IDEALIZATION AND DEVALUATION AS BARRIERS TO PSYCHOTHERAPY LEARNING

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Summary

In the following review the author describes, from his experience, how behaviors including idealization, devaluation and splitting may obstruct the learning of specific psychotherapy methods such as Intensive Short-Term Dynamic Psychotherapy (ISTDP). A working definition of idealization/devaluation and the problems that occur when it becomes entrenched in trainees or in training programs is described. It is hoped that this paper will stimulate reflection and discussion among psychotherapy students and teachers.

Introduction

This paper came about from the observed pattern, over 14 years of teaching and learning Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP), of some trainees experiencing extreme fluctuations in self-esteem and perspective on the treatment model. Some trainees have appeared so enthralled with the therapy method that it had adverse effects on the trainee, patients and the training program as a whole. At other times, trainees became self-deprecating or even devaluing of themselves and/or the methods, and this also had adverse effects on the therapist, patient and program. The objective of this paper is to raise the issue of idealization and devaluation as barriers to psychotherapy learning and professional growth.

Although the author will refer here to ISTDP, this should not be misunderstood as a problem confined to training in this therapy method. Rather, it can become a problem with any school of psychotherapy, school of thought or format of treatment, including biological and social interventions. For reasons described herein, this problem may be more problematic in emotionally intense psychotherapy methods like ISTDP.

This paper is impressionistic and experience-based. It lacks specific or numerical measures of the phenonema described and terminology used. It should not be taken as "the answer" or "ideal" in any sense, but as a stimulus for discussion and reflection amongst teachers and students of psychotherapy.

Supervision and training of ISTDP : some observations and thoughts

What is ISTDP?

The ISTDP understanding of the majority of resistant patients seen for psychotherapy is that unconscious emotions, and unconscious anxiety about these emotions are primary determinants of disordered behaviors (defenses). Interrupted attachments lead to blocked complex feelings. These feelings lead to the craving of attachments and simultaneously the thwarting of these efforts to attach through symptom formation and defensive behavior. Thus, the patient is burdened by defenses which interrupt relationships, enjoyment, insight and productivity. (Davanloo, 1990)

ISTDP therapy requires the therapist to be able to tolerate his or her own complex feelings and any anxiety that these feelings mobilize. These complex feelings are inevitable when dealing with

a patient who is at odds with himself, behaving in ways that are self-harming, or at least not self-caring. The position the therapist takes in this approach has been clearly and repeatedly described by Davanloo: namely that the therapist must have the utmost respect for the patient and, because of this, a conveyed lack of respect for the defenses that have paralyzed his or her functioning. (Davanloo, 1999) To do this requires the ability to feel positive feelings for the patient, and, at the same time, to actively dislike his or her defenses. Thus, the therapist must have capacity to not idealize or devalue the patient: he or she must be able to tolerate these complex feelings and any subsequent anxiety.

These capacities to integrate mixed emotions and tolerate anxiety are common factors across most psychotherapy schools. For example, the cognitive therapist must both care about the patient and challenge distorted thinking, the behavioral therapist cares and challenges disturbed behaviors and the interpersonal therapist cares and challenges disturbed relationship behaviors. Effective therapies with complex patients take place via a therapeutic alliance that stems from both caring for the patient and therapeutic challenge to change. The therapist must be able to experience positive feelings and negative feelings simultaneously to optimally provide these and perhaps all effective psychotherapies for patients burdened by major defenses.

Emotionally focused therapies, such as ISTDP, can be very challenging to learn since they require knowledge, technical skill, anxiety tolerance and emotional awareness in the therapist. ISTDP theory itself compels the trainee to look inward at his or her own emotions so as not to lead the patient away from his or her own feelings. Videotapes used for teaching ISTDP often show intense emotional experiences, including intense positive feelings and intense murderous rage and guilt. Observing these tapes mobilizes feelings in the trainee. These feelings can generate any symptom of anxiety and any pattern of defense in a trainee. (Said, 2000) For these reasons ISTDP is a challenge to learn for many, if not most, therapists.

