

# Supportive Therapy for Schizophrenic Disorders

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## Keywords

Supportive therapy · Schizophrenic disorders · Efficacy · Therapeutic alliance

## Summary

Cognitive behavioral therapy (CBT) for schizophrenic disorders has been increasingly established. The focus of research is now on the mechanisms of change. In this context, supportive therapy (ST) plays a major role as a non-specific control condition. The present article reviews the current research on ST for schizophrenic disorders. However, due to heterogeneous definitions of ST, study results are difficult to compare. A theory of possible underlying mechanisms for the effect of ST is presented and the importance of the therapeutic alliance as a moderator and mediator is discussed. On the basis of possible underlying mechanisms, we present our own conceptualization of ST, along with first results on the role of the therapeutic alliance from an ongoing study of positive symptoms in schizophrenic disorders.

## Schlüsselwörter

Supportive Therapie · Schizophrene Störungen · Wirksamkeit · Therapeut-Patient-Beziehung

## Zusammenfassung

Nach der empirischen Absicherung der Wirksamkeit Kognitiver Verhaltenstherapie (KVT) bei schizophrenen Psychosen stellt sich zunehmend die Frage nach den Wirkmechanismen. In diesem Zusammenhang spielt die supportive Therapie (ST) eine bedeutsame Rolle als unspezifische Kontrollbedingung. Die vorliegende Arbeit stellt den derzeitigen Stand der Forschung zur ST bei schizophrenen Störungen dar. Heterogene Definitionen von ST führen dabei zu schwer vergleichbaren Ergebnissen. Eine Theorie möglicher Wirkmechanismen von ST wird erläutert und die Moderator- oder Mediatorfunktion der therapeutischen Beziehung diskutiert. Aufbauend auf der Darstellung der Wirkmechanismen werden eine eigene Konzeption der ST sowie erste Ergebnisse zur Rolle der therapeutischen Allianz aus einer laufenden Studie zu Psychotherapie bei psychotischen Symptomen vorgestellt.

## Introduction

The efficacy of cognitive behavioral therapy (CBT) for persistent psychotic symptoms is increasingly well established empirically [Wykes et al., 2008; National Institute of Health and Clinical Excellence, 2009; Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, 2006]. The focus of research is thus increasingly directed to the mechanisms of change. In this context, there is renewed interest in

supportive therapy (ST). In current psychotherapy trials of schizophrenic disorders, ST displays moderate therapeutic effects, which although never greater than with CBT, are sometimes nearly as great [Buckley and Pettit, 2007a, b; Gould et al., 2001; Wykes et al., 2008, Zimmermann et al., 2005]. However, the concept of ST is vague, ambiguous, and requires clarification and refinement. The discussion of ST calls for specification of the factors that are postulated to be effective in CBT.

Against this background, this article provides an overview of clinical studies of CBT for schizophrenic disorders in which positive symptoms are predominant, and for which ST was used as a control condition. The possible mechanisms of change in ST and the role of the therapeutic relationship are discussed in this context. The meta-analyses of Buckley and Pettit [2007a, b], Gould et al. [2001], and Wykes et al. [2008] provide the basis for this overview. An historical outline of various conceptions of ST is subsequently presented. Finally, the conception of ST in the POSITIVE Study is presented and illustrated with a case study. The POSITIVE Study is funded by the German Ministry for Education and Research in the framework of the Psychotherapy Research program [International Standard Randomised Clinical Trials Number ISRCTN29242879].

### **The Effectiveness of Supportive Therapy Compared to Cognitive Behavioral Therapy for Schizophrenia**

Comparisons of the effectiveness of CBT and ST aim to assess the effects of specific therapeutic strategies. However, the term ‘supportive therapy’ characterizes heterogeneous therapeutic concepts [Buckley and Pettit, 2007a, b], which are still usually grouped together for analysis [Gould et al., 2001, Buckley and Pettit, 2007; Wykes et al., 2008, Zimmermann et al., 2005].

The issue of the efficacy of ST is treated in various meta-analyses. Buckley and Pettit [2007a, b] compare ST with other psychological interventions, such as various family therapies, Integrated Psychological Treatment (IPT), cognitive behavioral therapies, insight-oriented psychodynamic therapies, and case management. Any intervention was classified as ST, whose goal was to support patients in adapting to their current situation – i.e., to support their coping strategies. Interventions that aim to teach new skills were not considered. The meta-analysis only included randomized controlled studies. As primary endpoint, the study looked at the rate of hospitalization and relapse, as well as clinically significant worsening of the condition, whereby the 21 studies that were included focused on very different outcome criteria, such as ‘community adjustment,’ success in psychiatric rehabilitation, symptom management, relapse prevention, rates of hospitalization, encouragement of compliance, etc. In total, there are 13 outcome categories for short-, medium-, and long-term periods found in the meta-analysis by Buckley and Pettit [2007a, b]. The authors conclude that ST tended to be inferior to the other psychological interventions. The methodological quality of the studies, however, has so far made a definitive conclusion impossible.

