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Dynamic Supportive Psychotherapy

*Handbook of Short-Term
Dynamic Psychotherapy*

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McCullough**

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ORIGINS AND DEVELOPMENT

Supportive psychotherapy is widely practiced and may in fact be the treatment provided to most psychiatric patients. In the early years of psychoanalysis, it was generally assumed that anyone who studied psychoanalysis could automatically do psychotherapy. Since the 1950s it has been recognized that psychotherapy should be systematically taught as a modality apart from analysis and that it should be conceptualized on its own terms, not as a lesser form of analysis. However, supportive psychotherapy has seldom been taught.

It seems to be assumed that if one masters psychodynamic therapy, one is able to do supportive therapy, which has generally been seen as a therapy that requires less skill and is appropriate primarily for patients who are less intelligent, less well motivated, or less interesting (Winston, Pinsker, & McCullough, 1986). The consequence of this assumption has been that supportive psychotherapy is often conducted with the objectives and techniques of expressive therapy as the model. Paul Dewald (1971) described expressive therapy and supportive therapy as the poles of the continuum of dynamic psychotherapies. Most patients receive a therapy that incorporates both supportive and expressive elements. There is a model for the expressive,

or psychoanalytic, end of the continuum. Supportive psychotherapy has been described primarily as a body of techniques and in terms of subtraction of certain elements of expressive therapy, so there has been no model for the supportive end of the continuum.

Two rather different definitions of supportive therapy are current in the literature. Supportive psychotherapy is sometimes presented as a treatment for patients who are too fragile or too unmotivated to participate in therapy that is intended to bring about lasting personality change. Otto Kernberg (1984) has characterized as supportive therapy any therapy that is not primarily expressive. If one accepts his narrow view of expressive therapy, then supportive psychotherapy is what many practitioners think of simply as psychoanalytic psychotherapy. Lester Luborsky (1984) describes a continuum of psychotherapies. Between the poles of supportive and expressive therapies, he places expressive-supportive and supportive-expressive. In each instance, supportive psychotherapy is conceptualized primarily as a modified and truncated version of expressive therapy.

Our clinical and research psychotherapy group at Beth Israel Medical Center has attempted to define a separate supportive psychotherapy. We have codified and structured a stand-alone set of concepts, rules, and techniques embodying a treatment that may be useful for a wide range of patients and that may be tested within a brief psychotherapy research mode.

We have not invented a new modality of treatment. We believe we are making concrete and teachable an area of psychotherapy that has been widely practiced but not adequately articulated. Although it is not a new therapy, it is a new way of thinking about psychotherapy, and it may make it possible for new therapists to grasp more quickly the large body of clinical wisdom that most experienced therapists have discovered. We began by conceptualizing the essential elements of the supportive treatment provided to the most impaired patients. We then realized that psychotherapy based on this definition was appropriate for a much broader range of clinical problems.

The objective of expressive therapies is generally to bring about change in the patient's personality. Perhaps the most explicit statement that the objectives of expressive therapy must be the objectives of all therapy is the assertion that "if it is supportive it isn't therapy" (Crown, 1988, p. 266). We do not define supportive therapy as being intended to produce personality change, but we believe that if an individual's habitual responses and habitual ways of feeling are altered, personality change has occurred.

Here is our definition of supportive psychotherapy: individual dynamic supportive psychotherapy is a dyadic treatment characterized by use of direct measures to ameliorate symptoms and to maintain, restore, or improve self-esteem, adaptive skills, and ego function. To the extent necessary to accomplish these objectives, treatment may use the examination of

relationships, real or transference, and both past and current patterns of emotional response or behavior. Ego functions include relation to reality, thinking, defense formation, affect regulation, synthetic function, and others as enumerated by Beres (1956), Beliak (1978), and so on. What we term ego functions could alternatively be called psychological functions, since they are addressed by behavioral therapists and cognitive therapists, whose formulations do not include the ego as a component of mental apparatus. By adaptive skills we mean almost anything a person does to function more effectively. The boundary between ego function and adaptive skill is not sharply defined. The patient's assessment of events is ego function; the action taken in response to the assessment is adaptive skill. Ego function looks inward. Adaptive skill looks outward. Supportive therapy uses direct measures to accomplish these objectives. It does not assume that benefits will flow from greater maturity, insight, or the resolution of intrapsychic conflict.

Each of the three objectives must be addressed: self-esteem, adaptive skills, and ego function. If the therapy does not address each of these, it may be useful—it may be just what the patient needs—but it is not supportive therapy. Behavioral therapy, for example, may focus on adaptive skills and nothing else. Some patients—those who are most fragile and narcissistic—may need a supportive relationship and derive benefit from it, but if the therapy has no other ingredients, it cannot be called supportive psychotherapy. Some such patients, after a prolonged supportive

relationship, become able to participate in supportive therapy.

Lawrence Rockland (1989), in an important new book on supportive therapy, defined supportive therapy as focused on improving ego function and adaptation. Attention to self-esteem, an explicit component of supportive psychotherapy in our definition, is characterized by him as appropriate transference gratification.

Various psychotherapies can be conceptualized as being a continuum, with the most expressive, psychoanalysis, at one end, and the most supportive at the other. Various blends of supportive-expressive or expressive-supportive occur at the middle. Some treatment techniques may be found at any point on the continuum. For example, examination of patterns from the past may be part of any treatment, although this is not the major focus for the low-functioning patient, with whom it is often more useful to concentrate on current circumstances. The treatment techniques that are associated with the two ends of the spectrum cannot be randomly applied at the intermediate points of the spectrum. The therapist is real to the patient or not. Transference is the major focus or it is not. Fantasy is encouraged or not encouraged. Character defenses are attacked or accepted. Just as inappropriate support may be a contaminant in expressive therapy, the techniques of expressive therapy—which have been taught to most of us as universal techniques of therapy—may be contaminants in supportive

therapy.

