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How Do Supportive Techniques Bring About Therapeutic Change: The Role of Therapeutic Alliance as a Potential Mediator

Liat Leibovich and Or Front
University of Haifa

Kevin Scott McCarthy
Chestnut Hill College and University of Pennsylvania

Sigal Zilcha-Mano
University of Haifa

Although supportive techniques play an important role in supportive–expressive psychodynamic psychotherapy, little is known about the mechanisms responsible for their effect on treatment success. In this study, we propose and investigate a model according to which the mechanism of change underlying the effect of supportive techniques on therapeutic improvement is the strengthening of the therapeutic alliance. According to the proposed mediation model, the implementation of supportive techniques brings about strengthening in the alliance, which in turn results in subsequent reduction in symptoms. The present study was designed to test the proposed mediation model. Analyses were conducted on a sample of 61 patients diagnosed with major depressive disorder and enrolled in an ongoing psychotherapy trial. For each patient, Session 4 of the supportive–expressive treatment was coded for therapist adherence to supportive techniques, using the Penn Adherence–Competence Scale. The therapeutic alliance was assessed using a self-report scale, and the Hamilton Rating Scale for Depression was used to assess the subsequent change in symptoms. The analyses suggest a significant mediation model, according to which the implementation of supportive techniques resulted in improvements in the alliance, which in turn resulted in reduction in symptoms at the subsequent session (bootstrapping for the indirect effect, 95% confidence interval [−1.96, −0.16]). The findings support the proposed mediation model, suggesting that the alliance may act as a mechanism of change underlying the effect of supportive techniques on treatment success.

Clinical Impact Statement

Question: This study explored the question: Can the therapeutic alliance act as a mechanism of change underlying the effect of supportive techniques in supportive–expressive treatment with depressed patients? ***Findings:*** We found a mediation model where the alliance serves as a mediator between adherence to supportive techniques and improvement in depressive symptoms. ***Meaning***: The findings suggest that supportive techniques can improve symptoms by enhancing the alliance between the patient and the therapist. ***Next Steps***: Future studies are needed to understand the specific interrelationships between supportive techniques, alliance, and outcome.

Keywords: supportive techniques, supportive–expressive psychotherapy, alliance, outcome, depression

Supportive–expressive (SE) therapy is a short-term psychodynamic treatment adapted to treat major depressive disorder (MDD) and is found to be effective (Leichsenring & Leibing, 2007). SE is based on the implementation of both expressive (interpretive) and supportive techniques (Book, 1998; Luborsky & Crits-Christoph, 1998). Understanding the mechanisms of change in effective psychotherapies is critical for improving them (Crits-Christoph, Gibbons, & Mukherjee, 2013; Zilcha-Mano, 2018). The mechanisms underlying the effect of expressive techniques received much theoretical and empirical attention (Crits-Christoph et al., 2013), but little is known about the mechanisms underlying the supportive elements of SE. This lacuna is the focus of the present study.

In recent decades, the supportive techniques of psychodynamic psychotherapy and psychoanalysis received much attention from clinical theorists adhering to different psychodynamic schools (see, e.g., Alvarez, 2012; Kohut, 1984). The importance of supportive techniques specifically for short-term psychodynamic psychotherapy has also been noted (Balint, Ornstein, & Balint, 1972; Smith, 2006). Supportive techniques, in general, aim to strengthen

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Liat Leibovich and Or Front, Department of Psychology, University of Haifa; Kevin Scott McCarthy, Department of Psychology, Chestnut Hill College, and Department of Psychiatry, University of Pennsylvania; Sigal Zilcha-Mano, Department of Psychology, University of Haifa.

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Correspondence concerning this article should be addressed to Sigal Zilcha-Mano, Department of Psychology, University of Haifa, Aba Hushi, 199, Haifa, Israel. E-mail: sigalzil@gmail.com

the patient's ego, enhance self-esteem, and facilitate exploration of emotions, while encouraging higher level defenses (Appelbaum, 2006; Pinsker, Rosenthal, & McCullough, 1991). In SE, supportive techniques include (Barber & Crits-Christoph, 1996; Book, 1998) offering empathic, validating, and understanding comments, demonstrating genuine interest and respect, while choosing to maintain vital defenses (e.g., respecting the patient's narcissistic talk in a narcissistically fragile situation). The techniques also include maintaining appropriate self-object transferences, that is, "allowing" patients to use the therapist for their needs, for example, by mirroring positive aspects of the patient's self, and willingness to be the patient's object for idealization (Kohut, 1984). Supportive techniques should enable the therapist to focus on the here-and-now and on practical issues (Book, 1998). Another important aspect of supportive techniques is noting the patient's gains, supporting the patient's wish to achieve the goals of treatment, presenting realistically hopeful attitude that these goals can be achieved, and recognition of improvement toward the attainment of these goals. Therapists are encouraged to show their patient that they like them, believe in their strengths and their ability to find solutions, and to work together with the patient as a team for better self-understanding (instead of the therapist being responsible for delivering new understandings; Barber & Crits-Christoph, 1996; Book, 1998).

