Working With a Patient's Defenses in Supportive Psychotherapy

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My topic for this column is something I was once told was a contradiction in terms—working with a patient's defenses in supportive psychotherapy. Several generations of therapists learned and then taught that the essence of supportive psychotherapy is to leave a patient's defenses alone, and that the "supportive case" was in no shape for the lid to be lifted on unconscious affect and thought.

As a community psychiatrist I have always found this belief to be problematic. If we haven't forsaken the notion that character development is a source of psychopathology, how do we hope to treat those severely ill patients for whom maladaptive defenses are a primary presenting problem if, above all else, we steer clear of disrupting the existing defenses? Such a premise seems untenable to me. Must a group of our patients settle for a treatment that is more palliative than definitive? Or can we enlarge our technique to help the widest possible spectrum of patients? Certainly in community psychiatry we treat a broad range of disorders, and our treatments for some are more curative than those for others. Supportive psychotherapy will always encompass a variety of efforts to provide a supportive bridge for the adaptive ego functions that are in a deficit state for biological—and often irreversible—reasons.

But what about suffering rooted in development that has gone awry? Aren't there large numbers of highly symptomatic individuals whose personality growth we might hope to rekindle? I have always believed that there is a great danger of condescending to our patients in any broad dismissal we might make of the place of explorative psychotherapy in community psychiatry. Our profession needs a framework for supportive psychotherapy that guides us not only to help remedy deficits in adaptive function but also toward a supportive version of the defense work that can lead to resumption of ego growth.

Just what would such a framework look like? A common folly early in the training of many a therapist has been to use traditional regression-facilitating therapy technique—also referred to as analytic or expressive technique—with a patient who needs supportive work. The therapist is inactive, neutral, and anonymous, and the patient can't make use of the treatment as it is being conducted. It is unfortunate if this experience leads the budding therapist to decide that therapy cannot be conducted with these patients, or that analytic goals are irrelevant to therapy except for some tiny minority of patients.

In my experience as medical director of a community mental health center that has 1,500 patients, it seems that psychopathology does not sort itself simply into two spheres—severe mental disorders that are the proper province of biological treatments and case management, or mildly constricting neurotic quirks. It is a discredit to our profession for community psychiatrists to dismiss expressive psychotherapy as irrelevant "chitchat" and for talented therapists to dismiss a very disturbed patient as "just a supportive case."

A particular experience in my own career was a watershed, leading me to abandon simplistic notions about "proper" psychotherapy. Shortly after I finished my residency, a 28-year-old woman, whom I will call Ms. C, came to me seeking treatment. Ms. C had severe problems with anxiety, agoraphobia, dissociation, and use of cannabis. She had failed to recover despite having tried Narcotics Anonymous, systematic desensitization therapy, cognitive-behavioral therapy, and multiple trials of anxiolytics. I put her through a series of medication trials myself, but I also insisted that she needed a real go at expressive psychotherapy as I understood it—an open-ended process, with appointments at least weekly, focused on talking one's way toward increased insight, resolution of symptoms, and greater adaptation.

The patient made it clear, after a dozen sessions or so, that she could tolerate no such thing. Although her daily torments were clearly born of transference perceptions and of self-defeating behavior in response to anxiety triggers, she found it difficult to bear the greater awareness that came from simply talking every week. After every session, she would spend three or four days feeling like a total wreck. She decided she was going to come to therapy every other week, regardless of what I prescribed—to her, losing four days out of every 14 seemed preferable to losing four out of every seven.

Had I erred miserably by initiating this treatment? Was Ms. C really not up to the demands of expressive therapy? Would I make her worse? The rules I learned in my training said so. But Ms. C proved the rules wrong. She came to therapy every two weeks

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for four years, talking at length about her alcoholic mother and her sexually perverse father, all the time steadily improving. She began to go out of the house consistently enough to complete college courses rather than withdrawing after excessive absences, as she had done so often in the past. She obtained her degree and found regular temp work. At some point, Ms. C started coming to therapy every week. Finally, she landed a full-time job.

Something about Ms. C's treatment was working, but what? I was not merely being cheerfully supportive or giving advice; I also wasn't conducting "proper" expressive psychotherapy, in terms of its frequency, my inactivity, or my neutrality. I did maintain a high degree of anonymity and a consistent posture of exploration. But I combined this approach with highly increased verbal activity on my part, in support of adaptive behavior but also in active pursuit of defensive behavior and the underlying feared affect.

