Unipolar depression in adults: Supportive psychotherapy

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Literature review current through: **Oct 2023.**
This topic last updated: **Mar 19, 2023.**

INTRODUCTION

Supportive psychotherapy is used to treat depression by improving self-esteem, psychological functioning, and adaptive skills [1]. Therapy focuses upon current, problematic relationships and maladaptive patterns of behavior and emotional responses [2].

Supportive psychotherapy is used to treat a variety of psychiatric illnesses other than depression, including anxiety disorders, schizophrenia, substance use disorders, and personality disorders [3]. A survey of psychiatrists in 1998 found that 36 percent of them used supportive psychotherapy, often in conjunction with pharmacotherapy [4].

This topic reviews supportive psychotherapy for treating depression in adults. The initial treatment of depression; treatment of resistant depression; treatment of late-life depression; and diagnosis, prognosis, epidemiology, pathogenesis, and neurobiology of depression are discussed separately.

- (See "Unipolar major depression in adults: Choosing initial treatment".)
- (See "Unipolar depression in adults: Choosing treatment for resistant depression".)
- (See "Diagnosis and management of late-life unipolar depression".)
- (See "Unipolar depression in adults: Assessment and diagnosis".)
- (See "Unipolar depression in adults: Course of illness".)
- (See "Unipolar depression in adults: Epidemiology".)

INDICATIONS

Supportive psychotherapy is used as both a primary and adjunctive treatment with pharmacotherapy to treat depression. Supportive psychotherapy is suitable across a broad range of symptom severity and psychosocial functioning. Level of symptom severity and functioning are usually classified as [3,5-8]:

- High – Mild symptoms and impairment such as dysphoria, mild insomnia, distracted at work, and occasional lapses in household duties
- Moderate – Moderate symptoms and impairment such as chronic dysphoria, flat affect, circumstantial speech, estrangement from family, few friends, and inability to work
- Low – Serious symptoms and impairment such as psychosis, suicidality, alienation from family, no friends, difficulty retaining housing

The level of symptom severity and functioning is assessed at the beginning and throughout treatment, and determines the specific treatment interventions used by the clinician. (See 'Assessment' below and 'Therapeutic interventions' below.)

The patient must have the necessary motivation and interest, cognitive capacity, and energy required to participate in any type of psychotherapy. However, supportive psychotherapy does not require the high level of psychological-mindedness needed for psychodynamic psychotherapy, and does not require the level of motivation necessary to complete homework outside of the treatment sessions that is needed for cognitive-behavioral therapy [9].

Based upon our clinical experience, mild to moderate depression can be treated with supportive psychotherapy alone. Patients with moderate to severe depression, especially moderate to severe suicidal ideation or moderate to severe neurovegetative symptoms (decreased sleep, appetite, and energy), require pharmacotherapy in addition to supportive psychotherapy [10-12]. (See "Unipolar major depression in adults: Choosing initial treatment".)

Practice guidelines from the American Psychiatric Association, National Institute for Clinical Excellence, and the Canadian Network for Mood and Anxiety Treatments do not suggest supportive psychotherapy as a treatment for depression [10-13]. It's not clear why, but it may be that the guideline authors view supportive psychotherapy as a subset of psychodynamic psychotherapy, which the guidelines do suggest as a treatment for depression. (See 'Theoretical foundation' below.)

THEORETICAL FOUNDATION

It is thought that supportive psychotherapy works by improving self-esteem, psychological functioning, and adaptive skills [2,14]. The conceptual basis for supportive psychotherapy overlaps with psychodynamic psychotherapy and other psychotherapies [2,15,16].

It is hypothesized that supportive psychotherapy treats depression by improving [2,14]:

- Self-esteem – Patient's sense of self-regard, efficacy, confidence, and hope
- Psychological (ego) functioning – Reality testing, cognitive abilities, capacity to organize thoughts and behavior, affect regulation, capacity to relate to others, and morals
- Adaptive skills – Behaviors associated with effective functioning with family, friends, and coworkers

Assessment of events is a psychological function, whereas the behavioral response to the assessment is an adaptive skill; self-esteem usually depends upon both [2].