A meta-analysis by Driessen et al. (2010) suggests that psychodynamic therapies with a supportive emphasis are not significantly different in their effectiveness from expressive–interpretative ones. Another meta-analysis (Cuijpers et al., 2012) found that supportive therapy was effective for mild-to-moderate depression in adults. Although supportive techniques seem to show effectiveness, the mechanisms underlying their effect did not receive much empirical attention. Several potential candidates for the mechanisms of change underlying supportive techniques have been proposed. One mechanism that may be responsible for the effect of supportive techniques is the creation of intrapersonal change in patients, for example, strengthening their egos (Appelbaum, 2006; Pinsker et al., 1991). Another promising mechanism is the creation of interpersonal, rather than intrapersonal change in patients (Leibovich, Nof, Auerbach-Barber, & Zilcha-Mano, 2018). Leibovich et al. (2018) suggested that supportive techniques bring about therapeutic change by strengthening the therapeutic alliance between patient and therapist. A strong alliance is typically regarded as consisting of a strong bond and agreement between the patient and the therapist on the goals and tasks of treatment (Bordin, 1979). According to the proposed model (Leibovich et al., 2018), the alliance can be enhanced by using supportive techniques, by identifying the patient's main conflictual interpersonal wish (W), and striving to actualize it in the therapeutic relationship. This process is expected to occur within a given session, when supportive techniques enhance both the agreement on tasks and goals, and the bond between patient and therapist.

According to Leibovich et al. (2018), first, the therapist must strive to identify the patient's main conflictual interpersonal wish (W), as conceptualized using the Core Conflictual Relationship Theme (CCRT) framework. Next, the therapist must aim to actualize the wish in the therapeutic relationship itself by implementing supportive techniques. Such interventions are used even in relational enactments, or repetitions of the patient's problematic interpersonal patterns, which make it even more difficult for the patient's wish to be fulfilled. For instance, a patient with a CCRT involving abandonment might experience her therapist as withdrawing, as part of her expected response from other, even when the therapist does not intend to be withdrawing. A supportive intervention would reassure the patient of the therapist's continued presence and point toward all the times the therapist has been available for the patient. Supportive techniques can help fulfill the patient's wish without interpreting the vicious circles, creating a new corrective experience and enhancing the alliance, enabling the patient to practice new responses of his or her self.

Although this model has not yet been empirically tested as a whole, there is some promising evidence to support its validity. To enable empirical testing, the model may be regarded as two pathways that constantly repeat themselves between sessions and within sessions. On the first path, the implementation of supportive techniques results in the strengthening of the therapeutic alliance within the same session. This is considered to be a delicate process that unfolds within the framework of the session when the therapist is implementing the supportive techniques that are expected to affect the alliance at the next phase of the same session. On the second path, the strengthening of the therapeutic alliance in turn leads to symptoms reduction.

Regarding the first path, several studies found a positive association between greater use of supportive techniques in SE and the strength of the alliance (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Ogrodniczuk & Piper, 1999). A recent study showed that extensive use of common-factor techniques, such as supportive ones, in SE therapy, predicted improvement in the alliance later in the treatment (Solomonov et al., 2018). Although these findings are preliminary and test common factors rather than specifically supportive techniques, they provide some support to the first path of the proposed mediation model, according to which the use of supportive techniques results in the strengthening of the alliance. According to the second path, the strengthening of the alliance results in subsequent reduction in symptoms. Many meta-analyses published to date suggest that the alliance is a consistent predictor of outcome (Flückiger, Del Re, Wampold, & Horvath, 2018). To the best of our knowledge, the entire model claiming that the implementation of supportive techniques predicts strengthening of the alliance, which in turn predicts improvement in outcome, has never been investigated.