Conventional practice has been to depart from the model of pure expressive psychotherapy to the extent necessary to meet the patient's needs. It is our thesis that supportive psychotherapy should be conducted with the supportive psychotherapy model uppermost in mind, deviating in the direction of expressive therapy only to the extent necessary to meet the patient's needs, always recognizing departures from the supportive psychotherapy model. For example, in expressive therapy, making a direct answer to the patient's question, without exploring its meaning, is a departure from the model. In supportive dynamic psychotherapy, nonresponse to a question is the departure from the model.

Rockland's supportive therapy is based upon the model of expressive therapy. He permits silence, recognizing it as resistance, but it is resistance to the work of supportive therapy, not resistance to uncovering.

SELECTION OF PATIENTS

Expressive therapy has been widely accepted as the default therapy—the therapy to be provided unless there is some reason to do something else. Supportive therapy has been dismissed as a treatment for those who cannot or will not engage in what has been seen as the more substantial therapy. This is, perhaps, a legacy of Freud's (1919/1955) description of psychoanalysis as

"gold" as compared with the "copper" of suggestion.

Recent work has been more critical, with clinical assessment no longer based primarily upon global attractiveness. It is now recognized that being bright, verbal, and introspective does not really predict success in treatment. According to David S. Werman (1984), the typical patient for whom supportive therapy is indicated demonstrates some degree of ego deficit or insufficiency. Clinical characteristics include inability to introspect, alexithymia, inability to tolerate suffering, poor object relations, prominence of such primitive defenses as projective denial and splitting, weakness in trust, somatoform problems, and deficient energy. These are presented as indications for supportive therapy because they preclude expressive therapy.

According to Peter Buckley (1986), the following factors are indications for supportive therapy: (1) primitive defenses such as projection and denial predominate; (2) object relations are impaired and characterized by an absence of capacity for mutuality and reciprocity; (3) and in more extreme cases, inability to recognize the object as being separate from the self; (4) failure to adequately modulate affect, particularly aggression; (5) overwhelming anxiety around separation/individuation issues.

Rockland (1989) endorses the view that patients who have chronic neurotic or borderline character pathology of moderate severity and who also

have adequate intelligence, motivation, and psychological mindedness should be in exploratory psychotherapy. But even these patients, should they seek treatment during an acute crisis, should have supportive psychotherapy. Only after resolution of the crisis should the prospect of exploratory therapy be considered.

We believe serious consideration must be given to the proposition that treatment based upon the principles we have delineated as the foundation of supportive psychotherapy should be the basic or default approach. We propose that it is expressive psychotherapy, not supportive, that should be prescribed only when specifically indicated. It is beyond the scope of this chapter to explore indications for expressive treatment or for psychoanalysis. These indications probably include the presence of oedipal-level development, an assessment of remediable character pathology, and the presence of repeated ego-dystonic behavior. The basic treatment model should be supportive, with only as much expressive technique as necessary. This is the reverse of the usual practice, which is to provide only as much support as necessary.

The style of supportive therapy is more conducive to continued effort for most patients. The discipline of therapist nonresponse that characterizes good expressive therapy is chilling to many patients, and it is hardly a desirable model for human relationships.

Supportive therapy for the higher-functioning patient is, of course, not the same as supportive therapy for the low-functioning patient, as, for example, the chronic schizophrenic. With a low-functioning patient, patient-therapist conversation focuses on adaptive skills and self-esteem. With the higher-functioning patient, the content is more likely to be relationships and patterns of response, with room for exploration of the meaning of the patient's words. We are not suggesting that the therapy of the high-functioning patient involve unnecessary attention to life skills or to such ego functions as reality testing and impulse control.

There appear to be certain populations of patients for whom supportive psychotherapy is the treatment of choice. Edward Kaufman and Joseph Reoux (1988) have suggested that supportive psychotherapy is indicated for substance abusers who are in the initial stages of sobriety. This treatment may need to be continued indefinitely, with expressive elements added as needed within the patient's capacity for tolerance. Expressive therapy is generally contraindicated until the patient has developed a firm therapeutic alliance and has both a support system and a concrete means for maintaining sobriety. Premature use of anxiety-provoking psychotherapeutic strategies aimed at character change will tend to push the patient back into drug use as a means of modulating strong affect.

While there is little controversy about the prescription of supportive

therapy for the low-functioning patient, therapists have not been as comfortable with the prescription of supportive psychotherapy for the higher-functioning patient for whom expressive therapy has been the traditional treatment of choice. Since the traditional model for much of psychotherapy has been expressive therapy and since commonplace supportive psychotherapy has been derived by the removal of expressive elements from the traditional model, it is not surprising that there is an intuitive resistance to indicating supportive psychotherapy as the default treatment for high-functioning patients.

GOALS OF TREATMENT

A clear mandate of the supportive therapy process is to set explicit goals and a clear agenda. These are not required in traditional expressive treatment. The agenda may be set either by the patient or by the therapist. The therapist may set an agenda in order to follow through on an unfinished topic or to teach therapeutic process. Reduction of anxiety is a goal of supportive therapy, so it is important to consider ways in which the routine practices of conventional psychotherapy create anxiety. Allowing the patient to see the map before exploring the territory reduces anxiety and emphasizes that therapy is a rational collaborative process.

The therapist should have many ideas about the patient's dynamics, the

dynamics of the patient-therapist relationship, and his or her planned tactics. The therapist does not make a point of sharing everything with the patient, but in contrast to the traditional model that has taught to give as little as possible, the supportive psychotherapy model mandates a meeting of the minds about goals between patient and therapist. It is often helpful to make explicit how the topic at hand is connected to self-esteem, to a specified ego function, or to a specified adaptive skill. The patient who works at therapy extensively on his or her own often gains the most, so it is important that the patient understand the tactics of therapy. Since our model of supportive therapy is not conceptualized as the application of a theory of development or a theory of symptom formation, the supportive end of the supportive-expressive continuum involves only those goals that patient and therapist have agreed upon. In general terms, the goals are embodied in our definition of supportive therapy. To the extent that treatment is a mixture of supportive and expressive elements, there may be additional goals derived from theoretical positions.