The “trained” ISTDP therapist: humble and less isolated

To learn ISTDP is to have gained good general knowledge of specific unconscious emotional operations. This is not a small task. Doing this usually results in significant changes within the trainee including improved self-awareness, increased humility, less feelings of omnipotence, improved technical confidence and a better understanding of others.
Rather than creating barriers between the trainee and other therapists and theorists, this experience increases a sense of connectedness to others. Because of the understanding gained, the trainee can better see the bridges and parallels between apparently disparate therapies. He or she can understand why most psychotherapy research does not show difference in outcomes. For example, the trainee can see the primacy of therapist efforts to form an attachment, encourage change and manage affect in most all psychotherapy models.
Thus, if the trainee is truly learning about him or herself and others in depth, empathy for both self and others increases. Professional isolationism decreases as the trainee sees the important roles of everybody involved in health care. He or she truly becomes part of a greater whole of health care providers and healing elements of society.

The Problem

Along with many other forms of treatment, ISTDP is often mistakenly promoted and taught as “the ideal therapy”, the pure gold”, “the truth” and the “final answer” for human suffering. Davanloo himself has actively stated that his approach is not a panacea: a major disservice to him and his work is done when these distortions are perpetuated.
Worse, making such statements to trainees often simultaneously devalues other methods, including other closely related methods. For example, other brief therapy methods may be touted as “lies” and as “destructive to the unconscious”. Idealization and devaluation here are seen together as contrasts that point in only one direction for a student. (Davis, 1992)

This becomes compounded when the trainee is in search of the one "true answer", death to any uncertainty about his or her actions, the true "solid ground" to stand on as a therapist. It is when teacher and trainee agree that they have found "the truth" that learning stops and problems begin. (Davis,1992)
When such distortions are perpetuated the following events may start to occur:

1) Idealization of the treatment method
2) Idealization of the founder and teacher
3) Denial of limitations in the method: over-application in cases where psychotherapy should not be used
4) Denial of limitations in one's own ability to use the method: reckless application without respect to safeguards
5) Exaggeration of one's training level/skill
6) Exaggeration of one's outcomes, to keep up the need for it to be "perfect"
7) Idealization of oneself, since one is doing "pure good"
8) Devaluation of other therapies and therapists: since they aren't doing the ideal method
9) Blaming the patient when the "technique" fails
10) Dismissing any criticism of this distortion as "resistance", or due to the other person's "unconscious"
11) Mistrust of others outside the program
12) A feeling of uniqueness and entitlement coupled with the need to be protected from the resistance of others
13) Poor outcomes, drops outs, misalliances or passive compliance with patients

The end product is that others from within and from outside the training program will begin to devalue the method, teacher, therapists, and training program. The effort to put a particular method "first" results in it, and its associates, being placed "last".
This splitting results in more isolationism and camp formation. Those outside may start to refer to the idealizing group as "a cult" while those inside shield themselves from the "resistance" of others. In this splitting, each group becomes more and more comfortable within the group while they become more afraid of those outside. No one is anxious because there are no mixed feelings toward others either inside or outside the camp. Those who hold mixed views are either pushed to one side, pushed out or exit both groups. The group members find it harder and harder to question themselves and their positions.