The present study aims to investigate the proposed mediation model, according to which the working alliance may fulfill the role of a mechanism of change that enables supportive techniques to achieve better outcomes. The study tests the proposed mediation model using high-resolution psychotherapy research that zooms in on a specific in-session process of therapeutic change. We examined this model both at the macrolevel of analysis of a sample of patients receiving psychotherapy for MDD, and at a microlevel of analysis of a single therapeutic case study. This design enables us to focus on the temporal relationships between supportive techniques and alliance, which is not feasible in the macroanalysis because the measures are at the session level and the process of change occurs within the session. We hypothesized the existence of a mediation model, suggesting that the effect of supportive techniques implemented at one early session on subsequent symptom reduction from that session to the next one is mediated by the strength of the therapeutic alliance (see Figure 1). We expect the effect of supportive techniques on the alliance to be immediate,

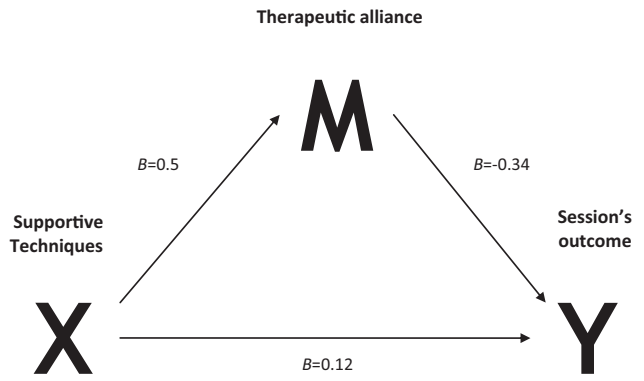

Figure 1. A mediation model between supportive techniques (PACS), alliance (WAI), and session's outcome (ΔHRSD). PACS = Penn Adherence–Competence Scale; WAI = Working Alliance Inventory; HRSD = Hamilton Rating Scale for Depression.

that is, to occur within the same session, rather than affecting the alliance later in the treatment. We focused on the initial stages of treatment (the first four sessions) because of the importance of this stage and its effect on subsequent processes and on the outcome of treatment. Previous studies have highlighted the importance of this early stage, where most of the changes in alliance and symptom reduction occur (Lutz et al., 2014; Rubel et al., 2015). This early change in treatment was also found to be a robust predictor of treatment outcome at termination (Haas, Hill, Lambert, & Morrell, 2002; Nordberg, Castonguay, Fisher, Boswell, & Kraus, 2014).

Method

Participants

Sixty-one patients with MDD were recruited through advertisements offering free treatment, as part of an ongoing trial conducted at University of Haifa Psychotherapy Research Lab Clinic (Zilcha-Mano, Dolev, Leibovich, & Barber, 2018). Inclusion criteria included the following: (a) a diagnosis of MDD based on the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Sheehan et al., 1998), with scores above 14 on the 17-item Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967) at two evaluations, 1 week apart, and current MDD based on the Mini International Neuropsychiatric Interview (Sheehan et al., 1998); (b) if on medication, patients' dosage had to be stable for at least 3 months before the start of the study, and they had to be willing to maintain a stable dosage for the duration of treatment; (c) age between 18 and 60 years; and (d) provision of written informed consent. Exclusion criteria included the following: (a) current risk of suicide or self-harm (HRSD suicide item >2); (b) current substance abuse disorder; (c) current or past schizophrenia or psychosis, bipolar disorder, or severe eating disorder, requiring medical monitoring; (d) history of organic mental disease; and (e) currently in psychotherapy.

Mean patient age was 32.1 (*SD* = 8.99); 36 participants (58.1%) were females; 71% were single, 24.2% married or cohabitated, 3.2% divorced or widowed; 11.3% were high school graduates, 37.1% had some college education, 25.8% were college graduates, 9.7% had some postgraduate education, and 14.5% had graduate degrees. At intake, all patients met criteria for a primary diagnosis of mood disorder, and 73.8% for anxiety disorders; 68.8% had a primary Axis-II personality disorder. The most frequent personality disorders were obsessive–compulsive (44.3%), avoidant (26.2%), and borderline (16.39%).

Treatments

Patients received 16 sessions of 50 min each, either in an SE or a supportive-only condition. The manualized treatment (Book, 1998; Luborsky, 1984, 1995), including both supportive and expressive techniques, was used. The supportive condition included all supportive techniques detailed in the manual but prohibited the use of any expressive techniques, as detailed in Leibovich et al. (2018). After the end of treatment, once a month, patients received a maintenance session with their treating therapists, for a total of four follow-up sessions.

