

ARTICLE

Supervised case experience in supportive psychotherapy: suggestions for trainers

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SUMMARY

The Royal College of Psychiatrists' guidelines for the psychotherapy training of trainee psychiatrists include a supervised case experience in supportive psychotherapy. There is, however, a lack of clarity over the concept of supportive psychotherapy and how this might be taught and supervised, and this may discourage trainers from offering formal clinical supervision in this modality. In this article we briefly describe the history of supportive psychotherapy, the various ways in which it has been conceptualised, and some of the research in the area. We discuss the case for training and make practical suggestions for how this experience might be offered by consultant psychiatrists in an everyday psychiatric setting.

DECLARATION OF INTEREST

None.

The Royal College of Psychiatrists' guidelines for psychotherapy training (Royal College of Psychiatrists 2008a) emphasise the need for psychiatric trainees to become better trained in the psychological therapies. Suggestions for training include supervised case experience in supportive psychotherapy.

In considering the local arrangements for psychotherapy training, we became interested in how training in supportive psychotherapy could be delivered. Discussions with local consultants suggested that although many considered themselves to be practising something akin to supportive psychotherapy in their everyday work, there was a lack of confidence in offering supervision. Further, a national report on implementation of training (Clarke 2005) identified that more thought needed to be given to the concept of supportive psychotherapy and how it might be supervised. Mitchison (2007) suggested that consultant psychiatrists might feel more confident as supervisors if they had a clear account of what was required of them. It has been suggested that obstacles to training in the USA are that the literature fails to clearly describe supportive psychotherapy (Pinsker 1994)

and that there is little guidance on how to teach it (Douglas 2008). It is likely that similar factors are discouraging trainers in the UK from offering supervised case experience.

What is supportive psychotherapy?

There is no straightforward answer to this question. Supportive psychotherapy has been, and remains, an evolving concept that has attracted many differences of opinion. The term 'supportive psychotherapy' has been used in the literature in a variety of ways and there is no single universally accepted definition. We describe some of the views and debates in an attempt to arrive at a clearer understanding of the current status of supportive psychotherapy.

Psychoanalytic origins

The early supportive treatments were felt to be largely unscientific, relying somewhat on suggestion and varying degrees of showmanship. The majority of psychoanalysts attempted to distance themselves by emphasising the differences between supportive psychotherapy and psychoanalysis. Hence in the 1920s, supportive psychotherapy lacked a positive definition, being described in terms of what it was not (relative to psychoanalysis), rather than what it was. However, as psychoanalysis began to be used with more damaged patients, such as those with borderline personality disorder, the limitations of the 'classical' model became increasingly apparent and some analysts began to acknowledge that certain patients required supportive techniques alongside exploratory ones (Holmes 1995).

Nevertheless, the place of supportive interventions in psychodynamic/psychoanalytic therapy remains contentious. Luborsky (1984), for example, views supportive and exploratory techniques as lying on a continuum, both being used in a psychoanalytic 'supportive expressive' therapy as appropriate to the patient's need. Others hold the dichotomous view that therapy is either supportive or exploratory. Indeed, some see support as anathema to psychoanalysis, where the

exploration of unconscious emotion is of necessity initially anxiety-provoking (Crown 1988).

Supportive psychotherapy within a psychodynamic framework

Several authors have conceptualised models in which supportive interventions lie firmly within a psychodynamic framework. In Rockland's (1987) psychodynamically oriented supportive psychotherapy, practised in the USA, patients with borderline personality disorder are seen once or twice weekly for 50 minutes. de Jonghe *et al* (1994) describe psychoanalytic supportive psychotherapy, and argue that it is a therapeutic modality in its own right. Another example is supportive analytical therapy, described by Holmes (1988) as lying somewhere between a formal analytical/psychodynamic psychotherapy and ordinary good psychiatric practice.

Supportive psychotherapy as an integrative model

The concept of supportive psychotherapy in more recent literature has broadened. It is now viewed by many as an integrative therapy which has no single theoretical background, but draws from many approaches, including psychoanalysis, Rogerian counselling, cognitive, behavioural, systemic, interpersonal and ego psychology and attachment theory. The practitioner will choose from the available techniques on the basis of the patient's need and, probably, their own training background.