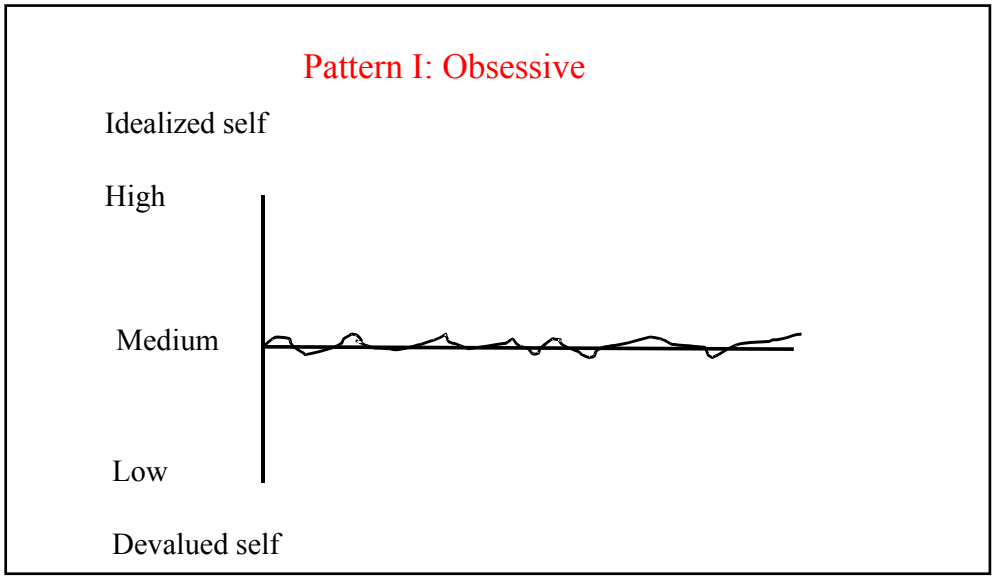
Not unique to ISTDP or Psychotherapy

This phenomenon of splitting applies to any treatment method or situation where views are expressed. For example, many psychotherapy methods have held high positions only to later fall to major devaluation. The best example of this in the past 50 years is psychoanalysis: with it's devaluation in many circles, everything psychodynamic has become discredited in some people's eyes. (Davis 1992) Biological psychiatry has had its day and continues to have strong proponents who devalue psychotherapy in any format. Hence, the issue is not one unique to ISTDP or even to psychotherapy. However, the emotional effects of ISTDP training, the videotaping and the theoretical and technical precision may either predispose to idealization or attract people who seek ideals.
The behavior of idealization of a method can be quite destructive to a program. Thus, it is a behavior that more healthy training programs talk about and challenge each other on. Like other forms of resistances to learning, idealization must be collaboratively and supportively addressed in the supervisory process. (Said, 2000, Davis, 1992)

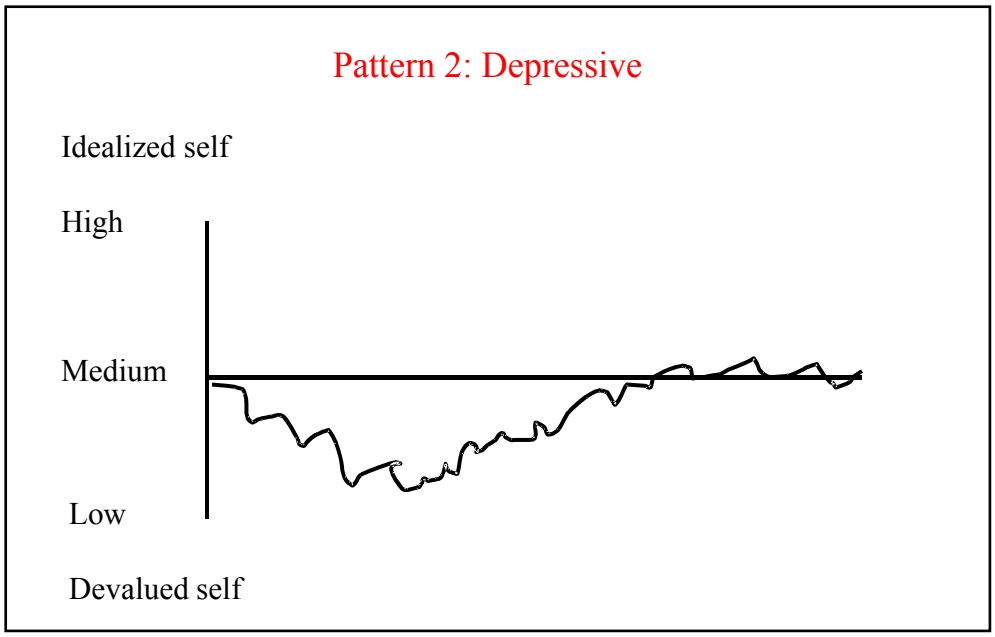
Defensive Patterns Observed in Trainees

From my experience, 5 defensive styles are seen to occur when trainees are exposed to videotape training. The "obsessive" trainee uses primarily intellectualization and isolation of affect. The "depressive" trainees appear to use repression, tending to go flat in therapy sessions. The "cyclothymic" trainee alternates repression with defensive self- aggrandization. The "hypomanic" trainee becomes enthralled with the method and him or herself and appears to use idealization. Finally, the "fixed depressive" trainee tends to experience self-devaluation. Occasionally a trainee is able to incorporate the learning without resorting to a major defensive response, so these descriptions do not apply to all trainees. While the etiology of these phenomena is described by some possible psychological mechanisms, biological factors are probable in some cases where these patterns are entrenched. The terms used here are purely descriptive, but, repeated experience with these patterns over 14 years of training and teaching supports them as separate entities.

