, 'here-and-now'-based object-relations approach more to his taste. Although familiar to most readers, I will lay out the basics of this contemporary psychoanalytic clinical paradigm so as to contrast it with the cognitive one. I approach this, I should say, from the traditional 'positivist' rather than an intersubjective 'constructivist' paradigm—that is, I see the primary object of study and discovery as being the inner world of the patient. While acknowledging the biases caused by our 'irreducible subjectivity' (Renik, 1998), I agree with Dunn (1995) that this does not reduce us to total ignorance. Thus I see the analyst as doing his or her best, with an imperfect and biased observing instrument, to strive towards understanding of the internal world of the other.

The CBT stance is intuitive and socially acceptable—indeed it is a specialised form of a familiar tutorial relationship. The psychoanalytic stance is counterintuitive and less socially acceptable—much harder to swallow for both analyst and patient. The therapist offers close empathic attention, but leaves the agenda to the patient's free associations, becoming involved with the patient as participant-observer in an unfolding relationship. The analyst often has powerful wishes to respond naturally to the patient, to explain and to reassure. Giving way to such impulses relieves the analyst—it makes him or her feel nicer and kinder. In particular, it spares the analyst the moral reproach intrinsic in being the negative transference figure (Milton, 2000). The paradox is that although the analyst is apparently being more 'real', this is illusory. He or she has in fact, by fitting in with the patient's pressures, remained a transference object, and it is this familiar, relatively weak figure that the patient is left with externally and internally (Feldman, 1993). Collapse of the analytic stance has removed the potential for the analyst to become a truly surprising and new object (Baker, 1993). This is a new object for internalisation, who can bear and reflect on the patient's projections, rather than quickly disowning them.

The analytic precepts of neutrality and abstinence do not as we know refer to coldness, but to a striven-for personal unobtrusiveness that allows the analyst to become clothed in whatever the patient needs to bring. By reducing the extraneous 'noise' from one's own personality, a clearer field is provided for locating this. 'Live' emotional experiencing is allowed to occur, sometimes fraught, anxiety-provoking or painful for analyst, patient or both. However, by activating distorted internal object relationships in a live way, they are potentially able to be explored and gradually altered by experience. In contrast to CBT, change promoted by psychoanalysis work is relatively independent of the conscious aspects of insight.

The analytic stance will frequently be lost, and have to be refound, as the analyst is subtly pulled into fulfilling the patient's unconscious scripts (Sandler, 1976; Joseph, 1985). There will be constant invitations, which the analyst will often partly accept, to become more prescriptive, or educational, more partisan, more emotionally reactive and so on. One could say that the patient tries all the time to get the analyst to be a different sort of therapist—whether this is more of a humanistic counsellor, a gestalt therapist, a guru, a teacher or, what I think is quite common, the patient unconsciously nudging the analyst into providing a weak version of cognitive therapy itself. All these therapies, including cognitive therapy but with the one exception of psychoanalytic therapy, use therapeutic stances that come more naturally because they are specialised forms of ordinary social contact. So it is always hard work, and work against the grain, to observe the collapse of the analytic stance, work it through in the countertransference, and re-establish its counter-intuitiveness and complexity again.

In CBT, the set up is such that the patient and therapist talk together about a disturbed patient they mostly only hear reported, and try to think, with the sensible patient in the room, ways to make him or her feel, and be, more reasonable. The rational part of the self is strengthened, in order to get on top of the disturbance. This maintains, even strengthens, a division in the personality between rational and irrational, conscious and unconscious. Analytic conditions, by contrast, allow disturbed aspects of the patient to come right into the room, with all their passion and irrationality, loving, hating, destroying and so on. The patient is encouraged to project, challenge, disrupt, complain, involve the analyst in myriad ways in the psychic drama. Primitive and disturbing phantasies, involving both body and mind, may come to light.

The analyst, then, has the advantage of a much greater range of orientations to the patient, and aspects of the patient, than the cognitive therapist has. Linked to this, an important but particularly intrusive feature of

psychoanalysis is the analyst's frequent orientation towards what happens in the therapeutic relationship from an observing 'third position'. This triangularity can arouse the primitive feelings of oedipal exclusion which Britton (1989) describes. The analyst's reflective, independently thinking mind can seem an infuriatingly private, superior place where an excluding sort of 'mental intercourse' takes place. It is easier and more comfortable to flatten the triangle, to discuss things that are already visible, from a shared position, or to get together to discuss someone else. The 'collaborative colleague' stance of CBT, together with a setting that does not invite live manifestation of disturbance, can avoid triangularity almost completely. I think this is a key issue in the difference. The psychoanalyst deliberately takes the risk at times of precipitating the patient's narcissistic indignation or even rage, by speaking openly about things he or she sees that the patient cannot see, or half-sees and wants to keep hidden. Although this is uncomfortable for both, it means narcissistic parts of the personality are activated and may become gradually modified and integrated.