The meta-analyses of Wykes et al. [2008], Zimmermann et al. [2005] and Gould et al. [2001] primarily focused on ST instead of CBT, and compared CBT with ‘Treatment as Usual’ (TAU) or ‘Routine Care’ (RC), ST, wait-list control groups,

or to problem-solving interventions. Positive symptomatology was the primary endpoint. There were pre-post change comparisons, as well as follow-up (FU) periods of up to 24 months. Wykes et al. [2008] explicitly discussed the methodological quality of the studies: that not all studies were randomized, and recruitment was not always systematic. Their meta-analysis also concluded that, although the preliminary results did suggest superiority of CBT over ST, the general quality of the studies was unsatisfactory for drawing any far-reaching conclusions.

From the above-mentioned meta-analyses, six studies were selected that compare CBT and ST, in an individual setting, for schizophrenic disorders with positive symptomatology (Table 1). Later published studies have not yet been systematically reviewed. As far as the authors know, however, no new, relevant studies have appeared on the topic. Besides the studies of Lewis et al. [2002] and Sensky et al. [2000], only additional secondary analyses of anxiety, depression, or suicidal behavior have been published [Turkington et al., 2008, Tarrrier et al., 2004; Samarasekera et al., 2007, Naeem et al., 2006]. Jackson et al. [2008] refer to the concept of ‘befriending’ put forward by Sensky et al. [2000].

One of the first studies to implement a consistent design for investigating the specific therapeutic effects of CBT was conducted by Tarrrier et al. [1998, 1999]. They investigated the efficacy of CBT in comparison with Supportive Counseling (SC) and Routine Care (RC). The goal of Supportive Counseling was to use unspecified ‘counseling skills’ to offer the patients emotional support and unconditional appreciation, and to promote their self-disclosure. The amount of therapeutic effort was identical to that of CBT. Routine care offers standard care without psychotherapy, and thus provides less therapeutic attention. The term Routine Care (sometimes called TAU) referred in this study to standard psychiatric treatment (medication and general psychiatric monitoring), as well as community-based psychiatric care [Buckley and Pettit, 2007a, b]. In this study, CBT was superior to Supportive Counseling with respect to positive symptomatology (measured by the Brief Psychiatric Rating Scale [BPRS] of Lukoff et al. [1986]). The effect sizes were 0.63 (post-treatment) and 0.77 (12-month FU). If we calculate the effect size on the basis of dichotomous criteria (proportion of patients whose symptoms are  $\geq 50\%$  improved) and determine the Number Needed to Treat (NNT), we get a different picture: at the 12-month-FU, we find an NNT of 54, which is a very small effect. However, it is important to note that dichotomized outcome criteria mask the effect size of continuous data [Kraemer and Kupfer, 2006]. Here, however, Supportive Counseling was better than Routine Care with respect to positive symptomatology, although the difference was not significant, and the effect size of Supportive Counseling fell between those of CBT and Routine Care. Regarding negative symptomatology, Tarrrier et al. found that Supportive Counseling and CBT resulted in comparable symptom reduction at the

end of therapy and at one-year FU. The following effect sizes for negative symptoms were calculated as standardized pre-post effect sizes for each group, using Rustenbach's formula [2003, p. 82], based on the data of Tarrier et al. [1999]. The retest reliability for the calculation of the standardized pre-post effect sizes is based on the results of Mueser et al. [1994]. The pre-post and pre-FU effect sizes for the respective groups are:  $ES_{\text{pre-post CBT}} = 0.42$ ,  $ES_{\text{pre-post ST}} = 0.22$ ,  $ES_{\text{pre-post RC}} = 0.05$ ,  $ES_{12\text{-month-FU CBT}} = 0.33$ ,  $ES_{12\text{-month-FU ST}} = 0.28$ ,  $ES_{12\text{-month-FU RC}} = -0.09$ . Tarrier et al. [1998, 1999] report a tendency for significant differences between the Supportive Care and Routine Care groups and between the CBT and Routine Care groups. The lack of difference between CBT and Supportive Care with respect to negative symptomatology is discussed, to the effect that patients learned socially and emotionally appropriate behavior through the process of model learning, and thus benefited from the support they received, in order to deal better with their everyday problems.

The study by Durham et al. [2003] was the only one that found ST to be superior to CBT. The effect here ( $ES = -0.32$ ) favored Supportive Psychotherapy (SPT) based on psychodynamically oriented psychotherapy.

