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Dynamic Supportive Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

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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 confrontional 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.