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Support in Psychotherapy: A Common Factor in Need of Empirical Data, Conceptual Clarification, and Clinical Input

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This article serves as an introduction to a series of contributions on the role and nature of therapist support in psychoanalytic, existential-humanistic, and cognitive therapies. Although support has been recognized as an important factor of change in these approaches, many questions remained to be answered regarding the form and impact of this therapeutic variable across different modes of therapy. This series addresses several of these questions by providing specific definitions of the concept of support, empirical observations of supportive interventions, and clinical illustrations of the use and impact of such interventions. Similarities and differences among the three perspectives on support are discussed in a concluding article.

KEY WORDS: psychotherapy integration; common factors; support in psychotherapy; process of change in psychoanalytic, existential-humanistic, and cognitive therapies.

The goal of this series of articles is to better understand the nature and impact of therapist support in different types of psychological treatment. To this end, expert therapists from psychodynamic, existential-humanistic, and cognitive traditions have agreed to present their views on the role that a supportive attitude plays in their practice and their orientation in general.

Since the very beginning of modern psychotherapy and psychiatry, therapist support has been recognized as a crucial element of therapeutic

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change. Philippe Pinel (1745–1826), arguably the founder of modern psychiatry, believed the cure of mental illness primarily required the kindness, compassion, and understanding of those who attended to the patients. Although Freud emphasized the importance of a neutral stance in his theoretical work, several authors have argued that an atmosphere of safety and support might well have been omnipresent in his consultation room (e.g., Strupp, 1977; Yalom, 1980). Freud's genuine interest and supportive attitude toward his patients may indeed explain why, for example, he gave a meal to the "Rat Man," sent him a postcard, asked him for a picture of his fiancée (Gill, 1982; Lipton, 1977), and why he frequently consoled another patient (Elizabeth von R) "by assuring her that she was not responsible for unwanted feelings, and pointed out that her degree of guilt and remorse for these feelings was powerful evidence of her high moral character" (Yalom, 1980, p. 4).

Over the years, support has gained more respect in theoretical writings of psychoanalytic therapists. As described by Wallerstein and DeWitt (this issue), psychoanalytic efforts to systematically define supportive interventions (e.g., encouragement, advice, environmental manipulation, coaxing, exhortion, praise, prescription of daily activities) date back to the seminal contribution of Knight (1949, 1952) a half-century ago. Two decades later, Rangell (1969) noted that "an objective and scientific attitude can, and indeed should, go hand-in-hand with analytic empathy, caring, and compassion . . . without needing to invoke any contradictory or mutually exclusive attitudes on the part of the analyst" (pp. 72–73, cited in Gill, 1982). Within the more recent object-relations movement in the psychodynamic tradition, Winnicott's emphasis on creating a "holding environment" provides a vivid testimony of the importance of therapist support for the client's healing.

Therapist support, of course, is at the heart of humanistic-existential therapy. A supportive attitude has been perceived by humanistic therapists as an integral part of the necessary and sufficient conditions for therapeutic improvement (Rogers, 1957). Furthermore, the lack of genuine validation and acceptance from significant others has been the cornerstone of the humanistic view of human suffering and psychopathology. Even today, more than 40 years after the emergence of the Third Force in Psychology, humanistic therapists still assign a pivotal role to therapist acceptance and support:

> The therapist experiences and communicates warm, unconditional *prizing* (Butler, 1952) of the client; a positive feeling is communicated that the client is a worthwhile person whose value does not depend on performing certain behaviors or having feelings. Prizing includes both acceptance (i.e., unconditionality), a general "baseline" attitude of consistent, genuine, noncritical interest in and tolerance for all aspects of the client (Rogers, 1957, 1959), and warmth, an immediate, active

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> sense of caring for, affirming, and appreciating the client at specific moments in therapy. (Elliot & Greenberg, 1995, p. 126)

