

Celebrating the ordinary and the heroism of coping: Supportive Psychotherapy with people with Intellectual Disability

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Abstract

Many clinical psychologists and psychotherapists are probably unfamiliar with Supportive Psychotherapy as an effective treatment modality. However, there is recent literature describing its use with range of clinical syndromes. Commonly accepted components of Supportive Psychotherapy include: a friendly conversational style, a nurturing approach, meaningful praise, reassurance, and advice and a focus on strengthening existing defences. Supportive Psychotherapy may be an effective treatment for people with intellectual disability and a range of mental health problems, and a case vignette describing its use is included.

Introduction

Many clinical psychologists trained in the past twenty years may recognise the term ‘Supportive Psychotherapy’ from research articles, describing this mode of ‘treatment’ as a benign intervention for control groups in studies of more ‘active’ or rigorous treatments. However, they are probably less familiar with Supportive Psychotherapy as an effective treatment modality in its own right. Supportive Psychotherapy is sometimes referred to disparagingly as a ‘lesser form’ of psychotherapy which may be expected to deliver little if any therapeutic benefit (Berlincioni & Barbieri, 2004), or a simple-minded endeavour that can be practised without special training (Sullivan, 1971). However in recent decades several books and book chapters have appeared as well as a substantial research literature on its application to specific clinical syndromes, e.g. schizophrenia, borderline personality disorder, affective and anxiety disorders, posttraumatic stress disorder, eating and substance misuse disorders, and in working with people (e.g. with cancer) in medical settings (reviewed by Rockland, 1993). In one recently reported study in New Zealand an unexpected outcome was the effectiveness of a variant of Supportive Psychotherapy (specialist supportive clinical management) with women with anorexia nervosa (McIntosh et al., 2006).

Commonly accepted components of Supportive Psychotherapy

There remains some confusion over what Supportive Psychotherapy is and is not (Conte, 1994) and debate about whether it is a proper therapy at all (Crown, 1988; Hoffman, 2002). ‘Support’ can be seen as a basic element in any patient-therapist relationship (Berlincioni & Barbieri, 2004), and the ability of the therapist to form a warm supportive relationship may be the major agent of successful psychotherapy (Luborshy, McLellan, Woody, O’Brien, & Auerbach, 1985). However, Supportive Psychotherapy is described as involving the ‘use of highly technical aspects of supportive functions’ (Berlincioni & Barbieri. p. 332) while still lacking a solid theoretical basis (Berlincioni & Barbieri).

Holmes (1995) describes Supportive Psychotherapy as ‘a long-term treatment offered to... quite disturbed individuals for whom it is the treatment of choice’ (p. 440), a treatment that ‘celebrates the ordinary, and the heroism of simply coping’ (p. 444). Hellerstein and colleagues (1998) describe Brief Supportive Psychotherapy, conducted over 40 sessions. Horowitz (1984) compared its use to a more psycho-dynamic approach and found it more effective for individuals with weaker ego strength.

Elements of Supportive Psychotherapy

1. Style of communication

- A friendly, conversational style with purpose and focus
- A therapist who asks few questions but offers more reflections, responsive without being intrusive
- The therapist is 'real' to the patient, as a mistake-prone human who nevertheless has understanding and skills to offer in a collaborative relationship (Lewis, 1978).

2. Respect

- Through 'interested listening' the therapist conveys a knowledge of the patient's current life and history of what may be a life-long disabling condition
- A commitment to 'stay with' the patient, not rejecting them for failing to get well (Winston, Pinkster, & McCullough, 1986)
- Continuing to work towards agreed goals in a persistently hopeful manner.

3. Nurturing & comforting

- These concepts are described and employed both literally (with coffee, fruit, biscuits) as well as emotionally (with affection and acceptance), to identify the therapist as a benign positive figure.

4. Meaningful praise

- Revelations about the patient that evoke admiration are used as an opportunity to deliver genuine meaningful praise for anything the patient regards as praiseworthy
- Carefully avoiding any suggestion of false, insensitive, or conniving statements
- Used especially for any movement towards agreed goals.

