Chapter # 1

OPEN-ENDED SUPPORTIVE THERAPY

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ABSTRACT
In this chapter, I examine the essential role of supportive interventions in treating patients who lack the ego strength for traditional psychodynamic or cognitive therapies. These interventions help individuals navigate life-altering events such as bereavement, relational conflict, medical diagnoses, trauma, or social and work-related stress. After outlining the core principles of supportive therapy, I present two case studies utilizing the Open-Ended Supportive Therapy approach (Hinshelwood, 2013). One case demonstrates the successful application of this method, while the other highlights its misuse, emphasizing the critical importance of adhering to the therapeutic fundamentals for effective outcomes.

Keywords: supportive therapy, therapy, counselling, psychodynamic

1. OPEN-ENDED SUPPORTIVE THERAPY

In this chapter, I will review the fundamental characteristics that make supportive interventions a crucial tool for helping patients who lack the ego strength required for traditional psychodynamic therapy and cognitive therapies. Support that assists the patient to cope with life-changing events, usually linked to bereavement, relational conflict, medical diagnosis of a loved one or themselves, readjusting to life after a traumatic event, or work/study/social-related conflict. After reviewing the fundamentals, I will provide two examples of Open-Ended Supportive Therapy being implemented using a single case study method (Hinshelwood, 2013), one applied successfully and the second one applied incorrectly, as a reference to the importance of fundamentals.

2. FUNDAMENTAL CHARACTERISTICS OF OPEN-ENDED SUPPORTIVE THERAPY (OEST)

Supportive therapy has long been a cornerstone of psychotherapeutic practice, with researchers such as Markowitz (2022), Novalis, Rojcewicz, and Peele (1993), and Winston, Rosenthal, and Roberts (2020) emphasizing its crucial role in promoting mental well-being. Building on these foundations, Open-Ended Supportive Therapy (OEST) focuses on developing a strong therapeutic alliance and adopting a flexible approach, with the central aim being the development of a strong therapeutic alliance, that addresses patient's needs while preventing early termination of therapy.

Supportive therapy is particularly beneficial for patients who may not engage with more interpretive psychodynamic methods or directive cognitive approaches. A practical and more gentle alternative to traditional therapy, it has been shown to improve emotional regulation and foster resilience in individuals under severe stress (Markowitz & Milrod, 2014). Research has also demonstrated that supportive psychotherapy can be just as effective as more structured dynamic therapies for treating interpersonal problems and mild

to moderate depression, yielding significant improvements in both mood and interpersonal functioning (Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 1999).

The versatility of supportive psychotherapy makes it an effective supportive treatment for a wide range of psychiatric conditions, including mood and anxiety disorders, schizophrenia, personality disorders, eating disorders, body dysmorphic disorder, and substance use disorders (Van Den Beldt, Ruble, Welton, & Crocker, 2021). Its aim will not be to reduce the symptoms of these conditions, but rather to create a supportive space for people living with them. This had been historically the approach of supportive interventions, to strengthen patients' coping mechanisms, enhance adaptive skills, and improve overall functioning. As Hellerstein, Pinsker, and Rosenthal (1994), Novalis et al. (1993), and Pinsker (1997) have noted, its core purpose is to help patients manage symptoms, improve their functioning, and enhance their quality of life, not to treat the symptoms or to find the unconscious source of them.

Open-Ended Supportive Therapy (OEST) is a psychodynamically informed approach that blends elements of traditional psychoanalysis, such as understanding the patient's internal world and using free association, with supportive techniques aimed at fostering emotional stability and therapeutic engagement. Unlike time-limited therapies, OEST allows patients to work at their own pace, without the pressure of predefined session limits, ensuring that the therapy is tailored to individual needs.

At the core of OEST is the therapeutic alliance, which research consistently identifies as a critical factor in achieving successful therapeutic outcomes (Horvath & Symonds, 1991). This alliance is particularly crucial for retaining patients who might otherwise prematurely terminate therapy due to feelings of being misunderstood, uncared for, or unimportant. These are often a projection of their own neglected experiences into the therapeutic process. Swift and Greenberg (2012) emphasize that building this connection early is fundamental for maintaining patient engagement and preventing early dropout.