Some view supportive psychotherapy as a 'common factors approach' (Trijsburg 2007). Common factors are the elements found in all psychotherapies, regardless of model, and it has been suggested that it is these commonalities that are the effective ingredients of psychotherapy (Frank 1991). Supportive psychotherapy contains many of these common factors. Pinsker (1994) conceptualises supportive psychotherapy as a body of techniques, or a 'shell', which can function comfortably with many various theoretical orientations. However, it is noted by Douglas (2008) that despite these moves towards an integrative model, psychodynamic language and theory continue to be present in much of the literature, making it difficult to practise supportive psychotherapy without some degree of psychodynamic understanding.

Models of practice

The traditional view of supportive psychotherapy in National Health Service work in the UK is that of a long-term therapy, held less frequently

than weekly (fortnightly, monthly or even two-monthly), lasting from 10 to 60 minutes and usually continuing over 2 years (Van Marle 2002). The patient group at which this long-term work is aimed is often described as being chronically psychologically weakened and unsuitable for more exploratory work. In practice, this group of patients usually have severe and chronic psychotic, mood, personality or anxiety disorders. Hartland (1991) defines this type of supportive psychotherapy as 'a long-term psychotherapy aimed at maximising the patient's strengths, restoring his equilibrium and acknowledging, but attempting to minimise, his dependence on the therapist.'

This view of supportive psychotherapy as long-term work for patients with chronic disorders has moved on. Short-term supportive psychotherapy is now well described for a wide range of psychiatric disorders, including depression, anxiety, adjustment disorders or other acute crisis or loss events. It is most suitable for patients who have current acute difficulties, perhaps associated with self-blame or internal conflict, but who had good premorbid functioning. Other patient characteristics which suggest suitability for short-term work include psychological mindedness, motivation for treatment, good impulse control, good reality testing, and mature coping and defence mechanisms (Novalis 1993).

Some authors view supportive psychotherapy as being a component of ordinary good psychiatric practice. For example, Pinsker (1997) makes a convincing argument when he writes: 'Many psychiatrists see patients briefly for management of psychopharmacologic treatment. Remarkably, often patients are efficient about the medication issues and quickly attempt to involve the "medicating" psychiatrist in conversation about his or her life, so supportive therapy is part of the package whether intended or not'.

Taking this flexible framework further, it has been suggested that supportive psychotherapy can take place in the context of just one or two meetings (Rockland 1989) or in regular annual sessions (Crown 1988). Within this broad view, it could be said that supportive psychotherapeutic work is carried out by many different healthcare professionals and in a wide variety of settings, both within and outside psychiatry. As Tyrer states: 'Literally thousands of therapists are providing something akin to supportive psychotherapy every working day throughout the land' (Robertson 1995).

Summarising from all of this, the current position of supportive psychotherapy is perhaps most accurately described by Van Marle & Holmes (2002) as 'a flexible, non-manualized form of

BOX 1 Aims of supportive psychotherapy

- To help the patient to reach and to maintain their best level of psychological and social functioning
- To reduce subjective distress
- To reduce behavioural dysfunction
- To improve self-esteem
- To minimise relapses
- To encourage and enhance the patient's strengths and coping skills
- To allow the patient to achieve the maximum possible independence from services and to gain support from other sources

therapy which is practiced in different ways and at different levels by a variety of professionals'.

Aims and techniques

There is general agreement in the literature on the aims and techniques of supportive psychotherapy. Some of the specific aims are listed in Box 1. Broadly speaking, the aim is to bolster and to improve the patient's psychological functions (or 'ego functions'), which are for some reason deficient. Applebaum (1989) draws parallels between supportive psychotherapy and a good early child-parent relationship: just as the parent fosters development in the child, so a therapist aims to foster psychological and emotional maturation in the patient.

Much can be written about the strategies and techniques of supportive psychotherapy. Here, we offer a brief overview, but highly recommend some of the available literature (marked in the reference list by an asterisk) for a more detailed account, including disorder-specific techniques. The key techniques are listed in Box 2.

