Supportive Therapy as the Treatment Model of Choice

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Supportive and expressive techniques in psychotherapy can be located on a continuum. Traditionally, psychotherapy has been oriented toward the expressive end of the continuum, applying the model of psychoanalytic or expressive therapy to all therapy. The authors propose that for most patients, the model for individual dynamic psychotherapy should be based on concepts from the supportive end of the continuum.

Supportive psychotherapy, according to most definitions, has the objectives of immediately reducing anxiety and maintaining a positive patient-therapist relationship with minimal focus on transference. Several definitions of supportive therapy can be found in the recent literature. Narrow definitions—for instance that of the American Psychiatric Association’s Commission on Psychiatric Therapies1—focus on a supportive relationship between an impaired patient and an authoritative therapist who provides advice, reassurance, and reality testing. In the spectrum of treatment, this approach is at the opposite end from the expressive approach. Broader definitions 2-4 describe supportive therapy as having many of the characteristics of exploratory or expressive psychotherapy. Buckley5 summarizes Kernberg’s view of supportive therapy as a treatment that “does not use interpretation, partially uses clarification and abreaction, and primarily uses suggestion and environmental intervention” (p. 515). Novalis et al.8 proposed a definition that emphasizes what supportive therapy does.

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rather than what it is. He defines these actions as 1) reducing behavioral dysfunctions, 2) reducing subjective mental distress, 3) supporting and enhancing the patient's strengths, coping skills, and capacity to use environmental supports, 4) maximizing treatment autonomy, and 5) facilitating maximum possible independence from psychiatric illness. Pinsker has suggested that supportive therapy should not be thought of as a type of therapy, but rather as a "shell" of techniques used by therapists of diverse theoretical orientations; their specific rationales for these techniques may include cognitive as well as dynamic explanations for what is below the surface.

Supportive therapy has been described as the appropriate treatment for lower functioning patients and for patients who are too fragile or too unmotivated to participate in more demanding expressive therapy, which might have more chance of leading to personality change. The treatment of choice for the patient who is analyzable is supposed to be psychoanalysis or psychoanalytically oriented therapy. In everyday practice, most psychotherapy involves a blend of approaches, aptly characterized by Luborsky as being on a continuum from expressive to supportive, with midpositions of expressive-supportive and supportive-expressive. To meet the patient's needs, elements of pure expressive treatment are withheld or supportive elements are added. However, the conceptual framework of individual dynamic therapy is intertwined with a model of treatment, such as the expressive model, that often has lasting impact in that the psychoanalytic techniques of abstinence and nongratification are adopted as the habitual stance of the therapist. If a body of evidence had demonstrated that exploratory therapy is more effective than supportive therapy for most patients, this would be justifiable. If evidence demonstrated that exploratory therapy is consistently best for a specific group of patients, that would be reason to recommend it, at least for that group. However, controlled psychotherapy outcome studies have thus far not demonstrated that one therapy is better than another for most patients, although it has been consistently observed that therapy is better than no therapy.

**Model of Supportive Therapy**

For the most part, supportive therapy has been defined by contrasting it to expressive or exploratory treatment, producing a definition that is essentially a set of subtractions from a standard. Although supportive therapy is not based on a specified theory of personality development or a theory of mental illness, it is possible to extract from the various definitions and descriptions of supportive therapy a statement of its essential characteristics and underlying premises. This body of premises and assumptions, and the techniques based on them, we characterize as the model of supportive therapy.

Elements of individual dynamic supportive psychotherapy include 1) strengthening the therapeutic alliance; 2) using direct measures to relieve symptoms and to minimize development of anxiety within the therapy; 3) focusing on self-esteem, adaptive skills, and psychological (or ego) functions (measures may include reassurance, encouragement, praise, advice, reframing, clarification, confrontation, education); 4) attention to negative aspects of the patient-therapist relationship when present, but not to positive transference; and 5) minimal interpretation of unconscious conflicts.