To consider now the case of the hypothetical depressed patient mentioned above who comes for help feeling no one is interested in her, and that other people are having better lives. A psychoanalyst she consults will not actively encourage her to challenge and test this belief outside the room. Instead, a neutral, unstructured setting will be provided, in which the patient may quickly experience the analyst as uninterested, involved in his or her own thoughts, and speaking from a superior and privileged position—the analyst, like the people she meets outside, she believes to be having a much better and exciting time with other people, while she is left alone with an inferior sort of life. By not encouraging and reassuring, the analyst may quickly find him or herself the target of this patient's miserable resentment. The nature and source of this resentment will become clearer, allowing it to be understood and questioned at a much deeper level. The patient's envious misery may prove linked to childhood feelings of exclusion from the parents' relationship and from the mother's relationship with other siblings. The 'other room' from which one by definition is always excluded (Britton, 1998) may, for many people, become idealised in a way that empties their own life of meaning, and halts the process of separation and independence. This deep sense of 'oedipal exclusion' may be linked to both childhood deprivations and a particular difficulty with tolerating separateness and difference. CBT is unlikely to reveal or to be able to address such complex dynamics.

It is certainly true that psychoanalysts reason with their patients, explain to them, make practical suggestions, and so on. Often, for example, I think this happens at the end of a bit of painful or stormy work in the transference. A narcissistic aspect of the patient has been finally understood and integrated (in Kleinian terms, for example, a move towards the depressive position) and the patient is thoughtful, curious and collaborative about what has happened and how it relates to current and past relationships. I think this is often the organising and contextualising phase of a piece of work, which is in many ways a final 'cognitive' phase. At other times, though, I think analysts become 'cognitive' as a short circuit, to avoid a painful but necessary bit of emotional experiencing. Thus a self-observing eye is needed, so the analyst can question whether he or she is beginning to sound very reasonable and sensible, trying to persuade the patient of some bit of reality, or push the patient into certain action. One might ask oneself at this point whether there is a wish to be seen as a good, blameless object—in which case it is worth wondering what form the bad object would take at this point that would feel so unbearable. It might also be that there is a larger picture to be seen in the transference and countertransference that is being missed. I will illustrate this latter possibility with the case of Mr A.

Mr A

A 45-year-old man who was still living with his parents, working in a clerical job far below his capabilities, Mr A came to analysis for help to move on. He intermittently would come to a session in a particularly thinking and constructive mood, wanting help with a particular plan for change—such as learning to drive, applying for a new job, buying his own flat and so on. I would feel encouraged and pleased for him, because he really was miserably stuck. I would join him in trying to analyse his difficulties with these tasks, linking things in, when I could, with the transference relationship and troublesome past relationships, in an ordinary sort of way. In subsequent sessions Mr A would have become very anxious and doubtful about the change. He would start to spin it all out—he would have a form to fill in but leave it at work, or lose it; he would tell me about a necessary phone call being put off, and so on, making sure I knew every stage of the postponement. He would still seem to want help with his fears. The nature of the scene-setting followed by the delays was such that I was often left with a very strong sense of thwarted desire.

At first I would find myself full of sensible and practical ideas and strategies for helping Mr A to challenge his fears, and (with a guilty sideways look towards my own analytic superego) I would slip into making interpretations which were really disguised practical suggestions, like 'it is interesting that you don't seem to feel that you could …' At this stage we would enter, as I came to see, a 'cognitive' mode that was ultimately unproductive. Mr A would passively seem to accept my cognitive and behavioural suggestions, but continue to let the project slide. As Mr A became flatter and more passive, I would find myself more and more lively. I would now perhaps analyse his resistance in terms of his rebellious attitude to me, or to his disowning and projection of his mind into me, or maybe in terms of his internal conflict. Nothing would happen—that is, Mr A would still report to me flatly or hopelessly, or sometimes a tinge triumphantly, that he had still not done anything about the project. I would sometimes feel pushed beyond endurance at this stage. If I could not contain my countertransference, I would hear myself making a rather sharp and impatient interpretation about Mr A's passivity. In response, he would become either very weak and demoralised, or alternatively subtly excited and mocking. He would typically report dreams at times like these, in which someone was pursued or intimidated by gangsters or con men—it was often unclear which side he was on in these dreams.