BOX 2 Some techniques of supportive psychotherapy

- | | |
|---|---|
| • Develop a strong therapeutic alliance | • Psychoeducation and reality-testing |
| • Convey acceptance of the patient | • Limit-setting, confrontation |
| • Convey empathy | • Help manage affect |
| • Offer containment and provide a secure base | • Cognitive-behavioural techniques (e.g. activity-scheduling, problem-solving, exposure work, challenging thoughts) |
| • Allow ventilation of feelings | • Manage the transference and countertransference |
| • Enhance self-esteem | • Use interpretation sparingly |
| • Model behaviour | • Provide medication and other treatments |
| • Offer reassurance when appropriate | • Environmental interventions |
| • Offer advice when appropriate | |
| • Encourage use of external supports | |

The supportive relationship

The most important component of supportive psychotherapy is the supportive relationship (also sometimes termed the therapeutic alliance). This relationship can be therapeutic in its own right, but also acts as the matrix within which other more specific techniques can be implemented (Novalis 1993). Many of the techniques are aimed at building this supportive relationship, within which the patient trusts the therapist and feels safe. Important in the therapist is a genuine, warm, respectful and non-judgemental attitude. The therapist works to be a 'real figure' and this may be facilitated by judicious self-disclosure or use of humour. Ruptures in the therapeutic alliance are noted and repaired as quickly as possible.

Communication style

Conversation is two-way and responsive, with no anxiety-provoking long silences. The therapist encourages the patient to talk, and listens actively, attempting to understand their story and to hear also what is not being said. Some interruption and persistence is appropriate if important issues are being avoided. Ventilation of feelings and expression of affect can bring relief, but should be encouraged only to the degree that the patient is able to manage. The therapist does not aim to uncover deeply repressed material. Accurate empathic responses show that the patient is being understood and encourage further communication.

Transference and countertransference

Being a 'real figure' helps the therapist to prevent a strong positive or negative transference developing, an approach some describe as 'managing the transference'. A mild degree of positive transference may help the therapeutic alliance and can be left intact. However, if negative transference is developing, the therapist may need to act to restore the patient's sense of reality. The therapist should be aware of the countertransference, particularly as the active-therapist stance necessarily involves making judgements. Again, ruptures in the therapeutic alliance are noted and repaired as quickly as possible.

A secure base and containment

The reliable and consistent clinician will come to form a secure base for the patient and some degree of necessary dependency may occur while the patient works towards greater long-term independence. The therapist acts to contain the patient's emotions, touched by them, but able to think about and manage them and to respond therapeutically.

Focus on current problems

The focus of the work is largely the present, helping the patient to examine and manage current difficulties. Goals are agreed collaboratively. Self-esteem and sense of mastery may be improved by encouragement and praise. The therapist may teach problem-solving skills and support the patient in using their own resources to solve problems. If this is not successful, then more direct suggestion or advice may be necessary. Reassurance is appropriate if the patient has unrealistic fears, but should be offered only once these have been adequately explored.

Behaviour

The therapist helps the patient to increase functional and reduce dysfunctional behaviours, although in the spirit of working with a patient's strengths, minor problematic behaviours could be selectively ignored. Functional behaviours can be encouraged through praise. An uncritical but questioning attitude towards dysfunctional behaviours may lessen these. If behaviour is unacceptable, non-negotiable limit-setting is sometimes required. These limits may serve to contain the patient and shape harmful behaviours into more appropriate ones. Patients who have difficulty in managing affect and controlling impulses may be assisted in recognising these patterns and trying alternative strategies.

The therapist can model behaviour such as being on time and maintaining boundaries. The self-critical patient can learn from the compassionate therapist how they might be kinder to themselves.[†]

Reality testing

The patient is assisted in reality testing. Psychoeducation can help greatly in correcting inaccurate views of the illness. Basic cognitive and behavioural techniques can be used to help the patient to identify and challenge distorted thinking, and to experiment with changing behaviours.

Defence mechanisms and interpretation

The emphasis of supportive psychotherapy is on respecting defence mechanisms and acknowledging their possible protective functions for the patient. Some healthy defences may be encouraged (for example, the sublimation of rage into exercise). Harmful defence mechanisms may, however, need to be challenged (for example, denial of a medical problem preventing appropriate help-seeking). There may be a place for some forms of interpretation, but the aim is to reduce anxiety and not to uncover deeply unconscious feelings.

For example, the supportive therapist may delay the interpretation until after the emotional tension has cooled – an approach described by Pine (1986) as 'strike while the iron is cold'. Some use a partial (inexact) interpretation, which offers an account that is only partly accurate, or a benign projection that attributes the problem to something outside the patient's control.