5. Reassurance and advice

- Based on the therapist's 'expert knowledge'
- As esteem building or reinforcement of reality testing
- Providing structure when a person becomes disorganised under stress ('Now would be a good time to....').

6. Self-disclosure and action

- Within the usual constraints of confidentiality and privacy, in straightforward and uncomplicated ways, it can be very therapeutic to know that another person has grappled with life's complexities

- Providing 'an active teaching parental figure' from whom to learn new methods of adaptation (Dewald, 1994). The therapist may 'act for the patient', intervening in situations or with problems the patient has been unable to cope with so far

- To reduce stress and present a model for action.

7. Defences and focus on strengths

- Maintaining and strengthening 'healthy' defences, while gently discouraging maladaptive defences
- Increasing awareness of the relationship between behaviour and the responses of others
- Understanding the cause and effect in relationships, and the connection between past and present patterns
- Working within the patient's overall character structure and building on strengths.

8. Termination

- To remain helpful, interested, and available
- Emphasising the need for follow-up
- Reduce the frequency of contact rather than terminating therapy.

9. Alternative definition of success

- Relief of symptoms
- Changing behaviour without significant personality change
- Maximum independence and autonomy
- Enhance patients' strengths and coping.

Whilst wishing to avoid a common approach of attempting to define Supportive Psychotherapy by describing what it is not, it seems important to reiterate a point made by Hellerstein and colleagues (1994), that Supportive Psychotherapy is not the therapy of 'relatively unskilled counsellors that was often recommended in the 1960s and 70s' (p. 306), but is based on a thorough knowledge of personality development

and psychopathology carried out by practitioners who have had specific therapeutic training.

Supportive Psychotherapy and people with Intellectual Disability

People with intellectual disability, however mild their cognitive deficits, are rarely offered the full range of psychotherapeutic treatment options. The terms 'therapeutic disdain' and 'un-offered chair' are used to describe the opinions and attitudes of professionals and the process of 'exclusion', that concludes that such a person would be unable to benefit from a particular therapeutic approach, or the therapist in question believes they do not have the skills required or they prefer not to work 'with this type of client'. Other approaches such as 'behaviour modification of challenging behaviour' or simplified cognitive therapy, for example, replacing negative thinking with positive, may be available, however there is an emerging body of literature about the range of psychotherapeutic approaches and their success with people with intellectual disability (Hollins & Sinason, 2000; Kroese, Dagnan, & Loumidia, 1997).

No literature could be located that describes the use and utility of Supportive Psychotherapy with people with intellectual disability. The following vignette is included to encourage psychotherapists and clinical psychologists to consider this treatment option.

Case vignette

Few details of this person will be given to protect his identity. Tony is 36; he has a mild ID. His childhood and early adult years were punctuated from an early age with distressing and traumatic events, for example, mother's death, rejection by father, many residential moves. He disclosed ongoing sexual abuse by a male carer and was admitted to a psychiatric hospital. His diagnosis was severe Post Traumatic Stress Disorder with eight months of unabating and frequent episodes of self injury, aggression, and isolation. He was heavily medicated with sedating drugs, was often restrained by staff to protect him and others and for the same reason spent many days each month

in seclusion. Relevant to the therapeutic process was his ability to read (10 yr. old level).

First stage of Supportive Psychotherapy (October)

Twenty-four short (10-20 minute) sessions, usually twice/week (over 3 months), were conducted in open spaces in the ward environment, with no scheduled times to avoid anticipatory anxiety. Very benign content was generated by the therapist, for example, "Let's write down things you enjoy", and a 'Therapy Book' was started so that each new session could begin with a review of previous sessions as appropriate. In the sixth session Tony began (unmasked) to relate details of the sexual abuse trauma. He decompensated immediately (staring, tense, shaking, breath-holding, tearful, unresponsive) but was able to sit quietly and relax to simple instructions from the therapist. He also requested extra medication (see November on Figure 1.) This was reframed as an important learning experience, and Tony was praised for his ability to 'cope'. In the 10th session an enquiry about spiritual beliefs led to Tony returning to his church community each week to attend mass.

