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
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
maladaptive efforts is not supportive; it will be experienced as an additional increase in pressure. Instead, one must search for strengths, for some area of effective functioning. For example, this patient had a semi-skilled job. This indicated she must have been able to finish high school and behave appropriately to get hired. A look at the medical form she had filled out in the chart revealed a beautifully written, accurately detailed form. There had been some ego capacity to order, organize and respond in a structured way. For example, she had married her lover in order to obtain greater stability from him. This was the place to focus, by asking her what she had tried to do by marrying. As she talked about her hopes, it was possible for her to see marriage had worsened the stability instead of improving it, and that she had previously had more sense of control over her life than she had now. One could then ask—if perhaps marriage was too much of a pressure for her man, and could he do more for her if he felt less burdened by her expectations? She recalled instances when this had been clearly so. For her, there was the enormous relief of feeling she could do something—release him from the marriage; that would restore some order to her life and enable him to feel again more positively toward her. As a result, she decided to end the marriage. She returned to her previous level of adjustment in which she provided a home for herself and her child and functioned adequately at her job, holding onto the man but without the added commitment of marriage.

Another question which explores a person’s source of strength is: “Who has ever been there for you?” If the answer is, “Well, there was my Aunt Lucy,” (or “my previous therapist”), one has meaningfully reminded the patient that someone can help, and one can get some valuable suggestions of helpful responses by listening to what Aunt Lucy did. If the answer is, “No one has ever been there for me”, one’s empathy with this isolation says that, at least at this moment, someone cares enough to share the pain. To accept someone’s feelings, no matter how painful, is supportive. The person no longer has to struggle to hide from others or from self, what he or she deeply feels. There will not be criticism, scolding, or ridicule for being upset; emotions will not be damaging. Feeling understood is a precious encouragement to a person’s sense of self-worth and capacity to cope with problems.

Sometimes, a patient answers this question, “Who has even been there for you?” by saying, “I, myself, have been the one I relied on.” The therapist should respond with interest, encouraging the patient to describe such times of self-reliance.

A 75-year old man came for help because his feelings toward his daughter and son-in-law were so filled with hurt and rage that he was even having trouble reality-testing in his interactions with them, feeling plotted against and manipulated. But in recalling his past self-reliance, he told of how he had managed his es-
cape from the Nazis, his survival of one of life's worst experiences. Talking about his strengths, focusing on them, revived his sense of capacity to cope, and lessened his undermining perception of himself as a helpless old man unable to protect himself from family persecution; and as he felt less helpless, he felt less persecuted, more realistic in his judgments.

There is another way to assess ego strength. Good therapists always puzzle over the precipitant. They want to know what went wrong, what changed, why does the person feel so troubled at this particular time? There is surely no more crucial question. The supportive therapist wants patients to look at their functioning before as well as after the problem arose. In their present pain, patients often forget past successes, and express some surprise as they hear what they are saying about how well they had been managing before. They then can feel some hope that the past level of adjustment can be restored. The college freshman who has "been feeling all this tension and anger" since he got here, remembers with surprise what a great summer he had in the law office. He had a lot of independent responsibility there and did well, so maybe, now too he can cope. In searching out previously successful adaptations, the person is required to use defining, observing abilities. Effective use strengthens these abilities.

Exercising existing skills encourages a person's sense of effectiveness, but removing impediments can also increase adaptive capacity. Anxiety is a primary obstacle; and the source of the anxiety has to be determined in order to discover which responses will be supportive. The supportive therapist asks, "How can I help this person use his skills to deal with the anxiety?" For example, a patient may be in a panic that rage will get out of control. The supportive therapist will not focus on the feelings of murderous hate and their origins, but may ask, "When have you ever really hurt someone?" If the answer is, "I never have actually," the questions will continue to focus on the reality that the patient has better controls than he felt he had. If the answer is, "I really smacked my daughter when she got out of bed the third time, and I couldn't stand it," one can explore ways of anticipating and lessening the precipitants by dealing with the first and second episodes so that the overwhelming third incident does not occur.

A supportive response to anxiety is based on an understanding of its causes. Take, for example, the increase in anxiety felt by any patient in response to a separation from the therapist. One patient of mine has enormous fear of her feelings of disappointment in a love object. In order to shut off awareness of her feelings of rage, she shuts off all feeling for the person. In a way, she loses me twice, once because I'm out of town, and secondly, because she cannot even bear to think of me at all. When she has the opportunity before I leave to recognize her anger and I accept it as understandable, she feels relieved of her anxiety that she will be to-
tally separated from me. Another patient, however, has the borderline characteristic of the need to split the good object from the bad object, and has related to me as the good object. When I focus on her anger at me, it greatly intensifies her anxiety by endangering the only good object she has at this time. The supportive response to her is to help her hold onto her loving feelings against the tide of anger. We need to focus on how important and useful therapy is to her. When she came in for the last hour before my vacation, sobbing with rage at the people she works with who had terribly disappointed her, I acknowledged how much pain she was feeling and offered an extra hour before I left. She was able then to control her anxiety with the assurance that she still had the good object.

