

Basic Strategies of Dynamic Supportive Therapy

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Supportive therapy is the psychotherapeutic approach employed with the majority of mentally ill individuals. Nevertheless, most mental health professional training programs dedicate little time and effort to the teaching and learning of supportive therapy, and many mental health professionals are unable to clearly and concisely articulate the nature or process of supportive work. Although supportive therapy incorporates many specific techniques from a wide variety of psychotherapy schools, it can be conceptualized as consisting of a more limited number of underlying strategies. The fundamental strategies that underpin effective supportive therapy with mentally ill individuals are described.

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Amidst the many psychotherapeutic schools, approaches, and techniques, it is easy to lose sight of the reality that the paradigm employed for work with the majority of mentally ill patients represents some form of “supportive therapy.”^{1–10} Indeed, Hellerstein et al.¹¹ have argued that supportive therapy should be viewed as the treatment model of choice, or default therapy, for most patients. Nonetheless, confronted with a confusing amalgam of psychotherapeutic theories and techniques—cognitive-behavioral therapy,^{12–16} interpersonal psychotherapy,^{17,18} psychodynamic psychotherapy,^{1,19} ego psychology,^{20,21} object relations,^{22–29} self psychology,^{30–33} eye movement desensitization and reprocessing,³⁴ to name just a few—beginning therapists often find it difficult to arrive at a set of consistent principles on which to base their supportive interventions. The problem is exacerbated by the mismatch between the frequent use of supportive therapy and the typically small portion of training program time and effort dedicated to teaching and learning in this domain. The result is that many mental health professionals are unable to clearly and concisely articulate the finite number of basic strategies on which effective supportive therapy is founded.³⁵

The goal of this paper is to present a concise and coherent description of the fundamental strategies underlying supportive psychotherapy. Novalis et al.⁶ note

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that supportive therapy may be conceived as an overarching therapeutic “matrix in which more specific techniques of therapy can be embedded” (p. 20). Thus, insofar as supportive therapy employs techniques from a wide variety of psychotherapeutic schools or disciplines, the nomenclature and terms presented here will derive from myriad sources and schools; no attempt will be made to restrict the elaboration of key principles to a single psychotherapeutic paradigm. In addition, the classification system used here to categorize the various supportive therapy strategies is but one such arrangement. Many of the identified strategies could easily be placed in different categories, or even in multiple categories.

THE BASIC STRATEGIES OF DYNAMIC SUPPORTIVE THERAPY

Strategy #1: Formulate the Case

The mere mention of the word *formulation* often unsettles psychotherapists, neophytes and veterans alike, calling forth fantasies of having to construct a lengthy and exhaustively detailed psychoanalytic understanding of every nuance of the patient’s mental life, beginning from birth (or perhaps even prenatally) and continuing to the present time. Insofar as the term *formulation* has a psychodynamic connotation resulting from its historical origins, some therapists prefer the term *case conceptualization* as one that is more neutral, suggesting a whole range of biopsychosocial etiologies. Whichever term is used, this not uncommon sense of dread and incompetence with respect to case formulation or conceptualization is unfortunate, not just because constructing one need not be a crushing burden, but also because a case formulation or conceptualization is vital to the success of the psychotherapeutic enterprise. It is the therapist’s “theory of the case,” his or her understanding of what is “wrong” with the patient, and, as such, it serves as a roadmap for future therapeutic interventions.^{36–42}

Whether explicitly or implicitly, every good therapist bases his or her interventions on an understanding of “Why?” and “Why now?” Why is this particular patient presenting with these particular difficulties at this particular time? Indeed, a perhaps incongruous but apt analogy may be made with the auto mechanic. Without

some theoretical understanding of how cars work, as well as some notion of “what’s broken,” an auto mechanic is unlikely to fix an automobile. The mechanic’s interventions will be, at best, random, shotgun attempts to alter something that, with luck, will occasionally result in a better-running automobile. So too for the psychotherapist: without some theoretical understanding (from whatever paradigm or combination of paradigms) of what it is that makes people tick, without some notion of “what’s broken” with this particular person at this particular time, the therapist can only guess at appropriate and useful interventions.

The case formulation serves other important purposes as well for the supportive therapist. It allows the therapist to keep an eye on the horizon, to make sure that, overall, therapist and patient are moving in the right direction, even if they have to tack left and right to get there. Furthermore, it serves to organize in the therapist’s mind the key problems and interventions. It also suggests hypotheses for further testing: “I need more information,” or, “Maybe this is why the patient is having trouble in this area.” It is through the testing of such hypotheses that the therapist comes to a useful understanding of the patient on which he or she can base beneficial psychotherapeutic interventions.

Another point with respect to case conceptualization: human beings—all individuals—are enormously complex in their thinking, feeling, and behavior. To come to a true and deep understanding of another person does not happen immediately or easily; it takes time and patience, effort, trial-and-error and hypothesis testing, an open and inquisitive mind. And just as one comes to have a deeper appreciation of friends and colleagues over time, so too does the supportive therapist become more knowledgeable about the patient over time. This means that the case formulation or conceptualization is never truly finished; it is, by definition, a work in progress, a fluid conceptualization that is altered as new information becomes available, old hypotheses prove unhelpful or untenable, and new aspects of the patient emerge. The good therapist is always updating, amending, and refining his or her understanding of the patient and of “what’s broken.”

The supportive therapist need not necessarily share this case conceptualization with the patient, nor is the patient required to have the same understanding of key issues as does the therapist. The important point is that the therapist has a case formulation or conceptualization and that he or she uses it and updates it regularly.

In order to illustrate an appropriate case formulation and how it might be employed in the implementation of dynamic supportive psychotherapy, an extensive clinical vignette, "Amy," follows the discussion of supportive strategies.

Strategy #2: Be a Good Parent

Perhaps the single most helpful concept in guiding the therapeutic interventions of the supportive therapist is to view the therapist–patient relationship in analogy to the parent–child relationship. Such an analogy does not imply that the patient in supportive therapy is a child or should be infantilized by the therapist. Rather, the analogy underscores the empirical observation that psychiatric patients, at least in some spheres of function, often think, feel, or behave like children, rather than as adults. Indeed, if the patient were functioning at a mature, adult level in most significant areas of life, he or she would likely not need a supportive therapist. The supportive therapy patient typically is operating ineffectively, that is, at a nonadult or childlike level, in one or more psychological domains such as reality testing, problem solving, affect modulation, impulse control, or interpersonal relations. Thus, to the extent that a patient is functioning at a childlike level in significant domains of life, the supportive therapist assumes a parental role with respect to the patient.

