# Beyond the Supportive-Expressive Continuum:
## An Integrated Approach to Psychodynamic Psychotherapy in Clinical Practice

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**Abstract:** A psychotherapy that is based on psychodynamic principles uses an understanding of unconscious processes in order to help patients with problematic feelings and behaviors. This can involve making patients more aware of their unconscious thoughts and feelings (expressive goal) and supporting weakened ego functions (supportive goal). These two techniques have generally been considered either completely separate types of psychotherapy, or two ends of the "expressive/supportive continuum." Instead, we suggest that all psychodynamic psychotherapies use both of these techniques in an oscillating way depending on the moment-to-moment needs of the patient and thus that an integrated model is the most useful for conducting this type of psychotherapy.

### What is psychodynamic psychotherapy?

Although psychodynamic psychotherapy is one of the oldest forms of psychotherapy, in many ways it is one of the least well defined. Unlike newer forms of psychotherapy, such as cognitive behavioral therapy and interpersonal psychotherapy, which were manualized from the start, psychodynamic psychotherapy developed from psychoanalysis, which was taught in a heterogeneous way by individual institutes and supervisors. The multiple models of psychodynamic psychotherapy differ in many ways, including their theories about how it works, their ideas about proper technique, and their recommendation about who it can help.

Despite these differences, the term "psychodynamic psychotherapy" has generally referred to a type of psychotherapy in which the therapist tries to help patients with symptoms and maladaptive character patterns by understanding the psychological motivations and internal conflicts influencing their thoughts, feelings, and behaviors, in particular, the "hidden" or unconscious factors that may have been previously out of the person's awareness. The psychodynamic psychotherapist also attempts to trace these factors back to their origins in the past, especially in the important relationships of childhood. The therapist then uses this understanding to help patients, either by making them more conscious of their unconscious thoughts and feelings or by supporting weakened ego function.

**CME Disclosure**

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All authors report no competing interests.

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These two goals have been broadly described as either exploratory/expressive or supportive. Both making the unconscious conscious (expressive goal) and supporting weakened ego function (supporting goal) use an understanding of unconscious processes to help relieve suffering, eliminate symptoms, and improve functioning.

The following two examples illustrate the differing ways in which the therapist uses his or her understanding of unconscious process to help patients, depending on their needs, problems, and vulnerabilities at any particular moment in treatment.

## CASE 1: MR. A

*Mr. A is a 35-year-old professional who presents with inexplicable feelings of unease and sadness after receiving a promotion. Despite the fact that he has been working toward this advancement for years, he felt "sad" and "like a fraud" when he finally moved his boxes into the "corner office." These feelings confused and upset him because he also felt excited about his achievement. Mr. A's father was an untalented and unsuccessful businessman whose unfulfilled ambitions made him and his family miserable until his death 10 years earlier. The therapist speculates that Mr. A's symptoms may be caused by unconscious guilt about attaining the success that his father never achieved. When the therapist helps Mr. A discuss his feelings about his father, he realizes that he had been unaware of his guilty thoughts and feelings. Once they become conscious, he is able to think about the situation in a new way. He realizes that although he felt* ***as if*** *his own success was somehow a betrayal of his father; in reality it was not. Separating this fantasy from his current reality markedly decreases his guilty feelings and allows Mr. A to enjoy his hard-earned success.*

Fears from childhood can loom large in a person's unconscious and make a person feel *as if* he or she is in danger, when in fact there is no danger at all. Mr. A felt *as if* his success represented a betrayal of his father, but by examining this fear in the conscious light of day, he increased his understanding and was able to free himself of his childhood fear. Making the unconscious conscious is a very powerful way in which we can use our understanding of the workings of the patient's unconscious mind to relieve suffering, alleviate symptoms, and create more adaptive ways of behaving.

## CASE 2: MS. B

*Ms. B is a 23-year-old college student who presents to the student counseling center during exams complaining of panicky anxiety that is interfering with her ability to study. She admits that she is compulsively playing video games—"the only thing that helps my anxiety"—and describes a history of other impulse control problems, including sexual activity and compulsive eating in times of stress. The therapist speculates that the stress of exams has weakened this woman's ego function, specifically her capacity for impulse control. Ms. B also reveals that when she was anxious about schoolwork as a child, her mother simply yelled at her, whereas her older sister was protective and would help Ms. B with her homework. "Sitting in my sister's room after school felt like the only safe place in the house," she recalls. Knowing this, the therapist asks Ms. B whether she has a supportive peer to study with and learns that that a hallmate she likes has offered to study together. The therapist suggests that studying with her friend in a common room in the library might be helpful in more ways than one—it would keep her away from her computer while helping her stick to a study schedule. Ms. B contacts her friend and with her therapist's encouragement, sets up a carefully outlined group study schedule. As she begins to do her work, her anxiety abates and she ultimately passes her exams.*