Other techniques

Many authors see prescribing of medication and environmental interventions as techniques of supportive psychotherapy.

The research

The literature on supportive psychotherapy contains many small studies and case reports. A few randomised trials include supportive psychotherapy, but usually as a control rather than a modality to be investigated in its own right. We have not attempted a comprehensive review of the research, but outline some of the more recent randomised trials. Methodologically, these are all fairly robust studies, although they have the usual difficulties associated with conducting psychotherapy research. A specific problem in interpreting the research in this area is that different researchers use slightly differing models of 'supportive psychotherapy'.

Anxiety disorders

Klein *et al* (1983) describe a randomised trial in out-patients comparing the combinations of behaviour therapy and imipramine with supportive psychotherapy and imipramine. Therapy sessions occurred weekly for 26 sessions. Supportive psychotherapy was found, surprisingly, to be as effective as behaviour therapy.

In a randomised trial involving older out-patients with a range of anxiety disorders, Barrowclough *et al* (2001) treated one group with cognitive-behavioural psychotherapy and the other with supportive psychotherapy. Three different anxiety scales were used to measure outcome. At the end of treatment, changes in anxiety symptoms measured by one of the scales demonstrated a significant benefit of cognitive-behavioural psychotherapy over supportive psychotherapy, but changes on the other two scales suggested that the two treatments were broadly equal in effect.

Depression

Short-term psychoanalytic supportive psychotherapy (SPSP), usually offered as 16 sessions over 6 months, was developed as a treatment for depression (de Jonghe 1994). A mega-analysis of

[†]Compassion in patient and therapist are discussed in Gilbert P (2009) Introducing compassion-focused therapy. *Advances in Psychiatric Treatment* 15: 199–207. Ed.

three randomised trials examining the efficacy of this approach in the out-patient setting (de Maat 2008) suggested that SPSP and antidepressants were equally efficacious, that combining SPSP and antidepressants was more efficacious than antidepressants alone, but that combining SPSP and antidepressants was not demonstrably better than psychotherapy alone.

A randomised trial in the treatment of depression in HIV-positive out-patients (Markowitz 1998) compared four treatment approaches. Interpersonal therapy and the combination of supportive psychotherapy with an antidepressant were most efficacious. Supportive psychotherapy and CBT were less efficacious, but equal to each other in effect.

Personality disorder

Hellerstein *et al* (1998) compared short-term dynamic and brief supportive psychotherapy (about 40 sessions) in high-functioning out-patients with personality disorder, predominantly of the Cluster C (anxious) category. Similar degrees of improvement were found across the two groups.

Vinnars and colleagues (2005) concluded that a manualised supportive-expressive psychotherapy was as effective as psychodynamic therapy in out-patients with mainly cluster C diagnoses who received weekly therapy for a year.

Clarkin *et al* (2007) compared transference-focused therapy, supportive psychotherapy and dialectical behaviour therapy in out-patients with borderline personality disorder. Therapy was offered weekly for a year. Although the three approaches had differing effects in some of the specific outcome domains, overall they were equivalent at producing broad positive change.

Psychosis

Stanton and colleagues (1984) conducted a trial in patients with schizophrenia to compare the effects of exploratory insight-oriented therapy (thrice weekly sessions) with reality-adaptive supportive psychotherapy (once weekly sessions). Patients were in therapy for up to 2 years, beginning in hospital, but continuing after discharge. Supportive therapy was superior on many of the outcome measures.

In a study of psychotherapy in out-patients with non-affective psychosis, outcomes for supportive psychotherapy were intermediate between those for cognitive-behavioural therapy (CBT) and routine care (TARRIER 1998).

Anorexia nervosa

In out-patients with anorexia nervosa, McIntosh *et al* (2005) compared three therapies: non-specific

supportive clinical management (a combination of supportive psychotherapy and normal clinical management), CBT and interpersonal therapy. Therapy consisted of 20 sessions over at least 20 weeks. The three treatments were found to have broadly similar results.

Effectiveness

From these studies we can perhaps reasonably conclude that elements of what these authors are calling 'supportive psychotherapy' are for some patients as effective, or more effective, than other forms of psychotherapy or medication. What the specific ingredients of effect might be, and which patients respond best, is an area that requires more study. Despite the increasing body of literature in the area, supportive psychotherapy requires more specific research before it can be considered evidence-based (Hellerstein 2008).