Table 1 compares the two models. Because the model of supportive psychotherapy does not specify that analysis of transference must be the basis for change, the therapist is "real" to the patient. When psychotherapy is based on the assumptions, premises, and techniques of expressive therapy (the expressive model), the therapist gives up only as much neutrality as necessary. With the supportive therapy model, the therapist is no more neutral than necessary. It is important
to note that this 180-degree shift does not imply that supportive therapy is undisciplined or that the relationship should ever be anything but professional. Transferential issues are examined only if they threaten to disrupt the treatment. Because the model does not specify that the unconscious must be made conscious, techniques developed to encourage the free flow of unconscious material are not used. Because the model does not postulate that continuing anxiety is desirable to motivate the patient to work at therapy, anxiety-reducing measures are employed readily. Maladaptive patterns are identified from the patient’s accounts of relationships with and feelings about figures in his or her current life or past. Although the patterns may be replicated in the patient-therapist relationship, no effort is made to encourage this. When this replication occurs, the therapist will not interpret it to the patient unless it threatens to interfere with the treatment.

It is important that the reader understand that what we are describing is not a new therapy. Supportive therapy has usually been presented as a set of techniques, not as a therapy based on a model, but it is our thesis that widely used approaches and techniques of supportive therapy and the assumptions that underlie them constitute a model that can appropriately guide psychotherapy for a wide range of clinical problems. The differential application of strategies developed for treatment of low-functioning patients thus defines a psychotherapeutic model also broad enough to serve the needs of higher functioning patients.

**TABLE 1. Comparison of critical aspects of supportive and expressive therapies**

<table>
<thead>
<tr>
<th>Supportive</th>
<th>Expressive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic alliance is of utmost importance.</td>
<td>Therapeutic alliance is of utmost importance.</td>
</tr>
<tr>
<td>Conversational style: patient is encouraged to be goal-directed.</td>
<td>Flow of material is important; patient is encouraged to say whatever comes to mind.</td>
</tr>
<tr>
<td>Conversational style: therapist is responsive, a real person in a disciplined relationship.</td>
<td>Therapist maintains abstinence to the extent possible.</td>
</tr>
<tr>
<td>Emphasis on understanding.</td>
<td>Emphasis on affect.</td>
</tr>
<tr>
<td>Direct measures are used to enhance self-esteem (praise, encouragement).</td>
<td>Self-esteem improves as a by-product of improved function and freedom from symptoms.</td>
</tr>
<tr>
<td>To the extent possible, therapy-related anxiety is avoided.</td>
<td>Therapy-related anxiety is accepted if not disruptive.</td>
</tr>
<tr>
<td>Defenses are supported unless distinctly maladaptive.</td>
<td>Defenses are often challenged.</td>
</tr>
<tr>
<td>Clarification and confrontation are employed.</td>
<td>Clarification, confrontation, and interpretation are employed.</td>
</tr>
<tr>
<td>Negative transference is examined; positive transference is not discussed.</td>
<td>Analysis of transference is a major focus.</td>
</tr>
</tbody>
</table>
There are a number of potential advantages to the use of the supportive psychotherapy model. It may be more palatable for many patients than an abstinent psychoanalytic approach. The style of supportive psychotherapy is conversational and aims to reduce, not increase, anxiety and to improve self-esteem. In contrast, the abstaining stance of exploratory therapy is socially unusual and can be anxiety provoking. If this approach cannot be proved to be more efficacious than supportive therapy, why subject patients to such discomfort? Moreover, such an approach does not provide the patient a pattern of normal human interaction, and many patients are quickly repelled by it. Theoretical considerations may determine the therapist's approach, but patients often use their therapists as models of correct thinking and speaking. Because the goals of treatment in supportive therapy are formulated explicitly, seeking to avoid implications that the therapist is the possessor of a body of secret knowledge, the therapy provides a realistic model of collaborative effort. Although cognitive-behavioral approaches have not been found to be less effective than supportive therapy, the exacting requirements of monitoring thoughts, keeping logs, and doing homework do not meet the needs of the large number of individuals who prefer treatment that involves an interactive relationship. It is interesting to note that, according to a study of therapists' preferences, practitioners of behavior therapy prefer an interactive relationship when they seek treatment for themselves.15

It is probable that far more patients are involved in treatment that resembles supportive therapy than in primarily expressive treatment. Because supportive therapy for the most part has not been formally taught, most therapists have figured out for themselves how to administer it. The fact that it has been conceptualized primarily as a series of departures from something else deprives therapists, until they have considerable experience, of the satisfaction associated with the knowledge that therapeutic activity is coherent and purposeful.

