The dynamic unconscious versus the cognitive thought: 
*An Evaluation of the Psychodynamic and Cognitive Models illustrated through the Dissociative Identity Disorder*

A psychological model, “spells out the scientist’s basic assumptions, gives order to the field under study and sets guidelines for its investigation. It influences what the investigators observe as well as the questions they ask, the information they seek, and how they interpret this information” (Sharf, 2000). These models provide the frameworks to understand and treat mental disorders, and it is important to understand their functions in order to comprehend the disorders themselves. This paper will explore the similarities and differences between the psychodynamic model and the cognitive model, investigating them through a case study of dissociative identity disorder, also known as multiple personality disorder. Dissociative identity disorder provides a particularly useful medium to examine these particular models because of the extreme, little known nature of the disorder, and the fact that its’ methods of treatments have evolved and are used in a parallel way to the evolution of the theoretical models. The basic beliefs and contributions of the respective models will be explored, followed by a look at their methods of treatment, their apparent flaws and the future implications for treating mental illness.

Dissociative identity disorder is characterized by a person being controlled by one of two or more distinct personalities, or sub personalities, each with its own memories, behaviors and emotions. The existence of these alter personalities raises many questions about the current assumptions of the way our consciousness is structured, how our personality comes together and how we can fail to integrate associated experiences (Comer, 2004; Putnam, 1989). This question about consciousness brings us to the underpinnings of the psychodynamic model, which is the most prevalent model both in the importance of theoretical development and in the study of dissociative identity disorder.

The psychodynamic model was pioneered by Sigmund Freud, who initiated the first systematic approach to show how psychological processes can result in mental abnormalities and disorders. This model is based on the role of unconscious processes determining all kinds of behavior, normal and abnormal (Butcher et al., 2004). Freud’s psychoanalytical model looks at human beings as being driven by powerful instinctual forces, the id, ego and superego, which strive for pleasure to satisfy instincts, the reason and judgment to align these instincts with social reality and the moral, judicial authority that is often assimilated from the parents (Cockerham, 2000). Freud has received
numerous critiques about his theories and their scientific validity, but they provide the basis for current viewpoints on psychodynamic theory and human nature and behavior.

Current theories such as the object-relations theory, the interpersonal perspective and the attachment theory have improved scientific efforts to measure conflicting relationships, but the idea of the unconscious is very hard to measure scientifically. This is also a problem with the identification and treatment of much more illusive disorders such as dissociative identity. The theories mentioned above are all based upon relationships, either with people’s own external and internal objects or with other people and their attachments formed with them (Henry et al., 1994). These bases are what make the psychodynamic theory so effective in being the primary or secondary perspective to use in treating many mental health issues from depression to personality disorders. It is one of the main theories utilized in exploring and treating patients diagnosed with dissociative identity disorder because it is thought that one of the causes may be the repeated pretending or repression that the painful experiences are not occurring and having more than one self or consciousness emerge to help to deal with it. Even Freud, who rejected hypnosis, a common technique used to treat dissociative identity, started off by looking into ideas of double unconsciousness (Putnam, 1989), but all theories that attempt to explain human consciousness and behavior contribute in some way to the symptoms seen in dissociative identity disorder.

The cognitive model, often combined with the behavioral model to form the cognitive-behavioral model, was developed by Albert Ellis and Aaron Beck and promotes the idea that our cognitive processes dictate behavior and thought and that problems are experienced when are cognitions are inaccurate or harmful (Comer, 2004). This model shares certain similarities with the psychodynamic model relating to the idea, but not the process, of avoidance of unpleasant thoughts or experiences. The psychodynamic model advocates the idea that hurtful memories or desires are repressed and pushed out of the conscious to the unconscious. This repressed material tries to push through and until a person succeeds to reintegrate it to the conscious mind, abnormal behavior can ensue.

The Cognitive model’s idea of the cause of abnormal behavior goes through very similar steps, although it has a different basis. Cognitive theorists maintain that we view the world and set up certain schemas, or structures of beliefs, that we measure events against. How these events compare to the schemas determines our emotional and behavioral responses (Blackburn and Twaddle, 1999; Butchner et al., 2004). If these schemas produce a particularly undesirable affect, schema-avoidance, like repression, occurs, and the individual will make strenuous conscious and unconscious efforts to avoid the affect; this process goes on unconsciously and can inhibit information processing (Kennedy et al., 2004). The problem with these propositions of avoidance and the subsequent difficulties caused is that they do not explain why only certain people who experience horrible events or have negative schemas end up with dissociation identity or other disorders.