All the other studies listed in Table 1 found a greater or lesser superiority of CBT compared to ST for positive symptomatology, general functionality (Global Assessment of Functioning Scale [GAF]; Kemp and David [1996]), satisfaction with treatment, and medication compliance. However, a number of issues remain unresolved. In the study by Sensky et al. [2000] the analysis showed that there were center effects. At one of the study centers befriending produced greater changes than CBT. Symptom change was measured by the Comprehensive Psychiatric Rating Scale [CPRS] of Montgomery [1978] and the Scale for the Assessment of Negative Symptoms [SANS] of Andreasen [1989]). The findings also vary with regard to the outcome criteria studied: for relapse and hospitalization, as well as drop-out rate, no differences were found between CBT and ST [Buckley and Pettit, 2007a, b]. For the comparison between ST and TAU, there were no significant differences reported for the outcome variables of relapse and hospitalization, state of mental health, general functioning, and overall benefit. The statement by Buckley and Pettit [2007a, b], that ST performed worse than all the other therapies with respect to the variables of medication adjustment, satisfaction with care, and social restrictions, is based, in each case, on data from just a single study, and seems therefore premature. Not least, the studies deal with very different stages of the disorder [Tarrier and Wykes, 2004].

A general superiority of CBT over ST is therefore not yet established with sufficient certainty. This raises the question of whether non-specific mechanisms of change, such as the quality of the therapeutic relationship, could be mediators of the effectiveness of both CBT and ST. On this background, we now present the various concepts of supportive therapy.

## Supportive Therapy Concepts in Schizophrenia

### *Psychodynamically Oriented Concepts*

Early concepts of ST come from psychoanalytic and psychodynamic therapeutic schools [Hellerstein et al., 1994; Holmes, 1995; Möhlenkamp, 1999, Ornstein and Ornstein 2000; Woeller et al., 1996]. They were developed for patients with defects of the ego structure and patients in acute crises. Among those viewed as weak-ego patients are patients with psychosis and with severe personality disorders, such as borderline personality disorder. The underlying assumption is that patients with ego weakness cannot tolerate conflict resolving or 'revealing' forms of treatment; i.e., they are actually destabilized by them. The objectives of ST are symptom remission, strengthening of ego functions, increase of functioning, and improvement of self-esteem [Hellerstein et al., 1994; Möhlenkamp, 1999; WATT et al., 1996]. ST adheres to the following principles: (a) active, empathic efforts on the part of the therapist to achieve a positive therapeutic relationship [Möhlenkamp, 1999]; (b) the therapist is to convey to the patient a cognitive orientation and help him to understand his behavior; (c) to give advice and guidance in crises and for everyday problems; (d) to enhance the patient's self-esteem through reinforcement and encouragement; (e) to work in a resource-oriented way, i.e., to help the patient acquire the ability for self-help; (f) to refrain from confrontational approaches and inducement of regression; if transference occurs at all, it is only in a controlled and carefully regulated way, to strengthen the person's defense, which is here equated with strengthening of the ego [Ornstein and Ornstein, 2000; Möhlenkamp, 1999; Watt et al., 1996]. Möhlenkamp [1999] describes the appropriate strategies for ST in detail.

### *Position 1: ST and Psychotherapy Are Mutually Exclusive*

From the perspective of psychoanalysis, psychotherapy requires the formation of a specific relationship, which is not compatible with the principles of ST. However, this position is, according to Möhlenkamp [1999], refuted by the Menninger Study [Wallerstein, 1986; cited by Möhlenkamp, 1999], which compared the effectiveness of ST and psychoanalysis. The study showed that among patients with severe neuroses, changes based on ST were just as stable as those based on psychoanalysis.

### *Position 2: ST as an Accessory Method*

ST is used as a supplement in certain phases of the therapeutic process. The aim is to promote a cooperative attitude (compliance) on the part of the patient, so that the 'real' therapy can proceed.

### *Position 3: ST as a Component of a Comprehensive, Eclectic Therapeutic Approach*

This position is associated with a relativized theoretical understanding. Examples of this approach are Linehan's dialectic-

tical-behavioral therapy [Möhlenkamp, 1999], which combines supportive-accepting methods with confrontational ones, or the process-oriented approach of self-psychology of Ornstein and Ornstein [2000]. The patient is offered an empathetic, tentative, preliminary understanding, again and again, until he is able to engage in an interpretive process himself.

#### *Position 4: ST as an Independent Psychotherapeutic Treatment*

According to this position, ST is applicable to certain disorders, such as psychoses or other chronic mental illnesses. Möhlenkamp [1999] maintains that this particular form of therapy requires disorder-specific knowledge and psychotherapeutic competence, to maintain a conversational relationship with severely disturbed patients. ST, in his view, is the 'psychotherapy of psychiatry' [p. 4], because this is what often takes place in day-to-day practice. The goals are not healing, but alleviation of the effects of disease, stabilization of patients, and prevention of relapse. He cites as examples from behavioral therapy for this type of ST, the practice of procedures for developing social skills or psychoeducationally transmitted methods of self-control. Möhlenkamp [1999] mentions the low appreciation of these procedures among practitioners, while emphasizing the professional qualifications required for ST, regardless of one's particular approach. The flexible application of a broad repertoire of supportive techniques, the ability to control transference processes and to recognize when supportive therapy is not indicated, he says, distinguish ST from non-professional assistance and make it a methodologically sophisticated procedure, because the course of therapy is not preordained, as it is in methodologically oriented therapeutic procedures.