By repeatedly working through these situations with Mr A, I came to understand a complex internal situation in which he was both trapped by, and took revenge upon, a monstrous internal figure which was partly a version of a very abusive stepmother. I came to see my 'cognitive' impulses as part of a larger picture in which we as an analytic couple enacted a sado-masochistic scenario that both trapped Mr A but also fulfilled a wish and need for a timeless infantile-like dependence on archaic objects. In phantasy, he seemed to have lodged himself inside me, projecting his active mind in a very wholesale way. Movement could only occur at times when I could get outside the situation, see the whole picture, and interpret it in a non-retaliatory way that Mr A could become really interested in, and concerned about. This work used to test my analytic capacity to the full, but it eventually enabled Mr A to experience his own mind more fully. This meant him having to face and mourn his own situation, internal and external, and experience his rage, guilt, sadness and ultimately his own considerable strength.

In my work with Mr A I was thus periodically nudged into doing fragments of a weak version of CBT. This illustrates what I mean by 'collapse' of the analytic stance into something simpler and more apparently common-sense. It will inevitably occur in our work from time to time, and it needs hard work in the countertransference to notice and rebuild the tension and complexity inherent in productive analytic work.

Comparing modes of learning in the psychoanalytic and cognitive-behavioural paradigms

We know that both psychoanalysis and CBT involve learning. The main sort of learning hoped for in psychoanalysis is learning from emotional experience. This may be, for example, finding that one's worst fears in a relationship are not confirmed, or, when they are, that the experience can be survived and thought about. CBT therapists also hope their patients will learn from experience. The whole point of homework experiments is that the patient can test out distorted preconceptions outside the session. Some cognitive therapists, nowadays, may even say to the patient, 'and can't you see how you're doing it with me too?' The analytic patient can, however, learn something quite subtle and complex through understanding, containment, repeated experiment and sustained experience within the therapeutic relationship, that (for example in Mr A's case) giving up a dependent, sado-masochistic way of relating involves both some loss and a new sort of loneliness but also a new freedom and independence of thought and action.

Implicit in CBT is that if one pays attention to modifying the patient's conscious distortions of reality, or 'dysfunctional assumptions', over a brief period, the deeper structures generating such assumptions will dissipate, or become far less powerful. Psychoanalysts are more sanguine about this. A patient Ms B may be relieved and encouraged to find as a result of a courageous homework exercise that her actual family are pleased about her applying for promotion at work. However, after a short remission she remains plagued and seriously inhibited in her life by a nightmarishly caricatured inner maternal figure who is weak, ill and reproachful if her daughter leaves her own depression and self-doubt behind—it feels at a deep level as if she is 'abandoning' the mother. Another patient Mr C, who fears (he knows irrationally) that sexual intercourse will somehow damage either himself or the woman, may be able to reality-test his fears behaviourally only to a very limited extent. Unconsciously his childhood fury about being left out of his parents' bedroom and their smugly exclusive relationship, leading to a phantasy of violent intrusion into his mother's body, means that he superstitiously fears he will damage the woman, and/or provoke attack from an internal nightmarishly vengeful phantasy couple.

Having said this, cognitive therapists argue cogently for the efficacy of CBT in combating vicious cycles of symptom generation. Thus someone who suffers from panic attacks which are ultimately generated, say, by fearful unconscious phantasies is often then subject to further spiralling hypochondriacal fear at the feelings of breathlessness and palpitations generated. CBT can be very helpful in modifying such positive feedback loops in symptom generation. However, one would predict a less radical and enduring effect from CBT than from psychoanalytic work which would aim in such a situation to address structures earlier in the causal chain.

Psychoanalysis has shed light on some barriers we have to learning. Learning certain fundamental truths about self and others is a complex process—both sought after but also desperately hated and resisted (Money-Kyrle, 1968). It is hard to give up feeling omnipotent, the centre of the universe, rather than dependent on others, and fully to know we are the product of a couple who came together outside our control, and have minds that are separate and different from ours. This involves the triangularity I have referred to. Psychoanalytic research shows how very active a part we play in what we learn or mis-learn all our lives, and that this is the product of both environment and constitution. An implicit message in much CBT (but mostly not in psychoanalytic) writing is that somehow the therapist should be able simply to transcend and transform the patient's maladaptive internal schemas by being a good, reasonable person. This view of human nature sees the application of reason and the right external conditions as sufficient for healing. The assumption is that the patient is simply a good and reasonable victim of mis-

understanding and neglect. Most psychoanalysts, in contrast, see man as subject to complex internal conflicts and strong tendencies towards unreasonableness—all needing to be understood and addressed in detail. This difference in philosophy, often unstated, has important clinical implications.