In Ms. B's case, the therapist's understanding of her history and the unconscious workings of her mind—including how her ego habitually deals with stress and her feelings of safety in the presence of a caring peer—allows him to individualize the forms of support he suggests. As with Mr. A, the therapist took a careful history to learn as much as possible about the way in which Ms. B's mind worked, but he used this information to support her weakened ego function rather than to uncover unconscious material. Without a working hypothesis about the unconscious motives, feelings, and conflicts underlying a patient's distress, the therapist has no basis for predicting what will or will not be supportive for the individual at any particular moment in the treatment. If we know what aspects of a person's emotional and mental functioning need support, we can determine what kind and what amount of support is required to help the patient with the problems that brought him or her to treatment.

## ONE PSYCHOTHERAPY OR TWO?

Given this, it seems evident that both expressive and supportive techniques are psychodynamic; however, there has been little consensus about whether these two techniques form an integrated type of psychotherapy and indeed whether supportive psychotherapy should be considered a psychodynamic treatment at all. Psychotherapy that primarily involves making the unconscious conscious has traditionally been called "psychodynamic" or "psychoanalytic" psychotherapy,

whereas psychotherapy that primarily supports ego function has been called "supportive" psychotherapy. Even the competencies of the Psychiatry Residency Review Committee (RRC) support this division, because there is one set of competencies for psychodynamic psychotherapy and another set for supportive psychotherapy. As illustrated in the above examples, both making the unconscious conscious and supporting weakened ego function use an understanding of unconscious processes to help eliminate symptoms and improve functioning. Because both uncovering and supportive technique are based on the psychodynamic frame of reference, why has there been a persisting tendency to differentiate between "psychodynamic psychotherapy" and "supportive psychotherapy"?

As Winston et al. reviewed (1), this conflict emerged from the psychoanalytic tradition that devalued supportive elements as "copper" compared with the "pure gold" of analytic technique (2). Attempts to understand the role of supportive psychotherapy within a dynamic framework were further complicated by a general confusion between the concept of supportive psychotherapy, with specific techniques, goals, and strategies and a nonspecific "supportive attitude" (1).

Begun in the 1950s, the Menninger Foundation psychotherapy research project (3, 4) was the first truly systematic methodologically informed study to compare the long-term outcome for patients with moderate to severe psychopathology treated in psychoanalysis, psychoanalytic psychotherapy, and supportive psychotherapy. The data revealed that

> . . . real treatments in actual practice are intermingled blends of expressive-interpretive and supportive-stabilizing elements . . . and that the kinds of changes achieved in treatment from the two ends of this spectrum are less different in nature and in permanence than is usually expected (4).

Similarly, Schlesinger (5) suggested that the usual dichotomy used in prescribing psychotherapy (supportive versus expressive) was inadequate and that a truly useful prescription should be explicit about *what* needs to be supported, and *when,* and *why*, and what needs expression and why.

## The supportive-expressive continuum

Developing Schlesinger's concept that psychodynamic treatment never uses only expressive or supportive approaches, subsequent authors (6–13) described a "supportive-expressive continuum" of psychodynamic psychotherapy, with supportive psychotherapy at one pole, expressive psychotherapy or psychoanalysis at the other pole, and varying blends in between. As Winston and Winston (12) described, the particular mix for any individual patient is based on the patient's current "level of psychopathology, adaptive capacity, self-concept, and ability to relate to others." However, while acknowledging that there is no such thing as "pure culture" supportive or expressive psychodynamic therapy, some contemporary theorists continue to describe the two forms of treatment as if they are separate and distinct entities, with significant differences in how the supportive end of the spectrum is both conceptualized and valued (14). Even Wallerstein (3) suggests that therapists should be "as analytic as you can be and as supportive as you need to be," implying somehow that an uncovering technique is the "gold standard" or the technique that will ultimately be more helpfully transformative.

Although the concept of the supportive-expressive continuum has greatly helped to dispense with the idea of the pure culture treatment, it also conveys the mistaken impression that the particular blend of "support" and "expression" for any single patient is fixed and static over the course of their entire treatment. In addition, the differences between conducting a "supportive-expressive" therapy versus an "expressive-supportive" therapy seem vague and hard to put into practice. Over the course of treatment and even within the course of a single session, psychodynamic psychotherapists move fluidly back and forth from trying to make the unconscious conscious to supporting ego function. Is there a more integrated way to conceptualize the use of these two aims in clinical practice?