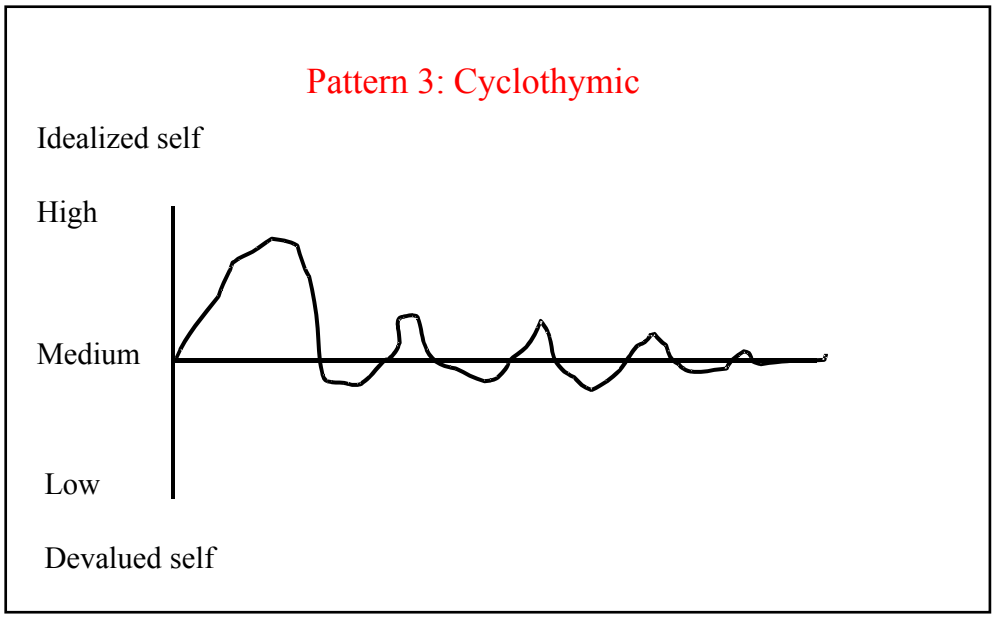
In the figures below, the Y-axis is observed level of self esteem as it relates to the training sessions and the X-axis is time. There are no specific measures employed here rather the markers medium, high and low levels of self-esteem. In relation to these patterns of self esteem, the trainee's perception of the therapy method is described in the text. The learning challenges and teaching efforts employed are also described for each category.