What does it mean to "be a good parent" in this context? The supportive therapist constantly assesses the patient developmentally with respect to the latter's strengths and deficits. The current context and stressors confronting the patient are considered. When appropriate, the patient is comforted and soothed by the therapist; at other times, the therapist serves as a cheerleader, encouraging, nurturing, validating, praising, or congratulating the patient. On still other occasions, however, the patient must be confronted with respect to self-destructive behaviors. Appropriate protection, containment, and limit-setting are balanced with promotion of autonomy and independence. Similarly, the supportive therapist offers whatever help is needed, but at the same time encourages the patient's growth and self-sufficiency. Suggestions, advice, and teaching are used to guide the patient's thinking and behavior; but, like a good parent, the therapist's intent is to help the patient reach his or her own goals rather

than to substitute the therapist's life plan or wishes for those of the patient. In contrast to the reserved stance of the psychoanalyst, the supportive therapist may use significant self-disclosure, sharing thoughts, feelings, or experiences that will help the patient manage similar issues in his or her own life. Overall, the supportive therapist attempts to help the patient develop into an individual who is mature, in control, effective, and satisfied, just as a parent does with a child. In the language of self psychology,³³ the supportive therapist is a good selfobject, providing needed mirroring, idealizing, and twinship experiences that allow the patient to internalize important psychological functions that are currently deficient.

A key question that is often helpful in guiding therapeutic decisions in supportive therapy is: "What would a good parent do in this situation with this person?" Other questions logically follow from this starting point: "Am I pushing too hard, or am I not asking enough of the patient?" "Will the particular experience under discussion be a good learning or growth promoting experience, or will it be an overwhelming, traumatic experience?" "Am I acting in the patient's best interests, or do I have another agenda?" "How can I help this particular person at this particular time in this particular situation accomplish his or her goals?"

The analogy between the therapist–patient and parent–child relationships is so important in guiding the supportive therapist's stance toward, and interventions with, the patient that it will be reemphasized throughout this article.

Strategy #3: Foster and Protect the Therapeutic Alliance

Although there is some disagreement, in general the failure to foster and maintain a good working or therapeutic alliance⁴³ between patient and therapist is a predictor of poor psychotherapy outcome.^{44–49} Indeed, this may be especially true in supportive therapy with poorly functioning patients, who may enter the therapeutic relationship with little trust, unrealistic expectations, and poor frustration tolerance. For some such patients, real and perceived mistakes, miscommunications, or disrespect on the part of the therapist do not merit a second chance, and such patients may terminate the therapy immediately thereafter.

Thus, the supportive therapist's first goal, and one

to which he or she must attend throughout the therapy, is the facilitation and maintenance of a good therapeutic alliance with the patient. Not surprisingly, a positive therapeutic alliance in supportive therapy often casts the therapist in the role of a good parent. The supportive therapist need not love the patient (indeed, it may be a matter of concern if he or she does love a particular patient), nor must he or she agree with or endorse all of the patient's thoughts, beliefs, feelings, or behaviors. What the therapist must do, however, is respect the patient as a person (though not necessarily respecting that person's behavior)—a person who, at least at some level, is struggling with the same life issues as is everyone else, mentally healthy and unhealthy alike. The supportive therapist must couple this respect with compassion, empathy, and commitment.

There are other important elements of a good therapeutic alliance. Even with the most disordered of patients, the therapist tries to ally with those parts of the patient that are the healthiest: a borderline patient's concern that his or her children not suffer the same childhood as did the patient, a schizophrenic's desire to become part of an appropriate social milieu, an alcoholic's wish to retain a good job and be a good provider for his or her family. Few indeed are the patients, no matter how psychologically or mentally disordered, that do not retain areas of higher, and appropriate, mental functioning. The therapist's task is to locate and identify these healthy parts of the patient and ally with them or enlist them in the service of the best interests of the patient.

A common strategy in this regard is the attempt by the therapist to use the patient's observing ego as an ally. The term *observing ego*⁴³ refers to an individual's ability to step back, get some distance or perspective, and observe himself as he would a friend or family member. This requires a patient to step outside of the moment and honestly critique his or her thoughts, feelings, and behaviors. Another example of a therapist's attempt to ally with the healthy parts of the patient: the supportive therapist and patient attempt to work collaboratively in the development of shared goals and strategies for the attainment of those goals. When a therapist and a patient share common goals, they become allies and find it easier to work together; in contrast, when the therapist's goals and the patient's goals differ, tension arises and the therapy often fails.

With respect to personal characteristics, the supportive therapist does not try to emulate the reserved

interpersonal stance of the psychoanalyst. He or she is friendly (although not necessarily a friend), parental (but not paternalistic), flexible, creative, and, above all, human. Humor, when used appropriately, is a powerful tool in the hands of a good supportive therapist and a robust coping mechanism for the patient. The supportive therapist is down-to-earth and practical, attempting to address everyday but important problems or difficulties in patients' lives. The supportive therapist does what the patient needs without fanfare or struggle; it is not a venue for long theoretical explanations or intellectual athletics. Unlike more psychodynamically and psychoanalytically oriented therapists, the supportive therapist is often very interpersonally active, asking questions, making suggestions, praising, suggesting, guiding, and so forth. Finally, a good supportive therapist believes in, and demonstrates, common sense, common courtesy, and the Golden Rule (i.e., the patient is treated as the therapist would want to be treated).

Strategy #4: Manage the Transference

Patients invariably have feelings about their therapists. When some of these feelings are "transferred" from early, important, childhood figures (e.g., the parents), to whom they were originally directed, onto the therapist, they are called "transference."^{43,50} Transference, by definition, results in a distortion of the patient's perception of the therapist; the patient cannot accurately perceive who the therapist truly is because the latter is viewed through the colored lens of previous experiences with significant others. Although most beginning therapists tend to think of transference as consisting of negative feelings toward the therapist (e.g., "You're mean, just like my father"), transference may consist of positive feelings as well. In the latter instance, the therapist may be seen as more intelligent, more powerful, or more loving than he or she really is.

In the classical psychoanalytic tradition, transference is "interpreted."⁴³ The psychoanalyst does not rush to explain or correct the patient's misperceptions of him or her; rather, the patient's feelings about the therapist are explored and related to previous important experiences with significant others. In contrast, supportive therapists typically do not interpret the transference; they "manage" it.

There are two key principles in the management of

transference. First, positive transference is not interpreted; it is used. This means that insofar as a patient may view the therapist as omnipotent, omniscient, purely loving, and the like, the therapist does not correct or interpret such distortions; instead, the therapist uses the patient's faith in him or her to further the aims of the supportive psychotherapy. Thus, the supportive therapist allows the patient's belief in his or her superior knowledge and experience to foster the likelihood that the patient will follow suggestions or advice put forth by the therapist. (A psychoanalyst, in contradistinction, might interpret the patient's overvaluation of his or her abilities as a reaction formation against deep-seated, but repressed, anger toward the therapist).