In these early weeks the foundations of the therapeutic approach were established:

1. Praise – heartfelt, frequent praise for any signs that Tony was trying to use the strategies he already knew helped him to cope and calm. These were mainly distraction (music and busy activity), exercise, and relaxation.
2. Spiritual and emotional support – Tony returned to his church and weekly contact with supportive friends in the church community. He also talked to a senior nurse in his ward about how he was coping each day.
3. Respectful listening and reflection – As Tony talked, the therapist listened carefully, made reflective comments and took notes. The next session began with a brief written summary of the previous one for Tony to read, comment on, and change if he wanted to.

Positive outcomes: Less sedating medication (see attached graph), no more seclusion episodes, church attendance, a friendship re-established,

'sheltered' work placement commenced one day/week.

Second stage of Supportive Psychotherapy (January)

This stage began when sessions lengthened to nearly one hour, were conducted weekly (both choices Tony made), and lasted for 9 months. Tony was educated about a therapist's role and constructed his own therapy goals (Coping with difficult situations, Planning for the future). A key belief of Tony's emerged (and was gently challenged) that made coping very difficult for him ('When bad things happen it's always my fault'). His reliance on 'thought blocking' as a major coping strategy was identified and its advantages and limitations explored. The 'Therapy Book' expanded to include simple mood monitoring strategies and summaries of significant events and insights Tony had in therapy.

As a community residential option was identified, therapy focussed on the task of coping with 'leaving a lovely place (the ward)', and 'being safe' in a new place. The plan is for therapy to continue as an outpatient.

Positive outcomes: No disturbed behaviour, no sedating medication, fulltime work placement, and discharge to community accommodation.

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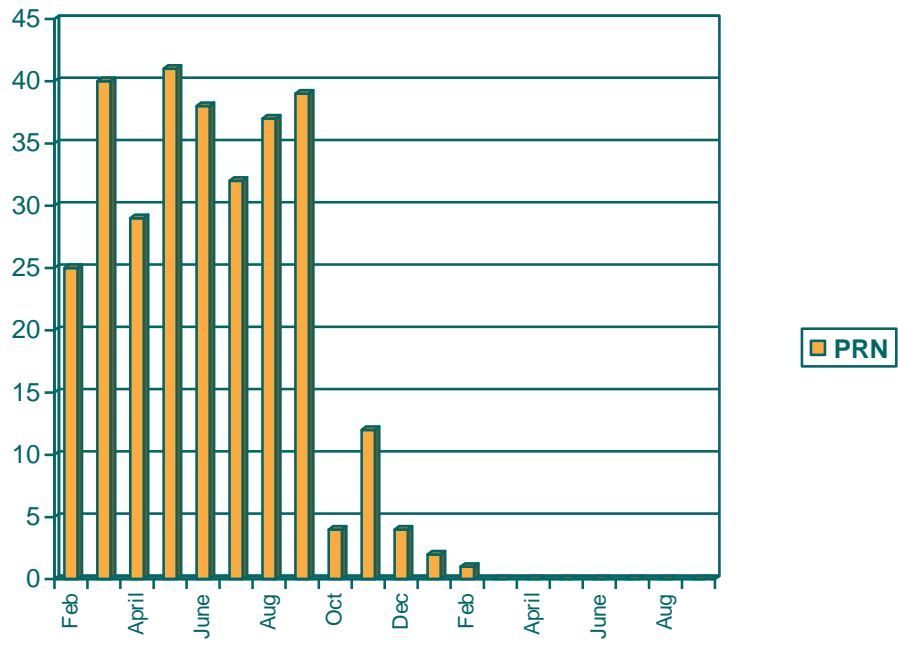


Figure 1. Monthly totals of extra doses of sedating medication.