## The integrated model in clinical practice

Rather than thinking of them as separate types of psychotherapy, we can think of making the unconscious conscious and supporting weakened ego function as being two therapeutic aims that are both based on our understanding of the patient's unconscious mental functioning. In clinical practice, all psychodynamic psychotherapies include techniques designed to achieve both therapeutic aims. As Wallerstein (3) suggested, "The question at issue at all points in every therapy should be that of expressing how and when, and supporting how and when." We base our decision about which type of technique to use

- for that particular patient
- at that moment in the treatment

not on which technique we think is "better" but on which technique we think will be most helpful to our patient at that moment in the therapy. Our best guide for this is a careful assessment of the patient. Although we assess the patient at the beginning of the treatment, we also have to ***constantly monitor*** the patient as the treatment progresses to evaluate any changes in the patient's mental functioning that might cause us to shift our therapeutic aim. Our assessment includes the following elements:

1. *History.* To best understand the patient, we need the full history of the present illness and past episodes of symptomatology and the patient's personal and developmental history. This last piece includes the patient's early temperament, attachments, relationships with caregivers and other family members, educational and vocational history, and pattern of relationships. Although we try to get as much history as we can at the outset of the treatment, ongoing acquisition of historical information can alter our formulation as we go.
2. *Diagnosis.* As psychodynamic psychotherapists, it is essential that we make a careful DSM diagnosis. Axis I and Axis II disorders can affect ego functioning in many ways, and many of our patients are often candidates for combined therapy with medication. We have to be mindful of the fact that just because someone does not have a DSM disorder at the beginning of the treatment does not mean that they might not develop one during the course of the therapy, and this in turn would influence our aims and approach.
3. *Assessment of ego function.* A careful evaluation of current and past ego function is essential here. Ego functions include reality testing, stimulus regulation, capacity for object relationships, and impulse control. Questions such as, "Tell me about your most important relationships?" "How do you tend to deal with stressful situations?" and "How do you think other people view you?" can help you to learn about these aspects of mental functioning. Remember, *ego functioning is not fixed* and can change depending on circumstances such as levels of stress and life cycle events; thus, it needs to be monitored and reassessed carefully at all times during the treatment.
4. *Goals for treatment and motivation.* To know how best to treat our patients, we have to know what THEY want to fix. Even if we think that they need to adapt in certain ways, they have to agree that these are problems and they need to be motivated to make changes. Again, as we learn more and the patient changes, treatment goals can change and should be discussed periodically with the patient.
5. *Psychological mindedness and capacity for self-reflection.* A patient who does not believe that he or she is affected by their unconscious thoughts and feelings will have a hard time being helped by making the unconscious conscious. We can assess psychological mindedness by asking patients to reflect on things they tell us about themselves to see whether they reference ideas and feelings that could be out of their awareness.

## DECISIONS ABOUT TREATMENT

Once we evaluate the patient, we can decide whether we think that making the unconscious conscious or supporting weakened ego function is more likely to be of help to the patient *at that moment*. In general, stronger ego function and psychological mindedness suggest that the patient will benefit from learning about his or her unconscious, whereas weaker ego function and less capacity for self-reflection suggest that supporting techniques will be more helpful. However, whatever we decide, *we will always use both types of techniques in an oscillating way, either to bring unconscious material into the treatment or to support weakened ego function.*

Two points are worth emphasizing:

1. *One intervention can serve two therapeutic aims.* Whether any single intervention is designed to make the unconscious conscious or support ego function depends on what we hope to achieve in making that particular statement at that particular moment in the therapy. We always have to ask whether we are 1) hoping to enhance self-understanding and provide insight into unconscious processes or 2) hoping to lessen painful feelings and support ego function.

Although certain interventions are MOSTLY used for making the unconscious conscious (interpretation and confrontation) and others are MOSTLY used for supporting weakened ego function (praise, reassurance, problem-solving, and advice-giving), occasions arise when supporting interventions may be used in the service of cushioning the emergence of painful unconscious material and other occasions when making unconscious material conscious can be used for supportive purposes rather than for making the unconscious conscious, for example, to

reduce anxiety and explain a patient's experience in nonthreatening terms.

2. *Our therapeutic aim can shift from moment to moment.* Whatever our overarching aims at the start of treatment, we should *always* be prepared to shift our approach flexibly depending on the patient's needs in the moment. If we have adopted a predominantly supportive approach, we should always be on the lookout for ways to promote the person's growth and independence and to enhance understanding of his or her own behavior. If our overarching approach is to make the unconscious conscious, we have to remain alert for moments along the way when it may become necessary to step in with more support. Some patients require nothing more than the implicit support conveyed in the therapist's attitude of empathy, understanding, and interest. Other patients may need just a little extra support at the beginning of treatment to get through a difficult spot or in the middle of treatment when a crisis occurs. With more fragile patients, it may be obvious from the very start that they may require lifelong support from the therapist.