The second element of the management of transference relates to negative transference. Here, again, the transference is not interpreted (e.g., "You are angry at me for not returning your phone call soon enough because you see me as a selfish and withholding person like your father, who never gave you what you needed"); no attempt is made to explore the childhood roots or early interpersonal experiences that may underlie the negative transference feelings. Nor, however, is negative transference used (unlike positive transference). Indeed, negative transference in supportive therapy must be aggressively confronted and corrected; failure to do so often results in rapid and premature termination of therapy. Thus, in the example above, the supportive therapist might manage the patient's negative transference by saying, "I'm sorry I didn't return your telephone call earlier, but I was already on the phone with a very agitated and suicidal patient." Rapid and vigorous correction of negative transference ("Yes, I spoke with your employer about your medications, but please remember that I did so at your request") is essential, especially with paranoid patients for whom perceived nefarious motives or misbehavior on the part of the therapist often represents sufficient cause to immediately discontinue therapy. More generally, management of negative transference often requires the therapist to openly, explicitly, and nondefensively discuss what he or she is doing and why such actions are being taken.

Strategy #5: Hold and Contain the Patient

The concepts of holding and containing refer to a therapist's attempts to be a good parent by providing

empathy, understanding, and verbal soothing; modulating affect; restricting self-defeating impulsivity or acting out; and generally setting appropriate limits.⁵¹⁻⁵⁴ Holding and containing may also include allowing the patient to ventilate, emote, or otherwise express his or her thoughts, fantasies, or feelings. At what point should a supportive therapist intervene? The answer, once again, is to think like a parent. When a very young child is frightened by a thunderstorm, a good parent comforts the child and makes him feel safe: "It's okay, it's just a thunderstorm and it will pass; we'll be safe inside at home." Similarly: "It's scary going for a job interview, but we've practiced repeatedly and I think you can do it; the worst that happens is that you don't get this job, but there are plenty of others."

Containing the patient may require more aggressive interventions as well, including the use of psychotropic medications and psychiatric hospitalization. Both of these interventions should be used when appropriate, with forthright explanations as to why the therapist thinks they are necessary and beneficial at this time. Similarly, a therapist may need to call a parent, friend, spouse, co-worker, employer, social service agencies, or even the police in order to prevent physically dangerous or seriously future-foreclosing behavior on the part of the patient. The courts may need to be involved. As is the case with a good parent, however, these decisions should not be countertransference-determined punitive actions, but calmly instituted interventions for the good of the patient.

Even when containing the patient, it is important to protect his or her autonomy as much as possible. As soon as the patient is able to regain control, make appropriate decisions, and take appropriate actions, the therapist should relinquish control in those domains. Often the degree of containment will vary with the patient's condition and the stressors to which he or she is exposed, as would occur with a child.

Strategy #6: Lend Psychic Structure

The notion of "lending ego" derives from the psychoanalytic tradition; and broadly conceived, it refers to a therapist's functioning as an "auxiliary ego" for the patient.⁸ The patient is allowed to use or "borrow" the therapist's presumably well-working mind and psychological capacities in order to enhance his or her own,

relatively deficient, psychic functioning in particular domains. In effect, the patient is encouraged to think like the therapist, who presumably represents a good role model for mental health.

What sort of ego functions are “lent” in supportive therapy? They may include any or all, in various combinations, of the important mental or psychological functions. Often of key importance is reality testing, since it is difficult to negotiate one’s environment successfully if one cannot distinguish between reality and fantasy. Other important ego functions that may be lent include problem analysis and solving, affect modulation, impulse control (“think before you act”), and, perhaps, the functions subsumed under the recently popular term of “emotional intelligence,”⁵⁵ which include interpersonal awareness, empathy, and social skills.

The concept of lending psychic structure may be enlarged to include the lending of superego or, simply put, conscience. Some patients need to be encouraged to relax the self-imposed restrictions of conscience; they need to “lighten up,” take chances, and have some fun. Conversely, other patients may require a bolstering of their superego insofar as they do not have, or do not sufficiently act upon, reasonable notions of right and wrong. In either case, the therapist may present his or her own superego as a model for appropriate use by the patient.

One final comment is in order regarding the “lending” of psychic structure. The supportive therapist is, indeed, making a “loan,” rather than a permanent gift, to most patients. Although it is true that some patients (typically those with chronic, severe mental illnesses) may need an auxiliary ego or superego for the foreseeable future, many patients will borrow the supportive therapist’s psychological functions for more circumscribed periods of time. The therapist lends the patient what psychic structure is needed at the time it is needed, but, concomitantly, the therapist tries to promote the patient’s growth, independence, and autonomy.

Strategy #7:

Maximize Adaptive Coping Mechanisms

In all psychotherapy, including supportive therapy, an important goal is to increase a patient’s coping skills and use of adaptive defense mechanisms.⁵⁶⁻⁵⁹ Adaptive defense mechanisms include intellectualization, rati-

alization, humor, anticipation, altruism, and sublimation; in contrast, the more maladaptive defense mechanisms include denial, splitting, projection, and acting out. The supportive therapist’s goal is not only to increase the use of the former but also to decrease use of the latter. Whether one uses the term *coping mechanisms* or *defense mechanisms*, the process involved is one of healthy adjustment by the patient to current stressors. Examples might include going for a walk, calling a friend, immersing oneself in work, applying relaxation techniques, speaking with a therapist, and so forth.

The supportive therapist can enhance a patient’s coping skills through education about, and repeated practice of, specific mechanisms for dealing with stressful situations. The literature is replete with concrete suggestions and training programs in this regard. Two of the most useful approaches are the “skills training” aspect of dialectical behavior therapy⁶⁰ (e.g., core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills), and the use of “coping cards” as described by Beck.¹⁶ Whatever training paradigm is used, it is crucial that the patient begin well ahead of time to prepare to use specific coping skills in particular circumstances. Patient coping skills may also be enhanced in supportive therapy through the therapist’s lending of ego as well as role modeling.

Strategy #8:

Provide a Role Model for Identification

A corollary of the therapist’s strategy of lending psychic structure to the patient might appear obvious, but it is worth underscoring because of its importance in supportive therapy: the supportive therapist should willingly provide him- or herself as a healthy role model with which the patient can identify. The patient is not encouraged to live a life identical to that of the therapist (e.g., to adopt the therapist’s political views or take up the same hobbies). Rather, the patient is offered the opportunity to identify with the healthy psychological structure and function of the therapist, especially with respect to reality testing, affect modulation, impulse control, problem solving, and interpersonal interactions.

To this end, and in contradistinction to the classic psychoanalytic approach, therapist self-disclosure can play an important role in supportive therapy. Such self-disclosure should be judiciously employed with the best

interests of the patient in mind; the therapist need not, and should not, reveal every personal detail. Nevertheless, to the extent that a supportive therapy patient can benefit from concrete examples of how others have handled specific situations, the therapist may offer him- or herself as an illustrative instance. In so doing, the therapist may not only provide an opportunity for valuable vicarious learning on the part of the patient, but may also foster the therapeutic alliance.