Therapists

Therapists acted as their own controls and provided treatment in both conditions to avoid nesting of therapists within a condition, which may result in unwanted confounding. Eight therapists participated in the study, three male and five female psychologists, with a range of 4–20 years of clinical experience. The therapists attended a 20-hr training workshop in supportive and expressive techniques. The training included formal teaching and role playing, using the different techniques. All therapists completed the treatment of two pilot patients, one of each treatment type, and had to demonstrate sufficient adherence in the two pilot cases before moving into the trial phase. During the pilot phase, and after the start of the research, each therapist received weekly group supervision, as well as weekly individual supervision. Individual and group supervisions made extensive use of videotaped sessions for feedback. The supervisor was a licensed clinical psychologist with 17 years of clinical experience, and a licensed supervisor with 11 years of supervisory experience in psychodynamic psychotherapy. The supervisor received supervision concerning the supervision process from an international expert in SE, with more than 20 years of experience in psychodynamic treatment for depression, and more than 15 years of experience in SE treatment in randomized controlled trials (RCTs). The mean number of patients treated by each therapist in the current study was 7.62 (*SD* = 6.7, range: 2–18).

Procedure

The trial procedure is described elsewhere (Zilcha-Mano et al., 2018). Potential patients were recruited by self-referral, based on advertisements, and received written and oral information about the content and extent of the planned study, including the information that all treatment sessions are videotaped and that they had the right to withdraw from the research at any time. Those who agreed to participate were required to sign the informed consent form. Measures were completed at two intake sessions, and subsequently session by session. For the present study, we focused on supportive techniques, as they were coded at the fourth session of treatment. To assess the strength of the alliance at this session, we used the rating of the working alliance by the patient after the

session. To create a correct temporal relationship between predictor and outcome, we used symptom reduction between measures taken before Session 4 and Session 5. Type of therapy (supportive or SE) cannot be included in the analysis yet because the RCT is ongoing, but all patients received the supportive elements of SE. The significant change and deterioration ratios of the sample cannot be reported yet either, because the RCT is ongoing.

Measures

Symptom severity. We used the primary outcome measure of the trial, HRSD (Hamilton, 1967), a 17-item clinically administered measure of the severity of depression, to assess symptom severity. The interrater reliability was 0.98.

Working alliance. The alliance was assessed after each session, using the 12-item version of the Working Alliance Inventory (WAI; Tracey & Kokotovic, 1989). Items were rated on a 7-point Likert scale, ranging from 1 (*never*) to 7 (*always*). Only the WAI scores from Session 4 were used in the present study ($M = 5.48$, $SD = 0.88$).

Use of supportive techniques. We used the Penn Adherence–Competence Scale (PACS; Barber & Crits-Christoph, 1996) to examine the degree to which therapists adhered to the manual and whether they were competent in the use of the techniques. The PACS includes three subscales: general therapeutic behaviors, a supportive component, and an expressive component. The research team was supervised by an international expert on the use of the PACS, with vast experience in using the PACS in RCTs of SE treatment. The coding was performed by two graduate students in clinical psychology who were blind to the treatment conditions. The training included a week-long workshop focusing on explaining the coding system and on coding demonstrations of each item. For 10 months, the coding team practiced coding other videos of therapeutic sessions of SE treatment, as well as of other types of treatment. The team first watched the videos and coded them together, after which the students coded tapes alone, until they reached an excellent intraclass correlation coefficient (ICC) of 0.9 in the Supportive scale. During the entire course of their coding for the study (3 years), the research team met for supervision sessions weekly. Each session was coded by the two coders and their ratings averaged. Of the 61 sessions, four sessions could not be coded by one of the coders because of an early acquaintance with the patient. Thus, a third graduate student in clinical psychology was trained, based on the above training protocol, and coded the remaining four sessions. To assess interrater reliability of the two main coders, the ICC was calculated using the SPSS statistical package, Version 22, based on a mean-rating ($k = 2$), absolute-agreement, two-way random-effects model. The reliability was calculated based on the average score of all the nine questions on the Supportive scale. The resulting ICC was in the excellent range, ICC (2, 2) = .93 (Fleiss, 1981), indicating that coders had a high degree of agreement and suggesting that the amount of therapist's use of supportive technique was rated similarly by the coders. The mean score of adherence to supportive techniques was 4.57 ($SD = 0.83$) on a 1–7 Likert scale.

Data Analysis

To examine the mediation model in which supportive techniques (PACS Session 4) predict the working alliance (WAI Session 4), which in turn predicts a change in outcome (change in HRSD score from Session 4 to Session 5), we tested a series of analytic models. Following Preacher and Hayes (2004), we examined mediation using two models: (a) a multiple regression of the association between the predictor (PACS Session 4) and the mediator (WAI Session 4) and (b) a multiple regression of the associations between the mediator (WAI Session 4) and the outcome (subsequent change in HRSD), controlling for the predictor (PACS Session 4). In all analyses, the predictors were mean-centered before the analysis, and a bias-corrected and accelerated bootstrapping test, based on 1,000 repetitions, was used to test the significance of the indirect paths (see MacKinnon, Lockwood, & Williams, 2004; Williams & MacKinnon, 2008).