The factors that psychoanalysts suggest make learning so difficult may mean that certain patients will simply not be able to tolerate the sort of knowing and understanding that psychoanalysis offers. They will neither want it nor be accessible to it. In such cases it would be arrogant (as well as pointless) for a psychoanalytic therapist to attempt to impose such treatment. A patient must be free to choose a collaborative, less ambitious and more directly educational approach that will not threaten needed defences. In a good assessment, one will hopefully be able to gauge how much intrusion a patient welcomes or is prepared to tolerate. This will mean for example that psychoanalytic psychotherapists in the public sector, funded to work only once a week with very disturbed patients, may find themselves introducing more cognitive parameters, and in effect collapsing the analytic stance. This collapse at least partially deprives the patient of a full opportunity to work in the negative transference—to project the very worst things in his or her internal world into the therapeutic relationship. Thus one does limit the scope of the work that can be done. A therapist might judge with a particular patient that this is wise, as these terrible things might simply not be able to be contained within the limited setting available. However, I think it is always worth questioning this, and for the therapist to ask him or herself whether it is really the patient being spared or the therapist—is one underestimating the patient's capacity to bear things, and avoiding an attack the patient really needs an opportunity to make?

There may be clinical reasons for knowingly collapsing the tension of the analytic stance in this way with particular patients, but collapse may also be part of ongoing debates and dialectics within the profession of psychoanalysis at different times and places. Abstinence and neutrality that harden into rigidity and arrogance may prompt some analysts to espouse 'human warmth' and experiment anew with gratification of the patient's infantile wishes. The pitfalls opened up by such an approach carried to extremes may then in turn provoke a countermovement. Partial collapses of analytic tension in one direction or another may become institutionalised in particular approaches. One analyst's collapse may be another's flexible and innovative experiment, and the debate thus launched may be creative within psychoanalysis, providing necessary challenges to stagnation. Moves towards more 'reasonable' and socially acceptable approaches may also be less creative, and related to analysts' own inevitable ambivalence about analysis and impatience with its slowness; its failure to live up to earlier, idealistic expectations.

'INTEGRATION' OF PSYCHOANALYTIC AND COGNITIVE THERAPIES

A number of psychotherapists believe you can combine all the advantages of the different techniques without losing power. Thus for example 'cognitive-analytic therapy' (CAT) (Ryle, 1990) is a brief, flexible approach where the patient is encouraged to think about themselves and their relationships and to formulate and monitor, with the therapist, what is habitually going wrong. The therapist may use classical CBT approaches such as encouraging the patient to keep a symptom diary and make homework experiments, while at the same time interpreting transference phenomena as they arise. The patient's resistances to diary keeping and other tasks often (for example) quickly provide material for work in the transference.

CAT sessions are less structured than classical CBT sessions, and unconscious as well as conscious meanings are certainly sought, but CAT has certain hallmark structural features. There is, as in CBT, reading matter for the patient, and stress on early collaborative written formulation of the problems. The formula-

tions can be referred back to when problems arise in the transference relationship or when difficulties outside are discussed. Another writing task is that both patient and therapist are supposed to write each other 'goodbye letters' expressing their views about the therapy as it comes to an end. Ryle (1995) describes CAT as a very useful and safe first intervention for patients referred for outpatient psychotherapy (in the UK health service).

Ryle (1995) regards the transference as a 'hardy plant' arising whatever one does, and certainly not requiring the therapist to be inactive. He regards the collaborative stance of CAT as less potentially dangerous than psychoanalysis, which he sees as placing the patient in quite a powerless position (Ryle, 1994). I agree with Ryle that bad psychoanalysis has more potential for harm than bad CAT. This is because conditions are created such that the 'hardy plant' of transference can flourish in a much fuller, often more disturbing way, much as the pot plants of colder climes become the bushes and trees of the tropics. In addition, many plants will not even germinate outside the tropics, and there will be important aspects of the transference and countertransference which will not come to light at all in the setting of CBT or CAT, which, in spite of superficial appearances to the contrary, I think have a fundamental similarity to each other and difference from a psychoanalytic approach. The therapist's active assertion of the benign colleague/teacher stance in CAT, as in CBT, and the structured nature of the work, help to limit the patient's regression, and the nature and intensity of the transference. This makes them on the whole safer therapies for relatively unskilled therapists to perform.

However, I think the same factors which limit the potential for harm and abuse to the patient in CAT and CBT also limit the potential power for good of the treatments, precisely because they restrict the nature and depth of the transference and countertransference. In both, a limit is put on the power and stature, both positive and negative, which the therapist can potentially have in the transference. The oedipal exclusion dynamic can be avoided or swiftly collapsed by the ready availability of cognitive escape routes—again, triangularity is bypassed. However CAT, like CBT, will for these reasons be more accessible and user-friendly on initial contact, and will engage a greater variety of patients.

I think another linked and important limitation of both CAT and CBT, as compared with the analytic approach, is the therapist's non-neutral alignment in CAT and CBT with the ideal of 'progress'. Through the introduction of explicit tasks, pressure and expectation on the patient is implicit from the outset, in however gentle and understanding a form it might be couched, to conform and to improve. I think this makes good CBT and CAT both more paternalistic than good analysis, and introduces a subtle moral restrictiveness through its very reasonableness and friendliness.