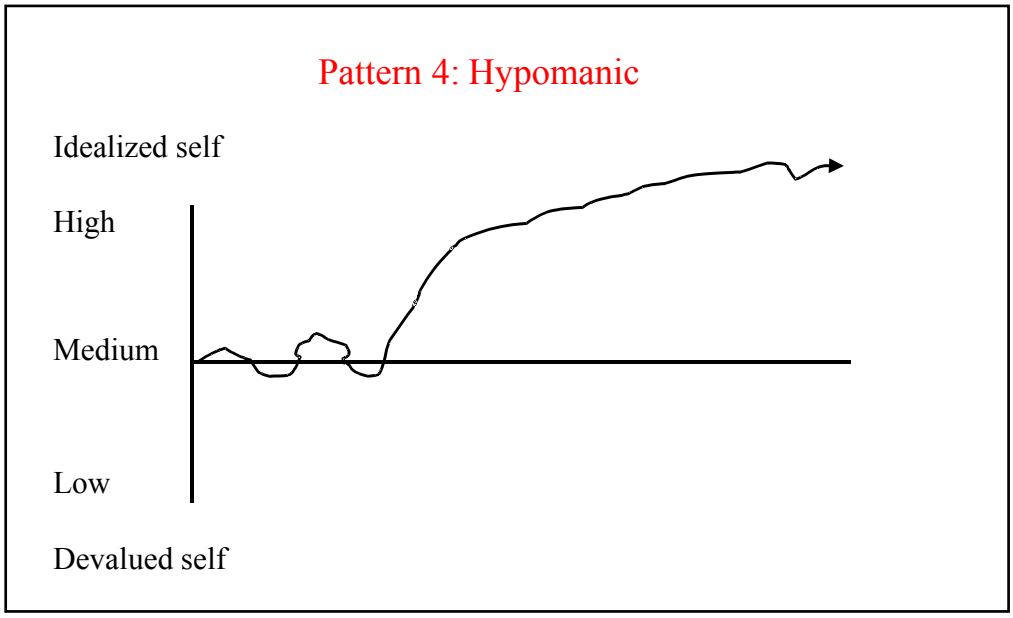
Pattern 1: "Obsessive"
The obsessive pattern is characterized by self-examination early in training. The trainee examines his or her own feelings while watching tapes. At first, the trainee ruminates about emotions and tries to feel emotions. He or she works to understand and undo his or her own defenses against emotional experience. Gradually they start to feel emotions and learning is incrementally increased when they do. They tend not to have major fluctuation of self-esteem in either direction. They tend to keep balanced view of the method, seeing it's strengths and limitations. Supervision tends to focus on the somatic experience of emotions versus the intellectual awareness of emotions.



Pattern 2 : “Depressive”
The trainee with depressive pattern experiences some degree of drop in self-esteem in the early phase of training. This may be reported with body anxiety symptoms including irritable bowel, migraine or other functional disorders. In trying to look inward, they initially become more self-critical and feel more guilt about what they learn about themselves. In training, they gradually gain self-esteem in a graded fashion, corresponding with emotional experiences and a new empathy for themselves. Supervisory process ends up focusing on the mechanism of repression and the graded format of ISTDP to help the trainee learn to self-modulate. (Whittemore, 1996)