Other similarities and differences between the psychodynamic and the cognitive model can be explored by looking at the methods of treatment each subscribes to help people
deal with mental illness. The cognitive model of therapy was largely influenced by the work of Aaron Beck who put the focus on the underlying cognition schemas and maintained that in order to treat problems, these schemas needed to be re-altered. The most common cognitive techniques include the therapist pointing out and monitoring automatic thoughts, attempting to change flawed logic and giving different tasks to change these irrational perspectives. (Beck et al., 2001; Comer, 2004). The problem with these general cognitive techniques towards therapy is that they depend upon the individual being willing to really work at changing these thought structures. It is as much up to them as it is the therapist, so if a person does not have a desire to change, the techniques have very little chance of being successful.

The psychodynamic approach uses many techniques to help the patient uncover and resolve any conflicts that are inhibiting their unconscious (Butcher, at al. 2004). It is like the cognitive approach in goals to be obtained from techniques like free association because both approaches try to make the individual themselves uncover and be aware of negative underlying dynamics. The therapies differ in the part of the self that the therapists are trying to work with. The cognitive approach has the individual talk about schemas that they know exist; they only have flaws or unreasonable interpretations of them. The psychodynamic approach, on the other hand, deals with a part of the person that they don’t know exists and can’t readily access, and it needs a two-step process. The many therapies included under the psychodynamic approach are usually very long and involved, and there is no guarantee that the right aspect is being explored.

The treatments for dissociative identity disorder often go through a step process in which many psychological models’ therapies and techniques are involved. The ultimate goal is to reintegrate the personalities into one complete personality. The patient first needs to be aware that a problem exists and that other personalities are present with in their psyche. This is done through taping episodes of hypnosis to show to the patient, a psychodynamic approach, or group therapy, leaning more towards a cognitive approach. The memories then need to be recovered using hypnosis, psychodynamic therapy or medicine, and then the integration of the personalities is attempted using a range of approaches from cognitive to drug therapy (Burton and Lane, 2001; Butcher et at., 2004; Comer, 2004; Dorahy, 2001).

Both the psychodynamic model and dissociative identity disorder fall into the same categories of unreliability shortcomings. As the fundamental thinking behind the two is the same, both are seen to be hard to define since there is no way of knowing what processes are actually taking place since the individual is unaware of most of the conflicts. The treatments are known to be very long and involved, requiring a consistent relationship with the therapist, and there is not a substantial guarantee that they will be affective. All of the known information about the two can be seen as unreliable at best, as most of the research done has been based on individual or small collections of case studies. There have been recent findings that give a little bit more validity to dissociative identity disorder. The use of a Positronic Electron Scan (PET) has enabled many researchers to do scientifically viable research in order to prove that one brain can generate more than one state of self-awareness in different states of consciousness.
(Reinders et al., 2003). This indicates that the illness is real and there might be a possibility to develop a medication or other medical techniques to facilitate the treatment of the disorder. On the other hand, the cognitive model is one that is very researchable and can be viewed scientifically in some instances, but the precise role of cognitive functions has yet to be determined. Also, the cognitive model may not necessarily provide enough support for the other dimensions of the individual that can come into play throughout the course of life (Blackburn and Twaddle, 1999).

Through the evaluation of the psychodynamic model and the cognitive model in the context of dissociative identity disorder, certain conclusions can be drawn. Both models have contributed a great deal to modern psychological theories and practices and will continue to provide a medium for further education and debate. Each model is better suited than other to deal with the explanation and treatment of mental illnesses in different areas. One model can not be viewed to be better than the other, and often, as with dissociative identity disorder, both, or many models need to be used to achieve adequate treatment results. The most important reasoning to be learned from comparing and contrasting such models is to keep an open mind and to not be hesitant to use and combine the practices of each to achieve the best results; one should never stop questioning and exploring.
References