The supportive therapist as role model cannot, and more importantly should not, present herself as a perfect human being. Not only is the therapist far from perfect, but there is much the patient can learn from the therapist's mistakes and failures as well as successes, from trials and tribulations as well as triumphs, from the therapist's "bad days" as well as "good days." Indeed, it is often of great benefit to the patient to learn (either through therapist self-disclosure of past events or through direct observation of the therapist in the office) how the therapist handles anger, irritation, confusion, disappointment, embarrassment, and failure—the vicissitudes of life that confront everyone, whether mentally ill or psychologically healthy. To the extent that the patient sees the therapist struggle to deal with such issues, the patient's thoughts, feelings, and behavior gain some measure of normalization ("Everyone gets mad sometimes; it's not just me"). This realization in itself may be an important vehicle by which the patient can experience an elevation in self-esteem. Thus, the supportive therapist does not hold him- or herself up as an impeccable role model with whom the patient should identify, but rather presents as a decent, mature human being.

Strategy #9: Decrease Alexithymia

The concept of alexithymia has generated considerable controversy.⁶¹⁻⁶⁷ Indeed, the very term *alexithymia*—literally, "no words for mood"—has been used in multiple ways in the psychotherapeutic literature. For some authors, the term refers to the inability to become aware of, or recognize, what one is feeling; for others, the term indicates an individual's inability to verbally label what he or she is feeling. Whatever definition one accepts, and in fact both deficits may be present in a given person, alexithymia is more than a simple cognitive deficit.

Indeed, the lack of awareness that one is experi-

encing feelings, the inability to recognize those feelings, and/or the lack of capacity to name those feelings is highly disabling. The very act of naming a feeling gives an individual a sense of understanding of and control over the emotion, analogous to finally learning the specific diagnosis of the medical illness from which one has been suffering. (This is true even if the illness is one for which there is no cure.) It is considerably more frightening to feel under assault by something unknown than known, and for many psychologically impaired patients the onrush of unidentifiable affects feels very much like an overwhelming assault or intrusion from the outside. In addition, the ability to identify and name feelings makes it easier to reflect on those feelings as well as discuss them with others. Finally, significant alexithymia makes it very difficult to engage in the next basic strategy outlined below: one cannot make connections between feelings and thoughts, behaviors, or events if one is unable to recognize and label those feelings. Thus, alexithymia is an appropriate target for supportive psychotherapy intervention. The goal is to help the patient recognize, acknowledge, identify, and label emotions.

Some patients benefit from a written list of feelings (available in many texts) so that they can review the list in a specific situation and attempt to find the word or words that best describe their affect. Many patients begin to recognize and label their feelings by concentrating on somatic sensations associated with particular affects: "It felt like my stomach was coming into my throat" for "fear," or "My head felt like it was going to explode" for "anger." In a related way, some patients find it helpful to describe their emotions in terms of metaphors relevant to their life experience or interests, whether in music, art, sports, or other areas: "I felt like a linebacker run amok," or "I felt like a winter night with a soft snow falling." Such metaphorical descriptions can then be given a specific label for convenient reference and communication. "I felt like a linebacker run amok" becomes "enraged," while "I felt like a winter night with a soft snow falling" becomes "serene."

Strategy #10: Make Connections

It is easy to underestimate the difficulty that psychologically impaired individuals may have in making the connections that otherwise healthy people make in

everyday life. And these connections—between thoughts and feelings, between events and subsequent thoughts or feelings, and between an individual's behavior and the response of others—are crucial to the ability to negotiate and function in the real world. A therapist's ability to enhance a patient's competence in making these connections will often result in substantial benefits in the patient's overall functioning and life satisfaction.

There are many patients, more severely impaired, who are unable to make the association between an event or situation in the real world and their subsequent feelings. For these individuals, feelings often seem to come out of nowhere. Inundated by affects they cannot understand or locate in a particular context, they feel affectively helpless and out of control. The realization that "I am feeling sad because my friend did not call me today as I expected" or "I am anxious because my therapist will be leaving on vacation" helps the patient to recognize the source of affects and to specifically target areas for intervention (e.g., "Perhaps you could call your friend," or "Maybe we should talk about how you're going to handle yourself while I'm on vacation").

Similarly, the basic notion, now enshrined in cognitive therapy, that thoughts and feelings are connected, is often alien to the more severely psychologically impaired. This relationship works both ways in the sense that either a thought or a feeling may be identified by the patient first. Nevertheless, a straightforward cognitive approach¹⁶ in which the patient is shown how to identify the underlying automatic thoughts and core beliefs that lead to unpleasant affects not only gives the patient a greater sense of control, but also allows for targeted cognitive interventions that can be made in conjunction with a therapist or on the patient's own.

Finally, a fundamental connection that is often deficient in personality-disordered and other severely psychologically impaired individuals is that between their behavior and the way in which others (particular people, the world in general) respond to them. In such cases the therapist might say, for instance, "Perhaps so many people are angry with you because you provoke them in some way," or "Maybe one of the reasons you so frequently feel abandoned by your friends has to do with how much you ask of them." Such confrontations must be done sensitively, empathically, and tactfully. The ultimate result is a change in locus of control from external to internal, a heightened sense of personal responsibility, and, not infrequently, relief on the part of

the patient at actually having some control over the way in which the world responds to him or her.

Strategy #11: Raise Self-Esteem

Foster Competency: All psychotherapies attempt to raise patients' self-esteem, although many different approaches (e.g., self-talk, correction of cognitive distortions, unraveling of unconscious guilt) may be taken in order to accomplish this goal. Nevertheless, perhaps the most direct and often the most robust means of raising self-esteem is by fostering an individual's competency in real skills. Indeed, there is nothing more effective in helping a patient feel better about him- or herself than the actual demonstration to self and others that he or she is truly competent. In this respect, talk may be beneficial in elevating self-esteem; but proof, and true belief, require competent performance in real-life situations.

What tactics are useful in promoting an individual's competence or mastery? Perhaps the most important are taking one step at a time and working to set a patient up for success rather than failure. In other words, the therapist guides the patient through individual steps of appropriate size and manipulates the variables to increase the likelihood of success at each step.

For example, a female patient has been unable to obtain a job for several years. Rather than simply send her on a job interview with the hope that she will be successful, the therapist may engage in behavioral rehearsal with the patient. Through role play, the patient may alleviate some of her anxiety, and together she and the therapist can problem solve potential difficulties (e.g., "How do I respond if I'm asked why I haven't been working for the past two years?"). The patient and therapist may agree to engage in "practice interviews" with employers in which the patient is not especially interested, using the experiences to prepare for future interviews for desirable jobs. At each step it is important for the therapist and patient to pay attention to key details. The therapist may specifically advise the patient with respect to her clothing, placement of hands, use of language in general, or phrasing of certain responses. The therapist attempts to optimize the likelihood that the patient will succeed at this particular task. At the same time, however, the therapist is ready to support and comfort the patient if she is unsuccessful; again, like

a good parent, the therapist serves as a cheerleader and encourages the patient to try again.

The ultimate goal is to enhance the patient's functional, healthy, adaptive behaviors through the mastery of key skills, especially interpersonal and social skills, problem-solving, and coping strategies. The therapist attempts to provide the patient with specific, concrete tools consistent with the latter's innate abilities and current functioning. It may be difficult for the supportive therapist to determine where the line is between appropriate encouragement and pushing too hard or giving up on the patient too early. Like a good parent, the therapist should not settle for too little from the patient, but must also beware not to not push the patient beyond his or her capabilities so that a learning, self-esteem-enhancing activity becomes a traumatic one instead.