Time-limited or brief therapy must be undertaken with realistic goals. It is reasonable to anticipate relief of specific symptoms, such as anxiety or depression. When longstanding personality characteristics are a major problem, the goal of brief treatment is for the patient to become able to formulate the problem; to understand how various symptoms, behaviors, or feelings are manifestations of this problem; and to gain command of

strategies for coping with it. The analogy of school is pertinent. School does not go on interminably. Each course has discrete organization, with a beginning, a middle, and an end. A period of therapy is like a course. The student who has a worthwhile experience is likely to return for more. It is not suggested that the outcome of therapy will be a new personality. It is suggested that at some time in the future, the patient may be able to benefit from another time-limited therapeutic endeavor.

In the Beth Israel Psychotherapy Research Program, brief treatment is defined as up to forty weekly sessions.

THEORY OF CHANGE

The theory of change in traditional expressive therapy is character transformation through the resolution of core neurotic conflicts and abandonment of maladaptive characterologic defensive strategies. This is achieved through the conduit of emotional insight into the transference.

The concept in supportive psychotherapy is that change stems from learning and from identification with or introjection of an accepting, well-related therapist, not through resolution of unconscious conflicts. Change is not a product of discovering reasons for the existence of the behavior or feelings, but rather it is a direct consequence of better self-esteem and improved adaptive skills. Poor self-esteem is associated with helplessness

and unwillingness to try new ways. If nothing new is tried, nothing can change. Low self-esteem is associated with demoralization and unwillingness to attempt anything new. Improved self-esteem, through a good (although uninterpreted) relationship with the therapist, may make it possible for the patient to make the conscious effort to change. Successful efforts then make for improved self-esteem. Distortions about self and others are corrected by education, not by removal of defenses.

The criteria for positive outcome in supportive psychotherapy relate to quality of life issues. Thus, a good outcome of therapy is increased self-esteem, reduction in experienced anxiety or dysphoria, and a resultant stabilization or increase in adaptive functioning. Character change per se is not our hallmark of successful supportive therapy, but it may be a positive effect of treatment. Self-understanding is not central to the treatment, and it is pursued only to the extent that it supports the accomplishment of patient goals and therapist objectives. It is not necessary for the unconscious to become conscious, and it is not essential that linkages be made between current and past figures. By a collaborative effort of the patient and the therapist, patterns of interpersonal or other behavior or of feeling responses are identified and strategies for changing them are devised to the extent possible.

Theory of the Therapeutic Process

Traditional expressive psychotherapy recognizes that there are two general categories of interpersonal dynamics in the exchanges between patient and therapist. One, recognized mostly by therapists with a psychodynamic viewpoint, is the transference relationship, which in latent or manifest form is the pattern of reflexive attitudes, thoughts, and emotional responses that are currently maladaptive and related directly to intrapsychic processes from an earlier time in psychosocial development. In expressive psychotherapies, it is this relationship that is deemed to be of paramount importance for revealing conflicts, and it is to the essentially noncognitive process of working through these transference relationships that therapeutic gain is ascribed.

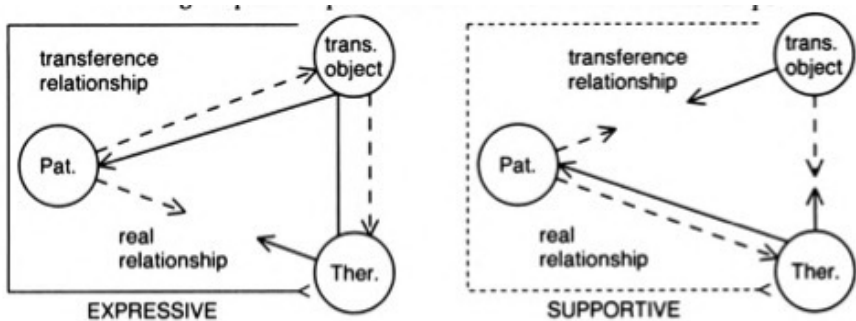
The second relationship is universally recognized and forms the context of all treatment, including expressive therapy. This is the "real" relationship that is manifested in the therapeutic alliance and coexists with, and is to some extent reflective of, the transference relationship. For example, what appears on the surface to be a positive therapeutic alliance may be bolstered, out of the patient's awareness, by the fact that dependency needs are gratified in the transference relationship.

In figure 1, we illustrate the way in which the two types of relationship—real and transference—are recognized by expressive and supportive therapies. It is the amount of emphasis upon each relationship that

distinguishes these two forms of dynamic treatment.

Figure 1

Differing Emphasis Upon Real and Transferential Relationships



In expressive treatment, the real relationship becomes a background or context within which the therapist responds mostly to the transference nature of the interpersonal process. There is a conscious minimization of real information about the therapist in the therapist's statements to the patient. Thus, much of the real relationship and therapeutic alliance depends upon the acceptance by the patient of the rules and agreements on the conduct of treatment and its relationship to the therapist.

Supportive psychotherapy, on the other hand, emphasizes the real relationship, as reflected in the therapeutic alliance. This process is a more globally recognizable and acceptable one, as it is based upon overt mutuality

in the conduct of therapy. The relationship between therapist and patient is a mirror of other current relationships. This is contrasted to the socially unusual and anxiety-provoking neutral stance of the therapist in expressive treatments. The therapeutic alliance in supportive therapy is enhanced through the use of accurate empathic responses, validation of feeling states, and so on, but development of transference neurosis is avoided. To that end, there is a minimization of focus upon transference material, and regression in the service of ego is not fostered. The fact that transference is not discussed does not mean that it is not recognized. Negative transference can threaten the alliance and the treatment, so the therapist must be vigilant about recognizing it and dealing with it. With higher-functioning patients, clarification of evidence of negative feelings or thoughts may be productive. With lower-functioning patients, it may be necessary for the therapist to change his or her stance, as people usually do when talking with someone who is becoming angry or distant.