The following regression equations were used:

Overall effect

$$\Delta\text{HRSD} = c_0 + c_1 \times \text{AS} + v$$

Effect on moderator

$$\text{WAI} = a_0 + a_1 \times \text{AS} + u$$

Direct effect

$$\Delta\text{HRSD} = b_0 + b_1 \times \text{AS} + b_2 \times \text{WAI} + e$$

where WAI represents the therapeutic alliance, ΔHRSD represents the change in the depressive symptoms (HRSD), and AS the adherence to the supportive technique. Furthermore, e, v, and u represent errors, are independent, and have a normal distribution.

Results

Mediation Model

The estimated variance of the therapist's random effect in a two-level model predicting change in HRSD score from Session 4 to Session 5 was not significant ($S^2 = 0.00$, $p = .99$, ICC = 0.00). To examine our hypothesized mediation model, we conducted a series of analytic models (see Table 1). The first model (Path 1) revealed a significant ability of supportive techniques, as coded in Session 4 (PACS), to predict the therapeutic alliance of the session (WAI; see Table 1). The use of more supportive techniques was associated with a stronger alliance. The second model (Path 2) revealed a significant ability of the therapeutic alliance to predict subsequent reduction in depressive symptoms (HRSD) in multiple regression, when controlling for the use of supportive techniques. In other words, stronger alliance predicted more subsequent symptom reduction. The full mediation model was significant (bootstrapping for the indirect effect, 95% confidence interval [CI: −1.96, −0.16]). The direct effect was no longer significant when controlling for the indirect effect, Path c′: $\beta = 0.12$, $p = .48$.

The full mediation model was significant (bootstrapping for the indirect effect, 95% CI [−1.96, −0.16]), and the mediator accounted for more than half the total effect, (the ratio of the indirect effect to the total effect was 0.59), suggesting that supportive techniques may not lead to better outcomes directly, but rather through the mediation of the therapeutic alliance (see Figure 1). Although conceptually we expected the effect of techniques on alliance to occur within the same session, we also explored an alternative model, in which techniques at Session 4 predict alliance at Session 5, which in turn predicts change in depres-

Table 1
Standardized Estimates for the Paths of the Mediation Model According to Which Alliance Mediates the Association Between Supportive Techniques and Depression (ΔHRSD)

Model	Effect	Estimate	*SE*	*t*[a]	*P*
1) Outcome = Alliance	Supportive techniques	0.50	0.11	4.4	.000
2) Outcome = Depression (ΔHRSD)	Alliance	−0.34	0.14	−2.35	.02
	Supportive techniques	0.12	0.14	0.80	.43

Note. HRSD = Hamilton Depression Rating Scale.
[a] The degrees of freedom of the first and second models are 59 and 58, respectively.

sion from Session 5 to Session 6. This mediation model was not statistically significant (bootstrapping for the indirect effect, 95% CI [−0.44, 1.13]).

Case Example

To focus on microlevel analysis of the proposed mediation model, a single case study was chosen from the trial. The session used in the macrolevel analysis (Session 4) was used in this case as well. We chose a case that was part of the pilot phase of the study, so that we can reveal that it was assigned to the supportive condition. The names and details of the patient and therapist were disguised, and they both signed informed consent forms agreeing that the information about them be published. For the case analysis, we used the same measures that we used in the macroanalysis, to which we added the analysis of the videotape of the session and the clinical supervisor's notes.

Mike, a 28-year-old man, grew up as the youngest child in what he termed a "perfectly normal" family. He remembered himself as a young child feeling strange and different, being angry at his parents for giving birth to him, while they were amazed that he was not happy to receive this gift of life. Mike went on living his life as he felt he was supposed to, continued to conform to expectations, finished college, was living with a girlfriend, and had a good job. He had never been in therapy before. His immediate reason for seeking short-term therapy for depression was that his girlfriend was interested in marriage and having children, whereas he did not want to become a father and do the same thing his parents did to him: bring more children into this world. Mike felt he could not explain himself to his girlfriend, and was afraid of the consequences of trying. At the intake sessions, he was diagnosed as having MDD. His HRSD score was 22, indicating moderate depression. He received supportive treatment from Elly, a therapist in her late thirties.