Questions have also been raised (e.g. Scott, 1993) about the rather functionalist and benign model of the mind and of internal relationships which underpins CAT (and indeed to my mind CBT). The possibility of truly establishing and maintaining a task-orientated therapeutic alliance in deeply troubled and self-defeating patients seems too easily assumed. I think it is important for the therapist to be aware of the limitations of an approach such as CAT, and to be sensitive to some patients' longing and need for something more and different. As indeed with psychoanalysis, there is a danger of partisan idealisation of one's own approach, without appreciation of both its advantages and its limitations.

THE REDISCOVERY OF TRANSFERENCE AND RESISTANCE IN CBT

I have argued that CAT (and other similar 'integrated' approaches) may be much nearer in their conceptualisation to modern CBT than to psychoanalysis, in spite of their attention to the unconscious and use of the transference. I think this is becoming more obvious as CBT moves into the treatment of personality disor-

der, and becomes itself more experiential and emotive and concentrates more on the therapeutic relationship. Beck himself has recently stated that CBT is an 'integrative therapy' *par excellence* (Beck, 1991).

Cognitive theory is evolving into something less mechanistic and more 'constructivist'—concerned with how the patient constructs reality. This moves from an idea of the therapist imposing their own 'rationality' on the patient. A number of authors (e.g. Power, 1991) have noted a 'psychoanalytic drift' in the practice of cognitive therapy, just as there was a 'cognitive drift' in the practice of behaviour therapy. Something a bit more object-related is seeping into schema theory also, via a flourishing of interest in Bowlby's ideas about attachment amongst cognitive theorists (e.g. Liotti, 1991). According to Weishaar (1993), there is active debate amongst cognitive theorists at the moment as to 'whether clinical deficits are cognitive or interpersonal in nature' (p. 125). However, in spite of this apparent 'analytic drift', I differ from Bateman (2000) in believing that the cognitive clinical paradigm remains fundamentally different from the psychoanalytic one, and that true rapprochement is more apparent than real. An examination of the way modern CBT therapists modify their technique will, I hope illustrate, this.

Alongside evolution in theory, therapists (e.g. Beck et al., 1990) now suggest modifications to standard CBT technique when working with personality-disordered patients. They include careful attention to the relationship between patient and therapist, which, if it is not addressed, can lead to losing the patient prematurely, or the therapy getting stuck. The patient (we are told for example) will not want to mention his or her troubling negative thoughts about the therapist, and instead will go silent, or show in other ways that something is being resisted, like pausing, clenching fists, stammering, changing the subject. To quote Beck: 'When questioned the patient may say, "It's not important, it's nothing". The therapist should press the patient nonetheless' (Beck et al., 1990, p. 65). This is reminiscent of Freud's early 'pressure technique', when he would insist that the patient tell him what was in their mind, however much they would prefer not to. Freud describes (Breuer & Freud, 1895) how it is often the most significant things that are withheld from the physician, though the patient insists that they are insignificant. In other ways, too, I think CBT can be seen as recreating earlier forms in the history of psychoanalysis. After all, at first Freud tried to cure patients using a simple cathartic method, and his initial attempts at dealing with transference were by explaining it to the patient as an archaic residue.

Giving a wealth of case examples, Beck describes how treatments have to be longer, and sometimes more than once a week. His therapeutic optimism is more guarded than before, and he talks of the difficulty of researching these longer-term more complex treatments using the controlled trial format, suggesting that one should value single case studies and clinical experience much more. (This might strike psychoanalysts, who are often criticised for doing just this, as a bit ironic.) He talks about the importance of getting to know about the patient's total life, and exploring their childhood, and not just focusing down too much, or too prematurely, on cognitions and tasks. He stresses the importance of here-and-now affective experience, and the use of experiential techniques.

Beck points out that for the patient to re-experience relationship difficulties in relation to the therapist may be useful and 'grist to the mill'. However, in contrast to the analytic approach, the therapist is supposed swiftly to challenge these negative transference phenomena, in order to re-establish a benign working relationship. Beck says one should: 'be in the role of friend and advisor', 'draw on one's own life experience and wisdom' in order to 'propose solutions' and 'educate the patient regarding the nature of intimate relationships', and become a 'role model' for the patient (p. 66). From the psychoanalytic angle, although the psychoanalyst may indeed at times be seen as a role model by the patient in the transference,

one tries as an analyst to analyse rather than accept this sacrifice of the patient's autonomy. Analysts might see Beck's statement as claiming some unwarranted superiority over patients in knowing how a life should be lived. The following quotation from Beck perhaps illuminates this assumption, by illustrating the simple 'deficit' model assumed in CBT, which requires the therapist to be a sort of teacher of life-skills: 'This process of re-education is particularly important in treating patients with borderline personality disorder, whose own personality deficits may have prevented them from acquiring and consolidating many of the basic skills of self-control and stable relations with others' (p. 66).