#### *Concepts Oriented toward Cognitive Behavioral Therapy*

The concept of ST has also been subject to very heterogeneous definitions in the field of cognitive behavioral therapy (cf. table 1). However, all these seem to view ST as an independent treatment, as in Position 4.

Thus ST is in some studies considered a synonym for 'befriending' [Jackson et al., 2008; Sensky et al., 2000]. Both studies define befriending as the cornerstone of ST. Other studies refer to ST as 'Supportive Counseling' (SC), which is intended to give the patient emotional support through the development of a therapeutic relationship [Tarrier et al., 1998, 1999]. General counseling skills are to be used to achieve this, but these are not described in detail. The aim is, in contrast to CBT, to achieve non-specific effects. Other authors speak of informal support coupled with instruction about leisure activities [Drury et al., 1996]. Lewis et al. [2002] want to monitor only the non-specific effects in therapeutic contact, providing no description of the concept of ST. The

conceptualization of ST by Pinto et al. [1999] and of Durham, et al. [2003] permits talking with patients about their problems and crises.

#### **Therapeutic Relationship as Central Mechanism of Change**

The therapeutic alliance or therapeutic relationship is consistently identified as an essential mechanism of change in ST [Penn et al., 2004]. This article uses these terms interchangeably.

In psychotherapeutic research, the therapeutic alliance is considered a pantheoretical construct. Some authors treat it as a 'working alliance' that helps the patient to accept treatment and to be cooperative [Horvath and Symonds, 1991; Horvath and Luborsky, 1993]. The effect sizes for the relationship between the quality of the therapeutic relationship and the outcome, in the study by Horvath and Symonds, amounted to  $r = 0.31$  and  $r = 0.30$ , regardless of the school of therapy being applied and the phase of the therapeutic process. Here the patient's assessments of alliance- and outcome-measurements were used. If therapist or observer ratings of the alliance- and outcome-measurements were consulted, the correlation was lower. If the therapeutic alliance was measured in cognitive behavioral therapy, the effect size was 0.26; in eclectic studies, the effect size was  $r = 0.28$ . No significant difference was found in the relationship between therapeutic alliance and outcome with respect to therapeutic school. Martin et al. [2000], in their meta-analysis a few years later, found an effect size of  $r = 0.22$  for the relationship between therapeutic alliance and outcome. The stability of the relationship was thus reconfirmed. The question of the therapeutic alliance as a non-specific factor and a mediator of clinical outcome emerges [Lambert and Ogles, 2004; Barber, 2007]. Lambert and Ogles [2004] explicitly point out that non-specific factors such as the therapeutic alliance, notably in control conditions, are even more important for the clinical outcome than in specific treatment conditions. Thus the studies of Carol, et al. [1997] and Krupnick et al. [1996] both showed that the relationship between the therapeutic alliance and the outcome in the control condition was at least as great as in the specific treatment condition. It accounted for 21% of the variance in self-reported and expert-assessed outcome [Krupnick et al., 1998; cited by Lambert and Ogles, 2004]. According to Lambert and Ogles [2004], the significance of non-specific factors may therefore be recognized only to a limited extent, as this implies less significance of the central postulated specific determinants and the corresponding therapeutic techniques.

The postulate that the therapeutic relationship is the central mechanism of change, however, is unsatisfactory, because the question remains, of what the effective psychological process is, for patients involved in the therapeutic relationship. In light of these considerations, Penn et al. [2004] postu-

**Table 1.** Definition of ST and reported effect sizes (ES) from meta-analyses of randomized clinical trials (RCTs) comparing CBT and various forms of ST for schizophrenic disorders with positive symptoms