The case for training

In a climate in which trainees have a limited amount of time in which to meet their psychotherapy training requirements, should supportive psychotherapy be prioritised over some of the more established psychotherapies? Despite having moved forward from its Cinderella status (Sullivan 1971) the value of supportive psychotherapy is still a subject of debate (Box 3). Is it valid as a specific therapy in its own right, as surely support is a component of all psychotherapies and all psychiatric work? Or, as Bloc (2006) would argue, is supportive psychotherapy differentiated by the fact that support is the central component of this work, rather than one of many components. Can this type of flexible working be termed 'psychotherapy', as has become convention, or would other terms such as 'psychotherapeutic management' be more accurate (Pinsker 1997)? How many sessions constitute supportive psychotherapy? What is the

BOX 3 Debates concerning supportive psychotherapy

- Are supportive techniques part of analytic/psychodynamic therapy?
- Is supportive psychotherapy a valid therapy in its own right?
- Can supportive psychotherapy work, when carried out flexibly in routine psychiatric practice, be termed 'psychotherapy'?
- Is supportive psychotherapy applicable to 'higher-functioning' patients?
- How interpretive can/should one be?

place of supportive psychotherapy with regard to psychodynamic therapy? Is it applicable to patients with 'high' as well as to those with 'low' psychological functioning and what is the place of interpretation in this work (Douglas 2008)? Is this just a 'pick and mix' approach or, as Trijsburg *et al* (2007) suggest, does integration in psychotherapy have a valuable, if not central, part to play in the direction of travel for psychotherapy. Could supportive psychotherapy encourage 'model hopping' each time the therapist meets resistance, leaving core problems unrecognised (Trijsburg 2007)? Or as Douglas (2008) suggests, is flexibility an asset in 'the real world' where patients do not necessarily fit one therapeutic approach.

Given the lack of consensus about the theory and techniques of supportive psychotherapy, there is unsurprisingly no consensus on what and how trainees should be taught. This lack of clarity may result in the neglect of supportive psychotherapy as a training need. However, we feel that this opportunity to place supportive psychotherapy on the training agenda alongside the other psychotherapies should not be lost. Whatever we choose to call it, this type of work goes on every day, often with little training or supervision. Recognising and naming this work would give trainees a framework for these interactions with their patients. Perhaps most important, it would assist trainees in thinking and acting psychotherapeutically in their everyday work.

We envisage that supportive psychotherapy is an area in which practice can drive the development of theory. As training becomes more established, we envisage the development of more clarity over what to teach and how to train.

A model of supportive psychotherapy for training

Here we draw on the available literature to offer a model of supportive psychotherapy for training that we believe offers a robust approach to this work. This could be used by interested consultants who wish to offer supervised clinical experience in supportive psychotherapy. In making these suggestions we take the broad conceptualisation of supportive psychotherapy as a form of work which can be integrated into everyday psychiatric practice and which is applicable to a wide variety of patients and settings. This would seem to be the most relevant model for basic training. Within this model, clinical experience could be offered in various training posts, many of which are outside of a 'formal psychotherapy' setting. Some may argue that psychotherapy should not be supervised by non-psychotherapists. We would suggest that the

training in this particular form of psychotherapy is best done in the general environment, where in reality it occurs. However, encouragement of consultant psychiatrists to take on this work may need to come at the level of job planning, and might require support from the local psychotherapy department.

The trainee

Trainees should be ready to take a case in the second or third year of specialty training (CT2 or CT3). A short case (12–16 sessions) may be more practicable than a long case. Necessary preparation will be some basic theoretical teaching in the psychotherapies which is usually provided through the local MRCPsych/masters teaching. This should include some teaching in supportive psychotherapy. At least a basic knowledge of psychodynamic concepts and of cognitive and behavioural interventions would be expected. Trainees may also attend a psychotherapy case discussion group.

Supervision and assessment of trainees

The consultant may be able to offer this supervision as part of the trainee's existing clinical supervision. Alternatively, specific supportive psychotherapy supervision for a group of trainees may enable shared learning. Regarding frequency, a guideline may be that supervision occurs at least every second session. Styles of supervision will vary; some supervisors prefer detailed written process notes of the session, some prefer a brief overview. Audio- or videotapes can be useful. For in-patients, some direct observation of doctor–patient interaction may be possible during the ward round.