A couple of years into her new job, Ms. C had clearly reached a plateau. Her enormous conflicts about the meaning of her success—given the echoes she constantly heard of a mother who bitterly resented successful women and a father who did not abide the thought of women as persons at all—threatened to undermine Ms. C's position at work. She found that her secret need to sabotage her own effectiveness was not quite as secret as she had thought, and she was placed on probation for poor job performance.

Ms. C initially greeted this news by planning to leave the job and find a new one before the probation period was up. I knew that her self-sabotage was defensive: it worked, in terms of assuaging fear that she was unworthy of her parents' love and approval—it gave her a sense of reassurance that she was indeed no threat to her parents—but adaptively it came at a very high cost. I confronted Ms. C's use of this defense in clear, emphatic terms. Did she plan to start over at a new job and spend another two years at self-destruction before facing her unconscious feelings and getting well?

Ms. C met with her supervisor at work. She obtained a list of objectives to be met by the end of the probationary period, and she set about meeting them. Soon she spoke in her therapy sessions about more frequent recall of traumatic dreams—dreams of herself in settings from her childhood, characterized not so much by specific events that happened in those settings as by the association of these settings to sadness and emotional distress. If her identification with her parents had always been suspiciously defensive, we were finally seeing what it defended against. At these moments I became even more active, exploring her feelings, empathizing, and vigorously interpreting their relation to her efforts at defense. Ms. C struggled, but she stayed the course with her new work plan.

Let me state what I believe is basic to giving defense-related work its proper place in supportive therapy. First is belief in the significance of defense and its determinants in a patient's need to keep a lid on unconscious affect and thought. Second is avoidance of the temptation to say, "This is not community mental health" or "These are not the problems of our patients." Yes, for years analytic thinkers mistakenly tried to describe a degenerative brain disease—schizophrenia—as well as major affective disorders as illnesses born of conflict or disadvantageous development. But that's no excuse for community providers to mistakenly describe all symptoms as being determined by biology. Two wrongs don't make a right.

Third, we need to orient ourselves to the distinctions and the overlap between supportive and regression-facilitating—traditional expressive or analytic—technique. The acquisition of increasing insight, whether in vivo or in the therapist's office, is usefully described as involving an oscillation from outer awareness—attention to current reality and to the demands of the external world—toward inner awareness—immersion in affect, memory, or fantasy—and back again, repeatedly. Some patients resist one or the other of these two areas of awareness and thus cannot compare them. The old notion of "proper" psychotherapy technique had it that patients had to make this oscillation almost without help; if they did not, they were either hopeless or, if pushed along, likely to crumble.

As a fourth principle I suggest that we need an understanding of psychotherapeutic tact that includes the assertion that, for some, this oscillation can and should be guided by vigorous activity on the part of the therapist. The patient who needs such activity or forcefulness will not feel condescended to but in fact will perceive remarkable empathy and commitment on the part of the therapist. With Ms. C, the moment for me to force this oscillation was not on day one or even in year one, when she was so clear that her affects were overwhelming. But if I had thought that she would never be capable of this oscillation, that would have said less about her inadequacy than it did about mine.

Some may raise the objection that the treatment I am proposing is long, labor-intensive, and expensive. In my own community mental health center most of the patients are with us for the long haul, and we see them regularly, for years on end. We spend hours conducting "supportive psychotherapy," lacking not so much the time to do it as we lack a clear conception of how it is done. A fully developed concept of supportive psychotherapy includes a specific enumeration of the adaptive ego functions that we are often called on to bridge, as well as a clear statement of how to combine that activity with an effort to rework defense.

In our profession, much of the time it seems as though those who treat and rehabilitate brain disease and those who facilitate resumed growth of the ego have permanently pushed each other out of bed. If we, as community providers, describe the place of character change in the treatment of some individuals who are severely disabled, articulate how that change can take place, and affirm the place of defense work in community mental health practice, we can help heal the destructive rift between brain-oriented thinking and mind-oriented thinking in mental health and serve the large number of patients who, regrettably, get lost in that breach. ♦