alleviate suffering in psychotherapy, changing the lives of both patients and therapists for the better.

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# In support of supportive psychotherapy

People get carried away by bells and whistles, but sometimes it is the basics that matter. Psychotherapists, like their patients, face discomfort with and may shy away in the face of strong emotions[1]. Yet focusing on strong emotions lies at the heart of psychotherapy. That is what good therapy, and particularly good supportive psychotherapy, should do.

At least before cognitive behavioral therapy took the world by storm, supportive psychotherapy was cited as the most widely practiced form of psychotherapy[2]. But what is supportive psychotherapy? It has meant too many things. The term initially denoted the lesser alternative to psychoanalysis in the last century, the treatment offered to patients who could not tolerate the interpretations or lack of structure of free association on the couch. In other words, anything other than psychoanalysis was supportive psychotherapy. Supportive psychotherapy has been variously described as an attempt to shore up rather than alter psychic defences and as gentle hand-holding. It has probably encompassed various forms of muddled eclectic psychotherapy[2].

Thirty years ago, we developed a time-limited, manualized form of affect-focused supportive psychotherapy in response to the long-standing research conundrum of what constitutes a psychotherapy control condition. Over the years we and others have tested this brief supportive psychotherapy (BSP) in nine randomized controlled trials to treat mood and to a lesser degree anxiety disorders, with a tenth study currently underway. In all of these instances, BSP has been the underdog comparison condition.

We recently amassed the results of those trials and found that BSP worked as well as the favored treatments in seven of the nine trials, and finished a credible, near-miss second in the other two[3]. This is actually big news: BSP performed very well, considering that researcher allegiance often affects trial outcomes[4]. On balance, the data indicate that BSP may have failed to resolve the dilemma of the less-active psychotherapy control condition. Whereas waiting lists and "treatment as usual" (at least in the fractured US health care system) are often unfairly weak comparisons, BSP may be too potent an intervention to serve as a less-active control[3]. On the contrary, it deserves listing in depression treatment practice guidelines. Other studies have used unmanualized, generic treatment titled "supportive therapy" (not BSP) with less positive results.

What is BSP? It is an elemental treatment: it distills psychotherapy to its emotional essence. Based on the work of psychotherapy giants such as C. Rogers[5] and J. Frank[6], BSP comprises the "common factors" building blocks that are part of all effective treatments and that account for the majority of all psychotherapies' outcomes[7] – the common factors, and not much more. Those common factors are: affective arousal, feeling understood by the therapist and developing a therapeutic alliance, providing a framework for understanding and a therapeutic ritual, evincing optimism for improvement, and encouraging success experiences[6]. Above all, BSP focuses on the patient's emotions and on emotional tolerance. Emotional tolerance may indeed constitute many patients' principal success experience in treatment. If psychotherapies are broadly divisible into exposure-focused and affect-based therapies, BSP surely falls in the latter camp: the only exposure here is to one's own emotional state.

BSP therapists are active listeners, often silent but encouraging, letting patients lead sessions, intervening only to steer patients towards recognition and tolerance of affect. The stance incorporates curiosity, sympathy, a search for mutual understanding of the patient's emotional state. Maintaining eye contact, the therapist mirrors the patient with nonverbal synchrony. Recognizing that patients are beset not only by outside stressors but by the stress of uncomfortable internal emotions, therapists help patients recognize and name their feelings ("What kind of upset? Which emotion is that?"). The therapist does not avoid powerful affects but seeks and tolerates them, demonstrating by example the mantra of treatment that *emotions are powerful but not dangerous*. Affect regulation, with the appreciation that one's uncomfortable feelings are meaningful reactions to life circumstances, is clinically helpful. This therapy is simple in its approach, yet not simple to deliver well.

While the patient is doing most of the talking, the therapist mentally sketches an emotional portrait of the individual. Who is this person? How does he/she react to particular situations, and with which emotions? Depressed and anxious patients frequently avoid interpersonal confrontations, having trouble asserting their wishes and struggling to say no. Helping to elicit emotionally-laden desires and particularly negative affects such as anger and sadness, the therapist normalizes them: "Is it reasonable to feel

angry if you don't like what he's doing?". This gives the patient implicit permission to understand, tolerate, accept, and perhaps express such impulses.

A danger with fancier, technique-heavy psychotherapies is that they can become mechanical, intellectualized, affect-drained exercises. One reason for the rise in so-called "third wave" cognitive behavioral therapies has been recognition of the sapping of affect from exposure-based treatments. In contrast, BSP focuses almost exclusively on the pursuit of affect: eliciting emotion, letting the patient sit with it (catharsis), eventually validating it where appropriate. Normalizing strong and subjectively "bad" negative affects such as anger and anxiety comes as therapeutic relief for patients ("Oh, I'm angry for a reason!"). Emotion makes sessions memorable. Emotion integrates insights as felt understandings rather than intellectualizations. Less can be more.

At a time when psychiatry faces training and reimbursement challenges, when the flash of novelty may obscure deeper meaning, too many psychotherapists collude with uncomfortable patients in pulling away from exploration of affect[8]. It may be time for a supportive psychotherapy comeback. A new BSP manual[9] provides a framework for this back-to-the-basics approach.

Moreover, even therapists who may not want to conduct BSP as such might benefit from a return to understanding the fundamentals of psychotherapy: learning how to dig for, sit with, and validate emotion, and how to use the "common factors" in appropriate balance. Again, these common factors are integral to every effective psychotherapy, important as well to pharmacotherapy in promoting the treatment alliance necessary to having patients accept taking medication[2,9]. Psychotherapists coming to BSP from exposure-based training backgrounds have remarked on how an understanding of these supportive techniques broadens their psychotherapeutic outlook and approach[3,9]. Thus, a supportive approach can hone and highlight understanding of the basic skills at the foundation of other therapies.

There are other affect-focused treatments, including interpersonal psychotherapy, well-conducted psychodynamic psychotherapies, and mentalization-based therapies. BSP is the pared down core of these approaches. It lacks and needs no bells and whistles. It just sticks with feelings. By letting the patient lead and focusing on his/her emotions, it maximizes patient autonomy. The therapist assigns no homework and applies no structure beyond the affect focus. A transportable, disseminable, inexpensive intervention, affect-focused BSP deserves a second look.

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