

DBT vs CBT vs Psychoanalytic Therapy

Aspect	DBT	CBT	Psychoanalysis
<i>Origin</i>	Developed by Marsha Linehan in the 1980s, drawing on CBT + mindfulness + dialectics	Developed by Aaron Beck in the 1960s, evolving from behavioural therapy	Originates with Freud (early 1900s), expanded by ego psychology, object relations, Bion, Lacan, etc.
<i>Main Theoretical Framework</i>	Biosocial model: emotional dysregulation arises from biological vulnerability + invalidating environments	Cognitive model: distorted thinking leads to emotional/behavioural problems	Unconscious processes, internal conflicts, transference, early relationships shape current difficulties
<i>Primary Goals</i>	Emotional regulation, distress tolerance, behavioural stability, improved relationships	Identify and change distorted thoughts and beliefs to reduce symptoms	Increase insight into unconscious dynamics, transform internal object relations, resolve deep-rooted conflicts
<i>Core Techniques</i>	Skills training, behavioural analysis, mindfulness, validation, dialectical strategies	Thought records, behavioural experiments, Socratic questioning, skills development	Free association, dream analysis, interpretation, transference work, working through
<i>View of Symptoms</i>	Symptoms are maladaptive coping with emotional pain—changeable through skills and validation	Symptoms are caused by distorted thinking and can be changed directly	Symptoms are expressions of unconscious conflict—not directly removed but transformed via insight
<i>Therapist Stance</i>	Active, validating, directive but collaborative; balances acceptance and change	Directive, structured, collaborative problem-solver	Neutral, non-directive (though varies); interprets rather than advises; therapeutic relationship is central

<i>Structure of Therapy</i>	Manualised, time-limited or long-term; includes group + individual; structured sessions	Manualised, typically 8–20 sessions (can be longer); goal- and symptom-focused	Typically long-term, open-ended; may be high-frequency (3–5x/week in classical analysis)
<i>Role of the Past</i>	Past is relevant only if it helps understand current behaviour patterns	Focuses mainly on here-and-now issues, some attention to developmental origins	Deep focus on early childhood, developmental history, object relations, transference
<i>Role of Emotions</i>	Central – clients learn to identify, tolerate, and regulate intense emotions	Emotions are influenced by cognitions; regulating thoughts helps regulate feelings	Emotions are clues to unconscious processes; felt in transference/ countertransference
<i>Use of Relationship</i>	Therapeutic relationship is a collaborative base for teaching and validating skills	Collaborative but more task-focused; therapeutic alliance supports change	Central mechanism of change; transference is interpreted and worked through
<i>Patient Suitability</i>	Chronic emotion dysregulation, self-harm, BPD, PTSD, eating disorders	Depression, anxiety, OCD, phobias, anger, insomnia, etc.	Complex personality structures, developmental trauma, identity disturbance, chronic relational issues
<i>Evidence Base</i>	Strong evidence, esp. for BPD and suicidality; also for PTSD, substance misuse	Extensive RCTs support effectiveness across many common disorders	Evidence base growing; strongest for long-term, complex cases; naturalistic and process studies used

In Summary

DBT = Acceptance + Change CBT = Challenge + Change Psychoanalytic Therapy = Insight + Transformation

DBT offers a structured behavioural framework with mindfulness and validation, especially effective for patients with intense emotions and chronic crises.

CBT is a shorter-term, structured therapy that focuses on identifying and correcting cognitive distortions.

Psychoanalytic therapy explores unconscious material, transference, and the internal world, aiming for deep structural change over time.