Early behavioral views of therapeutic change did not place a significant emphasis on the value of the therapist's nurturing and support. Such interpersonal factors were mainly seen as part of the so-called nonspecific variables in psychotherapy (i.e., noninstrumental elements of the therapeutic intervention that are auxiliary to the techniques, and are yet to be clearly understood [see Castonguay, 1993]). Several studies, however, have demonstrated that clients in behavioral therapy find supportive qualities of their therapist (e.g., therapist's encouragement and sympathy, confidence in his/her client's ability to improve, and client's feeling of being liked by their therapist) to be more helpful than the specific techniques that have been used to solve their problems (Mathews *et al.*, 1976; Ryan & Gizynski, 1971; Sloane *et al.*, 1975). Moreover, Bruninck and Schroeder (1979) have shown that behavioral therapists can be more supportive (i.e., reassuring, praising, and sympathetic) than psychodynamic and gestalt therapists. These results are particularly important considering the link between therapist support in cognitive-behavioral therapy and treatment outcome. Morris and Suckerman (1974) found that warm therapists obtained better outcomes than cold therapists in the treatment of snake phobia with systematic desensitization. Shearin and Linehan (1992) also found that a balance of both therapeutic challenge and acceptance was particularly effective in reducing suicidal behavior in the treatment of Borderline Personality Disorder. Moreover, Patterson and Forgath (1985) found that supportive and facilitative interventions are more helpful than teaching and confronting techniques for skills-oriented training of parents with conduct disordered children. The accumulation of such empirical data and the increased involvement of behavioral therapists with the treatment of personality disorders have led to a more explicit recognition of the therapeutic import of support (e.g., Arkowitz, 1992; Goldfried & Castonguay, 1993; Koerner & Linehan, 1992; Raue & Goldfried, 1994).

Studies supporting the value of therapist support have by no means been restricted to the conduct of behavioral therapy (see Lambert, 1992). However, despite considerable empirical evidence and an explicit recognition across different orientations, many questions remain to be answered regarding the nature and role of support in psychotherapy. For instance, it is not clear whether a supportive attitude takes a similar form and has the same impact in diverse types of therapy. Moreover, the relationship between therapist support and the use of his/her techniques is still mostly unknown at this point in time. To begin answering these and other important questions, what are needed are specific definitions of support from the perspective of different orientations, observations of therapist suppor-

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tive interventions during the process of therapy, and clinical illustrations of the enactment and impact of such interventions.

Each of these issues are being addressed in the following three articles. Wallerstein and DeWitt (this issue) describe the crucial place that supportive interventions have occupied, for the last 50 years, in the psychoanalytic tradition. They also summarize findings of an intense research project on the process of psychoanalytic treatment, which demonstrate the role of support within a large spectrum of psychoanalytic therapies (supportive therapy, expressive therapy, psychoanalysis). Based on these empirical findings, they offer a revised classification of psychoanalytic interventions, which contain specific definitions of a large number of supportive interventions. After describing the basic assumptions underlying the existential-humanistic orientation, Yalom and Bugenthal (this issue) discriminate between a general from of support present in all forms of therapy and the type of support that facilitates the process of change that appears to be unique to their approach. Following a detailed clinical illustration of their definition of support, they describe the therapeutic process as one that requires the therapist to challenge the client's resistance and yet maintain a supportive environment. Reminiscent of Linehan's (1990) dialectic notion of change and acceptance, this description reveals some of the complex and sometimes paradoxical interactions that can take place between the therapist's technique and the therapeutic relationship. The intrinsic link between technical and relationship variables is also addressed by Alford and Beck (this issue) in their challenge of some false dichotomies (e.g., supportive vs. directive) that have been used in reference to cognitive therapy. Defining the concept of support as the creation of a responsible or constructive dependency (as opposed to a regressive dependency), they describe a number of responsibilities on the part of both the therapist and client in the development of a supportive relationship. They then derive theoretical implications from the specific use of support in cognitive therapy, especially with regard to the viability of support as a common factor in psychotherapy.

The similarities and differences across these three perspectives on the role of support in psychotherapy are discussed in an article by Arkowitz (this issue).

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