Some authorities think supportive psychotherapy is a type of psychodynamic psychotherapy because of overlap in how they conceptualize and treat depression. However, the differences between the two therapies justify viewing them as distinct. The primary difference is that supportive psychotherapy focuses upon current relationships and conscious issues [5-7,15,17-19], while psychodynamic psychotherapy focuses upon childhood experiences, past unresolved conflicts, and previous relationships, as well as unconscious mental states and processes (including transference, countertransference, defense mechanisms, and resistance) [20,21]. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Fundamental concepts and processes'.)

Both therapies use many of the same interventions, which form a continuum [20,22]. At one end are techniques emphasized in supportive psychotherapy that directly support the patient and maintain adaptive defenses. At the other end are techniques emphasized in psychodynamic psychotherapy that increase the patient's insight through exploration and interpretation of the patient's behavior. (See 'Therapeutic interventions' below and "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Therapeutic interventions'.)

Supportive psychotherapy also draws upon ideas and techniques of other psychotherapies, including cognitive-behavioral therapy (CBT) [2,16]. CBT is based upon the theory that maladaptive thoughts and behaviors lead to psychopathology. The clinician addresses these dysfunctional cognitions and the patient tries to change the resulting problematic behavior.

Supportive psychotherapy also uses elements of behavioral activation, problem-solving therapy, and interpersonal therapy.

ASSESSMENT

The initial patient assessment consists of the history and mental status examination [23,24]. The clinician diagnoses the depressive syndrome; identifies any precipitating problems; evaluates the patient's the level of functioning, self-esteem, psychological functioning, and adaptive skills; and establishes the patient's goals [5,6,25]. Progress is determined by periodically reassessing the patient during the course of treatment.

The clinician asks about the patient's current life circumstances and prior experiences, and how the patient reacts and copes with stress [5]. Suggested questions include [5,18]:

- Can the patient perceive and appraise events accurately?
- Does the patient have at least one durable, reciprocal relationship?
- Can the patient experience and tolerate a wide range of affects?
- Does the patient tolerate frustration?
- Can the patient control impulses?
- Can the patient work toward goals, delay gratification, and enjoy leisure?
- Is the patient guided by internalized morals and ideals?

The clinician observes how the patient relates to the clinician, because this reflects behavior outside of therapy and suggests what types of reactions the patient evokes in others.

The clinician also observes the patient's defense mechanisms, which reveal how the patient unconsciously copes with anxiety and conflicts. Defenses exist on a continuum from immature (eg, projection, denial, and splitting) to mature (eg, suppression and humor). Defense mechanisms are discussed further within the context of psychodynamic psychotherapy. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Defense mechanisms'.)

Standardized, self-report rating scale — Patients complete a self-report, standardized, depression rating scale prior to the beginning of each session. We suggest the widely-used Patient Health Questionnaire – Nine Item (PHQ-9), which is a well-validated depression self-

report scale (table 1) [26,27]. Alternatives include the Clinically Useful Depression Outcome Scale (CUDOS) (form 1) [28,29] and the Quick Inventory of Depressive Symptoms – Self Report 16 Item (QIDS-SR16) (www.ids-qids.org) [30,31]. The rating scale quantifies the severity of the patient's depression and enables the clinician to track improvement over time. In addition, the scale educates patients about the clinical features of depression so that patients can learn to recognize them on their own.

Using scales to monitor treatment of depressed patients is discussed separately. (See "Using scales to monitor symptoms and treat depression (measurement based care)", section on 'Self-report scales in the public domain'.)

TREATMENT

Supportive psychotherapy consists of a number of general principles and specific interventions. However, treatment depends less upon any specific maneuver and more upon the therapeutic relationship between the patient and clinician.

General treatment principles — Therapy is directed towards improving self-esteem, psychological functioning, and adaptive skills [5,32]. Improvement in one domain promotes improvement in the other two domains. (See 'Theoretical foundation' above.)

Supportive psychotherapy focuses upon current problematic relationships and maladaptive patterns of conscious behavior and emotional responses [33]. The purpose is to help patients connect their behavior to resulting events or the reactions of others, shift the locus of control to the patient, and increase personal responsibility [2,5]. Although therapy focuses upon the “here-and-now,” earlier experiences may be discussed to understand the origin of current maladaptive behaviors [5,34]. This also creates a coherent biography to promote increased self-understanding.