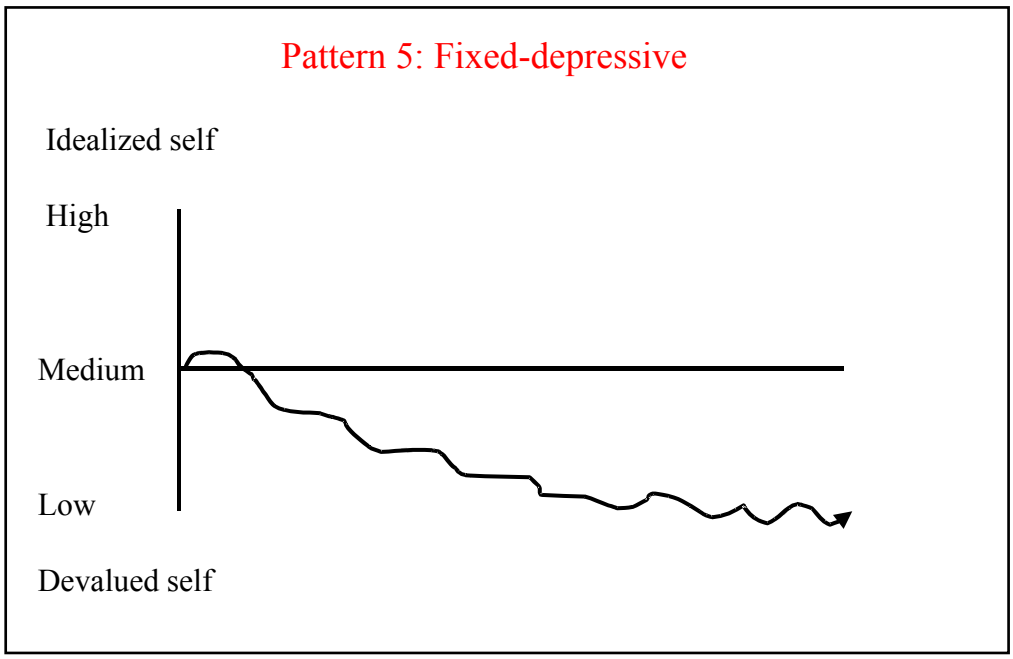


Pattern 3 : “Cyclothymic”
In the cyclothymic pattern, trainees tend to fluctuate between high and low self-esteem. Cycles of idealization of the therapy and oneself are followed by a “crash” to devaluation of self and the therapy. This “over-enthusiastic” trainee exhibits some or all of the problematic idealizing behaviors above. These individuals do not sustain the idealized position, but instead, alternate between this state and depressive self-devaluation. This trainee may actually keep idealizing the method while devaluing his or her own ability to use the method.
Over time, with supervisory input and tape self-review, these therapists can have smaller oscillations in esteem, corresponding to a budding ability to experience and tolerate anxiety. Their first experiences of anxiety are often in the form of drifting, blurring vision and some tendency to fall asleep. If they persist in training, they will gain anxiety tolerance in a graded way and finally start to feel complex feelings. When this starts to happen, the cycles reduce, the mood is balanced and the over-enthusiasm and self-criticizing are converted into good psychotherapy skills, as well as empathy for others (including patients) who have this same pattern. My experience is that this process takes from several months to a few years of supervision to start to take place. Initial cases treated are often patients with better capacities to tolerate anxiety than the therapist: the patient teaches the therapist a great deal and pressures him or her to boost up their ability to stay integrated. Indeed, the therapeutic alliance is often, if not always, a two-way street in which both therapist and patient learn from each other.



Pattern 4 : “Hypomanic”
This relatively rare pattern is characterized by the rapid development of fixed, idealized views of one self and the therapy method. It appears in these cases that the self-esteem is about to drop down, but then goes upward and does not come back down despite supervisory efforts. This pattern is characterized by devaluation of patients, other therapy methods and other theorists. There is little or no anxiety or uncertainty. The method must be “proclaimed”, as if to save the world, and save other therapists who may be seen as “lost”. Any different opinion is seen as “resistance” that must be battled. In other words, all of the 13 problems listed above start when a therapist and/or a program is in this mode.
The lack of anxiety corresponds to a lack of complex emotions being mobilized or experienced in the trainee. Thus, the development of anxiety tolerance does not take place. The therapist continues to idealize and devalue patients in therapy, with expectable adverse events and poor responses. The therapist may then blame the patient for treatment failures.
This pattern, while uncommon in the author’s experience, is a challenge to a supervisor and to his or her training group and program. Efforts to clarify the problem as a barrier to learning are

fraught with difficulty. Sometimes the trainee, rather than interrupting the pattern, will drop out and go on to idealize another method of treatment. This problem behavior then tends to occur in the next program as well.



Pattern 5 : "Fixed Depressive"
This relatively rare pattern is the mirror opposite of the hypomanic pattern. The trainee almost has a rise in self-esteem but then spirals downward to a self-deprecatory state that endures despite training and study. Typically these trainees continue to idealize the method, but lament that they aren't "able to do it". Thus, they continue self-devaluing, hoping for the day they "can do it". These trainees are not anxious. However, when confronted with the self-devaluation and idealization of the method, they become highly anxious and have major difficulty seeing this process. This patterns is also uncommon, but, is very problematic for teacher and trainee alike.
One could consider both the fixed depressive and hypomanic patterns as training failures, but there seems to be qualitative differences in both defenses and the degree to which these positions are held, at all costs. The defense mechanism at play here appears to be idealization and devaluation as opposed to repression. Biological factors including predisposition to major depressive disorder and bipolar disorder could also be factors. When these trainees are encouraged or pressured to have a balanced self-view, they will drift and become drowsy, supporting the idea that they have low capacity to tolerate anxiety and mixed feelings.

