Supportive Techniques
Are They Found in Different Therapies?

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Although many clinicians and theorists have emphasized the use of common therapeutic interventions across different therapies, there seems to be a consensus that, theoretically, at least, therapists from different schools of therapy also make use of techniques that are unique and specific to individual forms of therapy. For instance, dynamic therapists use expressive techniques such as interpretations, clarifications, and confrontation to treat patients, while client-centered therapists use reflection and positive regard. Cognitive therapists examine automatic thoughts, review evidence for or against certain beliefs, propose alternative explanations to specific events, and assign homework. Several studies have indeed shown that the use of specific techniques is observed in clinical practice. For example, early on, Strupp demonstrated that short-term analytic therapy was more interpretive than client-centered psychotherapy. Furthermore, Auerbach showed that experiential therapists surprisingly used more interpretations than short-term analytic therapists. It is also quite possible that different psychotherapy
theorists use similar techniques while giving them different names, or use different techniques to achieve similar goals. Initially, we will focus on the evidence for the use of distinct techniques in different therapies.

By delineating the specific methods associated with various therapeutic domains, the advent of treatment manuals has enabled researchers to examine differential treatment techniques more effectively. For instance, DeRubeis et al. showed that cognitive therapy and interpersonal therapy were identified as distinct treatments by independent judges. That is, cognitive therapists used more of the techniques relevant to cognitive therapy than did interpersonal therapists. Similarly, Hill et al. demonstrated that cognitive therapists who participated in the Treatment of Depression Collaborative Research Program employed more cognitive therapy techniques than interpersonal therapists or pharmacotherapists, whereas interpersonal therapists used more interpersonal techniques than either cognitive therapists or pharmacotherapists. With regard to other treatment modalities, Barber et al. for example, found that supportive-expressive (SE) dynamic psychotherapists employed more expressive interventions when treating cocaine-dependent patients than cognitive therapists or individual drug counselors.

Despite the many different approaches to therapy that exist, researchers have surprisingly found little disparity in their efficacy. On the contrary, a recurring finding in outcome studies is that different forms of psychotherapy often yield similar results. Furthermore, clinicians have noted that different therapies sometimes share similar techniques. Consequently, it has been proposed that the similarity of outcomes across treatment modalities may be related to the beneficial effects of techniques that are common to various forms of psychotherapy, in addition to the impact of techniques that are specific to particular forms of psychotherapy.

The purpose of this article is to explore the utility of viewing supportive techniques as commonly used techniques across different therapies and to provide empirical evidence for that. We will first examine some of the issues involved in defining supportive techniques. Then we will examine the existing literature that reports on the use of supportive techniques across different psychotherapies.

A prevalent misconception that can lead to exclusion of supportive techniques from the roster of common techniques is that supportive techniques are synonymous with the therapeutic alliance. Conceptually, however, supportive techniques are not the same as the therapeutic alliance. In fact, the use of supportive techniques does not always result in a better therapeutic alliance. Furthermore, other factors distinct from supportive techniques might be associated with greater alliance, such as therapists’ accurate interpretations of core conflicts and patients’ symptomatic improvement. It is also possible that a good alliance is conducive to the provision of adequate supportive techniques. Thus, we suggest that supportive techniques, including both those that may and those that may not encourage the development of a positive therapeutic alliance, are commonly used across diverse psychotherapies and may be among the factors that contribute to equivalent therapeutic effects across treatment.

**COMMON TECHNIQUES**

In this article we emphasize the role of therapists’ techniques rather than other patient or therapist variables that are predictors of therapeutic outcome. Examples of such patient variables are faith in the therapist, quality of interpersonal relationships, the degree of patient involvement in treatment, and patient’s positive expectations for treatment. Therapist variables such as interpersonal skills (e.g., warmth, empathy, congruence, and genuineness) have often been mentioned as being relevant to a variety of therapeutic approaches. A third set of variables addresses the quality of patient–therapist interactions. A good therapeutic alliance has been repeatedly shown to predict better treatment outcome. Although there is no doubt that these variables are relevant to the therapeutic outcome, they are not techniques.