The therapy started smoothly, with Elly getting to know Mike and his targets for the therapy. She conceptualized Mike's CCRT as having an unmet wish to be known and understood, but he often felt misunderstood in interpersonal relationships and was scared of being intruded upon or forced into something he did not want to do. He had a lifetime of experience hiding his true feelings. Nevertheless, at times Mike felt close to his girlfriend and comfortable with her and with some other friends. Thus, occasionally, his wish could be fulfilled, but not enough to make him feel less lonely, and he felt that no one seemed to know fully what he thought his good and bad sides were.

Elly felt that her bond with Mike was strong. She understood his conflict, tried to get close to him, but was careful not to be pushy. Elly and Mike discussed the goals of the treatment and agreed that they were for him to better understand himself and his recurrent depressive episodes. They also agreed on the fact that the tasks needed for achieving these goals were generally not easy ones for Mike: talking openly about his thoughts and feelings and exploring them with the therapist. Before Session 4 started, Mike's Hamilton score was 13, indicating a moderate (subclinical) level of depression. Elly implemented several types of supportive techniques during Session 4, including striving together for better self-understanding; demonstrating genuine interest; staying in the here-and-now; and offering empathic comments, noting gains, maintaining defenses, and maintaining appropriate self-object transferences, as demonstrated below. The adherence rating of supportive techniques in Session 4 was 4.28 out of 7, indicating a moderate use of supportive techniques. At Session 4, the WAI, measuring the patient's perception of the therapeutic alliance during the session, was 4.9, indicating moderate-to-high alliance.

Example 1: "Striving together for better self-understanding (through exploration)" and "demonstrating genuine interest." This example it taken from the very beginning of the session.

Elly: *How are you?*

Mike: *I'm O.K . . . My head hurts a little.*

Elly: *Do you know why?*

Mike: *I'm stressed about work . . . it started yesterday. Maybe I didn't drink enough. Now I do not leave behind my water bottle* [points at the water bottle on the table . . . short silence].

Elly: *Do you take too much on yourself at work?*

Mike: *I do not take too much on myself. There's this deadline. I only work there two days a week. I've been there yesterday, and everybody is stressed. The problem is I do not have any way to calm myself. Maybe I'll go and work out after the session. Maybe it will help . . .*

Even in this brief excerpt, we can see that from the beginning of the session Elly shows interest in Mike, aware of his wish to be known and understood. She looks for meaning in his psychosomatic symptoms, taking them seriously, suggesting that they are meaningful and of interest to her. By doing so, she is already showing a different reaction to his wish than what Mike expects (not interfering or neglecting), and as a result a corrective experience is starting to emerge. Yet, when Elly makes her first sugges-

tion ("Do you take too much on yourself?"), Mike turns it down. Mike did not like Elly's suggestion, not at this point, when she was only guessing. Later Elly will try to avoid making such suggestions. The therapist already knows that the patient has an unmet wish of being known, respected, and not intruded upon or taken over by others, although at this point of the session, she probably does not have the opportunity to stop and reflect on it. Trying to fulfill this wish may be the path to improving the bond part of the alliance.

Example 2: "Staying in the here-and-now" and "offering an empathic comment."

Elly: *What calms you down? Does sports do it?*

Mike: *Sometimes . . . pushing yourself so hard you cannot think of anything else . . .*

Elly: *What else?*

Mike: *I do not know*. . . [assumes a wondering, sad face].

Elly: *You're facing lots of pressure right now . . . in your relationship too . . .*

Mike: *There's something else that can either calm me or put more pressure on me . . . my tendency to analyze things and situations*.

Elly: *With yourself?*

Staying in the here-and-now of Mike's life enables the therapist to relate to the patient as a specialist on himself, and to suggest that the symptom (not being able to calm himself down) at times is present and at other times it is not (Wachtel, 2011). This may be seen as a version of what Book (1998) listed as "noting gains," and it is helpful to use when the patient shows depressive attitudes and tends to miss minimal steps in the process of change. As the session proceeded, Elly stayed close to what Mike was describing, *demonstrating genuine interest and respect and offering empathic comments*.

Example 3: "Maintaining vital defenses." In the next phase of the session, Mike talked fluently about how he could never feel good about himself or enjoy the good things that people said about him, and how he could never show his true feelings. He gave many examples of this pattern, which are often a sign of a good working alliance. It appeared that it was easy for him to talk and that he was emotionally connected. Then, again Elly sought an example of an instance when it was different for Mike, but she was careful in the use of her words or definitions, because she knew that Mike was especially sensitive to it. This move was appropriate for Mike and sensitive to his needs (Stiles, 2013) because of the nature of his unmet interpersonal wish. The therapist could therefore be understood as *maintaining his defenses* and not challenging them.