Study	Description of ST	Sample/Recruitment (systematic/non-systematic)	Operationalization of positive symptomatology	Blinding/Same therapists for both conditions?	Control for initial values	ES in meta-analyses <sup>a,b,c</sup> N and N per group	NNT
Drury et al. [1996]	'Recreation therapy and informal support (ATY)'; in case of positive symptoms patients are referred to a psychiatrist	acute patients with delusions or hallucinations acc. to WHO inclusion criteria [Harrison et al., 1988] – not systematically recruited	PAS	no/yes	NR	ES = 1.26 <sup>a</sup> ES = 0.93 <sup>c</sup> ES <sub>9-mo.FU</sub> = 1.77 <sup>a</sup> N = 40 n <sub>CBT</sub> = 20 n <sub>ATY</sub> = 20	NNT = 5 for best 'outcome' at 9-mo. FU
Tarrier et al. [1998]	'Supportive Counseling': emotional support through therapeutic relationship, unconditional appreciation, promotion of self-disclosure	chron. patients with schizophrenia, schizoaffective or delusional disorder [DSM-III], persistent positive symptoms for ≥ 6 months, medicated – systematically recruited	BPRS PSE	yes/yes	yes	ES = 0.63 <sup>a</sup> ES = 0.73 <sup>e,f</sup> N = 86 n <sub>CBT</sub> = 33 n <sub>ST</sub> = 26 n <sub>RC</sub> = 27	NNT = 6 for 50% improvement
Tarrier et al. [1999] 12-month FU for Tarrier et al. [1998]					yes	ES <sub>12-mo.FU</sub> = 0.77 <sup>a</sup> N = 70 n <sub>CBT</sub> = 23 n <sub>ST</sub> = 21 n <sub>RC</sub> = 26	NNT = 54 for 50% improvement
Pinto et al. [1999]	'Supportive Therapy': empathic listening, reassurance, reinforcement of healthy behavior, help in crises, advocacy for the needs of patients, basal psychoeducation	chron. patients, mixed: schizophrenia [DSM-IV], ≥ 2 antipsychotics ineffective – not systematically recruited	BPRS	no/NR	Initial values not signif. different, no covariates in the analysis	ES = 0.99 <sup>c</sup> N = 41 n <sub>CBT</sub> = 20 n <sub>ST</sub> = 21	NR
Sensky et al. [2000]	'Befriending' (BF): empathetic, non-directive relationship formation; neutral topics such as hobbies and sports; psychotic symptoms should not be treated	chron. patients with schizophrenia, persistent symptoms for ≥ 6 months – not systematically recruited	CPRS	yes/yes	yes	ES = 0.20 <sup>a</sup> ES = 0.14 <sup>c</sup> ES <sub>9-mo.FU</sub> = 0.52 <sup>a</sup> N = 90 n <sub>CBT</sub> = 46 n <sub>BF</sub> = 44	NNT = 4 for 50% improvement on 9-mo. FU
Lewis et al. [2002]	'Supportive Counseling' (SC): description as in Tarrier et al. [1998]	acute inpatients with schizophrenia, schizoaffective, schizophreniform, delusional disorder [DSM-IV] score ≥ 4 for PANSS delusion or hallucination – systematically recruited	PANSS PSYRATS	yes/yes	yes	ES = 0.12 <sup>e,f</sup> N <sub>overall</sub> = 307 n <sub>CBT</sub> = 99 n <sub>ST</sub> = 106 n <sub>RC</sub> = 102	NR
Durham et al. [2003]	'Supportive Psychotherapy' (SPT) based on psychodynamic assumptions. The creation of a safe and supportive atmosphere with warmth, empathy, and authenticity is intended to provide relief and lead to new perspectives.	chronic patients with schizophrenia, schizoaffective disorder, delusional disorder [ICD-10], persistent positive symptoms for ≥ 3 months, medicated for ≥ 6 months – systematically recruited	PANSS PSYRATS	yes/no	yes	ES = -0.32 <sup>e,f</sup> N <sub>overall</sub> = 66 n <sub>CBT</sub> = 22 n <sub>SPT</sub> = 23 n <sub>TAU</sub> = 21	NNT = 11 criterion of 50% improvement on 3-month follow-up

<sup>a</sup>Gould et al. [2001]; <sup>b</sup>Buckley and Pettit [2007]; <sup>c</sup>Wykes et al. [2008].  
 BPRS = Brief Psychiatric Rating Scale [Lukoff et al., 1986]; CPRS = Comprehensive Psychiatric Rating Scale [Montgomery et al., 1978]; PANSS = Positive and Negative Syndrome Scale [Kay et al., 1989];  
 PAS = Psychiatric Assessment Scale [Krawiecka et al., 1977]; PSE = Present State Examination [Wing et al., 1974]; PSYRATS = Psychotic Symptom Rating Scale [Haddock et al., 1994].  
 NNT = Number needed to treat for the specified dichotomous improvement criterion compared to ST; NR = not reported.  
 \* The meta-analysis does not indicate whether the ES for the comparison CBT-ST, CBT-RC, or both groups was averaged.

late that a major goal of ST is to increase resistance to stress ('stress buffering'). The theoretical assumptions for this are based on the so-called stress-buffering hypothesis of Cohen and McKay [1984] and two other models of Cohen et al. [2000] and Rhodes and Lakey [1999]. The therapeutic relationship, in their view, can contribute in three ways to increase resistance to stress:

1. Many patients with schizophrenic psychoses, have only a limited social network due to their social withdrawal. The therapeutic alliance can be for them a special source of perceived social support [Cohen and McKay, 1984]. In this sense, the therapeutic relationship is an external resource for coping with stress, which can be distinguished from the patient's internal resources (strengths, abilities, and skills).
2. The therapeutic alliance promotes the learning of healthy behavior [Penn et al., 2004]. The therapist acts as a model for functional behavior [Cohen et al., 2000] and is available for advice and guidance, so the patient can also learn functional behavior.
3. According to the theory of symbolic interactionism, a person's self-esteem is influenced by how he sees himself as perceived by others. In a positive therapeutic alliance, the therapist evokes positive thoughts and conceptualization about the patient's self-image, and thus contributes to increasing self-esteem [Rhodes and Lakey, 1999].