Some of the common techniques often mentioned in the literature are related to the therapeutic frame. The frame refers to the structural and procedural components of a therapy session. Techniques fostering a frame, such as setting of fees, scheduling of sessions, and discussion of the client’s role in therapy, are included in this realm. In general, the fundamental purpose of the frame is to preserve the integrity of the therapeutic process, and it has been suggested by some that deviations from the frame can be detrimental to treatment. On the contrary, Gold and Cherry have suggested that too much inflexibility in this domain may constrict the therapist’s ability to help the patient. Nonetheless, they still affirm that a therapeutic frame is necessary to
maintain the focus of treatment on the patient’s well-being. In addition, research investigating the link between client role preparation and treatment outcome has generally found positive associations, although there is a lack of research on whether or not discussion of fees and session schedules is effective. Regardless, the structural and procedural components that comprise the therapeutic frame are common across all therapies, and to the extent that they can be captured by specific techniques, these can be considered common techniques.

Additional common techniques include those that provide an environment inconsistent with patients’ expectation (i.e., facilitating corrective experiences); facilitate the exploration and expression of negative and difficult feelings; increase patient awareness and self-understanding; and use operant conditioning principles to shape patients’ behavior.

**SUPPORTIVE TECHNIQUES AS COMMON TECHNIQUES: THEORETICAL AND CLINICAL CONSIDERATIONS**

One set of techniques seldom mentioned by theorists in this context is supportive techniques. Supportive techniques are thought to contribute to the therapist–patient relationship as well as enhance the therapeutic environment for the patient, and it is possible that despite their traditional association with psychodynamic therapy, these techniques are implemented by therapists of various orientations. In fact, it makes sense that therapists from different traditions would make use of supportive techniques, given the goals of these techniques. For example, supportive techniques are used to reduce anxiety and thereby promote improvement in the patient’s functioning.

It is possible that supportive techniques have been underemphasized because they have not been clearly differentiated from supportive therapy. It might therefore be important to distinguish between the use of supportive techniques and the conduct of supportive therapy. Pinsker et al. defined supportive psychotherapy as “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” (p. 221). Although originally believed by psychoanalytically oriented therapists to benefit only less intelligent and less motivated patients, supportive psychotherapy has proved to be effective in a variety of settings. Recently, in a substudy of the Beth Israel Brief Psychotherapy Program, Rosenthal et al. demonstrated that supportive psychotherapy effectively improved patients’ interpersonal functioning. On the basis of their results, the authors suggest that supportive psychotherapy can be a successful treatment for a greater variety of patients than originally thought. Furthermore, Hellerstein et al. assert that supportive psychotherapy provides effective treatment for the broadest range of clinical problems and therefore should be considered the “default” treatment model of choice, rather than the basic exploratory psychodynamic model traditionally adopted. Rockland has similarly manualized a psychodynamically oriented supportive approach to therapy. This form of therapy specifically implements a number of techniques, many of which have been traditionally deemed supportive.

Therapies are often labeled either “supportive” or “expressive” rather than identified as having characteristics of both. It is possible that most forms of dynamic therapy involve both supportive and expressive components. According to Miller, any effective psychotherapy is necessarily supportive, in that the therapists must have supported patients to a point that enabled them to return to normal functioning. Unfortunately, Miller does not present any data to support his claim. Dewald clarifies this point further by conceptualizing all psychotherapies as existing on a spectrum ranging from expressive techniques at one end to supportive techniques at the other. Contrary to this outlook, Luborsky seems to view expressive and supportive techniques as constituting two independent dimensions. Thus, an interesting empirical question that remains unaddressed is whether supportive and expressive techniques are two dimensions (albeit related) or one dimension.