### Models and Departures From Models

A therapist applying the expressive model traditionally uses supportive techniques as needed, but this is always seen as a departure from the basic psychoanalytically oriented model.16 However, if the default model of treatment is supportive therapy, whenever a technique from analytic therapy is employed (such as silent listening, parrying questions, or focus on transferential material), it must be recognized as a departure from the model. The therapist should have a rationale for its use. Just as support has been seen as a possible contaminant of analytic therapy, analytic techniques must be seen as potential contaminants of supportive therapy. When the supportive model is used, honest praise or other esteem-building comments are volunteered when the opportunity presents itself, and the therapist is always alert to avoid ambiguities that might foster anxiety. If the therapist asks a question, for example, the patient should always know what the therapist has in mind. In expressive therapy, answering the patient's question directly, without exploring its meaning, is a departure from the model. In supportive psychotherapy, it is the nonresponse to a question that is a departure from the model, because therapy is conducted as a conversation, not a monologue or an interrogation. In contrast to expressive therapy, where transference is a major focus, in supportive therapy, transferential aspects of the patient-therapist relationship are a focus only when negative interaction threatens to disrupt the treatment. Fantasy and free association are not encouraged. Character defenses and neurotic defenses are challenged only if maladaptive. Therapy is considered successful if the patient achieves his or her goals. It is not essential that affective change occur or that the patient acquire insight about the origins of the disturbance.
IMPLICATIONS OF RESEARCH FINDINGS

A growing psychotherapy-outcome literature suggests that 1) positive outcome in psychotherapy is frequently related to a positive patient-therapist relationship and 2) there is little evidence for differential efficacy for specific psychotherapeutic approaches. Smith et al., for instance, in their often-cited 1977 paper "Meta-Analysis of Psychotherapy Outcome," a review of 400 outcome studies, found convincing evidence for the efficacy of psychotherapy; however, "few important differences in effectiveness" could be established between very different types of psychotherapy. Furthermore, they found that the greatest overall effects of all forms of therapy were on 1) reduced fear and anxiety and 2) increased self-esteem. Both are areas of specific focus for supportive treatment.

Further, a small but growing literature suggests that supportive therapy approaches may have significant efficacy themselves, comparable with, if not at times better than, exploratory or behavioral approaches. Conte and Plutchik reviewed the evidence for the efficacy of supportive psychotherapy. We briefly describe some of these studies below.

In a study of behavioral versus supportive therapy in phobic patients, Zitrin et al. found no difference in effectiveness between behavioral therapy and supportive therapy, both of which produced moderate to marked benefit. In a population of schizophrenic patients, Stanton et al. and Gunderson et al. studied two forms of psychotherapy: an exploratory, insight-oriented therapy compared with a reality-adaptive, supportive therapy. They found minimal outcome difference between the two treatments, but the supportive therapy subjects had less recidivism and increased independent functioning, in addition to less time spent in the hospital. Thus, supportive therapy was felt to be the treatment of choice.

In another, more provocative, article, Wallerstein reviewed outcome for 42 subjects treated at the Menninger Clinic with as much as 30 years' follow-up. In a naturalistic follow-up study with a complex design that involved 1) review of initial treatment, termination, and a follow-up assessment and 2) a synthesis of treatment course and outcome, he compared 22 psychoanalyses and 20 expressive or supportive therapies in patients whose diagnoses were severe neuroses, character neuroses, and impulse neuroses. Wallerstein concluded that the results from psychoanalysis were more limited than expected, and that supportive interventions were surprisingly important in achieving significant and lasting change: "Changes achieved through supportive therapies...provided often enough just as much structural change and proved just as stable and enduring as the changes achieved through expressive/analytic therapies" (p. 203).