The clinician balances the patient’s need for support with the desire for competence and autonomy [5,14,15,34]. A patient overwhelmed by stress may need comforting to regain equilibrium and function better, and at other times, might require an encouraging “push” to try something new [14,34,35].

A conversational approach is used [33]. The clinician is active, answers questions, takes positions, and directs the session to keep the emotional intensity at manageable levels [5,6,32]. Anxiety-provoking, prolonged silences are avoided, as are challenging questions that put the patient on the spot [33]. The clinician acts like a “real person” rather than striving to be a neutral, anonymous “blank screen.” Clinicians respond to personal questions from the patient

within appropriate social conventions of privacy [2]. Self-disclosure should have a therapeutic rationale, such as validating reality, modeling behavior, teaching, and fostering the therapeutic alliance and the patient's sense of autonomy.

Supportive psychotherapy provides a "holding environment," meaning that treatment is marked by emotional safety, trust, consistency, and structure [15,33,36]. This promotes corrective emotional experiences, in which the patient learns to tolerate situations that were previously intolerable. The clinician expresses empathy to corroborate the emotional experience of the patient [33]. The clinician also conveys interest, respect, acceptance, and approval of the patient to promote a positive therapeutic alliance. This helps the patient to identify with the clinician, become more amenable to specific interventions, and predicts a positive outcome [5,37]. In addition, the clinician solicits feedback from the patient to ensure that the clinician correctly understands what the patient says. The therapeutic alliance is discussed further within the context of psychodynamic psychotherapy. (See "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Therapeutic alliance'.)

If a rupture develops in the therapeutic alliance, the clinician promptly attempts to repair the alliance and prevent the patient from prematurely quitting treatment [5-7,14,15]. An open and nondefensive discussion of the clinician's actions can help dissipate the patient's negative feelings [5,14]. In addition, the relationship between the clinician and the patient may be examined to better understand and ameliorate problems in the patient's other relationships [14,32].

Logistics and structure of treatment — There are several logistical aspects that determine the course of treatment. These include the number, frequency, and duration of sessions, which is flexible and determined by the intensity of symptoms, chronicity of the depressive illness, and rate of progress [5,7].

At the beginning of treatment, the clinician and patient should set specific, realistic outcome goals, and during the course of treatment discuss progress. The clinician should discuss what will occur during the sessions and what the patient is expected to do, as well as the policy for tardiness, missed appointments, telephone calls, emergencies, and payment [33].

The therapy is often open-ended and continues until symptoms are reduced or eliminated, and functioning is restored [5-7]. However, based upon our clinical experience, if little or no progress is made within four months, the therapy should be stopped and the treatment plan revised. A randomized trial assigned 90 patients with moderate to severe major depression to 8 or 16 sessions of supportive psychotherapy as adjunctive treatment to pharmacotherapy [38].

Remission at week 24 did not differ significantly between patients who received psychotherapy for 8 weeks compared with 16 weeks (33 versus 29 percent), nor did social functioning [39].

The frequency of sessions depends upon the stage of treatment. Actively depressed patients are typically treated once a week until the illness resolves. As the end of treatment approaches, therapy can be tapered by increasing the interval between visits. At the end of treatment, clinicians should inform patients that if symptoms recur, patients can return and be re-assessed for resuming supportive psychotherapy. Thus, the treatment relationship is open-ended, rather than formally terminated [5].

Maintenance therapy is used to delay or prevent recurrence of major depression, and should be considered for lower functioning patients with previous episodes and hospitalizations. Euthymic patients in maintenance treatment may be seen as often as once or twice per month or as infrequently as a few times per year, depending upon their stability and needs. Lower functioning patients or patients with chronic depression not responding to other types of treatment (such as pharmacotherapy), are generally seen one or two times per month to preserve psychosocial functioning and prevent further deterioration. During times of crisis, the need for more frequent sessions often becomes apparent when the patient calls frequently between sessions, unable to cope with stress. However, there is no evidence that supportive psychotherapy is efficacious as maintenance treatment.

Session duration is typically 45 to 50 minutes [5,7]. However, some clinicians can provide elements of supportive therapy during medication management visits, which typically last for 15 to 20 minutes [40].