## AN INTEGRATED EXAMPLE

### EVALUATION

Ms. C is a 32-year-old married mother of a 2-year old son who is 5 months pregnant with her second child. She presents to Dr. Z for treatment shortly after learning that she is carrying a normal healthy girl. Although her first pregnancy was relatively uneventful and she has enjoyed the experience of raising her son, she now finds herself awakening each morning with a sense of intense dread and panicky anxiety. Because she wanted to become pregnant, she has found these feelings both confusing and vaguely guilt provoking. She is not aware of feeling depressed, but her difficulty "facing the day" and caring for her son is making her feel like a "terrible mother." She has had trouble falling asleep at night, often lying awake for hours anticipating her daily morning dread of facing the day, and she will occasionally "sneak" a glass of wine now before bed. She takes great pride in compliments she receives about her mothering and now feels "mortified" about the harm she might be causing the baby by drinking. Even with wine, she sleeps only 3 or 4 hours at night, feels depleted during the day, and worries about whether she will be able to care for two small children. She has concealed her drinking and the worst of her worries from her husband, and her exaggerated sense of guilt about her current difficulties have also led her to isolate herself from friends and other family members rather than asking for help.

Although she has always been "a worrier" and "a perfectionist," Ms. C has never consulted a mental health professional in the past but mentions that her mother experienced a postpartum depression after the birth of her only sibling, a younger sister. Ms. C was 4 years old at the time and remembers little about this experience but was told that her mother was "dysfunctional" for months thereafter and that her maternal grandmother had to move in with the family for a period of time to help care for the new baby.

### ASSESSMENT/INITIAL FORMULATION

After taking a history and evaluating Ms. C's ego function, Dr Z's thoughts are as follows:

- Ms. C's symptoms suggest that she could be having a major depression.
- Although Ms. C's ego function has been quite good in the past, she is now having difficulty functioning in many ways. Her self-esteem regulation is currently quite fragile, as is her capacity for impulse control. In addition, she has isolated herself from friends and family.
- Although the cause is not clear, the current episode was temporally related to her discovery that she was carrying a baby girl.
- Ms. C's associations suggest a potential unconscious connection between the traumatic childhood experience of her mother's severe depression and withdrawal after the birth of her sister and her own current symptoms.

Although Dr. Z is interested in the way in which Ms. C's unconscious identification with her mother could be affecting her current difficulties, he determines that, given Ms. C's distress and present state of ego function, the primary therapeutic aim at this time should be to support her weakened ego function. In particular, Dr. Z decides that this means helping Ms. C to manage her feelings of anxiety, shame, and guilt. Other priorities include addressing ways of dealing with insomnia without resorting to alcohol and concretely helping Ms. C to functioning better during the day.

### EARLY TREATMENT

Dr. Z thus decides to "supportively bypass" Ms. C's childhood experiences for the time being

(which she has not mentioned since their first meeting) and to focus on improving Ms. C's current functioning. Here is part of their second session in which Dr. Z's primary aim is to support Ms. C's mental and emotional functioning:

*Ms. C:* I just feel so bad. I really wanted to have this baby but now I don't even know if I can take care of it.

*Dr. Z:* You've always prided yourself on being a good mother—and from everything you've said, it sounds like you are a very loving and involved mother—so it is especially painful to find yourself struggling like this and doubting whether you'll have the strength to care for two. Frankly, given how hard it's been for you to think about this, it was brave of you to come in to talk today. *[Here, Dr. Z **empathizes** with Ms. C's distress in a way that conveys an understanding of her distress based on what he has learned about possible unconscious factors and fears that are fueling her symptoms, and he offers **reassurance** about her capacity to mother. He also **praises** her for seeking help and **compliments** her judgment for seeking help.]*

*Ms. C:* I'm just not sure that I can keep it up, though. Things that seemed so easy before, like sitting and playing on the floor with my son, now feel so difficult. What's wrong with me?