The current competency-based curriculum in psychiatry does not specifically delineate psychotherapy competencies. However, we have extracted some of the competencies that may be relevant to clinical work in supportive psychotherapy (Box 4). These may be helpful in setting learning objectives and assessing progress. A potential tension may lie in reconciling this flexible and integrated approach with the need for a robust and evidenced training experience. Trainees should keep a record of patient contacts. The trainee logbook is likely to require a completed SAPE: Assessment of Psychotherapy Expertise (Royal College of Psychiatrists 2008b). A case report may be helpful.

For many consultants, the supervision of a trainee undertaking supportive psychotherapy will be a new experience. Some guidance comes from Pinsker (1994) and Douglas (2008). It may be helpful to offer the trainee some direct 'coaching' in communication skills and to model the interpersonal

BOX 4 Suggested competencies of trainees in supportive psychotherapy**Psychological thinking**

- Develop a biopsychosocial formulation and treatment plan
- Demonstrate an understanding of the humanity of the patient and of their life apart from, but influenced by, their illness

Communication skills and the therapeutic alliance

- Apply good communication skills, including with patients who are distressed, angry, difficult to understand or challenging of the therapeutic relationship
- Monitor and modify their own communication style in response to the patient's reactions
- Use the concepts of transference and countertransference to understand the possible communicative function of feelings induced in themselves

- Develop and maintain a therapeutic alliance
- Recognise potential threats to the alliance
- Engage the patient cooperatively in the development of the treatment plan

Reflective practice and emotional intelligence

- Seek feedback from the patient and relevant others
- Show self-awareness in not imposing their own personal solutions onto the patient
- Recognise and reflect on the impact of therapist factors on therapy
- Manage the personal/professional boundary to minimise the impact of this work on their own well-being
- Monitor their own feelings towards the patient
- Reflect on lapses in the therapeutic alliance
- Demonstrate professional, ethical and non-discriminatory behaviour and attitudes

Boundaries

- Plan and structure therapeutic work
- Create an appropriate environment for the work
- Plan for absences
- Manage issues relating to ending therapy
- Maintain professional boundaries; understand how boundary violations may occur; demonstrate a capacity for managing and reflecting on any lapses

Theory, techniques and education

- Know the basic techniques and use them appropriately
- Understand the dynamic and attachment issues that can affect therapy endings
- Be aware of the literature and be able to critically appraise research
- Be able to present a case of supportive psychotherapy at a case conference

style the therapist should aim for. The supervisor may help the therapist to identify and repair alliance ruptures, to understand their responses to the patient, and to think psychoanalytically while behaving supportively. Also important is helping the therapist to do 'just enough': to set modest goals, to use supportive techniques judiciously and to value small improvements (Douglas 2008). Supervisors may find it helpful to meet together, where possible with facilitation by a consultant psychotherapist.

Patient selection

Patients suitable for short-term work are likely to be found among those who are referred from primary into secondary care for out-patient treatment. For many of these patients, this work may be sufficient to resolve the crisis. For others, it may be a holding or preparatory intervention before another psychotherapy (most commonly a psychodynamic therapy or CBT) is accessed. The setting for this work is likely to be the existing out-patient clinic, and in reality the work may differ from the current work of a trainee only in that it is more intensive, more planned out and more closely supervised. In-patients may benefit from short-term work during the admission and immediate post-discharge period. The necessarily high frequency of contact with in-patients may help the trainee to reach the requisite number of sessions. Supportive psychotherapy for the carers

of patients with dementia has also been described (Junaid 2007).

Those with severe and chronic illness are most suited to long-term work, and Meaden & Van Marle (2008) describe such work in the assertive outreach setting. This lengthy timescale may not be feasible for a trainee, but these patients may benefit from additional short-term work by a trainee during admission or other acute crisis.

Supportive psychotherapy should not be used with people who would clearly gain more benefit from another form of psychotherapy. Other exclusion criteria include those who have failed to benefit from or have worsened in previous supportive psychotherapy (Novalis 1993).

Starting therapy

The assessment for a training case in supportive psychotherapy is most likely to occur in the context of the wider psychiatric assessment. Assessment should include a clear diagnosis, formulation and some defined goals of the work. Given the time constraints, it may be useful to identify a potential patient before the trainee comes into post.