The use of medication to control anxiety requires similar understanding. Whether a pill will be supportive or not depends on its meaning to the person at a particular time. A patient with intractable headaches interpreted the prescribing of medication as proof that she could only remain helpless. Another patient, frightened of being overwhelmed by anxiety, may be reassured that the pills can mean he does not have to be helplessly out of control. A paranoid patient will feel that the hostile others are going to get him now; the oral dependent patient will feel "someone cares about me and I will be fed". The point is that there is such variety in human responses. What will be supportive for one person may be undermining to another. Only when one discovers the source of anxiety for a particular patient can one know what response will prove supportive.

Not even the giving of special effort and care is necessarily supportive. Sometimes, in fact, it is undermining. There are times when more help may be less useful, when it increases rather than decreases anxiety. This can be observed in the borderline patient who presents excessive demands. As Dr. Elizabeth Zetzel (1971) has pointed out, such patients experience increased anxiety in an unstructured situation. "Stability, consistency and the ability to set realistic limitations are of primary importance". When the therapist is especially available and helpful, such a borderline patient's ability to function may deteriorate. One such patient is described by Bursten (1973) as a "paranoid personality type of narcissistic character". Such a person is extremely anxious, suspicious, and demanding, convinced that no help is really possible and often has a history of unsuccessful treatment in the past. The expression of so much discomfort and so little faith can make one feel almost taunted into producing a cure. However, an ambitious effort is the worst plan. It mobilizes the patient's negativism and need to defeat others. As Bursten has described, the stronger the fantasy of an "omnipotent other" becomes, the stronger is the yearning to merge with it, and the greater the pressure to defend against the yearning by erecting walls of hostile resistance. When asked to perform in treatment, the person is infuriated because this violates the fantasy of being helped while remaining totally passive.
Mr B. was such a patient. Now age 26, he had suffered for ten years from debilitating anxiety attacks, psychosomatic symptoms, and paranoid ideation. Although an excellent student, he had to leave graduate school because of progressive symptoms of anxiety and increasing alcohol intake. For five stormy years, he had been in treatment with a dedicated private psychiatrist, who finally referred the patient to a clinic when the family refused to finance further treatment. Mr. B. appeared to be extremely anxious, suspicious, negativistic and demanding. During the evaluation period, it was important to establish a slow pace, and to remind the patient that there were no quick and easy remedies for his discomfort. The major issue was his inner pressure to live up to his own and his family’s high career aspirations, though he felt certain he could only fail. The clinic staff, however, recognized his gravely impaired functional capacity and did not expect him to perform at the level of his high intelligence and family background. For example, when he complained bitterly that he was merely holding a menial job, the evaluator responded by asking, “What’s wrong with a construction job?” During an extended evaluation, (and it was useful to call this an evaluation, not treatment, in order to lessen the expectations), his anxiety diminished and his level of functioning markedly improved both at work and with friends. He has been in treatment for the past year. Medication has been a continuing necessity and has been provided in a supportive group setting. There has been an acceptance of whatever gains Mr. B. reported, but no pressure to change. The only expectation has been that there would be gradual progress toward the goal of decreased anxiety and distress, and this goal has been achieved.

Similar issues arise with another type of patient, for whom schizophrenic anxieties are prominent. Such a person clearly describes severe emotional isolation, mental confusion, and inappropriate fears. Probably hospitalized in the past, at least briefly, he or she is barely able to maintain self in the community. Impressed by suffering, and sometimes by outstanding intelligence, one may be tempted to offer the maximum therapeutic effort. However, raising the expectations will greatly increase the anxiety. Reaching out to help may mean to this person that the therapist will overwhelm and annihilate him or her as a separate entity. Also, major treatment ambitions reinforce grandiose fantasies of self, against which he or she is struggling for control. Instead, the supportive technique is to lower the expectations and reject the rescue fantasies. This is indeed difficult. It requires the therapist to accept the devastating reality of this patient’s suffering which can only be diminished, not removed, in treatment. The supportive approach is like feeding a squirrel. One holds the food where it is available, but if one reaches toward the squirrel, the squirrel will flee. Only if one remains very still, will the creature come and take it.