These preliminary research findings also point to the importance of distinguishing theory from technique. For instance, psychoanalytic theory of mental function may be informative and helpful, but employing a psychoanalytic technique such as abstinence may be a less effective way to achieve change than a more flexible, conversational supportive technique. It is worth emphasizing that the aforementioned authors did not employ any consistent definition of supportive therapy; nevertheless, their findings suggest that more attention should be paid to the importance of supportive techniques in psychotherapy treatment and research.

SUPPORTIVE THERAPY AS THE "DEFAULT" TREATMENT

Therapists who were trained in the 1950s, '60s, and '70s learned that

The therapist's task is to help the patient understand himself by bringing unconscious ideas and memories into his consciousness through verbalization of them. The patient must be left as
freely as possible to develop spontaneously those reactions determined by his childhood experience. . . the less the patient really knows about you the greater the chance to make transferences, which are precious material for the therapeutic process.²⁷ (pp. 23–24)

The proposition that supportive psychotherapy could be the default treatment must appear quite foreign to those who attempt to give the "gold" of psychoanalysis whenever possible, reverting to what may be seen as a diluted form of treatment if the patient's motivation, ego structure, or constitution are not up to the challenge. According to Rockland,³ some experienced therapists have stated that they do not know how to do supportive therapy.

In sum, we are proposing that the approach to most individual psychotherapy be based on the model of supportive therapy. Contemporary psychotherapy attempts to provide each patient with the optimum mix of supportive, supportive-expressive, and expressive elements. The traditional approach, using expressive therapy as the model, calls for rationalization of any departure from this basic model. If supportive therapy is the model, it is departure from that model that must be rationalized. We propose that not only supportive therapy, but also supportive-expressive and expressive-supportive therapy should be based on the model of supportive therapy. We are proposing that unless there are specific indications to the contrary, all therapy should be based on a real, but disciplined, relationship between patient and therapist, should involve direct measures to enhance the patient's self-esteem, and should avoid measures that diminish self-esteem (such as nonresponse, subtle argumentative style, or questions that may be perceived as attacking).¹² Therapy should attempt to allay anxiety and should avoid measures that are associated with continuation of anxiety. Only when specifically indicated should therapy be conducted in a manner designed to facilitate development of transference responses, and only when specifically indicated should transference be interpreted.

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 (for example, use the cheapest broad-spectrum antibiotic with the fewest side effects unless the pathogen is resistant or unusually virulent). Analogously, supportive psychotherapy provides the broadest sufficient and effective coverage for most problems presented for psychotherapy. Specific types of treatment problems demonstrated to be unresponsive to supportive therapy might then suggest different modes of treatment, such as expressive or cognitive-behavioral therapy.

It is clear that psychoanalytic therapy is no longer seen as the acme of therapies. Cognitive and interpersonal therapies, which emphasize the patient's learning, have become widely accepted. Treatment based on Self-Theory requires of the therapist a much greater degree of interactivity and focus on the patient-therapist relationship. Rockland¹¹ has noted that in the opinion of department chairmen and training directors, the importance of psychoanalytically oriented psychotherapy has declined in relation to the importance of supportive therapy. Nevertheless, there have been no articles on education in supportive therapy,¹⁰⁻²⁷ and supportive therapy is rarely taught to psychiatric trainees. Although supportive-expressive and expressive-supportive therapies are employed far more often than psychoanalysis, teaching dynamic psychotherapy presents the student simultaneously with a body of theory about personality formation and a model of treatment based on it. When psychodynamic psychotherapy is taught, the assumptions of expressive therapy are omnipresent. If supportive therapy is to provide the model on which most therapy is based, supportive as well as analytic techniques must be taught, supervised, and mastered during training.
**Conclusions**

In the past, conventional views have limited the use of supportive therapy to patients with whom expressive techniques are not expected to obtain good results. We suggest that these conventional views may deprive many patients of the benefits of an effective form of psychotherapy that is more comfortable, more palatable, and, for many patients, more effective than treatment in which the therapist’s style is based on the psychoanalytic model of therapy. This treatment should be guided by the rationales of supportive therapy and should use the techniques of supportive therapy. It is not the therapy by unskilled counselors that was often recommended in the 1960s and ’70s, but instead should be a supportive therapy based on thorough knowledge of personality development and psychopathology, carried out by practitioners who have had specific training and supervision in this modality.

**References**

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