Beck, in this recent work, refers frequently to disappointment, frustration and other negative feelings that will be induced in the therapist by these difficult patients. He stresses the importance of supervision in such cases, and also refers now and again in the book to the idea of the therapist dealing with his negative feelings and impulses towards the patient by keeping a 'dysfunctional thought record' of his own. Although Beck makes no mention of it, there is some indication nowadays that trainee CBT therapists are entering personal psychotherapy more often, albeit on a non-intensive basis, as an aid to their work. It seems to me that this has to be a logical progression of these new (re)discoveries in CBT. Without personal analysis, for example, most people are ill-equipped to make sustained clinical use of their countertransference rather than enacting it.

Empirical research comparing psychoanalytic and cognitive therapies

Unfortunately, both professional rivalries and political pressures mean that something of a 'horse race' mentality can enter into the empirical comparison of outcome in cognitive and psychoanalytic treatments. Competition for scarce resources, for example in the UK public sector, can mean that clinicians using the different methodologies are eager to prove that their brand of treatment is more efficacious than the other. There are indications that clinicians of different temperament tend to be drawn towards the different modalities (Arthur, 2000), making it hard for each to appreciate both the value of the other's way of working and the limitations of their own.

One oft-quoted argument for offering CBT rather than psychoanalytic treatments to patients in the public sector is that there is so much more empirical research evidence for its efficacy. It is also asserted as being cheaper, as it is brief and needs far less training to apply. CBT, as a brief, focused therapy, lends itself well to the popular randomised controlled trial (RCT) format, which has been repeatedly and enthusiastically undertaken, albeit often not with typical outpatient populations (Enright, 1999). Outcome measures are usually in the form of simple symptom scores, and follow-up periods short.

Psychoanalysis itself, of course, requires four- or five-times-weekly sessions over some years; one often sees radical changes in the patient's relationships, work capacity and creative fulfilment, over and above 'symptom relief'. Such outcome criteria are difficult and complex to measure, though progress is being made in this area of 'objective measurement of the subjective' (Luborsky et al., 1986; Barber & Crits-Cristoph, 1993; Hobson & Patrick, 1998). Psychoanalytic psychotherapy as it is typically constrained within the public sector uses the same methodology, usually on a once-weekly basis over one or several years, and expects to foster the same sorts of changes to a lesser degree. My view is that what I was describing earlier—the striving towards the tension of the analytic stance—characterises the psychoanalytic approach, whether it is carried out once or five times a week, and whether it is brief or long term. The vital factor to my mind is that for a therapist to be able to establish and maintain an analytic stance requires training on a very intensive, experiential and long-term basis.

When attempts are made to fit psychoanalytic work into the extremely atypical sixteen-

session format suited to CBT, most psychoanalysts would not predict more than symptomatic change, or a temporary alteration in surface cognitions, as there is no opportunity for vital working through. Thus one might expect the efficacy of very brief psychoanalytic psychotherapy to resemble that of CBT. This is borne out in the relatively few circumstances where good quality comparative trials of CBT and brief psychoanalytic psychotherapy have been carried out—there is found to be essentially no difference in outcome (Crits-Cristoph, 1992; Luborsky et al., 1999).

One study attempting to link process and outcome in brief cognitive and dynamic therapies has suggested, interestingly, that it is the more typically 'dynamic' elements of therapy that are important (Jones & Pulos, 1993). These authors expected to find that cognitive therapy worked via cognitive procedures and dynamic therapy through dynamic ones. Instead they observed that 'evocation of affect', 'bringing troublesome feelings into awareness', and 'integrating current difficulties with previous life experience, using the therapist–patient relationship as a change agent' (p. 315) all predicted improvement in both therapies. This was in contrast to the more typically 'cognitive' procedures of 'control of negative affect through the use of intellect and rationality' and 'encouragement, support and reassurance from therapists', (p. 315) which were not predictive of positive outcome.

Jones & Pulos suggest that all such treatments work via the provision of a unique, safe context within which relationships with the self and the world can be explored. They are aided by privileging emotional experience over rationality, and by emphasis on developmental history. According to this study at least, in so far as cognitive therapists take a 'rationalist' approach, in which affect is conceptualised and treated as the expression of irrational and unrealistic beliefs, and in so far as they view their role as one of imparting technical instruction and guidance, the therapy appears to be less successful. Another study comparing process in 'dynamic-interpersonal' and cognitive–behavioural therapies (Wiser & Goldfried, 1996) looked specifically at the types of interventions made in sections of sessions the experienced therapists themselves deemed change-promoting for their patients. Again, these researchers noted an unexpected tendency in the cognitive therapists towards both using and valuing more 'dynamic' techniques, and suggest that this is part of the recent shift in CBT towards a more interpersonal focus.