Therapeutic interventions — The specific interventions listed below are used to treat depression by improving self-esteem, psychological functioning, and adaptive skills [5-7,14,18,19,32,33]. Each intervention is aimed primarily at one of these three domains, but may secondarily improve the other domains.

The clinician chooses specific therapeutic interventions based upon the patient's current symptoms, level of psychosocial functioning, and what occurs during a particular session [5,14]. As treatment progresses, the patient's needs are reassessed and the clinician adjusts the interventions accordingly [14,34].

Self-esteem — Self-esteem consists of the patient's beliefs about his inherent value and competence [33]. Interventions to improve self-esteem include:

- **Praise** – Depressed patients often focus exclusively upon their shortcomings and failures [5,6,33]. Praise helps these patients recognize their strengths and reinforces new, adaptive

behavior. Praise should be grounded in the patient's values, and can be given for accomplishing a task, using an adaptive skill, or adopting a more emotionally mature strategy. The clinician should avoid offering insincere praise that is not deserved, because the patient can experience this as hollow and invalidating.

- **Reassurance** – Allaying the patient's fears with truthful information provides reassurance about negative self-appraisal and expectations [5,6,33]. The clinician should understand the patient's situation before offering reassurance. If reassurance is premature, the patient can feel dismissed and brushed off. In addition, clinicians should not mislead patients [2]. As an example, if a patient asks whether the depressive syndrome will remit, rather than simply saying, "Yes," a more appropriate response is to state that, "Most patients with depression get better."

  - Normalizing is a common form of reassurance that compares the patient to people whom the patient regards as normal. "Many parents feel a loss when their kids leave home. That's why people talk about the 'empty nest syndrome;' it's a tough transition for many people."

- **Encouragement** – Encouragement is used to counteract passive inactivity and instill hope in patients feeling demoralized, defeated, or powerless [2,33]. Transforming an overwhelming task into manageable, small steps encourages activity and promotes competence [5]. Pointing out instances of healthy, effective functioning also provides encouragement (and praise). The clinician should avoid contradicting the patient's viewpoint, which risks making the patient feel misunderstood [5]. Asking the patient what he thinks of the clinician's statements helps circumvent this problem.

  - Exhortation is a more insistent form of encouragement (and advice) that recommends a particular course of action [33]. It is typically used with lower functioning patients. For example, "We know that you feel worse when you don't exercise, and that you feel better overall when you do. So, I suggest that you start back at the gym on your old three times per week schedule." Exhortation should be used to encourage behavior that the patient can likely manage successfully. Otherwise, the patient may feel overwhelmed, discouraged, or criticized.

Psychological functioning — This includes mental operations such as perceiving reality, regulating emotions, thought processes, capacity to organize thoughts and behavior, capacity to relate to others, and morals [33]. Interventions that improve psychological functioning will also decrease anxiety or increase awareness.

- **Structuring the environment** – For lower functioning patients, the clinician should intervene when necessary to increase the amount of structure available to the patient [14,18,33]. This includes talking with key people (eg, family, employers, or case managers) and directing the patient to necessary resources (eg, assistance with disability application or referrals to vocational rehabilitation). Patients who cannot maintain their own safety should be hospitalized.

- **Naming the problem** – Identifying and labelling the problem helps the patient conceptualize and understand it [5,6,33]. The problem may then become less overwhelming and more amenable to change as the patient gains a greater sense of control. As an example, the clinician may use the term social isolation to describe the patient's social withdrawal and lack of interest in others.

- **Rationalizing –** The clinician suggests reasonable explanations for behavior, motives, or feelings that the patient finds unacceptable. As an example, maladaptive behavior can be rationalized as appropriate for an earlier stage of life [5,6,14]. This tactic should be used in a manner that avoids arguing with the patient.

  - Reframing is a type of rationalization in which the clinician proposes a different way of looking at events that the patient views as negative [2]. As an example, a mother/caretaker may believe her toddler is losing interest in her because the child runs away from her. Reframing this involves explaining that the child feels secure enough to explore the world.

  - Minimization is another type of rationalization in which the clinician suggests that the patient may be experiencing a small amount of an affect that is unacceptable and denied [33]. As an example, if the patient denies feeling anger about an event, the clinician can ask, "Perhaps you felt a little angry?"