A Realistic Picture: ISTDP and STDP Research

ISTDP has certain benefits and limitations as does every established psychotherapy method, including STDP in general.
In addition to Davanloo's breakthrough qualitative research and large case series, (Davanloo, 1980) ISTDP has controlled trial research supporting it with a range of patients including those with personality disorders in individual outpatient (Winston et al 1994, Hellerstein et al 1998, Abbass, 2001) and hospital based programs (Cornelissen, 2002). ISTDP has data to support its cost effectiveness and clinical effectiveness in real-world samples. (Abbass, 2002a, Abbass 2003) It appears to be effective with a very broad range of patients, up to 86% of a psychiatric office sample. (Abbass 2002b) It is an open learning model with videotaping and live interviews as main learning vehicles. (Said, 2000, Abbass, 2004)

However, ISTDP has not been shown to be better than any other therapy method. Conversely, ISTDP has not been outperformed by any treatment method in head to head studies. The current method of ISTDP (since Davanloo, 1990) has not been subjected to any head to head research to establish it's relative efficacy. Because ISTDP can be used with such a broad range of patients and produce good results in a short treatment course, it may turn out to be superior to other, or at least shorter than, other methods when research is done to test this. For now we can say ISTDP is effective but not more effective than other methods. We cannot say it is the best because there is no direct research evidence to make this statement.

The same applies to STDP methods in general. STDP has been found equally effective as other bona fide psychotherapy models across a broad range of patients. It has not been shown more effective, despite several well-designed randomized controlled trials. There are some suggestions that STDP is superior to other methods in certain groups of patients, such as those with personality disorders, but, this has not yet been established. (Svartberg et al, 2004) Overall, the methods, do appear better than minimal treatment controls, waitlists and medications alone.
The same does not apply if we were to say, "is emotional experience important in healing trauma". If this question is posed to diverse therapists, most will agree that emotional experience is central in all therapies, although, each may examine and work differently with emotions. Hence, the central therapist activity in ISTDP has as much face validity as any other method.

Is it possible to do "bad" when one is trying to do "the best"?

Any system that idealizes itself without any evidence to support it's claims is doing harm because it is perpetuating a lie: the content may be good but the process is not. Hence, it is indeed possible, under the guise of "promoting the best method", to have a damaging effect on oneself and others. Personal growth and learning are stagnated and misalliances are formed.
Splitting, including self-idealization or self-devaluation has a destructive effect that prevents learning, prevents development of anxiety tolerance and prevents development of professional integrity. When these occur, it is indeed a sad outcome of all the efforts that STDP theorists have made to promote the development of excellent therapy skills.

Amelioration?

The teacher has a central role in shaping the culture of training groups. Thus, the onus falls on the teacher to manage him or herself and present a balanced view with whatever the available evidence is for the method. He or she should be versed in common psychotherapy factors that seem to render therapies equal in overall effects. These should be taught so trainees can see how one method overlaps with others. Certainly, a focus on emotions and how emotions are blocked somatically and behaviorally should be part, but not all, of the training experience. Cognitive and behavioral elements of the method can be underlined when showing tapes so trainees can appreciate overlaps in other established treatment methods.
Ongoing small group videotape supervision and modeling by teachers is a main method to manage extremes of idealization/ devaluation. Direct supervisory input, including confronting an idealized or devalued position, should be done in a supportive way, recognizing that there are usually good reasons a person becomes stuck in these modes. Peer input and modeling in this format also help to maintain balance during an emotionally challenging training process.

Conclusions

Idealization and devaluation are behaviors which can occur in psychotherapy training programs. They may occur more frequently in treatment programs where technical precision is high, where patient responses are specific and where emotions are a central focus. They result in stagnation of growth of the members and the program itself. Thus, these behaviors must be discussed and managed as any other barrier to learning.

Modeling by a supervisor, direct supervisory input and peer feedback can help counter both of these perceptual extremes. A culture of balanced, program self-examination that recognizes common therapy factors across schools can help maintain integrity and growth of a program and it's members. Thus, bridges rather than barriers between schools and colleagues may develop for the benefit of both. The end result is that schools and their discoveries may be shared with colleagues who see that there is both respect for others and recognition of the common goals of therapists and training programs. Differences may then be respectfully debated with specific reference to cases, leading to evolution and growth of those people and programs involved.

About the author

Allan Abbass, MD is Associate Professor, Director of Education and Director of the Centre for Emotions and Health, Dalhousie University, Halifax, Canada. He conducts original research in STDP and provides workshops and videotape supervision to psychotherapists and physicians in Canada and abroad.

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