Encourage Employment: Although this is not true for all psychologically disturbed or mentally ill individuals, the great majority of psychiatric patients will benefit from having a job, even if it is an unpaid, volunteer position. For psychiatric patients especially, work serves other important functions besides providing an income. It structures an individual's time, provides a sense of identity, increases self-esteem, and furnishes a sense of belonging to a larger community. For patients with interpersonally barren lives, work provides a ready-made socialization experience that allows them to observe and incorporate the social skills of others and practice those skills in a real-world setting. Thus, as a general rule the supportive therapist encourages a patient to work in whatever capacity or setting is consistent with the patient's overall level of functioning.

Normalize Thoughts, Feelings, and Behaviors: Perhaps with the exception of severely personality-disordered patients, most mentally ill individuals believe that they are "not normal." Whether it be particular thoughts, certain feelings, or specific behaviors, such patients suspect that they are in some fundamental way different from healthy, effective, and happy people. Often at some level they recognize that they are not functioning as well as those around them.

One does not successfully allay such anxieties by giving false assurances. On the other hand, it can be very helpful for patients to recognize that they are not alone. The realization that everyone struggles with the fundamental human issues (work, love, play, illness, loss, death) can provide solace, just as can the realiza-

tion that simply "being angry" may be normal rather than a sign of mania or personality disorder. Even the narcissistic injury engendered by the realization that one is engaging in highly maladaptive behaviors can be reduced and normalized by noting that such behaviors, while currently destructive, may have been highly appropriate, perhaps even life-saving, in an earlier time or context.⁶⁸ The therapist might note, for example, "One of the reasons that it's hard for you to assert yourself at work is that when you were growing up your alcoholic father would physically assault you if you spoke up. Being more assertive would be helpful to you now, but had you been so as a child, it might literally have been fatal." Patients are often greatly relieved, sometimes even proud, to learn that current counterproductive behavior is mistimed or misplaced but is the result of highly adaptive attempts to cope with very difficult earlier life situations.

Strategy #12: Ameliorate Hopelessness

Hopelessness in mentally ill individuals is often related to cognitive constriction, the patient's sense of having few options at his or her disposal. In that respect, removing the blinders, if you will, often greatly increases a patient's hope for the future; the patient needs to learn that there are more options available than he or she imagined. A useful approach to this problem is that of cognitive-behavioral therapy,¹⁶ with specific discussion of negative cognitive distortions that lead to hopelessness, as well as behavioral practice to reinforce a new way of thinking.

In a similar way, the use of reframing as a psychotherapeutic tactic can combat feelings of hopelessness. The patient is helped to see the "silver lining" in his or her circumstances. One instance of the reframing technique has been described above in connection with the normalization of destructive behaviors. Likewise, a supportive therapist might reframe a 25-year-old patient's bitter struggle with her parents as an attempt, perhaps misguided in its tactics, to obtain the entirely legitimate goal of adult autonomy: "I think what you're trying to do, to take responsibility and to control your own life, is very appropriate; perhaps together we can discover some ways to do this that don't cause such anger between you and your parents."

In supportive therapy the therapist may take active

steps to combat hopelessness through direct environmental manipulation. Helping a patient obtain disability status, get a new apartment, keep a job, find transportation—all of these everyday specifics can be of crucial importance to the patient, and their successful negotiation leads to increased optimism about the future. Hopelessness can also be ameliorated by elevation of the patient's self-esteem; as previously discussed, the most effective way to do this is through the development of true competence or mastery of specific skills.

Strategy #13:

Focus on the Here and Now

Supportive psychotherapy is not a classical “depth psychology” in which the therapist attempts to explore the patient's childhood experiences in order to understand the effect of those experiences on present-day thoughts, feelings, and behaviors. This is not to say that such exploration may not be appropriate and useful in supportive therapy, only that the primary focus should be on the “here and now” rather than the “there and then.”

The here-and-now issues that should be the primary focus of supportive therapy are those concerning everyday functioning. How is the patient feeling? How is the patient getting along at work, with family, with friends? Is the patient able to pay the rent? Does he or she have difficulty finding transportation to and from work? Is group therapy beneficial? Is the patient taking his or her medication, and have there been any side effects? It is through these everyday details that the therapist has sufficient data to judge how the patient is doing and what should be the focus of their work together. Once current mood and symptoms as well as logistical issues concerning rent, transportation, medication, and the like have been satisfactorily reviewed or addressed, the here-and-now focus should concentrate on a crucial area for most psychologically impaired patients: interpersonal relations and social skills. The more the therapist can help a patient increase his or her interpersonal awareness and reality testing as well as develop appropriate social skills, the better the patient will function in everyday existence. Hence, social skills training, whether part of a formal program or simply integrated into the fabric of the supportive therapist's general work with the patient, is of prime importance to the patient's overall functioning and life satisfaction.

The supportive therapist should work collaboratively with the patient to set an appropriate agenda for each session. Nevertheless, it is the therapist's ultimate responsibility to ensure that the most important issues confronting the patient or therapy are addressed in a timely fashion. Thus, it is often helpful for the therapist to have in mind a “hierarchy of thematic priority”²⁹ or a “hierarchy of primary targets”⁶⁹ with which to rank the significance of the various issues to be addressed in a given session. As a general rule, at the top of such lists are the following:

1. Threats to physical safety of the patient or others, such as suicidal or homicidal thoughts or behaviors.
2. Therapy-interfering behaviors, such as requests to decrease session frequency or to terminate the therapy, plans to leave the geographic area, failure to pay for therapy, destruction of office property, boundary intrusions involving the therapist.
3. Future-foreclosing events or plans,⁵⁴ such as precipitously leaving a job or moving out of one's house without alternative living arrangements.
4. Treatment noncompliance, such as failure to take necessary medications or to see an auxiliary therapist or psychiatrist.
5. Negative transference.

Strategy #14:

Encourage Patient Activity

It is crucial that the supportive therapist help the patient to become active, to “do” rather than simply “say” or “talk about.” Whether in the office with the therapist or in the everyday world, the patient is encouraged to experiment with new ways of thinking, feeling, and behaving. Talking about issues is often very beneficial in supportive therapy, but in the long run, discussion alone is no substitute for action. Only through the successful testing of new interpersonal behaviors or skills, the conquest of specific fears, or the mastery of feelings of inadequacy will the patient truly be convinced that he or she is capable in various domains. It is one thing to talk to a 10-year-old boy about his feelings of failure; it is quite another to teach him to hit a home run when playing baseball with his friends; it is the latter experience that is most likely to serve as an antidote to his feelings of inadequacy.

It is also helpful to have the patient set concrete,

achievable behavioral goals. “I want to be happy” or “I want to be a better person” are legitimate goals, but they are so broad as to be difficult to operationalize; in addition, such general goals make assessment of progress difficult, often resulting in the patient experiencing a sense of “going nowhere.” Thus, “I want to be a better person” might be concretized into specific behavioral objectives as follows: “I want to apologize to my family when I become unreasonably angry with them, and I want to return telephone calls from friends within 24 hours.”