Before commencing therapy, we recommend an explicit discussion and collaborative agreement between therapist and patient over the rationale, goals and duration of the work, for example 'We agree to meet for half an hour every 2 weeks, for ten sessions, to help you to start an antidepressant and to look together at how you can feel better'.

Reflecting the flexible and practical approach described by many authors, it is suggested that sessions may vary in length between 20 and 50 minutes, and in frequency from as much as several times a week (perhaps for in-patients) to once a month. Session length and frequency can be titrated according to patient need.

Conclusions

We feel that a supervised case in supportive psychotherapy is a valuable training experience which will help trainees to develop the competencies required to practise a more considered, patient-centred and psychotherapeutic psychiatry. We hope that this article will assist consultants in offering this training.

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- *Publications offering a more detailed account, including disorder-specific techniques.

MCQ answers

1 d 2 d 3 e 4 a 5 e

MCQs

Select the single best option for each question stem

1 Supportive psychotherapy:

- a is a well-defined way of working
- b has not been researched
- c has clear training guidelines
- d is widely practised
- e has a single theoretical orientation.

2 Supportive psychotherapy:

- a always requires weekly supervision
- b always requires weekly contact with the patient
- c can be done only as a short-term therapy
- d can be practised by therapists of various theoretical backgrounds

e can be offered only in specialised psychotherapy settings.

3 Supportive psychotherapy aims to:

- a uncover deeply unconscious conflict
- b push the patient to overcome all obstacles
- c create a dependence on psychiatric services
- d break down defence mechanisms
- e build on the patients existing strengths.

4 Supportive psychotherapy is unsuitable for patients:

- a who would clearly benefit from another form of psychotherapy
- b with severe and chronic mental disorder
- c experiencing an acute crisis

d with from depression

e with borderline personality disorder.

5 The techniques of supportive psychotherapy:

- a require the therapist to be a 'blank screen'
- b require no attention to the transference
- c cannot include the prescription of medication
- d aim to increase anxiety in the patient
- e are common to many other therapies.

IN OTHER WORDS

'A crisis in my mental history', from *Autobiography* by John Stuart Mill

Selected by Femi Oyeboade

John Stuart Mill (1806–1873) was a philosopher, political theorist and liberal thinker. He was also a Member of Parliament. This extract is from *Autobiography*, Chapter V: A crisis in my mental history. One stage onward (first published in 1873).

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It was in the autumn of 1826. I was in a dull state of nerves, such as everybody is occasionally liable to; unsusceptible to enjoyment or pleasurable excitement; one of those moods when what is pleasure at other times, becomes insipid or indifferent; the state, I should think, in which converts to Methodism usually are, when smitten by their first "conviction of sin." In this frame of mind it occurred to me to put the question directly to myself: "Suppose that all your objects in life were realized; that all the changes in institutions and opinions which you are looking forward to, could be completely effected at this very instant: would this be a great joy and happiness to you?" And an irrepressible self-consciousness distinctly answered, "No!" At this my heart sank within me: the whole foundation on which my life was constructed fell down. All my happiness was to have been found in the continual pursuit of this end. The end had ceased to charm, and how could there ever again be any interest in the means? I seemed to have nothing left to live for.

At first I hoped that the cloud would pass away of itself; but it did not. A night's sleep, the sovereign remedy for the smaller vexations of life, had no effect on it. I awoke to a renewed consciousness

of the woeful fact. I carried it with me into all companies, into all occupations. Hardly anything had power to cause me even a few minutes' oblivion of it. For some months the cloud seemed to grow thicker and thicker. The lines in Coleridge's "Dejection" — I was not then acquainted with them — exactly describe my case:

"A grief without a pang, void, dark and drear,
A drowsy, stifled, unimpassioned grief,
Which finds no natural outlet or relief
In word, or sigh, or tear."

In vain I sought relief from my favourite books; those memorials of past nobleness and greatness from which I had always hitherto drawn strength and animation. I read them now without feeling, or with the accustomed feeling *minus* all its charm; and I became persuaded, that my love of mankind, and of excellence for its own sake, had worn itself out. I sought no comfort by speaking to others of what I felt. If I had loved anyone sufficiently to make confiding my griefs a necessity, I should not have been in the condition I was. I felt, too, that mine was not an interesting, or in any way respectable distress. There was nothing in it to attract sympathy.