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Psychology & Psychological Research International Journal
ISSN: 2576-0319

Realization of Reality: The Relevance of a Supportive-Humanistic Approach in Psychotherapy

Bandyopadhyay C*

Consultant Clinical Psychologist, India

***Corresponding author:** Chitrankana Bandyopadhyay, Consultant Clinical Psychologist, RCI CRR No: A71998, Kolkata, West Bengal, India; Email: cynica2012@gmail.com

Clinical Note

Volume 7 Issue 3

Received Date: August 01, 2022

Published Date: August 12, 2022

DOI: 10.23880/pprij-16000307

Abstract

It is of common perception that modalities of psychotherapy that are 'Supportive' and/or 'Humanistic' in nature are not practically intervention-oriented, but rather pre-cursors to actual therapeutic work. This article offers a clinical opinion that aims to suggest the intensive and change-inducing capacities of these approaches, especially in cases where the individual's psychopathology is a direct outcome or reflection of their environmental challenges, threats, injustices or demands that are objectively traumatic or at least, burdening. The application of the same has been described through the exploration of three different types of symptomatic presentations with varied backgrounds and perceptions of external stress, where the common theme remains the perception of omnipresence of an undeniably unforgiving and unfair reality. Through this discussion, it is proposed that a Supportive-Humanistic approach may be viewed through the clinical lens of what can be a sufficient and effective modality of intervention on its own; more so in cases where there are patient-specific barriers in implementing change through traditional cognitive behavioral or dynamic models of psychotherapy. It is concluded that these approaches often mobilize the individual to make positive, resilient changes within the limits imposed by their external world, simply by virtue of a mutually genuine understanding, processing, acceptance and validation of their difficult experiences within the therapeutic alliance. In essence, a Supportive-Humanistic clinical style can thus be as potent in enhancing coping skills of a person as any of their counterpart models of psychotherapy, in the face of an uncontrollable reality.

Keywords: Humanistic approach; Supportive psychotherapy; Intervention models; External factors; Psychopathology

Abbreviations: OCD: Obsessive Compulsive Disorder; BT: Behavioral Therapy; ERP: Exposure and Response Prevention; CBT: Cognitive Behavioral Therapy; UPD: Unipolar Depression; MET: Motivation Enhancement Therapy.

Introduction

In a definition that is universally acknowledged by clinicians as the gold-standard of what encapsulates 'psychotherapy', Wolberg (1962) [1] describes it as "the treatment by psychological means, of problems of an emotional nature, in which a trained person deliberately establishes professional relationship with the patient, with the object of:

1. Removing, modifying or retarding existing symptoms.
2. Mediating disturbed patterns of behavior.
3. Promoting positive personality growth and development.

In a nutshell, it is thus emphasized that psychotherapeutic interventions should primarily aim to focus on building internal resources of the individual, most often in the face of difficult situations that may either cause or contribute to their symptom manifestation. In close relevance, Goldfried

(1980) envisions psychotherapy mainly as a tool for general coping-skills training, which goes beyond the resolution of specific problems of the patient's priority and the choice of modality of the psychotherapist [2]. The underlying implication however, is that the difficulty of the external environment remains and persists as something that is beyond the scope of control of the patient or the clinician, which in turn often renders it comparatively irrelevant in treatment. In this pursuit of intervention models (broadly, cognitive or dynamic) that typically 'intervene' with only the person's disturbed mode of functioning, 'Supportive' and 'Person-Centred'/'Humanistic' techniques are often viewed as less consequential pre-requisites or adjuncts that are restricted to the initial purpose of rapport-building in long-term psychotherapy. However, in many scenarios, clinical presentations have strong roots in the environment that turn out to be overwhelming, undeniable and all-pervasive maintaining factors of psychopathology. In this context, the focus of this article would be to highlight the role of a Supportive-Humanistic approach (referred to as 'S-H approach' henceforth) in psychotherapy that aims to:

1. Validate the perceived unjust nature of the precipitating or perpetuating external factor(s) that have forced the individual into a victim role.
2. Identify and accept the real consequences that are direct outcomes of environmental, contextual and/or systemic difficulties.
3. Make space for the person's helplessness, learned or legitimate, till they want to reclaim autonomy in the face of uncontrollable adversities.