In Short-Term Dynamic Psychotherapy, as described by Habib Davanloo (1980), the development of transference neurosis is avoided by constant interpretation of the transference. Supportive therapy does not confront defenses unless they are grossly maladaptive—for example, primitive projection, splitting, and the like.

While supportive psychotherapy is dynamic, and attention is paid to

transference material by the therapist, responsiveness of the therapist is most likely to be within the domain of the real relationship. It is essential that negative transference be recognized and dealt with and that primitive defenses be recognized and refuted. Clearly, to understand psychodynamic principles is necessary within our model of supportive therapy, but it is not sufficient for the conduct of treatment.

Interpersonal versus Intrapsychic Approaches

Expressive therapies have a primarily intrapsychic focus with respect to the therapist's attention to and interaction with patient material. The therapist and patient examine the conflicts between the patient's mental constructs of id, ego, and superego, or, stated in developmental terms, conflicts between the inner representations of self and others. The therapist's persistent attention to these conceptual frames during the process of treatment assists the patient in being aware of and then consciously contributing to material with this focus in mind.

In contrast, supportive psychotherapy has a predominantly interpersonal focus in that adaptive strategies, coping skills, and anxiety reduction are attended to within a frame of reference that looks at patterns of interpersonal behavior. In current usage, the term interpersonal psychotherapy refers to a variety of treatment approaches extending from the

classic work of Harry Stack Sullivan (1953) to more recent work by Jack Anchin and Donald Keisler (1982). The relationship between the patient and the therapist is used to teach the patient about difficulties in transactions with other people, with the intent of improving the quality of the patient's relationships. The focus of an interpersonal psychotherapy model developed for research purposes by Gerald Klerman is on social and interpersonal functioning, morale, and coping with stress (1984).

Approach to Defensive Structures

It is necessary for the therapist to have an awareness of the patient's object relations, defensive structures, and conflictual issues. The therapist makes hypotheses about the patient's core conflicts and defensive structure, then responds with these specific hypotheses in mind. In this way, therapist responses can be modified to strengthen relatively adaptive defenses— such as healthy narcissism; reasonable, possibly soothing rationalization; and esteem-protecting generalization—or to sidestep anxiety-provoking transference-linked postures. In general, the therapist conveys implicit respect for the character structure as presented.

TECHNIQUES

Our model of supportive therapy is applicable to both higher-

functioning and lower-functioning patients. With markedly impaired individuals direct measures are used to improve self-esteem and to improve function. These measures include reassurance, praise, encouragement, and so on, techniques customarily enumerated as the constituents of supportive therapy. With higher-functioning patients, direct supportive measures are less frequently used because sessions deal—as in expressive therapy—with relationships, self-concept, and patterns of feeling, rather than defective coping skills or poorly contained symptoms.

The following discussion of techniques addresses first approaches applicable to all patients, then techniques that become more important with the lower-functioning individual.

Reduction of Anxiety

The style of supportive psychotherapy is conversation. It is remarkable how much of the style of conventional psychotherapy keeps the patient off balance and out of control. Patients learn to tolerate the style, but they do not benefit from it, unless it is specifically indicated to raise anxiety as a motivational strategy from within the model of expressive therapy. Silent listening is appropriate only when the patient prefers it. We make interjections or comments as we would do in a social situation. We might ask a question just to show that we are listening. If we ask a question and the

patient answers, we acknowledge in some way what has been said. Conversational style does not mean that therapy is ordinary conversation, for in therapy, it is never the therapist's turn to take the floor. Whatever the therapist says is intended to be useful for the patient. The therapist's responses are not limited to simple conversational devices. Leston Havens (1986) provides a treatise on the therapeutic use of language, and most of his illustrations are brief responses.

Fred Pine (1984) has written about techniques for reducing anxiety in the analytic situation. He points out that if an interpretation or other comment is made, the patient is called upon to respond. This is experienced as a challenge. To avoid challenging the patient, which would increase anxiety, the interpretation can be embedded in other comments so that the patient is not forced to respond immediately. Another of Pine's suggestions is to warn the patient that you are about to say something that might be upsetting, and ask the patient if he or she is willing to go on with it. This gives the patient a measure of control, and does allow postponement when the patient feels it necessary. When the patient becomes upset, it may be helpful to wait until the emotion has died down before discussing the matter, which is, as Pine says, to "strike when the iron is cold."

If we want to reduce anxiety and increase the patient's sense of control, then we explain what we are doing and we do everything possible to allow

the patient to be prepared for what will happen. Medical students learn to do this while conducting a physical examination. In the psychiatric setting, this might take the form of a statement such as: "I have some questions that may make you anxious. Do you think you can handle this now?" or "I'd like to talk about medication sometime soon."

It is especially important to have thorough and extended discussions about medication. The psychotherapeutic stance of collaboration is often suspended when medication is the topic, and the psychiatrist reverts to the authoritarian medical role. Medication then becomes a power issue instead of a shared concern. Kernberg (1984) has pointed out that medication should be an integral part of a treatment plan and not be introduced haphazardly when the patient fails to improve. Bad response to medication, he has said, is often a manifestation of negative transference.

Enhancing Self-Esteem

Many psychotherapists undoubtedly work with a supportive style, but the field of psychotherapy has not given the formal attention to measures for protecting the self-esteem of their patients that salesmen use to protect the self-esteem of their prospects. For example, Tom Hopkins's best-selling book *How to Master the Art of Selling* (1982) details ways in which the salesman may lose control of the situation by stimulating negative responses. He lists

three precepts that every "champion" lives by. Two of them are: (1) don't argue—it's trying to beat the prospect down, and (2) don't attack them when you overcome their objections. Of course, the therapist has the patient's interests at heart, whereas the salesman's goal is to sell. However, as Hopkins points out, the customer is paying for something that will be of benefit. Although the therapist and the salesman have different objectives, the patient and the customer both seek to benefit.

Hopkins instructs the salesman to avoid asking a question that the prospect cannot answer and to avoid questions to which the answer might be no. It is important not to destroy the positive feeling that is essential to make the sale.