The setting of specific, concrete, achievable behavioral goals serves another important function: it enables employment of the behavioral principle of “shaping.” Patients, like psychologically healthy persons, may not perform complex behaviors well on the first attempt. Often they must first practice and master part-behaviors or components of the overall skill. Subsequently, these component behaviors are integrated with one another in increasingly sophisticated ways that ultimately lead to competence in the application of the entire, complex skill.

Returning to a previous example, a patient needs to get a job in order to support herself. The supportive therapist may work sequentially with the patient on each of the steps involved in the process of obtaining a job: selecting the right job, constructing a resume, choosing the right clothes, practicing appropriate manners, coherently describing occupational goals, responding to difficult questions, and following up on the interview. By setting specific, concrete behavioral goals, it is possible to break large accomplishments into smaller ones, transform seemingly overwhelming tasks into manageable lesser tasks, and set the patient up for success rather than failure.

The supportive therapist, like a good parent, should assess the patient’s current psychological state and capacities, the overall context, and the specific task under consideration, pondering if, when, and how the patient should venture forth into a new or difficult experience. Thereafter, the therapist should work with the patient to devise a specific plan of action, using whatever techniques may be most beneficial in dealing with a particular issue or problem for this particular patient.

With the typical supportive therapy patient, behavioral approaches—behavioral rehearsal, role playing, relaxation, graded exposure, visualization and imagery, and so forth—are often the most useful in helping the patient to reach his or her goals. Many of these tech-

niques are enumerated and detailed by J. S. Beck¹⁶ and by Linehan.^{60,69} The patient may also be encouraged to become active through the assignment of homework to be completed between sessions. J. S. Beck¹⁶ provides sensible guidelines in this regard, stressing the importance of working collaboratively with the patient to set homework; starting assignments in the office; reviewing homework at the next session; anticipating and troubleshooting potential difficulties; and, more generally, attending to activity monitoring and scheduling.

In terms of encouraging the patient to be active and experiment with new ways of thinking, feeling, or behaving, it is helpful to emphasize patience (“Everything in its time and place” or “Rome wasn’t built in a day”), persistence (“Winners never quit and quitters never win”), and practice (“Practice makes perfect”). Here, again, the supportive therapist serves as a cheerleader for the patient’s efforts, even if such efforts are initially unsuccessful or even disastrous.

Strategy #15: Educate the Patient (and Family)

Education is invariably a large and important part of the supportive therapist’s work. Using understandable, nontechnical language and employing sensitivity to what the patient can and cannot tolerate hearing at a given time, the therapist tries to help the patient learn about his or her illness (e.g., depression). The illness’s symptoms, course, and prognosis are discussed. Special attention should be directed toward precipitants of decompensation (e.g., particular situations, times of year, stressful circumstances, alcohol or drug use) as well as premonitory symptoms (e.g., decreased sleep, change in appetite) that presage impending decompensation. Armed with knowledge of precipitants and warning symptoms specific for a particular illness in his or her particular case, the patient can take steps to prevent, or at least ameliorate, psychological breakdown. If the patient is prescribed psychotropic medications, he or she should be educated with respect to indications for the pharmacologic intervention, expected time course and benefits, and risks and side effects. Throughout the continuing process of such education, it is important that the supportive therapist preserve hope in the patient, balancing the reality of the patient’s circumstances with appropriate optimism for the future.

Especially with the more severely or chronically

mentally ill, there may be great benefit to similarly educating the patient's family, significant others, key friends, employer, or various social agencies. Such persons can serve, if they are willing and able, as additional "observing egos" and "auxiliary egos" for the patient. At the same time, however, the patient's wishes, autonomy, and confidentiality must be respected. Except in cases of emergency (e.g., imminent risk of physical danger to self or others), the therapist should ask the patient's explicit permission to speak with others about his or her case.

A second educational role of the supportive therapist has already been mentioned above. That is, the therapist may also educate the patient with respect to reality testing, modulating affect, controlling impulses, making connections, developing social skills, obtaining a job, preparing a budget, using public transportation, applying for social security disability, and any other specific tasks or functions that the patient is unable to enact without help.

In each of the above instances, knowledge empowers the patient, leading to actual competency and elevated self-esteem.

Strategy #16: Manipulate the Environment

Some of the differences between supportive therapy and psychodynamic, psychoanalytic, or insight-oriented psychotherapies⁸ have already been highlighted. A final consideration in this regard relates to the therapist's willingness to manipulate the environment around the patient.

The supportive therapist, unlike the typical psychoanalyst, may intervene with other persons or agencies to help the patient, again with due regard for the patient's independence and privacy. Hence, the supportive therapist may attempt to maximize family support by working with key family members. The therapist may enlist the aid of various social service agencies, speak with an employer to explain the patient's condition, communicate with the court system, perhaps even accompany the patient to the Social Security office if necessary. The supportive therapist's role is once more akin to that of a good parent. He or she provides the help that is needed (i.e., the accomplishment of important tasks of which the patient is currently incapable)

while simultaneously promoting the patient's growth and ultimate independence.

CONCLUSION

Although it is the most common psychotherapeutic treatment paradigm for mentally ill patients, supportive therapy receives relatively little time in the typical mental health professional training curriculum. This, in conjunction with the employment of diverse techniques from different psychotherapy paradigms, has left many mental health professionals confused as to the fundamental nature and process of supportive therapy. The basic strategies that provide the foundation for effective supportive therapy have been described so that the supportive therapist can focus his or her interventions to maximize benefit to the patient.

CLINICAL VIGNETTE: AMY

Amy is a 22-year-old college senior who presents to the Student Health Service Counseling Center on her own initiative with a 2-month history of depressive symptoms accompanied by faltering grades and intermittent alcohol abuse. There is no history of psychiatric hospitalization, suicide gesture or attempt, or previous contact with a mental health professional other than the school counselor. Early in her junior year at college, Amy's primary care physician had prescribed fluoxetine 20 mg daily because of dysphoria, impaired sleep and concentration, and decreased appetite with a 5-pound weight loss over the preceding 3 months. Four months later, however, Amy discontinued the medication on her own, feeling that it had provided no significant relief. Up until her senior year Amy had been a very good student, maintaining a B+ grade point average while majoring in history. Over the course of the last semester, however, her grades have fallen markedly. Even more worrisome for Amy herself has been the new onset of excessive drinking, a behavior very unlike Amy.

Amy has a number of pressing concerns. As the end of her senior year in college approaches, she is still unsure about a future career. Her father wants her to enter law school, but she is more inclined to become a writer, an occupation that he views as frivolous and risky. A second concern for Amy is that she has become increasingly estranged from her two female roommates, feeling over the past semester that she has less and less in common with them. Indeed, while her roommates are planning for, and looking forward to, successful careers, Amy feels "stuck" and confused about her future occupation. Finally, Amy is unhappy with her relationship with her "intermittent boyfriend" and unsure of their future. He is a bright but rigid and demanding premedical student who is very critical of others. Often the boyfriend tells Amy that her thoughts and feelings are

“just plain wrong.” More generally, although intelligent, attractive, athletic, and possessing a good sense of humor, Amy has always felt insecure in relationships with men.