Elly: *Can you remember a time when maybe you felt something else? I do not know what is the right word to describe this something else. You say it, what do you say you miss?*

Mike: *I'd like to accept the good things people say about me, to feel that they're right*.

Elly: *That you believe what they say*.

Mike: *Yes*.

Elly: *And in yourself*.

Mike: *I do not have an example of something that's the same outside and inside for me, maybe with very close friends . . . Not always, quite seldom actually*.

Elly: *That you what?*

Mike: *With some of them . . . talk when the situation is not good for me*.

Elly: *Without a façade*.

Mike: *Not always . . . I know today that if I feel the need not to hide, with some people I'll do it. But it will not be easy. I'll always think about how it'll be for this person, maybe they have bigger problems and it'll hurt them to hear mine, maybe it's not the right time . . .*

When Elly used the words "without a façade" she was repeating a term Mike had used in an earlier session. This can be helpful in giving the patient a sense of feeling understood and remembered by the therapist, without being intruded upon. It was especially useful for enhancing the alliance with this particular patient. We may wonder why Elly asked about the past rather than staying in the here-and-now. This may be explained by the fact that it was still an early session, and she was trying to get to know Mike and his history, but also by the fact this was a prime goal of the therapy, agreed upon by patient and therapist, to understand better the reason for Mike's long-lasting depression.

Example 4: "Offering empathic, validating, and understanding comments" and "maintaining appropriate self-object (mirroring) transferences." In a later part of the session, there was a moment when Mike articulated what it was he really appreciated in a relationship. This was not interpreted in the session, but the opportunity to stay with it and think about it together was important and validating. Book (1998) included *maintaining appropriate self-object (mirroring) transferences* (Kohut, 1984) as a supportive technique in SE. Helping the patient empathically explore his depression and get a better understanding of himself can be achieved by maintaining appropriate self-object transference, as demonstrated in the brief excerpt below, from that session.

Elly: *Do you remember what was it like to be sad and down when you were younger?*

Mike: *I'm not sure what the reasons were . . . I remember some triggers, a character in a movie that made me feel sad. I felt lonely I guess . . .*

Elly: *Yeah . . . it sounds like it . . .*

Mike: *Yes. People are around me and want to be with me, but none of them really know me, understand me. There were times I felt as if the "human being"* [makes the quotation marks sign with his fingers] *closest to me was my dog*.

Elly: *You loved her?*

Mike: *Very much*.

Elly: *What was there that felt comfortable?*

Mike: *She was not the kind of dog that jumps on you when you get home, hugging and licking you.*

Elly: *It suited you well?*

Mike: *A little bit like me.*

Elly: [Smiles]

Mike: *She was just there with us, not asking or investigating too much. Simply there. Everybody that met her said she had a bad character for a dog. I really loved her* . . . [the conversation goes on about how the dog died and how big of a loss it was].

The very gentle inquiry and validation (including the validating smile) fulfilled Mike's wish of being known but not intruded upon, of being together with someone during a special emotional moment.

This example shows that Mike came to the session suspicious, concrete, and somatic, stating that sports may be helpful for him. In the course of the session he calmed down, opened up, and removed some of his façade, going through a new corrective experience with Elly and widening his emotional scope. Elly seemed careful in using supportive techniques that she probably felt were consistent with the patient's wish. Their bond was enhanced in the course of the session. Mike was doing meaningful therapeutic work and was probably feeling that the other parts of the alliance (their agreement on the goals and tasks of therapy) were also enhanced. The gain on the HRSD score from that session to the next was 3 points, indicating an improvement in depressive symptoms after the critical session reported here. Thus, appearing to be consistent with the macrolevel analysis, the supportive techniques seemed to have enhanced the alliance, which in turn contributed to treatment outcome.

Discussion

Although the literature suggests that supportive techniques are effective and widely used, little is known about the mechanisms underlying their effect on therapeutic change. The present study proposed and investigated a mediation model according to which supportive techniques bring about therapeutic change by strengthening the therapeutic alliance. According to the proposed model, the mechanism of change by which supportive techniques affect outcome is the creation of interpersonal change in the course of therapy. The present findings provide initial support for the proposed mediation model.