*Dr. Z:* You are blaming yourself, but your symptoms—insomnia, feeling overwhelmed, and having difficulty facing the day—are the kinds of things that women have when they're depressed and anxious during their pregnancy. It's not uncommon for certain kinds of anxiety disorders to get worse during pregnancy. You're certainly not the only pregnant mom with a young child at home who feels depleted and exhausted. We can address these with psychotherapy, but it might also make sense for you to talk to your husband and your obstetrician about the possibility of using some medication to help with. I would be happy to speak to them as well. *[Dr. Z offers **psychoeducation** about mood and anxiety disorders during pregnancy to give her information and to **normalize** her experience. He also makes a **suggestion** that she consider the use of medication and offers to **communicate with others** if this would be helpful.]*

*Ms. C:* I just haven't been able to share this with him or with anyone. I don't know why; I'm usually so talkative, on the phone with friends all the time, and Jim and I are really open with each other.

*Dr. Z:* Let's talk about this, because it would really be a good idea for you during this period to have as much help from people in your life as possible. What kinds of things come to mind about discussing this with your husband? *[Dr. Z gives Ms. C **direction**, helping to shape the session during this period of distress. He also asks Ms. C to **explore unconscious feelings or fantasies** that could be contributing to her isolation.]*

*Ms. C:* I don't know—maybe something like he'll realize that I'm damaged goods or that I'm not what he thought I was.

In this session, Dr. Z uses techniques that are primarily designed to support Ms. C's weakened ego function, although toward the end of the sequence he does ask her to try to explore some unconscious material. In 2 weeks, Ms. C's anxiety abates and her sleep improves. She begins to speak to her husband and friends about her symptoms and learns that many of the "other moms" have had similar feelings. Ms. C and Dr. Z decide together that medication is not indicated at this time. Ms. C feels good about meeting with Dr. Z and becomes hopeful that psychotherapy can help her. As they continue to meet, Ms. C spontaneously begins to question why this pregnancy has made her so anxious. Here is a portion of a session from this time in the therapy:

*Ms. C:* I wonder why this pregnancy made me so anxious. This didn't happen the last time. And you know, I was really fine until after I got the amnio results. Last time, finding out that everything was OK really made me worry less—this time it totally shook me up and started this whole thing.

*Dr. Z:* Well—you got slightly different results this time—you found out that you were having a girl. What kinds of feelings have you had about that news? *[Remembering his earlier thoughts about Ms. C's possible identification with her mother, Dr. Z **asks for more associations.**]*

*Ms. C:* It's weird; I've wanted a girl so much but I have this feeling that it was when I heard that news that I started to freak out. My mom always wanted girls—and I think that she was happy to have two of them.

*Dr. Z:* But you mentioned that she was quite depressed after having your sister. *[Dr. Z's last question deepened Ms. C's associations, and she mentioned her mother. Dr. Z now **confronts** the fact that Ms. C has only mentioned the good half of the memory.]*

*Ms. C:* I hate to think about that part. I'm so like my mother—I think that on some level I'm so worried that that could happen to me. I'd hate for my son to have to suffer like that. When I think that, I think that I never should have gotten pregnant to begin with—but even when I say that right now I feel terrible—like it will make something terrible happen to the baby if I don't want it 100%. Now I'm worried that I'm going to think about that all night.

*Dr. Z:* Talking about your feelings is difficult, but it won't hurt the baby in any way. In fact, it will probably help you and the baby because you have feelings bottled up inside you that you're afraid to think about and that might be contributing to some of your symptoms.

*[Given Ms. C's recent symptoms, Dr. Z rapidly **reassures** Ms. C to diminish her anxiety and provides **psychoeducation** about the value of making the unconscious conscious.]*

*Ms. C:* Phew—that makes me feel better. It's good to talk about this, but it's scary, too. I think that I'm more worried about becoming dysfunctional like my mother did than I allowed myself to admit.

In this sequence, Dr. Z's aim is primarily to help Ms. C become aware of unconscious material. But when Ms. C becomes highly anxious and worries about having insomnia, he immediately shifts tack to support her ego function. Rather than shut down her capacity to explore her unconscious, his reassurance and information helps her to move forward to an even deeper understanding of her fears and the way in which they might be contributing to her presenting problems. Staying aware of the patient's needs at each moment in the treatment allowed Dr. Z to shift seamlessly from trying to bring unconscious material to light to supporting weakened ego function—and vice versa. Both aims are constantly at play in the treatment, adding richness and attunement to the therapeutic work.

## CONCLUDING REMARKS

This illustration demonstrates the way in which our understanding of the patient's unconscious guides our moment-to-moment decisions about how best to help him or her. Flexibility, based on careful, ongoing assessment of ego function, allows us to move fluidly from exploring unconscious material to supporting weakened ego function, and back again, often in the same session. Like a mother's constant attunement to her child, our readiness to shift our approach in response to our patients' needs helps them to feel heard and understood, enhances the "holding function" of psychotherapy, and ultimately improves our psychotherapeutic technique.

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