Amy is the youngest of three sisters. Her father, an attorney at law, is a hard-driving, perfectionistic, and demanding senior partner of a prestigious law firm in a large city. Amy’s father has high expectations of everyone in the family; he requires each family member to be intelligent, attractive, physically fit, and successful. In contrast, Amy’s mother, formerly a nurse but now a full-time homemaker, is much less assertive than Amy’s father. Indeed, she too seems intimidated by her husband’s demands for excellence. All of the women in the family—mother and daughters—have felt his pressure to remain trim and attractive, attain top grades, and be occupationally successful. Amy’s eldest sister has completed law school and is now clerking for a prominent federal judge. The middle sister is in her final year of law school, planning to specialize in international finance. Amy, in contrast, not only is uninterested in a legal career, but also has maintained “only” a 3.4 grade point average (her sisters are both straight-A students, like their father). There is no history of mental illness within the family.

Amy has no history of significant medical illnesses or surgery. Her only regular medication consists of a multivitamin tablet daily. Amy has briefly experimented with marijuana and cocaine, but currently she acknowledges only the use of alcohol. Although abstaining from alcohol consumption during the week, on a typical weekend evening over the past 2 months Amy has consumed several cans of beer followed by three to five mixed drinks. These drinking binges typically occur in a local bar with acquaintances from class. The next morning Amy feels very guilty, remorseful, and angry with herself for her “irresponsible” behavior.

Formulation.^(#1) The most important psychological issues for Amy are low self-esteem and difficulties in establishing her own identity, especially one different from that expected of her by her father. These concerns have intensified during Amy’s senior year in college as she is forced to confront the question of what she will do after graduation. In spite of her many strengths (intelligence, humor, athletic prowess, and physical beauty), Amy feels fundamentally unlovable, unattractive, and incompetent.

Amy’s feelings of low self-esteem are related to her unsuccessful lifelong attempts to be a “good enough” daughter in her father’s eyes. Amy is well aware that her father is greatly disappointed in her insofar as she is unwilling or unable to follow in the footsteps of her older sisters, who are both straight-A students well on the path to becoming powerful and successful lawyers as well as beautiful women. In this respect Amy identifies with her mother, a passive and depressed woman who analogously feels that she can never do, or be, enough for her husband. Not only does Amy share with her mother a deep-seated sense of unworthiness, but also in her relationships with men Amy demonstrates her mother’s passivity, masochism, and fears of criticism

and rejection. Like her mother, Amy is reluctant to become emotionally intimate with a man, believing that such a relationship ultimately places her in a vulnerable position from which she is likely to experience more pain and disappointment than gratification. In contrast, Amy’s recent estrangement from her female roommates and her generally limited relationships with other women her age reflect long-standing conscious and unconscious competition with her older sisters. Amy views other women, especially aggressive and successful women, as competitors in relation to whom she always appears to be inferior.

Over the years Amy has developed coping/defense mechanisms that reflect her biological temperament and innate abilities, modeling by her parents, and environmental reinforcement. Isolation of affect and turning anger against the self, both modeled by Amy’s mother, serve to contain Amy’s feelings and prevent angry retaliation on the part of her aggressive father; the latter defense, however, results in feelings of guilt, shame, and depression. Through the defense mechanism of displacement, Amy is able to channel her aggressive and competitive impulses into athletic activities that avoid direct conflict with her family. Intellectualization serves a similar purpose, allowing Amy to compete with her father and sisters in the cognitive domain (although in areas other than law), which they most highly value. The process of intellectualization also reinforces the containment of feelings that Amy is fearful of releasing. The recent onset of excessive drinking and perhaps falling grades may reflect Amy’s underlying depression, but they also serve to act out some of her unconscious conflicts. Thus, alcohol abuse and poor grades represent an indirect means by which Amy can express her anger toward her father (by behaving in ways that embarrass him and sabotage his goals for her) and also punish herself for not being “good enough” as well as for having hostile feelings toward her father. Amy’s increasing depression and recent acting out have been precipitated by the pressure of her impending graduation from college, forcing her to confront issues about herself and her family that she has tried to suppress. Finally, Amy’s choice of boyfriend suggests a transference reenactment and/or a neurotic self-fulfilling prophecy: she has chosen to become involved with a man very much like her father. Although unconsciously Amy symbolically seeks her father’s approval and acceptance within her relationship with her boyfriend, instead she experiences criticism and rejection that recapitulate her relationship with her father.

In addition to her intelligence, humor, athletic prowess, and physical attractiveness, Amy has other strengths. Her interpersonal anxieties notwithstanding, Amy is socially appropriate and adept and has good empathy for others. In general she is an unselfish and kind person. In many areas of functioning she has demonstrated creativity, persistence, and courage. Her current lack of impulse control with respect to alcohol consumption is the exception rather than the norm. Finally, although currently feeling overwhelmed and confused, Amy generally possesses good introspective

capacities, including the ability to view herself and her behavior objectively.

Supportive Interventions. Amy easily falls within the inclusion criteria for a variety of psychotherapeutic approaches, including, at the very least, supportive psychotherapy and psychodynamic psychotherapy. The therapist's decision to employ supportive therapy as the primary approach in Amy's treatment reflects his assessment of the realities of patient choice, resource limitations, and college life. Although Amy could certainly benefit from psychodynamic psychotherapy, she is, in fact, a soon-to-be-graduating senior in college who will likely move to a different area of the country. Even more immediately, however, Amy, like many patients, seeks rapid amelioration of her symptoms and concrete guidance in moving forward in her life. At this particular moment she is less interested in a deeper understanding of her difficulties—"insight"—than in a speedy "cure." And, to this end, she welcomes a more active, here-and-now approach. As noted earlier, and consistent with changing patient expectations, needs, and resources, Hellerstein et al.¹¹ have argued that the treatment model of choice, or default therapy, for most patients should be supportive therapy.

For Amy, the supportive therapist as a good parent^(#2) requires appropriate containment of her self-destructive behavior balanced with validation of her strengths, dreams, and goals. The therapist's objective is not to impose a particular occupational choice or life plan on Amy, but rather to help her make her own choices as well as to find, and accept, herself.

The focus of supportive work with Amy will be less on the psychodynamics of her family and peer relationships than on the present (the here and now^(#13)) and the future: controlling her acting out and fulfilling her academic requirements for graduation; defining a career choice and pursuing the necessary steps to enact her aspirations; dealing with her father's domination, disappointment, and rejection; and forging satisfying and appropriate relationships with men and women her age. Such therapeutic work may involve exploration of the past in order to understand Amy's present situation, thoughts, feelings, and behavior; the goal, however, is not to recapitulate the past in the present (e.g., in the transference) but to rapidly construct a better future.