This is to suggest that an intensive S-H approach may itself be able to motivate and mobilize a person in the face of deep burnout of survival and coping skills that depletes their natural reserves of resilience. Thus in essence, it might have the potential for recognition as more than just an initiation into the psychotherapeutic process. To elucidate this in terms of practical application, three different clinical presentations are discussed as follows.

Case 'A': Treatment Resistence and the S-H Approach

Index patient 'A', aged 72 years, cis-male, married, retired, hailing from an urban area of Kolkata, India was presented with Obsessive Compulsive Disorder (OCD), with obsessive symptoms of intrusive thoughts related to death and suicide and compulsive, ritualistic random motor movements. Previously his symptom presentation included obsessions related to germs and contagion along with hyper-religiosity, and compulsive acts of repeated hand washing and cleaning, all of which developed insidiously since the beginning of the global pandemic following his retirement, 2 years ago. The intensity and frequency of complaints were drastically exacerbated by the sudden death of his older brother due to Covid-19 infection, nearing the end of 2020. He had been compliant to psychiatric treatment for one and a half years before visiting for psychotherapy and claimed that although improvement was noticeable; his symptoms would not entirely remit and often change presentations. The case was conceptualized with Behavioral Therapy (BT), with focus on Activity Scheduling and Exposure and Response Prevention (ERP); as well as with Cognitive Behavioral Therapy (CBT), that included Cognitive Restructuring of rigid, dichotomous distortions of generalization, personalization, catastrophization and thought-action fusion. However, the patient was unusually unresponsive to efforts at rapport building and would be non-compliant to therapeutic suggestions for the initial sessions even after repeated Psychoeducation. He would also display consistent avolition in spontaneously interacting in sessions and would require continuous probing. Instead of aiming at psychopathology and symptom remission only, a primarily S-H approach was then adopted to address the perceived reality of the Covid-19 pandemic. This eventually revealed unexpressed worries and melancholy regarding the chronic sense of restriction on personal autonomy, the severe lack of confidence for being unproductive post retirement, the valid fears of untimely death in the context of the pandemic and the unprocessed grief of the loss of his brother, as well as that of a general sense of safety and predictability. Results were noticed in the form of increased motivation in enhancing daily engagement and adherence to ERP exercises; and in gradual voluntary efforts at active evidence-testing of fears and anxieties. As symptoms reduced with progression in treatment, the patient was found to respond to exploration of intrinsic, primal death anxieties and related existential concepts of worth and self-sufficiency that drove illness-manifestation, thereby reducing chances of relapse post termination of psychotherapy.

Case 'B': Limited Internal Resources and the S-H Approach

Index patient 'B', aged 24 years, cis-female, separated, employed as a nurse, hailing from a rural area of Bhubaneswar, India was presented with complaints indicative of a severe depressive episode with nihilistic ideations and greatly impaired socio-occupational and personal functioning. History was suggestive of several previous episodes of Unipolar Depression (UPD) with an approximate onset at age 19, precipitated by the termination of a long-term romantic relationship. These episodes were either ignored by immediate family or were subjected to inconsistent, non-compliant psychiatric treatment over the years. She reported the present episode to have insidiously developed post-partum, 3 years back. Major perpetuating factors were found to be a hyper-critical, unsupportive, biased and

dominating familial environment since childhood, along with a strained and distant relationship with husband of 4 years. Additionally, the patient was subjected to persistent discrimination, ridicule and harassment at her workplace for having a diagnosed mental illness. The primary goal of psychotherapy was to improve her functioning at home (personal grooming and hygiene, carrying out house-hold and parental responsibilities) and at work (identifying repeated errors and addressing consistent inattention and avolition at work), as well as to enhance her overall coping with her environmental stressors in order to improve persistent low mood and feelings of loneliness. The case was conceptualized with Supportive Psychotherapy (with emphasis on Catharsis, Guidance and Environmental Manipulation), BT (with emphasis on Activity Scheduling, Assertiveness Training and Social Skills Training) and CBT (with emphasis on Behavioural Activation and Cognitive Restructuring of distorted perceptions of social interactions and relationships). However, in the light of the socio-cultural and educational background of the patient, along with the intensity and longevity of stressors that exceeded and burdened her existing resources of coping, she was found to be minimally reflective in psychotherapy. This rendered the case inappropriate for traditional CBT. Since she required a more direct and suggestion-oriented approach in dealing with practical problems at work and in personal relationships, a primary S-H modality was adopted with allied BT techniques that in turn increased insight of her own contribution in the maintenance of said interpersonal struggles through supportive trial and error. The outcomes of psychotherapy were noted to be mood improvement and a subjective perception of enhanced competence and confidence in dealing with contextual challenges.