In addition to the confusion between supportive techniques and supportive therapy, there are other confusions about supportive techniques that may impede their being recognized as common interventions across different forms of therapy. For example, it is often difficult to distinguish between a supportive technique and the supportive aim of an intervention (whether the intervention is supportive or not). Furthermore, it is often difficult to distinguish between a technique that fosters a supportive relationship and a supportive technique. Because of these difficulties, and because supportive techniques can often appear in different forms, it has
been quite difficult to define those techniques. It would be tempting to define a technique as supportive if it is experienced as supportive by the patient. However, using such a definition for supportive techniques would only confuse the matter even more because one would need to wait for the outcome in order to classify the technique.

Luborsky, one of the important contributors to the refinement and implementation of supportive-expressive dynamic therapy, provides a detailed list of supportive techniques. Because of the large amount of work done by Luborsky and colleagues to manualize supportive-expressive psychodynamic therapy and to develop instruments to measure different aspects of the therapeutic process, we have adopted his approach. Luborsky lists the following techniques as supportive: 1) demonstration of support, acceptance, and affection toward the patient; 2) emphasis on working together with the patient to achieve results; 3) communication of a hopeful attitude that the goals will be achieved; 4) respect of the patient’s defenses; and 5) focus on the patient’s strengths and acknowledgment of the growing ability of the patient to accomplish results without the therapist’s help.

Supportive techniques may be implemented at the onset of treatment to create an atmosphere in which the patient feels stable, which in turn allows treatment to progress. Alternatively, they may be employed in the middle of treatment should a crisis occur, enabling the patient to overcome the situation responsible for halting further improvement. Supportive techniques are maintained throughout treatment to foster a positive therapeutic alliance. By creating an environment in which the patient is likely to feel more secure, supportive techniques may enable the patient to express thoughts and feelings that are otherwise too difficult to discuss, thereby increasing the degree of closeness between the patient and therapist. Overall, although the use of supportive techniques certainly contributes to therapist-patient rapport, the benefits these techniques afford extend beyond this dimension and therefore warrant a classification of their own.

SUPPORTIVE TECHNIQUES IN DIFFERENT THERAPIES: EMPirical FINDINGS

The following review examines research from different treatment modalities that has looked at the use of supportive techniques, or research that has looked at what therapists of differing therapeutic orientations may consider to be supportive techniques. We wish to determine across which modalities, if any, supportive techniques are similarly employed. We also assess how therapists from different schools assess the supportive value of different techniques.

We found three studies that have examined the use of supportive techniques across therapies and one that has examined the supportive value of techniques to therapists from different orientations.

As part of the Woody et al. study that examined the efficacy of individual drug counseling (IDC), supportive-expressive psychotherapy (SE), and cognitive-behavioral psychotherapy (CBT) for opiate-dependent outpatients, Luborsky et al. examined if these three treatments could be discriminated. Audiotapes of a subset of 44 male veterans who were opiate addicts receiving methadone treatment and who had been randomly assigned to participate in one of the three time-limited treatments were rated. Two independent judges rated 15-minute samples of sessions for the presence of core elements of the manual-specific interventions. Overall, the judges found that therapists used interventions consistent with the treatment manuals, such that the techniques suggested for use by the manuals were employed most often in that therapy. For example, “finding cognitive distortions” was rated highest for CBT therapists, “facilitating self-expression” was rated highest for SE therapists, and “giving advice” was rated highest for IDC counselors. However, the item “giving support,” used by Luborsky and his colleagues to represent the use of supportive techniques, was rated almost identically in all three treatments. This finding contradicts a possible prediction that supportive techniques, since they are prominently expressed only in the SE manual, will be present only in SE.