In concrete terms, this may mean that when the patient says the problem is just fatigue, one does not challenge nor contradict, but will focus instead on what the person does each day when feeling this way. It may mean not closing the door, but letting the patient decide whether it should be open or shut. It may mean offering a shorter hour, 30 minutes once a week, being very clear and definite about what is offered and recognizing that such a patient will continue to need supportive treatment.
for years. The focus will be on current reality, letting the pathological fantasy material go by, not challenging or criticizing it, but paying attention to the patient’s needs in the day-to-day situation. With these patients, one is an external support; and it is wise to involve as many diverse “props” as possible so that if one is removed, others will remain. A variety of community resources should be mobilized: church groups, welfare services, drop-in centers,—all contribute stability. Also, family contact will be of use, first, because family help may be needed from time to time if hospitalization has to be arranged, and secondly, because family members can report reality information that the patient may not be able to acknowledge. In turn, the family can be helped to be a more adequate part of the patient’s supportive network. The aim is to spread out the burden of this patient’s long-term needs for support, and to keep the involvement of any one of the “props” limited and clearly defined.

Even when there is less obvious pathology, therapeutic ambitiousness can be a real hazard for the patient who requires supportive treatment.

Mrs. P. was a young woman in her twenties, working effectively in an office, married to a graduate student for eight months. The marriage was going well and was solidly based. Her family background was stable and caring. She was a college graduate, though she had never until now lived away from home. The presenting problem was her distress about two issues: her body, and her sister-in-law. Regarding her body, she had decided, after a recent visit with her in-laws, to lose weight, and she had done so. Never really obese, and now quite slim, she was still not sure how thin to get, nor how she should dress. How alluring should she be? Should she wear formfitting pants and sheer blouses? She had never gone to the beach because she had never been willing to be seen in a bathing suit. So it was all new to her now, she felt. These concerns were described with a rather flat matter-of-factness, sounding troubled, but heavily controlled. The sister-in-law problem had recently upset her too. They had once been best friends, but now this girl lived a “hippy” life, strongly advocating sexual freedom and being very demanding that her family gratify her wishes no matter how disapproving they felt. She had so greatly provoked the patient in an argument that the patient had become enraged and struck her.

Although Mrs. P. had demonstrated many areas of competence in her life, there were indications of a severe ego impairment because she seemed to be unsuccessfully struggling with impulses, primarily rather primitive sexual ones, projected onto the sister-in-law, that she could not adequately control. Further sessions revealed much rigidity, and confirmed that the focus should be supportive. Her strengths were her compulsive defenses, her ability to intellectualize, to plan, and to carefully organize her activities. Looking at the precipitants indicated the loss of a major support, which had been her feeling of being protected at home, whereas now she had no comparable external control over herself.

Supportive treatment, then, would focus on how she could plan her diet and appearance, and her encounters with her sister-in-law. It would be focused on what she could expect, the options available to her, the
ways she could handle the conflicts and feelings. Also important was to think with her about how to involve her husband in these plans. Previously she had not shared these worries with him but as she did so, he responded as the protective, reliable family she needed to replace. We met weekly during times of special stress, and less often in calmer periods. It was only after a year of treatment that I tentatively wondered with her if the sister-in-law had been so upsetting because she reminded the patient of parts of herself. The patient indicated she had “sort of thought so, but that had just made it harder to deal with her.” Now she felt stronger and none of these thoughts was so disturbing. Treatment which had begun by exploring her sexual wishes and conflicts might well have aroused deeply unsettling anxieties which would have undermined her sense of control, and would have been too ambitious for her at that time.

As mentioned in the statement quoted earlier, supportive therapy may have to precede analytical therapy, but it seems that the “giving” versus “investigative” distinction is meaningless.

Finally, it is important to note that even in the midst of insight-oriented therapy, the patients’ functioning may become inadequate. These supportive techniques may be needed to enhance the patients’ capacity for growth and change. It is also pertinent to consider that intensive therapy which is focused on the pathology, its antecedents and patterns, is ultimately supportive. When patients recognize that they are repeatedly re-running the old script and that the ending can never alter, and when they accept the disappointment of what never was, therapy has removed the toughest impediment to appropriate functioning, which is the repetition compulsion.

These examples indicate that supportive treatment is clearly defined, focused and selective. It is not merely a reassuring, soothing encounter, asking nothing of the patient, offering only sympathy and encouragement. Rather, it requires both the therapist and the patient to search out and to revive useful pre-existing strengths, and to find ways of identifying and reducing the undermining anxieties. The outcome is reflected in the person’s increased confidence in the ability to be self-supporting.

REFERENCES