When we research outcome in more typical length psychoanalytic treatments, the 'gold standard' RCT format, which works reasonably well for brief therapy, poses huge logistical problems and may be quite inappropriate (Galatzer-Levy, 1995; Gunderson & Gabbard, 1999). We are dealing with a complex interpersonal process involving multiple variables. Controls may become impossible to achieve and randomisation is a questionable activity in comparative trials where patients show marked preferences or aptitudes for different ways of working. The relative dearth of RCT evidence for the efficacy of psychoanalytic work is a function of the huge difficulties involved in researching typical psychoanalytic treatments in this way, and is often falsely equated with 'evidence against' (Parry & Richardson, 1996).

Having said this, there is a growing body of empirical research concerning more typical length public sector psychoanalytic psychotherapy in adults and children (e.g. Moran et al., 1991; Sandahl et al., 1998; Bateman & Fonagy, 1999; Guthrie et al., 1999). Taken together with studies of psychoanalysis itself, the hardest of all to research, evidence begins to emerge that these lengthy, more ambitious treatments may indeed offer important additional benefit. Fonagy et al., (1999) have collected and critically reviewed fifty-five studies of psychoanalytic outcome. These authors, although they expose many methodological limitations in the data, adopt overall what they term a 'cautiously optimistic' attitude to psychoanalytic outcome given the evidence available. Key provisional findings (which are fully referenced in the work itself) include the following: (1) intensive psychoanalytic treatment is generally more

effective than psychoanalytic psychotherapy, the difference sometimes only becoming evident years after treatment has ended, this applying particularly to the more severe disorders. (2) Longer-term treatment has a better outcome, as does completed analysis. (3) There are findings that suggest psychoanalysis and psychoanalytic psychotherapy are cost-beneficial and perhaps even cost-effective, and that psychoanalysis can lead to a reduction in other health-care use and expenditure, although one study suggests an increase. (4) Psychoanalytic treatment appears to improve capacity to work, to reduce borderline personality disorder symptomatology, and may be an effective treatment for severe psychosomatic disorder.

SUMMARY AND CONCLUSIONS

I have tried to show how I see the CBT paradigm as a useful but less complex paradigm than the psychoanalytic one, limited in its explanatory power and in terms of the change its therapeutic application can be expected to achieve. Its far less intrusive and threatening nature will, however, make it more acceptable for a number of patients. I have also tried to show how there is a strong attraction towards working in a 'cognitive' way, for both psychoanalyst and patient, and that the inherent tension and complexity of the analytic stance is constantly on the brink of decomposing, or collapsing, sometimes resulting in a weak version of cognitive therapy taking place. However, if the tension of psychoanalytic work can be borne by both patient and analyst, the reward can be experiential, emotional learning by the patient, which is likely to be deeper and more enduring than purely cognitive learning.

I have also suggested that, because psychoanalysts and cognitive-behavioural therapists share the same field of study, they are increasingly going to discover the same clinical phenomena, and indeed are now doing so, although they may then approach these phenomena in fundamentally different ways. It is important, I think, both that the shared endeavour is recognised, to relieve the misery of psychic suffering, and also the differences, which will have important implications for which patients are treated, in what way, and with what aims. It is unfortunate that clinicians from the two groups are currently often pushed by external economic pressures to compete with one another in the public sector, which exacerbates the innate rivalries that are bound to exist between practitioners of two such very different sorts of treatment.

The selected empirical evidence I have quoted gives some interesting indications as to shared therapeutic factors in brief psychodynamic and cognitive therapies. In the relatively few instances in which comparative studies of CBT and very brief psychodynamic therapy have been carried out, there is found to be essentially no difference in outcome. This should be no surprise to a psychoanalyst, as we would not predict deep and lasting change in inner world structures without considerable opportunity for working through. We might, in fact, be rather surprised and impressed that psychodynamic therapy does as well as CBT under such circumstances. The claims I made earlier in the paper about psychoanalysis as a method facilitating deep and lasting change certainly need substantiating empirically rather than simply asserting, and I think we are not yet able to do this with confidence and in detail. However, research evidence of the last couple of decades is beginning to confirm analysts' expectations that intensive and long-term psychoanalytic treatments have something substantial to offer over and above what brief treatments, whichever the modality used, can provide.