Medical students learn to take a history by asking questions. The patient doesn't know the intent of a question or the implications of the answer. It is like being cross-examined in court, or giving a deposition, for the traditional style of medical history taking is attacking.

With practice, one can reduce the number of questions that have a challenging or attacking impact. Most questions that begin with the word *why* are challenges or criticisms. People learn during childhood that when a parent or teacher asks *why* they did something, the implication is, "You shouldn't have done that!" If it is hard for the patient to talk about something,

consider asking, in a nonchallenging way, "How can we talk about this without increasing your anxiety or without making you feel that you're being pressured?" It may be that the patient will not be able to answer in a useful way, but at least you will have had another chance to demonstrate that you understand, and this has implications for self-esteem and empathy. When a patient misses a session, any attempt to discuss the absence may be experienced by the patient as criticism. The therapist must decide whether it is more important to explore the patient's defensive avoidance or more important to abstain from sounding critical. Helping the patient to see that his or her actions are responsible for the way people respond to him or her is a regular technique of psychotherapy. For some narcissistic patients, the idea is intolerable. At times, talking about patterns of behavior is palatable when it is linked to concrete steps for improvement or change.

With higher-functioning patients, the therapist's interest and responsiveness may provide a suitable degree of gratification. With those who are significantly impaired, it may be appropriate to be more active, as described by Leopold Beliak: "Implicit support is provided by the therapist's statement of his availability or by feeding a variety of possible oral gifts: cigarettes, coffee, cookies, fruit, etc. to foster the incorporation of the therapist as a benign introject" (1978, p. 87).

The essence of supportive therapy is not specific supportive actions but

continuous concern about self-esteem and anxiety and deliberate effort by the therapist to avoid subtle actions that might lower self-esteem or increase anxiety.

Respecting Defenses

Expressive therapy has, as one of its objectives, getting rid of character defenses so that the core neurosis can be exposed. In supportive psychotherapy adaptive defenses and the patient's personal style are generally respected. The individual whose defense is maintaining control over emotions should not be too quickly asked to relax this control. For example, one often sees this in a treatment plan: "Encourage patient to verbalize feelings." Sometimes this is the right treatment and sometimes it is the wrong treatment. The advice that "it's all right to cry" may be the wrong intervention with a person who has a great need for control and who, with a little support, may be enabled to regain control. A businessman who was accustomed to overcoming all obstacles by taking decisive action described in his first meeting with a therapist an unusual combination of external events that had created stresses that he could not master by his usual methods. He had to wait until others acted. When tears welled up in his eyes, the therapist changed the topic, calculating that the patient would overcome the problem by use of his usual mastery and that his self-esteem would be further lowered by crying in the presence of a stranger. Although defenses in general are to be

supported, this support stops when the defense is maladaptive or pathological, such as regression or most projection. Pathological defenses, such as projection, maladaptive denial, and grossly unrealistic planning, should be challenged.

Denial, when adaptive, is compatible with good emotional health and is therefore supported. For most of us, if we are to live in the real world, it is not love that makes the world go round, but denial. If a patient says about something important, "I don't want to think about it," the therapist might ask: "Does it work? Have you found that not thinking about something is an effective way of coping with it?" Because if the patient believes that not thinking about it has been an effective way of reducing anxiety, the therapist could never succeed by attacking the defensive denial. Chances are, asking the question, which shows respect for the defense, will open the way to useful discussion of the problem. The more mature defenses—repression, reaction formation, rationalization, and intellectualization—are generally encouraged. Even immature defenses, as Rockland (1989) has pointed out, may be supported if they are adaptive.

Dreams may be discussed, but they are used as indicators of the patient's concerns, not as undefended glimpses of the unconscious.

Clarification, Confrontation, and Interpretation

Clarification, confrontation, and interpretation are useful in supportive psychotherapy, but not with the requirement that the unconscious be made conscious or that full linkage be made with impulses or affects connected with genetic figures.

Clarification is used extensively in supportive psychotherapy. This means summarizing, paraphrasing, and organizing the patient's statements, without elaboration or inference. These techniques have the supportive effects of providing the patient first with evidence that the therapist understands and then with a frame of reference within which to understand the patient's patterns of thought, feeling, and action.

Clarification promotes interpersonal communication in the therapeutic process. Since the model of process in supportive psychotherapy specifies that the style is conversational, and since the therapist is obligated to obtain feedback on his or her understanding of the patient's utterances, the use of these techniques can facilitate the therapeutic alliance.

Confrontation, which brings to attention a pattern of behavior or something that the patient is avoiding or not attending to, can be useful as a technique within the setting of supportive psychotherapy, but needs to be put into a specific context (for example, to increase adaptive skills). Although the objective of supportive psychotherapy is not analysis of defenses, it is correct

to discourage the use of maladaptive defenses, such as the projective blaming of others, rationalization of inactivity, excessive attention to detail, power struggles, an unrealistic sense of entitlement, or an obfuscatory style of speaking. Even the most supportive treatment has the objectives of increasing the patient's awareness of the relationship between his or her behavior and the responses of other people; to improve the patient's ability to sort out cause-and-effect relationships; and to foster the patient's appreciation on a manifest level of the connection between past and current patterns. When unrecognized anger is an issue, it is usually necessary for the patient to recognize it and to develop strategies for dealing with it.

As previously described, interpretations or clarifications may be postponed until the affect is no longer intense, shifting emphasis from the feeling to the thought; or the patient may be protected by being warned that something potentially anxiety-provoking is about to take place. The therapist can make an "incomplete interpretation," which may leave out the genetic references or may generalize the subject to reduce the experienced demand for response. This is related to but differs from Ernest Glover's (1931) inexact interpretation, which protects the fragile patient by offering an explanation about impulses or behavior that is plausible but not the whole truth about infantile fears. For example, the therapist might explain unacceptable homosexual wishes to the patient as a defense against heterosexual fears. In making an incomplete interpretation, the therapist might interpret anxiety

around pursuit of a love object as fear of competition without localizing it to the original oedipal triangle, even if the genetic references are clear from the latent content of the patient material.