- **Clarification** – The clinician organizes and paraphrases what the patient is discussing in a vague and uncertain manner [2]. The clinician's summarizing statement ensures that both parties agree on what is being discussed and demonstrates that the clinician is listening attentively. As an example, after the patient talks for several minutes about the boss's failure to notice his work and his wife's talking on the phone rather than with the patient, the clinician clarifies: "It sounds like you are feeling ignored." Clarification illuminates the significance of what the patient is saying [17]. Clarifications are often used and posed as questions. As an example, "I wonder, are you really saying that you're not sure you want to keep your current job?"

- **Confrontation** – This tactic makes the patient aware of something that is avoided, such as an unrecognized pattern of maladaptive behavior [33]. The clinician provides a rationale when confronting the patient to demonstrate empathy [6]. As an example, "From our discussions, I have noticed that when you become romantically interested in people, you start avoiding them. I am bringing this up because you told me that you want to be in a relationship."

- **Interpretation** – An explanatory statement that links a feeling, thought, behavior, or symptom to its unconscious meaning or origin [5,6,15,18,19]. Interpretation is used infrequently, and employed only to manage a rupture in the therapeutic alliance or to address maladaptive patterns of behavior [6,17]. As an example, the clinician may state, "It seems that since I returned from vacation, you have not spoken about the painful problems you have with relationships. Is it harder to trust me? Do you feel like I abandoned you when I went away?" The clinician modifies the interpretation by following the dictum, "do not say everything that you know, only what will be helpful" [15]. Patients are more likely to seriously consider an interpretation if it is presented as a possibility or hypothesis, rather than a definitive conclusion. In addition, interpretations should be used only after the clinician has gathered enough evidence to substantiate them.

Adaptive skills — Adaptive skills consist of behaviors that lead to effective functioning with others. Interventions intended to increase functioning impart knowledge [33].

- **Advice** – For higher functioning patients, the clinician should generally advise patients only about mental health issues [5,6,14]. With lower functioning patients, specific and directive advice about daily life may be required. The clinician avoids nagging or critical comments, unwanted advice, and issues that patients can decide for themselves. In addition, clinicians should not impose their personal values upon the patient.

- **Teaching** – Teaching involves psychoeducation about the signs and symptoms of depression, different treatment options including medications, and prognosis [14]. In addition, teaching includes principles for adaptive functioning that can be generalized and applied to different situations [33].

- **Anticipatory guidance** – This intervention consists of preparing patients for difficult situations [2]. The clinician and patient discuss step-by-step how to approach upcoming challenges. This includes anticipating problems, considering different plans of action, and rehearsing selected behaviors [5,6,14].

- **Modeling** – The clinician uses his interactions with the patient to demonstrate adaptive behavior [33]. The behavior is more likely to be adopted by patients who identify with the

clinician. As an example, modeling occurs when the clinician makes a mistake and responds with honesty, humility, and resilience; or when the clinician makes an exception to the treatment rules and accommodates a patient in crisis.

Pharmacotherapy combined with supportive psychotherapy — Supportive psychotherapy is compatible with pharmacotherapy, and depressed patients are often treated with both [4]. The two treatments can be started concurrently at the beginning of treatment, or monotherapy with either can be initiated at the outset and the other therapy added later [40]. One clinician can provide both supportive psychotherapy and pharmacotherapy, with some sessions focused upon medication psychoeducation and side effects.

Combination treatment has several theoretical benefits [40]. Pharmacotherapy may incompletely treat the depressive syndrome, and supportive psychotherapy can address residual symptoms, as well as psychosocial impairment, comorbidities (eg, substance use disorder or personality disorder), and adverse life circumstances (eg, trauma or losses). In addition, control of moderate or severe symptoms with pharmacotherapy may enable patients to make better use of psychotherapy. Psychotherapy may also improve adherence to treatment.

If treatment is split and one clinician provides supportive psychotherapy and another clinician prescribes antidepressant medication, they need to work together to maintain consistency in the treatment plan. The clinicians should communicate with each other about any concerns that arise, and must have an agreement with each other and with the patient that there are no secrets between the two clinicians.