The findings of the present study suggest that greater use of supportive techniques in an early session of treatment was associated with what the patient perceived as stronger alliance at that same session. The stronger alliance, in turn, predicted subsequent symptom reduction. The fact that the direct association between the use of supportive techniques and subsequent symptom reduction was no longer significant when controlling for the alliance may suggest that supportive techniques may not lead to better outcomes directly, but rather through the mediating role of the therapeutic alliance. A close look, through a case study, at the process taking place in the session provided a clinically detailed demonstration of the proposed mediation model. In the case study, the therapist used the patient's case formulation (based on the CCRT) to implement supportive techniques. Understanding the patient's unfulfilled wish in interpersonal relationships, and seeking intentionally to provide the patient with a corrective experience, the therapist was able to work collaboratively with the patient in the session in a way that improved the alliance between them. In this example, the alliance served as an active ingredient in the treatment, and not only as a facilitating environment for the implementation of other techniques (Zilcha-Mano, 2017). The case study showed how competent use of supportive techniques in the session may have strengthened the alliance and led to subsequent therapeutic gains.

If the present findings can be replicated using a larger sample, with session-to-session assessment of adherence, alliance, and outcome, it can have important implications for clinical practice. As demonstrated in the case study, using supportive techniques, as suggested by Book (1998), can enhance the therapeutic alliance, and thereby lessen the subsequent symptoms of depression. Therapists should consider using supportive technique with the aim of enhancing the alliance. The techniques we demonstrated include striving together for better self-understanding (through exploration), demonstrating genuine interest, staying in the here-and-now, offering an empathic comment, maintaining vital defenses, and maintaining appropriate self-object (mirroring) transferences.

The proposed mediation model is part of a wider theoretical model that conceptualizes the mechanisms of change underlying the effective use of supportive techniques in treatment and suggests how the effectiveness of such techniques can be enhanced (Leibovich et al., 2018). According to the model, identifying the patient's underlying interpersonal wish and striving to fulfill it can help guide the therapist in the supportive techniques used and in tailoring them to individual patients to meet their unmet interpersonal needs. The importance of a case formulation to guide the use of supportive techniques was demonstrated in the case study reported in this article. The case study demonstrates how the therapist can work actively and intentionally to fulfill the patient's wish, in this instance, the wish to be known without being intruded upon. The therapist selected which supportive techniques to use and in which way, based on the case formulation. She was careful not to impose her formulations, using the patient's own words and taking a genuine interest in him. She used empathic comments and enhanced the mirroring self-object transference. This may have enhanced the alliance and led to greater emotional sharing and relief. The therapist worked according to the proposed theoretical model and used the case formulation to deploy supportive techniques effectively in the session. According to the theoretical model, such systematic work in treatment can be effective in both supportive and expressive treatments. Further investigation of the complete model is needed.

The implications of the current findings should be evaluated in light of the limitations of the study. The most import limitations are as follows: (a) the small sample size, which may have prevented detecting small effects, such as the small direct effect of supportive techniques on symptomatic change, even after controlling for the alliance. (b) The model was not tested in session-by-session over the course of treatment. Because we chose only one session, early in treatment, our result reflects the early phase of therapy (Book, 1998), and should be replicated in a study that covers the full course of treatment. (c) Supportive techniques and

alliance were measured based on the same session, precluding the possibility of establishing a temporal relationship between them. Our model was not significant when we isolated the temporal association. This could be expected because the supportive techniques are supposed to influence the alliance at the same session, whereas the techniques used in the subsequent session are more likely to influence the alliance at that session. Thus, not conducting within-session measurements of changes in alliance and techniques is a limitation of the present study, awaiting future research. To establish such a temporal relationship between processes occurring within the same session, future studies need to code alliance and techniques from one segment to the next within the same session. Additionally, given that the RCT is still ongoing, we could not use the assignment to treatment condition as a potential control variable. (d) Our sample included a relatively large number of personality disorders in addition to MDD. (e) Finally, the present study focused only on a potential interpersonal mechanism underlying the effect of supportive techniques and, therefore, should be integrated with previous studies focusing on intrapersonal mechanisms.

Supportive techniques are considered to be effective across many theoretical clinical conceptualizations (Alvarez, 2012; Kohut, 1984; Smith, 2006), and are widely used in clinical practice. Yet little is known about the mechanisms underlying their effect. Such knowledge could be instrumental in improving the effective use of such techniques. The present study offered and examined empirically a potential interpersonal mechanism of change at the basis of the effect of supportive techniques, suggesting that it may affect outcome through the mediating effect of the therapeutic alliance. This mechanism of change is part of a larger theoretical model (Leibovich et al., 2018) that may enable practitioners to use case conceptualization to guide their systematic implementation of supportive techniques. These efforts may stimulate further research and help bridge the gap between psychotherapy research and effective clinical practice.

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