Robert Langs (1973) elaborated on interpretation upward, on devaluing primitive fantasies, and on other supportive techniques for dealing with especially terrifying material in the course of psychoanalytic psychotherapy. An example of interpretation upward would be statements by the therapist to a highly narcissistic patient that he is enraged and wants to punish a particular person who frustrates him, when the latent content indicates that the fantasy is primitive oral rage in which the patient wants to tear apart and consume his tormentor. These techniques are useful as well in supportive psychotherapy proper, when interpretation is indicated. Interpretations of transference may incorporate genetic figures if specifically indicated within the context of treatment, if the patient is clearly aware of the connections and is "running with the ball." The therapist must be relatively sophisticated in order to give partial interpretations that at the same time support and increase emotional awareness, where the full interpretation might bring increased anxiety or the use of more primitive defenses.

In anxiety-raising therapies, a patient might be challenged for being vague. In supportive psychotherapy, the patient would be urged to be more specific. The goal is not to explore the motivation for vagueness, but rather to

guide the patient to more effective communication. Only when this strategy is proven ineffective do the previously mentioned specific indications for a more anxiety provoking style of therapy become relevant.

Rationalization

Politics, religion, and self-help books all teach rationalizations and intellectualized formulas for helping people get through life. Psychotherapists have done this, too, but often the therapist is ashamed of doing it. Yet rationalization is a legitimate technique if done knowingly and for a reason. The adult patient who dwells excessively on what his or her parents did wrong may benefit from a statement like, "Your parents seem to have been very rigid and cold, but you know, they were doing what the experts taught was the most scientifically correct way to raise children in the 1930s; they may have been doing the best they could." The parent who broods about his disappointment in an adult child may be helped by being told, "You do the best you can, but you can't always determine how your children will grow up." We remind the disappointed parent that Benjamin Franklin's son was the royal governor of New Jersey and that he tried to guide the British to Washington's encampment.

Reframing

Reframing is a cognitive technique that can be used to assist the patient in diffusing or sidestepping painful affects or negative self-references, thus enhancing self-esteem. In addition, the therapist can reframe a maladaptive behavior in order to make it ego dystonic, a standard psychotherapeutic technique, if it fits into the basic format of supportive psychotherapy.

Encouragement

Encouragement may include reassurance, praise, and the empathic comments and subtle encouragements that are part of everyday life among people who have good feelings about each other. Most therapists have learned to offer empathic comments as responses to particularly difficult circumstances. "That must have been hard for you." "That was rough." "You must have felt terrible." "You must have been frightened." "Anyone would be frightened if that happened." Or "I would have been frightened (or angry) if that happened to me." We try to go further and find opportunities to add words that tell the patient something good about himself or herself. "It sounds like that was a brave way to handle it." "That took courage." "You must be very determined (or tough) to have kept going so long when you were that anxious and had voices after you all the time." Milton Viederman wrote, "It is rare to find a patient who does not reveal something that can evoke admiration. . . . The support of self-esteem is such a central issue in any supportive therapy that one would think it barely deserves mention.

However, young psychiatrists with a sense of constraint are reluctant to 'flatter the patient' and in particular 'to feed the narcissism' " (1984, p. 151).

It is very important, though, when offering praise, that it be based on facts, that it be directed to something the patient considers worthy of praise. Defective praise undercuts the patient. It raises the suspicion that the therapist is impersonal, inattentive, or false. Defective praise may damage the therapeutic relationship. Most patients who are new to therapy or new to the therapist appreciate being told that they are doing it right.

Just as praise must be expressed in terms that are meaningful to the patient, so must reassurance. As every physician knows, reassurance can be powerful, but if the reassurance fails, credibility may be lost forever. It is reckless to say, "This medicine will make you feel better." It is more prudent to say, "This medication makes most people feel better," or "It usually helps people with conditions like yours." The best reassurance draws on what the patient has already demonstrated that he or she can do. "Yes, you have recurrences, but you always get over them—your spirit doesn't seem to have been destroyed." Reassurance based on expert knowledge may be useful, provided it is accurate. Reassurance is a direct means of reducing anxiety. It also fosters the therapeutic alliance.

Suggestion was a popular tactic when psychiatrists dealt with dramatic

symptoms in hysterical patients. However, when it fails, the healer's power is lessened. If it succeeds and the patient learns of it, the patient may feel deceived.

Advising

Advice must be factual, related to the therapist's expert knowledge, and limited to the topics of therapy. With lower-functioning patients, every aspect of daily life may be within the scope of the therapy. Advice may be relevant if it is designed to help the patient act in a way that will enhance his or her self-esteem, to improve adaptive skills, or to improve ego function. The basis and rationale for the advice must always be stated. Not "You should work," but "Most people who stop working don't feel better—not working protects you from some stresses, but it's usually bad for self-esteem." It is the therapist's expertise, not his or her authority, that is crucial. Identification with the therapist—as a focused, reasonable professional—may be an important aspect of treatment. It is well to remember, however, that in all forms of therapy, patients have a habit of construing as advice almost anything the therapist has said.

Modeling

In any therapy the therapist may, intentionally or unintentionally,

provide a model of behavior and responsiveness. Our concept of supportive therapy does not include activity outside the therapeutic encounter—social activity with the patient, for example. Many descriptions of supportive therapy have included the notion that the therapist lends his or her ego to the patient. One might think that this refers to modeling, but the phrase seems to be a jargon metaphor for counseling and for applying to the patient's problems the therapist's problem-solving skills and knowledge of individual and social behavior.

Rehearsal or Anticipation

Anticipatory guidance is a technique that allows the patient to move through new situations hypothetically, considering the possible events and ways of responding to them. This allows the patient to become acquainted with the context of the future event, reducing some of the anticipatory anxiety associated with it. Rehearsal further allows the patient to work out more appropriate or even novel ways to participate in future events, thus adding to his or her repertoire of adaptive skills. Anticipatory guidance is used early in therapy with patients who are likely to drop out, instead of waiting for negative attitudes to become evident.