TRANSLATIONS OF SUMMARY

L'auteur suggère que l'enthousiasme contemporain apporté à la thérapie cognitive-comportementale reflète notre désir de soulager rapidement et rationnellement la souffrance psychologique. La compétition présente dans le monnaiement menace la présence de la psychanalyse dans le secteur publique. L'auteur comparent les modèles psychanalytiques et cognitifs-

comportementaux et souligne la richesse relative du paradigme psychanalytique. Elle montre que le modèle cognitif est sens commun, mais moins complexe et possède moins de potentiel explicatif et a moins de pouvoir thérapeutique. Elle montre la façon dont la sphère analytique subit toujours la pression de 's'effondre' en des modes plus simples, dont l'un ressemble au mode cognitif. Ceci apparaît aussi inévitablement dés lors que l'on s'efforce d' 'intégrer' les deux modèles. Les traitements cognitifs et 'intégrés ont néanmoins l'avantage d'être moins envahissants et donc plus acceptables pour certains patients. L'auteur traite du processus empirique et du résultat de la recherche cognitive et des thérapies psychanalytiques. Des thérapies brèves de l'un ou l'autre des modèles ont des résultats proches et modestement bons, et il semble que cela soit du plus à des éléments dynamiques du traitement que du à des éléments cognitifs de ce dernier. Des études formelles sur le résultat des psychothérapies psychanalytiques typiques et sur la psychanalyse elle même commencent à montrer que ces traitements longs et complexes sont efficaces dans la manière plus compréhensive prédite par le modèle.

Nach Meinung der Autorin reflektiert der heutige Enthusiasmus für kognitive Verhaltenstherapie unsere Sehnsucht nach schneller, rationaler Hilfe für seelisches Leiden. Der Wettstreit um finanzielle Mittel bedroht die psychoanalytische Präsenz im öffentlichen Sektor. Das psychoanalytische Modell und das Modell der kognitiven Verhaltenstherapie werden einander gegenübergestellt, und der relative Reichtum des psychoanalytischen Paradigmas wird dargelegt. Nach Meinung der Autorin entspricht das kognitive Modell dem allgemeinen Menschenverstand, ist aber weniger komplex und seine potentielle erklärende und therapeutische Kraft ist geringer. Sie diskutiert, wie die analytische Haltung immer unter Druck ist, zu einfacheren Modalitäten „zusammenzufallen", von denen eine der kognitiven ähnelt. Dies geschieht nach ihrer Meinung unvermeidlicherweise auch, wenn man versucht, die zwei Modelle zu „integrieren". Kognitive und „integrierte" Behandlungen haben andererseits den Vorteil, dass sie weniger tief eindringen und dadurch für manche Patienten akzeptabler sind. Ausgewählte empirische Prozess- und Outcome- Forschung von kognitiven und psychoanalytischen Behandlungen wird diskutiert. Kurztherapien haben ähnliche, mässig gute Ergebnisse in beiden Richtungen, wobei es einige Evidenz gibt, dass dies mehr auf „dynamischen" als auf „kognitiven" Behandlungselementen beruht. Formale Outcome-Studien von typischerer psychoanalytischer Psychotherapie und Psychoanalyse weisen dahin, dass diese langen und komplexen Behandlungen in der umfassenderen Weise effektiv sind, wie sie das Modell voraussagt.

La autora sostiene que el entusiasmo actual por la terapia cognitivo—conductual refleja nuestros intensos deseos de lograr que el alivio del sufrimiento psíquico sea rápido y basado en la lógica. Las rivalidades económicas ponen en peligro la presencia del psicoanálisis en el sector público. Se contrasta el modelo psicoanalítico con el cognitivo—conductual, subrayándose la mayor riqueza del primero. La autora opina que el modelo cognitivo, aunque tiene su lógica, es menos complejo, tiene menos posibilidades explicativas y menores posibilidades terapéuticas. Estudia cómo la postura psicoanalítica está siempre bajo presión y a punto de resquebrajarse, para acercarse a modelos más sencillos, uno de los cuales suele ser el cognitivo. Según la autora, esto ocurre, inevitablemente, cuando se hace un intento por 'integrar' ambos modelos. Los tratamientos cognitivos e 'integrados' tienen la ventaja de que son menos intrusivos y, por lo tanto, mejor aceptados por algunos pacientes. Se analizan los métodos empíricos y los resultados de algunas investigaciones. Las psicoterapias breves de cualquier tipo pueden tener un resultado parecido y relativamente bueno. Y es evidente que, en tales casos, se basan más en elementos dinámicos que en elementos cognitivos. Estudios más profundos sobre los resultados de las psicoterapias psicoanalíticas más típicas y del mismo psicoanálisis empiezan a indicarnos que esos tratamientos, largos y complejos, son eficaces en un sentido más completo, ya pronosticado por el modelo.

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