In another study, Barber and Crits-Christoph compared therapy sessions conducted by SE therapists and cognitive (CT) therapists as part of the validation of the Penn Adherence/Competence Scale for Supportive-Expressive Dynamic Psychotherapy (PACS-SE; J. P. Barber, unpublished manuscript, 1988). The PACS-SE is a 45-item scale designed to measure both the frequency (adherence) of certain therapeutic actions that correspond to those specified by Luborsky’s SE manual and the quality (competence) of the delivery of those actions. Using that scale, Barber and Crits-Christoph have shown that the competent delivery of expressive
techniques in time-limited SE therapy predicted patients’ reduction in depressive symptoms. Forty depressed patients were treated by either one of four SE therapists \((n=33\) patients) or one of four CT therapists \((n=7\) patients). Two independent judges rated audiocassettes from both of these conditions. The results indicated that CT and SE could be distinguished from one another on both the adherence and competence scale scores of the total scale as well as on the expressive subscale of the PACS-SE. The two therapies, however, did not differ on the adherence aspect of the supportive subscale, although SE therapists were more competent in this dimension. These results again suggest that the supportive components of SE are not specific to this modality.

Similarly, Barber et al.\(^1\) examined the ability of raters to discriminate SE from CT and IDC by using the Adherence/Competence Scale for SE for Cocaine Dependence (ACS-SEC). Two independent raters judged the performance of therapists treating cocaine-dependent patients in 32 audiotaped SE therapy sessions, 10 audiotaped CT sessions, and 10 audiotaped IDC sessions. Although SE therapists used more expressive interventions than CT therapists, the therapists did not differ in their adherence to supportive interventions. Conversely, when SE was compared with IDC, SE therapists were found to engage in more expressive and supportive interventions than IDC counselors. These results suggest that although supportive techniques may be used in both CT and SE, they may not be used in all treatment modalities. Such was the case in this study with respect to IDC, a form of 12-step drug counseling.

Finally, Halperin and Barber (1997, unpublished manuscript) examined perceptions of the supportive value of techniques to therapists from different theoretical orientations. A questionnaire containing 100 items describing in-session therapist actions was presented to practicing psychotherapists. Of these therapists, 13 identified themselves as primarily psychodynamic or psychoanalytic in orientation and 11 identified themselves as primarily cognitive-behavioral. Items on the questionnaire were taken from various psychotherapy rating scales, including the manual for ACS-SEC,\(^1\) the rater’s manual for the Collaborative Study Psychotherapy Rating Scale (M. D. Evans et al., unpublished manuscript, 1984), the user’s manual of the Coding System of Therapeutic Focus (M. R. Goldfried et al., unpublished manual, 1989), and the Psychotherapy Process Q-Sort (E. E. Jones, unpublished manual, 1985). Respondents were asked to rate the degree to which each questionnaire item was supportive of the patient on a 7-point Likert-type scale. Results indicated that only 5 items were rated as significantly different in their supportive value between therapists of different orientations, which would be expected by chance alone. This data therefore indicated that no differences existed in the perceptions of support in various techniques between cognitive-behavioral and psychodynamic/psychoanalytic therapists.

**DISCUSSION**

Despite the numerous indications that supportive techniques are widely used in different treatments, there is a great scarcity of studies in the literature investigating which therapists actually practice these techniques. Of the four studies reviewed here, three concluded that the use of supportive techniques is shared across modalities, and one concluded that therapists of different modalities hold common perceptions of what is considered “supportive.” In regard to the use of supportive techniques, the finding that they are shared across therapeutic domains was particularly prominent when supportive-expressive psychotherapy, a form of time-limited dynamic psychotherapy, was compared with cognitive therapy. In contrast to the general conclusion was the finding in Barber and colleagues’\(^1\) study that IDC counselors treating cocaine-dependent patients did not engage in supportive techniques as often as SE or CT therapists. (Earlier, however, Luborsky et al.\(^4\) had reported that IDC counselors engaged in as many supportive techniques as SE or CT therapists while treating methadone-maintained opiate-dependent outpatients.) The findings of Barber et al.\(^1\) seem to suggest that drug counselors adopting a 12-step program, such as IDC counselors, might not use as many supportive techniques as cognitive and dynamic therapists, even when working with the same population. These findings are not surprising in light of the confronting stance held by drug counselors conducting 12-step programs. This pattern of results is interesting because researchers often tend to make a dichotomous distinction and classify techniques as either entirely nonspecific, and therefore found in all therapies, or as exclusively specific to a certain treatment modality. Rarely are techniques depicted as being shared by a particular subgroup of the general
body of therapies, as may be the case with supportive techniques.