Responding to Ventilation

Ventilation, or "getting it off your chest," may be useful to the patient when a traumatic event is experienced or when something important has been unexpressed. The fact that the therapist has heard the patient's story and does not reject him or her may be the essence of support for some. The therapist's active responses may include tracking (indicating that he or she is following the patient), universalizing (making it clear that many people have similar feelings, wishes, or problems), or decatastrophizing (minimizing issues or problems that the patient has exaggerated). The patient may be permitted to recount events at length, without interruption, but the objectives of supportive therapy cannot be achieved by passive listening.

Techniques Not Used in Supportive Psychotherapy

A resident told her supervisor that she had been talking with her new patient, a depressed elderly woman, about things that the patient liked. The patient said, "I like opera." The resident replied, "I do, too." She asked the supervisor, "Was that a mistake? I've been told you shouldn't do that in psychotherapy." Over the years, the techniques of expressive psychotherapy have become the model for all psychotherapy. One of the most commonplace examples is the practice of not answering questions. The patient asks, "Are you married?" The therapist replies, "Do you think I am married?" or "Does it matter whether I am married or not?" The public has come to believe that this is the way psychiatrists talk.

The techniques of psychoanalysis were developed to accomplish specific purposes. The analyst presents as little of himself or herself as possible in order to maximize the chance that the patient will invest the therapist with feelings and reactions that originated in past relationships—transference. The therapist does not answer questions because the development of fantasy is encouraged and the tension or anxiety generated by this lack of gratification helps to maintain the therapeutic process.

Expressive therapy presumes that the therapy is the central point of the patient's life; supportive therapy assumes that it is just one of the patient's activities. In fact, if the patient misses a session, his or her explanation may be accepted at face value, although the therapist must be alert to the possibility that unconscious motivations may have to be explored, since missing a session can be part of a pattern of maladaptive behavior.

Central to expressive therapy is the principle of free association. Furthermore, the patient always speaks first. Again, skillfully practiced supportive therapy does not employ technical maneuvers that were invented for the specialized psychoanalytic situation and that have become erroneously institutionalized as universal rules of psychotherapy. At the same time, supportive psychotherapy requires that the therapist limit what he or she says to that which is useful for the patient. To do otherwise would be to exploit the patient.

Edwin Wallace summarized the thesis that the practice of supportive psychotherapy is more difficult than the practice of uncovering therapy:

There is a wider range of responses by the therapist, and it is difficult to decide which response is correct. You cannot wait for the patient to make connections. . . . you must decide . . . now to come down on the side of expressiveness, now of restraint, now to confront his intellectualization or reaction formation, now to support it, now to analyze the transference, now to utilize it as a suggestive reinforcing lever . . . now to ask him what goes into his question, now to answer it immediately and directly, now to gratify his request for coffee or advice, now to analyze it. (1983, pp. 345-346)

CASE EXAMPLE

The following vignette illustrates supportive techniques. The patient was a young woman who began treatment because she felt depressed, was dissatisfied with her life, and had been vacillating about continuing the relationship with her boyfriend. It became clear as therapy got under way that she saw herself as indecisive and uncertain about everything. In this session the patient discussed having taken a second job, a night job at a bar, which she quit after a few days.

Patient: At first I felt bad to start and quit. It wasn't as good as I thought it was going to be, and I was very tired the next day. It's more important that I do well at my regular job.

Therapist: (*Clarifies*) You felt bad about quitting, but only a little bad.

Patient: Yeah. I felt a little bad because I could make money if I stuck it out, but I realized it was going to be hard. If people stayed late, I'd have to stay, too.

And they wanted me to work on nights when I had school.

Therapist: (*Asks for confirmation of his understanding of the patient's statements*) Well, would I be correct if I said that you still think an extra job to make some money is a good idea, but that this isn't the way to do it?

Patient: I just realized I didn't have time for school. The best thing about it is that now I value my time more. After that, now my schedule seems great.

Therapist: (*Fact-based praise*) Well, you made this decision without a lot of uncertainty.

Patient: No, I was pretty sure.

Therapist: (*Asks for feedback about accuracy of praise*) It sounds to me like taking the job was a reasonable thing to do, and getting out as soon as you saw that it wasn't good was also a reasonable thing to do. Would you agree?

Patient: Yeah.

Therapist: (*Reminds patient of their agenda and attempts to enhance self-esteem by reinforcing patient's awareness of good adaptive function*) Since I'm always coming back to the issue of self-confidence—what did it do for your self-confidence that you made a decision to do it and then you made a decision to stop doing it?

Patient: Yeah, it was OK. At first I thought I was copping out because I didn't think I'd be able to handle it, but by the third night, I was catching on . . . so last week was a tough week.

Therapist: (*Makes empathic conversational response*) It sure sounds like it!

Patient: (*Sets a different agenda*) There's something I wanted to talk about . . . going home and seeing my parents. It was very upsetting.

Therapist: (*Asks a focusing question, potentially reducing anxiety by interrupting the*

beginning of an intensely felt expression) When did you do that?

Patient: I went home Wednesday night. My parents picked me up. This was the worst time I can remember with my mother in a long time. She was horrible.

Therapist: (*Asks another question, maintaining conversational style, again intending to mitigate intensity*) What happened?

Patient: I couldn't deal with it in my usual way. I was, I wouldn't say antagonistic, but I reacted to her. I couldn't believe what was coming out of her mouth!

It's upsetting to me that at this point I still can't deal with her at all.

Therapist: (*Focuses, without confronting defensive postures*) Let's have some specifics.

Patient: The first thing she said was "How's Jerry? I guess you're not seeing Jerry any more." I tried to explain the situation to her. I told her I'd gone out with Ben, that she'd met him, that I have a great time with him. Right away she asks, "What kind of people are these? Drug addicts?" How can you infer this from what I'm saying? Do I look like I hang around with people who take drugs? He didn't fit her cookie-cutter mold and instantly she assumes there's something wrong with him. She hears that he's an artist and assumes I'm hanging around with a bad crowd. She moved from one thing to another. She made some ridiculous comment about "What do they expect if they buy you dinner? Sexual favors?" Mom, I can't even be in this conversation because you don't know what you're talking about. She has no idea who I am. She has no faith in my judgment.

