THE SUPPORTIVE APPROACH TO THERAPY

Shirley Greenberg

ABSTRACT: This paper attempts to correct the misunderstanding of supportive therapy as non-specific, reassuring response to a patient's overwhelming stress. Supportive treatment methods require perceptive assessment of the particular coping skills used by the patient, and an understanding of the ways in which empathic contact revives the sense of capacity to endure. What is usefully supportive for one person may be anxiety provoking and undermining to another. Case examples are used to illustrate the clear definition, focus, and selectivity necessary in supportive treatment.

Mental health professionals are frequently called upon to provide supportive therapy. Yet even among skilled and experienced practitioners, there is a widespread misconception of what constitutes "support". It is often stated, for example, that supportive therapy (the giving approach) may have to precede analytical therapy (the investigative approach). In this paper, I hope to demonstrate that this is a false and misleading distinction.

What, then, is supportive therapy? Is it support as in propping up a wall, to hold up, take the weight of? Without the supporting beam, the wall collapses. This often happens in the name of "supportive treatment", when the rescuers of the needy, the magic healers, leave town, lose interest, and/or give up; then someone else must try to deal with the painful turmoil left behind. Supportive therapy, ideally, should mean healing, that kind of healing which comes through an increase in a person's ability to discover, recognize, or create ways of dealing effectively with needs and feelings.

A supportive approach is the treatment of choice whenever the adaptive capacity of the patient is inadequate to cope with basic needs. In order to assess a person's capacity to cope, the following questions require

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consideration. Does this person make reasonable judgments and recognize the realities, or does he distort, misperceive and deny the realities in life? Is affect available, appropriate and manageable, or is it inappropriate, flattened, or overwhelming? Does the person have a variety of responses, and flexibility, or are reactions stereotyped and rigid? Even under pressure, does he or she have some sense of humor and some underlying confidence in self and others, or is the experience only of helplessness and defeat? Has the person managed any life situations well—leaving home, holding a job, making friends, facing bereavement—or instead, been unable to cope with developmental tasks? Are there serious somatic complaints such as addiction, ulcerative colitis, anorexia, debilitating headaches? Is there evidence of disturbed mental status such as delusions, hallucinations and ideas of reference? When these assessments indicate severely impaired functioning, supportive therapeutic efforts are needed. Even a much healthier patient can have times of crisis when the therapist has to be concerned with ways of lessening the pressure and strain which are interfering with functioning.

What, then, can be done specifically to increase a person’s ability to cope? The therapist tries to find whatever skills are already available for this person, and to work out ways of using those skills in the current difficulties. In searching for strengths, one asks, “When you have managed in the past, how have you managed?” Then one listens for the defenses and character traits which work for this patient. At times, it may seem almost impossible to detect any evidence of competence, and the clues may be concealed or obscure, as in the case of Mary B.

She is a twenty-eight year old clerical worker of middle class background, mother of a two-year old girl. She was referred by her employer because of increasing absences and interruptions in work. Still on six-month’s probation, she would be fired if she did not settle down at work. She presented herself as rather composed even though she felt in an acute crisis because she had not heard from her husband and their child for twenty-four hours. In fact, this was a much more chronic problem. For four years, she had felt deeply in love with this man, father of their out-of-wedlock child; but she knew he was a drug user and pusher as well as a thief and a pimp who had frequently deserted and beaten her. Several months ago, she had married him expecting this to stabilize the relationship. Now she had agreed to transfer the child’s care from the Day Care Center to him. Careful exploration of her family ties indicated that those connections had been broken.

Her ability to reality test was seriously impaired. She was unable to see the danger to herself of this relationship; and even more disturbing, she was unable to recognize that she was endangering her child. Massive denial and masochistic solutions rigidly dominated all other possibilities. She made it clear that she did not want to end the relationship.

The temptation for the therapist was to try to break through the denial by focusing on the reality dangers. But trying to disrupt a person’s