The most immediate goals for Amy's therapy are to ameliorate her depressive symptoms, contain or limit her self-destructive acting out through the abuse of alcohol, and prevent serious damage to her future career by academic failure in her senior year at college. Because Amy already knows full well, and feels guilty about, the destructive nature of her behavior (her current conduct notwithstanding, she possesses a strong sense of right and wrong), and has demonstrated good impulse control throughout most of her life, it is likely that the supportive therapist will not need to aggressively set limits (i.e., hold and contain^(#5)) on her use of alcohol except to ensure that Amy is not drinking and driving or otherwise engaging in life-threatening conduct. In-

deed, the very fact of addressing her problems with a mental health professional may be sufficient to allow Amy to regain her usual appropriate control of her behavior. Amy's depression will require supportive therapeutic techniques that focus on both short-term and long-term issues, perhaps in conjunction with antidepressant medication if her symptoms are sufficiently severe.

Amy is struggling with the definition and consolidation of her identity as an individual, an identity distinct from that dictated by her father. In this struggle Amy is neither alone nor abnormal, for a key developmental task of late adolescence and early adulthood is to forge such a new sense of self. Similarly, it is not uncommon for this healthy consolidation of identity to result in family conflict, especially in families that implicitly or explicitly demand that children follow their parents' dictates and aspirations rather than their own. Amy may benefit from a reframing^(#12) of her difficulties with her father as a strength, rather than a failure, on her part—a sign of her struggle for autonomy and an authentic self. Indeed, she might even be portrayed as more independent and courageous than her more highly acclaimed sisters for daring to go her own way. Thus, by normalizing^(#11) and reframing^(#12) Amy's depression and recent abuse of alcohol as a struggle for individuation from her family, the supportive therapist will concomitantly begin to raise Amy's self-esteem^(#11) as well as decrease her hopelessness^(#12) about the future ("I know it's hard now, but this is just one of the many things everyone has to deal with as he or she grows up and begins to move away from the family. Ultimately, you'll get through this just like other people your age."). To this end, the therapist may disclose^(#8) some of his own difficulties in defining himself and breaking away from his family of origin (i.e., provide a role model for identification^(#8)).

Although Amy is currently feeling overwhelmed, her life history suggests that she is generally capable of functioning at a mature psychological level. Thus, the supportive therapist's lending of psychic structure^(#6) is likely to be temporary and situation-based. Reality testing^(#6,#8) might focus on the recognition and acknowledgment of Amy's real strengths (e.g., intelligence, creativity, humor, athleticism), helping to elevate her currently impaired self-esteem.^(#11) Problem-solving skills, perhaps role-modeled^(#8) by the therapist, would initially emphasize here-and-now issues such as preventing academic failure in Amy's senior year and taking concrete steps to investigate and pursue a career as a writer. The therapist would do well to encourage activity.^(#14) He could encourage Amy to actively explore taking the GREs in order to apply to graduate school in journalism, or to investigate potential job opportunities in journalism for recently graduated collegians, as well as consider the practical concerns of where she might live and how she would support herself. By breaking down the seemingly overwhelming task of deciding on a career and finding a job into smaller, definable, stepwise goals, the therapist sets her up for success rather than failure^(#11) and, concomitantly, ameliorates hopelessness.^(#12)

Amy would also benefit from borrowing the supportive therapist's superego,^(#6) but not because she lacks sufficient feelings of guilt or shame regarding her recent alcohol-related acting out and academic decline. Quite to the contrary, the therapist might want to help Amy stop castigating herself for not being exactly what her father wants her to be, to learn to accept herself for who she is and what she wants to do in life. Thus, it is a less harsh, more forgiving superego that the therapist might provide for Amy's use and internalization. As previously noted, control of Amy's acting out requires more ego than superego; she already feels guilty and ashamed of her behavior, but she does not understand why it is happening and how to stop it. With sufficient clarification and support, Amy will likely regain control over her self-destructive actions.

The supportive therapist is required less to foster competency^(#11) in Amy than to help her recognize and accept the many competencies already in her possession, even if they are not the same skills valued by her father. In this respect a cognitive therapeutic approach may be helpful in allowing Amy to have a more balanced perspective on her strengths and weaknesses. Nevertheless, in comparison to her other talents, Amy is considerably less capable and competent in her interpersonal relationships with men and, more recently, with women her age. A combination of an exploratory approach (e.g., making connections^(#10) between her sisters and her roommates as well as between her father and her choice of boyfriend) and a supportive approach might be helpful, again accompanied by appropriate therapist self-disclosure^(#8) and role modeling.^(#8) A specific, longer-term goal in this regard might consist, for example, of developing a nonabusive, intimate relationship with a man; specific steps (through the provision by the therapist of an auxiliary ego^(#6)) might include finding the right man (where, how, when) and learning to tolerate intimate feelings as well as feelings of rejection. As above, the development and pursuit of smaller, stepwise, definable goals (rather than "I want to get along with everybody") assists the therapist in setting Amy up for success rather than failure.^(#11)

Amy needs only a modicum of education^(#15) about mental illness per se (e.g., depression); more important is education about how she manages her feelings of failure, rejection, competition, and anger. The supportive therapist

may help Amy to make connections^(#10) between her feelings and both her depressive symptoms and her acting out. Making these connections can help with maximization of her adaptive coping mechanisms^(#7) (e.g., intellect, humor, sports), which are currently overwhelmed. Thus, for example, as Amy becomes more aware of her anger at her father, the therapist may work with her to replace destructive coping strategies (e.g., turning anger against the self and acting out) with ones that are more appropriate (e.g., direct expression of her frustration with her father, humor). Similarly, the therapist might elect to use another of Amy's strengths, her wordsmithing abilities as a future writer, to help her identify, acknowledge, and appropriately express her feelings^(#9) about her family.

Amy's therapist needs to be aware of and to manage transference difficulties^(#4) that may impinge on the therapeutic relationship. In particular, Amy may react to a male therapist with feelings transferred from her relationship with her father, misinterpreting the therapist's comments as dominating, critical, and rejecting. She may then respond to these feelings by becoming passive or defensive or by increased acting out. In contrast, Amy might view a female therapist, especially one closer to her age than to her mother's, as a competitive sibling to be regarded coldly, suspiciously, and enviously. In either case, the supportive therapist should foster the therapeutic alliance^(#3) by attempting to ally with Amy's healthy ego—those parts of her that are appropriately concerned with her falling grades, alcohol abuse, career dilemma, and interpersonal difficulties.

The supportive therapist would need to enact relatively few environmental manipulations^(#16) on Amy's behalf. For example, because she is 22 years of age, many therapists would be reluctant to speak directly with her family, feeling that Amy's age-appropriate developmental task is to increase her autonomy and learn to negotiate issues with her family on an adult-to-adult basis. On the other hand, a supportive therapist might help Amy to obtain the application materials for the GREs, make specific contacts for a job after graduation, or refer her to an appropriate group therapy experience with similar high-functioning individuals.

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