### **Supportive Therapy in the Framework of the POSITIVE Study**

POSITIVE is the name of a multi-centered, randomized, clinical study for patients with positive symptoms of psychosis [Klingberg et al., 2008]. ST, which was chosen in this study as a control condition for assessing the efficacy of CBT, was conceptualized on the basis of Penn et al. [2004].

In the context of relationship formation, the therapist has the task from the beginning of therapy to create a relaxed atmosphere for discussion. Empathy, affirmation – i.e., validation of the suffering the patient has experienced – respect for the patient's autonomy, and, where appropriate, humor and a certain self-disclosure on the part of the therapist are intended to ensure that the patient perceives the relationship with the therapist as helpful and supportive. After a roughly three-hour phase of compiling the case history, potential problem areas are identified, to be addressed in therapy. Usually these are problems in the areas of work/education, housing, social contacts, finances, as well as everyday and leisure activities. A strict sequence of sessions is not scheduled after the third session. The main objective of ST is stress reduction through application of five principles of intervention: (1) promotion of self-esteem/internal resources, (2) activation of external resources, (3) advice/guidance, (4) implicit problem solving, (5) structuring.

These principles are to be applied to the selected problem areas and are mediated primarily through the therapist-

patient relationship. Questions of self-esteem and self-image are taken up in the discussion of values and goals that are important to the patient. The extent to which the patient has already realized what his important values and goals are, they are discussed in order to promote self-esteem, and also for the purpose of establishing both a suitable and positive self-description. Additional optional therapies include Jacobson's Progressive Muscle Relaxation and exercises to improve concentration or memory. Explicit homework is not given. The therapist should not attempt to change positive symptomatology. If the patient talks about that on his own, the therapist should listen empathetically and attentively, but then steer the conversation toward a different topic. This seems a consistent application of a still-current directive in the care of schizophrenic patients: that supporting elements should be in the foreground, while positive symptomatology is not to be discussed [Möller et al., 2009].

Should the patient explicitly want to talk about his positive symptoms and should the therapeutic relationship be compromised if the therapist does not comply, the therapist's language should be implicitly aimed at the strategy of problem solving. He should orient toward the steps of 'describing the problem,' 'assembling ideas for solutions,' and 'selection of an idea for a solution.' This meta-model approach should not, however, be explained or its structure conveyed. With a pragmatic focus on solving everyday problems, the patient should be helped to cope better with the positive symptomatology in daily life. Delusional assumptions and/or interpretations of hallucinations are thereby not called into question.

ST is performed by the same therapists who provide CBT. The following case study presents one possible course of ST treatment, according to the manual.

### *Case Study*

The 53-year-old patient of Asian origin has been suffering from paranoid schizophrenia since about 1990, with hallucinations in the form of hearing voices that comment and sometimes demand, which the patient interprets in a delusional way. He feels himself to be the 'false Christ,' who can see things that will soon happen to other people around him. This bothers him greatly, since he cannot do anything to prevent it. The voices often tell him that he should take his own life, which the patient is well able to disregard. The patient lives in a supervised individual residence and works in a workshop for the disabled. Except for one friend, he has no close relationships in Germany, but is loosely involved with a Christian congregation, going to their church services on Sundays. He is in sporadic contact with his family at home, but this is burdened by simmering conflicts.

After the first four hours, the case history phase was largely completed. Four therapeutic areas were agreed upon: work situation, financial situation, relaxation exercises, and discussion of sexual problems. As the promotion of self-esteem as well as the activation of internal and external resources are important mechanisms of change, the focus was on these, before the pursuit of the four therapeutic goals began. The patient's strengths were first identified, e.g., his ability to remain calm in stressful situations. His friend, his psychiatrist, the therapist, the pastor of

his congregation, and his neighbor were explicitly named as sources of support. The therapist would reinforce the patient for seeking help to deal with his suicidal thoughts and clamoring voices. His distraction strategies, developed over time (taking a walk or going to the cafeteria 'to meet people') were affirmed. On the subject of finances, the approach was implicit problem solving and counseling. A savings plan was devised, as the patient said he still had debts from his old mobile phone contract. The therapeutic relationship served not only as an external resource for emergencies or crises, but also for affirmation of the stress experienced daily. Using empathy, respect for the patient's autonomy, and humor, it was possible to create for the patient a space of security and a feeling of self-acceptance. The patient said from time that he was glad to come, to feel that someone understood him and to finally have someone who did not think he was funny or crazy, if he explained his symptoms.

### *First Results on the Therapist-Patient Relationship from the POSITIVE Study*

The quality of the therapeutic alliance was measured after each treatment session, using the Bern Post-Session Report [Regli and Grawe, 2000], which has a patient version and a therapist version. In a first analysis [Wittorf et al., 2009], the first three therapy sessions of  $N = 80$  patients showed no significant difference between the assessment of the therapeutic relationship for patients receiving ST or CBT ( $M_{\text{CBT}} = 1.62 \pm 0.77$ ,  $M_{\text{ST}} = 1.73 \pm 0.98$ ).