EVIDENCE OF EFFICACY

Studies of supportive psychotherapy as a primary or adjunctive treatment for depression in adults have yielded mixed results [41]. A number of studies have found that supportive psychotherapy is either comparable or inferior to other psychotherapies for treating depression [21,42,43]. However, supportive psychotherapy may be comparable to pharmacotherapy [41]. In addition, evidence is mixed as to whether adding supportive psychotherapy to pharmacotherapy improves treatment of depressive syndromes [41,44].

Psychotherapy trials, like pharmacotherapy trials, are methodologically variable. Some psychotherapy trials are rigorous and specify a priori hypotheses and analytic tests, use active psychotherapy comparators that control for the nonspecific aspects of psychotherapy, use standardized diagnostic criteria and outcome measures, carefully blind outcome ratings, develop manuals for the psychotherapies that are studied and measure adherence, and stratify

patients on predetermined risk variables. Less meticulous studies use open-label designs, less rigorous comparators (eg, treatment as usual or waiting lists), or fail to adequately blind outcome ratings. Although it is commonly believed that blinding of patients in psychotherapy is less successful compared with pharmacotherapy trials, this has never been studied.

Meta-analyses appear to overestimate the clinical effect for nearly all types of psychotherapy in treating depression [45-47]. These inflated clinical effects seem to be the result of publication bias and study quality.

The overlap between various psychotherapies makes it difficult to interpret some studies. It is sometimes not clear whether a type of psychotherapy constitutes supportive psychotherapy or an amalgam of different therapies. In addition, techniques from supportive psychotherapy have been adopted by other psychotherapies, and some studies have found that it is the supportive elements of other therapies that lead to beneficial outcomes [48-50].

Supportive psychotherapy — Supportive psychotherapy can be effective for treating depressed outpatients and appears to be comparable to other psychotherapies [51].

Compared with treatment as usual — A meta-analysis of 18 randomized trials (962 depressed patients) compared supportive psychotherapy with a control condition (treatment as usual or waiting list), and found a significant, clinically moderate effect favoring supportive psychotherapy [52]. There was little to no heterogeneity across studies.

Compared with other psychotherapies — A number of studies have found that supportive psychotherapy was either similar or inferior to other psychotherapies for treating depression; however, studies that found supportive therapy was inferior may have been biased due to researcher allegiance to the alternative psychotherapy [53]:

- A meta-analysis of 31 randomized trials (2508 depressed patients) compared supportive psychotherapy with other psychotherapies (eg, cognitive-behavioral therapy, interpersonal psychotherapy, or problem solving therapy). Although there was a clinically small effect favoring other therapies, there was no difference between supportive psychotherapy and other therapies in the 11 trials that did not appear to be biased to the alternative therapy due to researcher allegiance [52].

- A meta-analysis of randomized trials included 30 comparisons of supportive psychotherapy with another type of psychotherapy for patients with mild to moderate depression, and found a significant but clinically marginal effect favoring all other types of psychotherapy combined together, compared with supportive psychotherapy [21]. However, a separate analysis compared supportive psychotherapy with cognitive-

behavioral therapy, and found that improvement of depressive symptoms was comparable.

- A subsequent, 48-week randomized trial compared supportive psychotherapy (32 sessions) with cognitive-behavioral analysis system of psychotherapy in patients with chronic depression who were not taking antidepressant medication (n = 268) [54]. Cognitive-behavioral analysis system of psychotherapy is designed specifically for chronic depression, whereas supportive therapy is not specific for chronic depression but is more widely available. Response (reduction of baseline symptoms ≥50 percent) occurred in fewer patients who received supportive psychotherapy than cognitive-behavioral analysis system of psychotherapy (41 versus 53 percent).

  However, the mean number of severe adverse events, such as new symptoms or adverse events related to personal life or occupational life, was less with supportive psychotherapy (1.4 versus 2.6) [55]. The authors hypothesized that because cognitive-behavioral analysis system of psychotherapy aims to break avoidance patterns in interpersonal behavior, the therapy may have led to a transient increase in interpersonal conflicts, which were reported as adverse events.

  Follow-up assessments for two years posttreatment found that on multiple measures, the benefits of the two treatments were comparable. As an example, the mean number of weeks during the two years, in which patients had no or minimal depressive symptoms, did not differ statistically between supportive psychotherapy and cognitive-behavioral analysis system of psychotherapy (40 and 49 weeks) [56].