The study that investigated therapists’ perceptions of support within techniques indicated that these perceptions do not differ significantly between therapists practicing from different therapeutic orientations. Some techniques were rated as highly supportive by therapists across modalities, and others were rated consistently low in supportive value. This result supports the likelihood that different therapists might use similar techniques when their objective is to provide patient support.

One may argue that although research specifically examining supportive techniques is sparse, an abundance of literature investigating the therapeutic alliance exists in its place. But supportive techniques and the therapeutic alliance are not the same. It is easy to assume that the therapeutic alliance accurately reflects the quality of supportive techniques employed by the therapist, and it is therefore often concluded that a positive therapeutic alliance necessarily follows from the successful use of supportive techniques in therapy. Whether this is the case or not is an open-ended empirical question that has rarely been addressed in the literature. In the current context, the therapeutic alliance could be considered an outcome measure designed to reflect the quality of the patient–therapist relationship; the alliance emerges and fluctuates in strength during the course of therapy. That relationship, however, may be affected by many factors in addition to the use of supportive techniques. For instance, patients’ moods may alter their perceptions of the therapist and therefore affect ratings of the therapeutic alliance while having nothing to do with the supportive stance of the therapist. Consequently, it could be misleading to draw definitive conclusions regarding the use or nonuse of supportive techniques based on reports of the therapeutic alliance alone. In fact, Barber and Crits-Christoph showed that alliance was not correlated with supportive technique at session 3 of time-limited supportive-expressive therapy for depression. This finding makes sense when one considers that supportive techniques are not the only factor affecting the therapeutic alliance, but rather work in conjunction with a variety of other factors to determine the ultimate quality of the patient–therapist relationship.

The results of our review indicate that supportive techniques may be shared across some but not all treatment modalities. It seems that supportive techniques, as defined by Luborsky, may be commonly employed in different psychotherapies but used much less frequently in treatments such as drug counseling. This conclusion is not emphatic, however, as IDC (a form of drug counseling as opposed to psychotherapy) demonstrated conflicting frequencies of supportive techniques in two of the studies. It is unfortunate that because the amount of research examining this issue is very sparse, our review is able to consider only a limited subset of the existing array of treatment modalities. Consequently, our conclusions remain tentative. Nevertheless, given that both supportive techniques and effective outcome persist across at least some therapeutic disciplines, research investigating whether a supportive approach to therapy may be accounting for some of these shared benefits could be warranted. Some researchers have already taken a first step toward making possible the empirical study of this question. Ogrodniczuk and Piper have recently developed a new scale, the Interpretive and Supportive Technique Scale (ISTS), which is designed to measure the interpretive and supportive techniques implemented across a broad range of dynamically oriented psychotherapies. Future research on supportive techniques should incorporate measures such as the ISTS to ensure high-quality research methodology.

When discussing the use of supportive techniques as common interventions in psychotherapy, the distinction between “supportive aim of a technique” and a primarily “supportive technique” requires further elaboration. Although it may be the case that techniques identified as primarily supportive are used less in some therapies than others, the supportive value of techniques or aspects of the therapeutic setting may not be reflected in such measurements. It is possible, for example, that patients in IDC may feel highly supported by a counselor who consistently keeps scheduled appointment times, since drug-addicted populations have been found to have substantial problems with interpersonal functioning, resulting in turbulent and unreliable relationships. It follows that although a therapy such as SE may include more supportive techniques than IDC, patients in IDC may experience their therapy as more supportive than patients in SE. Unfortunately, because the supportive value of any particular technique or aspect of the therapeutic setting will vary for each individual patient, examination of this more general aspect of support does not readily lend itself to empirical investigation. In lieu of existing empirical data, however,
it is difficult to refute the notion that the patient's experience of support is present in all psychotherapies and should therefore be considered common therapeutic techniques across different types of therapy.

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