This is preliminary evidence that ST is actually equivalent to CBT, with regard to the quality of the therapeutic relation-

ship, and that the main aim of the introduction of this control condition can be achieved in the study. This finding supports the conjecture that the positive therapeutic effect of ST is based on the fact that a positive therapeutic relationship can be established.

## Conclusions

Supportive therapy, mediated through the therapeutic relationship, seems to promote the regulation of self-esteem and the activation of resources, and so contributes to stress reduction. The empirical verification of this hypothesis, however, needs to be improved. Heterogeneous definitions of ST are a hindrance and should be avoided in the future. Preliminary results of the POSITIVE study confirm that the therapeutic relationship in ST is just as good and as satisfactory for patients, as in CBT.

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## References

- Andreasen NC: Scale for the Assessment of Negative Symptoms [SANS]. *Br J Psychiatry* 1989;155:53–58.
- Barber JP: Issues and findings in investigating predictors of psychotherapy outcome: Introduction to the special section. *Psychother Res* 2007;17:131–136.
- Buckley LA, Pettit T: Supportive therapy for schizophrenia. *Schizophr Bull* 2007a;33:859–860.
- Buckley LA, Pettit T, Adams CE: Supportive therapy for schizophrenia. *Cochrane Database Syst Rev* 2007b;2:CD004716.
- Cohen S, McKay G: Social support, stress, and the buffering hypothesis: A theoretical analysis; in Baum A, Taylor SE, Singer JE (eds): *Handbook of Psychology and Health*. Hillsdale, NJ, Erlbaum, 1984, pp 253–267.
- Cohen S, Gottlieb BH, Underwood LG: Social relationships and health; in Cohen S, Underwood LG, Gottlieb BH (eds): *Social Support Measurement and Intervention*. Oxford, Oxford University Press, 2000.
- Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (Hrsg): *Behandlungsleitlinie Schizophrenie*. Darmstadt, Steinkopf, 2006.
- Drury V, Birchwood M, Cochrane R et al: Cognitive therapy and recovery from acute psychosis: a controlled trial. I Impact on psychotic symptoms. *Br J Psychiatry* 1996;169:593–601.
- Drury V, Birchwood M, Cochrane R: Cognitive therapy and recovery from acute psychosis: a controlled trial. 3. Five-year follow-up. *Br J Psychiatry* 2000; 177:8–14.
- Durham RC, Guthrie M, Morton RV et al: Tayside-Fife clinical trial of cognitive-behavioural therapy for medication-resistant psychotic symptoms. Results to 3-month follow-up. *Br J Psychiatry* 2003;82: 303–311.
- Gould RA, Mueser KT, Bolton E: Cognitive therapy for psychosis in schizophrenia: an effect size analysis. *Schizophr Res* 2001;48:335–342.
- Haddock G, McCarron J, Tarrier N et al: Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales [PSYR-ATS]. *Psychol Med* 1999a;29:879–889.
- Harrison G, Owens D, Holton A et al: A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychol Med* 1988;18:643–657.
- Hellerstein DJ, Pinsker H, Rosenthal RN et al: Supportive therapy as the treatment model of choice. *J Psychother Pract Res* 1994;3:300–306.
- Holmes J: Supportive psychotherapy. The search for positive meanings. *Br J Psychiatry* 1995;167:439–445.
- Horvath AO, Luborsky L: The role of the therapeutic alliance in psychotherapy. *J Consult Clin Psychol* 1993;61:561–573.
- Horvath AO, Symonds BD: Relation between working alliance and outcome in psychotherapy: A meta-analysis. *J Couns Psychol* 1991;38:139–149.
- Jackson HJ, McGorry PD, Killackey E et al: Acute-phase and 1-year follow-up results of a randomized controlled trial of CBT versus befriending for first-episode psychosis: the ACE project. *Psychol Med* 2008;38:725–735.
- Kay SR, Flszbein A, Opfer LA: The Positive and Negative Syndrome Scale [PANSS] for Schizophrenia. *Schizophr Bull* 1987;13:261–276.
- Kemp R, David A: Psychological predictors of insight and compliance in psychotic patients. *Br J Psychiatry* 1996;169:444–450.
- Klingberg S, Sickinger S, Wittorf A et al: Kognitiv-verhaltens-therapeutische Behandlung von Positivsymptomatik psychotischer Störungen. *Nervenheilkunde* 2008;27:1014–1020.
- Kraemer HC, Kupfer DJ: Size of treatment effects and their importance to clinical research and practice. *Biol Psychiatry* 2006;59:990–996.
- Krawiecka M, Goldberg D, Vaughan M: A standardized psychiatric assessment scale for rating chronic psychotic patients. *Acta Psychiatr Scand* 1977;55: 299–308.
- Lambert MJ, Ogles BM: The efficacy and effectiveness of psychotherapy; in Lambert MJ (ed): *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. New York, Wiley, 2004, pp 139–193.
- Lewis S, Tarrier N, Haddock G et al: Randomised controlled trial of cognitive-behavioural therapy in early schizophrenia: acute-phase outcomes. *Br J Psychiatry Suppl* 2002;43:91–97.
- Lukoff D, Liberman RP, Nuechterlein KH: Symptom monitoring in the rehabilitation of schizophrenic patient. *Schizophr Bull* 1986;12:578–602.
- Martin DJ, Garske JP, Davis MK: Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *J Consult Clin Psychol* 2000;68:438–450.