Additional information about the efficacy of supportive psychotherapy compared with other psychotherapies is discussed separately. (See "Unipolar major depression in adults: Choosing initial treatment", section on 'Selecting a specific psychotherapy'.)

Compared with pharmacotherapy — Limited data suggest that supportive psychotherapy may be comparable to pharmacotherapy for treating mild to moderate major depression. A meta-analysis of 3 randomized trials (142 patients) found the rate of remission at 6 months was comparable for supportive psychotherapy and pharmacotherapy (31 versus 24 percent) [41], and a subsequent meta-analysis of four trials found that the effect of each treatment was comparable [52].

Supportive psychotherapy combined with pharmacotherapy — There is mixed evidence about the efficacy of supportive psychotherapy plus pharmacotherapy (combination treatment) for treating depression [41,44].

Compared with pharmacotherapy alone — It is not clear whether combination treatment is superior to pharmacotherapy alone for treating depressive syndromes:

- In one meta-analysis of three randomized trials, remission occurred in significantly more patients who received combination treatment compared with pharmacotherapy alone (40 versus 24 percent) [41].
- A randomized trial in 128 patients with unipolar major depression found that after six months, remission occurred in significantly more patients who received combination treatment compared with pharmacotherapy alone (43 versus 23 percent) [57].
- A randomized trial enrolled 167 patients with unipolar major depression and found that improvement of blindly rated depressive symptoms was similar for combination treatment, compared with pharmacotherapy alone [58]. However, scores on the self-report depression rating scale were significantly better for patients who received combination treatment.

Compared with psychotherapy alone — It is not clear whether combination treatment is superior to supportive psychotherapy alone for treating depression:

- A meta-analysis of three randomized trials compared combination treatment with supportive psychotherapy alone [41]. The rate of remission for combination treatment was comparable to supportive psychotherapy (40 versus 31 percent), as was the rate of attrition (28 versus 24 percent).
- A randomized trial enrolled depressed patients infected with the human immunodeficiency virus (HIV) and found that depressive symptoms improved significantly more in patients who received combination treatment, compared with supportive psychotherapy alone [59].

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Depressive disorders".)

SUMMARY

- Supportive psychotherapy is used to treat depression by improving self-esteem, psychological functioning, and adaptive skills. Therapy focuses upon current, problematic

relationships and maladaptive patterns of behavior and emotional responses. (See 'Introduction' above and 'General treatment principles' above.)

- Supportive psychotherapy is used either alone as a primary treatment or as an adjunctive treatment with pharmacotherapy to treat depressed patients with a broad range of functioning. Mild to moderate depression can be treated with supportive psychotherapy alone. Patients with moderate to severe depression, especially moderate to severe suicidal ideation or moderate to severe neurovegetative symptoms (decreased sleep, appetite, and energy), require pharmacotherapy in addition to supportive psychotherapy. (See 'Indications' above.)

- The initial patient assessment consists of the history and mental status examination. The clinician diagnoses the depressive syndrome; identifies any precipitating problems; evaluates the patient's psychosocial functioning, self-esteem, psychological functioning, and adaptive skills; and establishes the patient's goals. Progress is determined by reassessing the patient prior to the beginning of each session with a self-report, standardized, depression rating scale, such as the Patient Health Questionnaire – Nine Item (PHQ-9) (table 1). (See 'Assessment' above.)

- A conversational approach is used. The clinician is active, answers questions, takes positions, and directs the session to keep the emotional intensity at manageable levels. Anxiety-provoking, prolonged silences are avoided, as are challenging questions that put the patient on the spot. (See 'General treatment principles' above.)

- A number of specific interventions are used in supportive psychotherapy: praise, reassurance, encouragement, exhortation, structuring the environment, naming the problem, rationalizing, reframing, minimization, clarification, confrontation, interpretation, advice, teaching, anticipatory guidance, and modeling. (See 'Therapeutic interventions' above.)

- Supportive psychotherapy is effective for treating depressed outpatients and appears to be comparable to other psychotherapies. Limited data suggest that supportive psychotherapy may be comparable to pharmacotherapy for mild to moderate depression. However, evidence is mixed as to whether adding supportive psychotherapy to pharmacotherapy improves treatment of depressive syndromes. (See 'Evidence of efficacy' above.)

Topic 14687 Version 14.0