Case 'C': Prevailing Systemic Issues and the S-H Approach

Index patient 'C', aged 38 years, cis-male, unmarried, owner of a business, hailing from an urban area of Kolkata, India was presented with chronic alcohol dependence, low mood, anhedonhia, hopelessness and anger outbursts since the last 23 years approximately. He identifies as a gay man and partly attributes his complaints to several failed romantic relationships since adolescence. Additionally, although he perceives his parents to be otherwise supportive of his identity, he holds them accountable for imposing their academic and career-related ideals on him since childhood. As a result, he is unable to feel fulfilled and satisfied with his sense of self, his prior achievements and his present lifestyle. He also believes that his hopelessness regarding the future stems from not being allowed to explore his own choices when young, such that he tends to feel like a "failure" at present. He claimed to have lost faith in the idea of a sustained, healthy romantic relationship and insisted that the resultant loneliness would have been easier to cope with had he been given the opportunity to find meaning in his individual needs and desires on an occupational front of preference. This leads to bitter, aggressive outbursts towards his parents, frequently under the influence of alcohol. The index patient also tends to withdraw from his friends and community, who he describes as caring but busy and unavailable. There was a long history of poor compliance to treatment, with multiple visits to different psychotherapists and psychologists all of whom were perceived as "unhelpful and unable to understand the problem" after the initial few sessions. He justified attempting psychotherapy again partly out of curiosity and partly because his mental health was subjectively deteriorating more than before. Strong, long-term defences of denial, intellectualization and rationalization were identified and that of suppression, displacement and projective identification were suspected. The case was conceptualized in a Dynamic-Existential modality with Motivation Enhancement Therapy (MET) techniques (for alcohol dependence), with special emphasis on Queer Affirmative philosophies of treatment. However, owing to consistent indications of possible negative transference on past clinicians that lead to repeated, abrupt termination of treatment; primary focus was laid on an S-H approach to explore and acknowledge feelings of helplessness, hopelessness and despair of being at the expense of chronic, bipartite social restrictions. The first being familial demands that were limited to cultural over personalized understandings of ideal occupational success, while the second being systemic oppressions and prejudices that prevail in the Indian society for the LGBTQIAP+ community. The latter affected the patient indirectly as none of his previous partners could commit to a long-term relationship owing to lack of acceptance of their sexual identities. As a result, before any of the (well-established) ego defences could be targeted, it was essential to grieve for the missed opportunities and deprivations that were imposed on him in his perception with the S-H approach. Through this approach, emotional acceptance of the objective unfairness of societal evils and orthodox traditions was facilitated through the deliberate act of mourning. This allowed the patient to receive tangible support while he underwent guided re-traumatisation in the therapeutic process. This in turn, enhanced willingness to claim unhelpful reasoning that maintained drinking behavior and avolition in modifying career identity. He was also more compliant in evaluating his own role in perpetuating and adhering to privileged, heteronormative ideas of ideal companionship and affiliation that are unsuitable for members of a marginalized community such as that of his own. Patient feed-back included a greater sense of ease and readiness in actively working towards an end-goal of re-envisioning meaning, fulfilment and purpose of life regardless of the socio-cultural limitations imposed; than he had experienced in past attempts of problem-solving

approaches in psychotherapy.

Conclusion

In light of the previous case discussions, it is thus suggested that the S-H approach in psychotherapy has the potential to be an exclusive clinical tool that facilitates the unearthing, awareness and dissipation of emotional blockages that traps an individual in a victim role of learned helplessness and renders them unsuitable for or unresponsive to therapeutic attempts. In context of the pervasive nature of struggles of specific realities (objective or subjective) of patients, the clinician must nearly expect a natural exhaustion and resistance in having to take charge of their own well-being despite adversities. Through the S-H approach, it is possible to introduce and develop a perception of survival that is often lost in the experience of terror of having to survive threats and challenges. To paint an analogy, no human can be expected to swim through tides without building faith in the act of swimming at first. This model may indirectly enhance coping of the patient who was otherwise stuck blaming their environment for their distress and waiting for it to change for the better. With the intention of locating possibility of growth and development outside of the source of distress, the S-H approach of psychotherapy mobilizes intervention, and thus positive transformation in the patient's life.

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