Therapist: (*Makes a clarification and supports the therapeutic alliance*) So, you're not only single, but you're doing bad things, and nothing you say to her gets through.

Patient: The fact that she assumes this makes me not want to talk to her.

Therapist: (*Asks about adaptive skills rather than focusing on affect*) You didn't tell her that it isn't so?

Patient: I kinda got that across.

Therapist: *(In conversational style)* What did you say to her? How did you go about trying to present yourself?

Patient: She started on the attack right away, so I was just trying to defend myself. But in the case of Jerry, I didn't have a good answer, so I can see where she might have had a point in being confused.

Therapist: *(Clarifies)* She may be confused about what's going on between you and Jerry, but does that make it correct for her to impute that you are involved with drug users who buy you dinner and immediately want sex?

Patient: I don't know where she dreams up the world she's living in.

Therapist: *(mildly confronts the patient's prior selling herself short, focusing on adaptive strategies)* These are familiar stereotypes, but these stereotypes are not you. Did you explain that to her?

Patient: I couldn't even comment.

Therapist: *(Proposes clarification)* It's understandable that when something is outrageous, that you don't know how to think. I wonder if you felt anger at the same time?

Patient: Yes, I was furious.

Therapist: *(Cushions confrontation to avoid forcing patient to agree or disagree)* Maybe anger plays a part in some of the feeling of uncertainty you describe at other times. That's not the only possible explanation, but it could play a part.

EMPIRICAL SUPPORT

Supportive psychotherapy has not been thought of as a potent modality

of treatment, so it is not surprising that it has not been the subject of many studies. Psychotherapy research has paid much attention to the concept of therapeutic alliance, and although supportive psychotherapy involves more than maintaining a supportive relationship (Winston, Pinsker & McCullough, 1986), the repeated finding that therapeutic alliance is a crucial variable is relevant.

Supportive maneuvers have been shown to be at least as helpful as drugs or other therapies (such as cognitive, behavioral, or insight-oriented therapy) in the treatment of coronary artery disease (Razin, 1982), opiate addiction (Woody et al., 1983), phobia (Klein, Zitrin, Woerner, & Ross, 1983), and "anxious depressives" (Schwab, 1984).

Probably the strongest support for the value of supportive therapy has come from the findings of two large studies. One involved several years of treatment of chronic schizophrenic patients (Carpenter, 1984), and the other was the forty-year Menninger Clinic study of psychotherapy with severely disabled nonpsychotic patients (Wallerstein, 1989). Contrary to their predictions, supportive psychotherapy proved at least as effective as expressive methods, and in some cases, more so. On the other hand, Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum (1984), in a study of psychotherapy of patients with bereavement reactions, observed that supportive actions by therapists were positively related to better outcome for

patients who had low development-level scores, while there was a negative relationship for those who had high development-level scores.

Process research is now beginning to examine supportive maneuvers. Hill et al. (1988) showed that interventions intended as supportive are rated as not helpful by therapists, but are rated as moderately helpful by patients.

The Beth Israel Psychotherapy Research Program is continuing Hill et al. (1988) and Elliot et al.'s (1987) style of intensive process analysis, using videotaped sessions and the Psychotherapy Interaction Coding System (McCullough, in press), which codes both therapist and patient behaviors for each minute of a fifty-minute session. A preliminary analysis of data comparing individual dynamic supportive psychotherapy with Intensive Short-Term Dynamic Psychotherapy^[1] (Laikin, Winston, & McCullough), a confrontational therapy based on Davanloo (1980), and Brief Adaptational Psychotherapy (BAP) developed at Beth Israel^[2] (Pollack, Flegenheimer, & Winston) has been completed. Therapists in the supportive mode were significantly more likely to give information, make directive statements, or use self-disclosure than were the therapists providing more insight-oriented or expressive therapies. They were less likely to use confrontation. The groups did not differ in the number of clarifications or interpretations. However, the content of interpretations was significantly different in the supportive condition. Defensive maneuvers were interpreted only one-fourth

as often, and no transference or patient-therapist issues were interpreted in the sessions analyzed so far. Although the number of actual supportive interventions is relatively low in the supportive group, it is significantly different from the other conditions, in which support rarely occurs. The supportive therapists used many more informational interventions (eighteen per session, compared with one per session in the other groups) and much less confrontation (four per session, in contrast to twelve to thirty per session).

The patients in the supportive group showed differences from the ISTDP and BAP groups, whereas the ISTDP and BAP patients' responses were more similar to each other. Defensive responding is the most notable difference because of the higher frequency of intermediate responses (nineteen per session, compared with nine) and the reduced number of immature responses. The brief anxiety-provoking therapies seem to elicit more immature responding, while the ego-building supportive therapy allows or even encourages intermediate defensive responses (such as intellectualization and rationalization).

Outcome research is beginning to demonstrate the efficacy of supportive interventions, and process research is beginning to intensively examine these interventions in relation to other interventions and other aspects of treatments.

CONCLUSION

We believe that the efficacy of supportive psychotherapy can be enhanced and the satisfaction of the therapist increased if the therapy is conceptualized as a distinct modality of dynamic psychotherapy and if it is appreciated that doing it well requires considerable skill. Supportive psychotherapy is usually recommended as the treatment of choice for the lower-functioning patient. We believe it should be the treatment of choice for most patients. There is ample precedent in medicine for holding the more invasive and more expensive treatments in reserve for use only when the gentler treatment has been found ineffective.

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Notes

[1] Intensive Short-Term Dynamic Psychotherapy is also available as a free ebook from [IPI ebooks](#).

[2] Brief Adaptive Psychotherapy is also available as a free ebook from [IPI ebooks](#).