- Möhlenkamp G: Supportive Therapie – eine nützliche Nebensache oder ein psychotherapeutisches Basiskonzept? *Sozialpsychiatr Informationen* 1999;29:2–6.
- Möller HJ, Laux G, Deister A: *Psychiatrie und Psychotherapie*: Stuttgart, Thieme, 2009.
- Montgomery S, Asberg M, Jornestedt L et al: Reliability of the CPRS between the disciplines of psychiatry, general practice, nursing and psychology in depressed patients. *Acta Psychiatr Scand Suppl* 1978;271:29–32.
- Mueser KT, Sayers SL, Schooler NR et al: A multisite investigation of the reliability of the Scale for the Assessment of Negative Symptoms. *Am J Psychiatry* 1994;151:1453–1462.
- Naeem F, Kingdon D, Turkington D: Cognitive behaviour therapy for schizophrenia: Relationship between anxiety symptoms and therapy. *Psychol Psychother* 2006;79:153–164.
- National Institute for Health and Clinical Excellence (NICE): Schizophrenia. Core interventions in the treatment and management of schizophrenia in primary and secondary care (update). National Clinical Practice Guideline Number 82. National Institute for Health and Clinical Excellence, London, 2009.
- Ornstein A, Ornstein P: Alle «guten» psychoanalytischen Psychotherapien sind supportiv – und was zeichnet «gute» Psychotherapien aus? *Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie* 2000;5:186–196.
- Penn DL, Mueser KT, Tarrier N et al: Supportive therapy for schizophrenia: possible mechanisms and implications for adjunctive psychosocial treatments. *Schizophr Bull* 2004;30:101–112.
- Pinto A, La Pia S, Mennella R et al: Cognitive-behavioral therapy and clozapine for clients with treatment-refractory schizophrenia. *Psychiatr Serv* 1999;50:901–904.
- Regli D, Grawe, K: *Die Berner Stundenbogen Version 2000 – ein Forschungsinstrument*. Unpublished manuscript. Universität Bern, 2000.
- Rhodes GL, Lakey B: Social support and psychological disorder: Insights from social psychology; in Kowalski RM, Leary MR (eds): *The Social Psychology of Emotional and Behavioral Problems: Interfaces of Social and Clinical Psychology*. Washington, DC, American Psychological Association, 1999, pp 281–309.
- Rustenbach RJ: *Metaanalyse: Eine anwendungsorientierte Einführung*. Bern, Huber, 2003.
- Samarasekera N, Kingdon D, Siddle R et al: Befriending patients with medication-resistant schizophrenia: Can psychotic symptoms predict treatment response? *Psychol Psychother* 2007;80:97–106.
- Sensky T, Turkington D, Kingdon D et al: A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Arch Gen Psychiatry* 2000;57:165–172.
- Tarrier N, Wykes T: Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? A cautious or cautionary tale? *Behav Res Ther* 2004;42:1377–1401.
- Tarrier N, Yusupoff L, Kinney C et al: Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. *BMJ* 1998;317:303–307.
- Tarrier N, Wittkowski A, Kinney C et al: Durability of the effects of cognitive-behavioural therapy in the treatment of chronic schizophrenia: 12-month follow-up. *Br J Psychiatry* 1999;174:500–504.
- Tarrier N, Lewis S, Haddock G et al: Cognitive-behavioural therapy in first episode and early schizophrenia. *Br J Psychiatry* 2004;184:231–239.
- Turkington D, Sensky T, Scott J et al: A randomised controlled trial of cognitive-behavior therapy for persistent symptoms in schizophrenia: A five-year follow-up. *Schizophr Res* 2008;98:1–7.
- Wing JK, Cooper JE, Sartorius N: *Measurement and classification of psychiatric symptoms. An instruction manual for the PSE and Catego program*, Cambridge University Press, 1974.
- Wittorf A, Jakobi U, Bechdolf A et al: The influence of baseline symptoms and insight on the therapeutic alliance early in the treatment of schizophrenia. *Eur Psychiatry* 2009;24:259–267.
- Woeller W, Kruse J, Alberti L: Was ist supportive Psychotherapie? *Nervenarzt* 1996;67:249–251.
- Wykes T, Steel C, Everitt B: Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophr Bull* 2008;34:523–537.
- Zimmermann G, Favrod J, Trieu VH et al: The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: a meta-analysis. *Schizophr Res* 2005;77:1–9.