Individuals who lack the ego strength needed for deep interpretive work may find problem-focused therapies, such as Cognitive Behavioral Therapy (CBT), inadequate for addressing their emotional needs. Their difficulty tolerating the complexity of relating to the therapist and the therapeutic task can lead to conflict in the process, potentially causing them to drop out of treatment instead of finding support. Research by Hamilton, Wininger, and Roose (2009) found that 24% of patients drop out of training therapy within the first six months, with even higher dropout rates (67%) among those with borderline personality disorder (Cooper, Hamilton, Gangure, & Roose, 2004; Horner & Diamond, 1996). In these cases, patients already struggling with ego capacities are further burdened by current life stressors, which exacerbates their difficulty in engaging with therapy and makes them more vulnerable for early termination.

For example, narcissistic individuals may struggle in therapy due to the fear of being overwhelmed by the therapist, leading to relational patterns characterized by envy, love, or dependency as is commonly seen in narcissistic patient (Britton, 2018). Such individuals often feel they do not need anyone else (Rosenfeld, 1987), creating a "perfect storm" of life stressors and the perceived threat posed by therapy when the therapist comes emotionally closer, triggering feelings of dependency. Other patients, as described by Glasser (1986) under the name of "Core Complex", normally manage intimate relationships in an avoidant way, manoeuvring around feelings of claustrophobic sensation in the close emotional states fostered by therapy and feeling lonely or abandoned when they distance themselves. Similarly, Rosenfeld (1987) described a subgroup of narcissistic patients with "thin-skinned" personalities, a concept echoed by Britton (2018), who referred to those lacking a "triangular space," and Alexandra Lemma (2009), who described these patients as

relating to others through a "one-way mirror" mother. All of them describe a patient with an overly sensitive condition, that would easily feel criticized by interpretations, envious or phobic to intimacy. With such circumstances and with an external stressor in their life, is where the therapeutic alliance is not aimed at the discovery of the unconscious, but rather at the protection and preserved of the treatment. This way support is not about treating or improving in their condition, but to find a supportive relationship during difficult times.

OEST's flexibility is crucial in addressing the needs of these complex patients. By creating an adaptable therapeutic environment, OEST minimizes the risk of premature termination, and utilises psychoanalytic understanding, to address the complexities of the relationship. Is a complex valance, where the therapist encourages emotional availability, validation and a supportive framework that prioritizes patient engagement, while simultaneously avoiding collusion with pathological narratives, such as victimization. Studies by McCrady, Epstein, Cook, Jensen, and Ladd (2011) and Lambert and Barley (2001) emphasize the importance of maintaining flexible therapeutic boundaries to ensure the therapy process remains intact. Although there might be a flexibility, a boundary in the therapeutic contract is essential and should remain for the length of the process.

A key feature of OEST is the psychodynamically informed formulation of the patient's internal world and relationships with the therapist. This psychoanalytic understanding guides the selection of appropriate interventions, enabling the therapist to balance support with therapeutic neutrality. Supporting the patient does not equate to agreeing with their pathology, but rather offering a space where the patient feels heard, cared for, and understood.

The open-ended nature of OEST also provides patients the freedom to explore their feelings and experiences without the constraints of a fixed timeline. In contrast to more structured, goal-oriented therapies focused on symptom resolution, OEST allows for deeper exploration of the patient's emotional and psychological processes, facilitating more comprehensive healing. Not having an end date, fosters a sense of safety that avoids the anxieties linked to separation and abandonment, accompanied to endings, until it is the correct time and the patient is ready to end the process, not before.

3. THE STEPS OF OEST

1. Setting and Alliance: Establish a persistent, reliable, and predictable therapeutic alliance. Agreeing on a setting that covers the practical areas of the therapeutic work.
2. Understanding and Expression: Create a space where the patient feels understood and can express emotions freely. Ideally, the patient can use the therapist and the therapeutic space in a unique, personal way, not governed by the superego.
3. Avoiding Repetition: Use interventions not to explore the unconscious but to prevent actions that could lead to early termination, by repeating early patterns of experiences.
4. A good ending: An ending that comes from mutual agreement, that is talked about in length, it is not an acting and that leaves the door for the patient to make contact again if needed.

4. ASSESSMENT AND SUITABILITY

The assessment process for Open-Ended Supportive Therapy (OEST) involves exploring three critical areas:

Patient Suitability: The assessment should explore the reason for consultation, family and developmental history, mental health background, risk, and previous therapy experiences. If a patient has experience or is experiencing a difficult time, and is looking for someone to believe them, to listen to them, but they are not looking to explore the reason why they are in such predicament and they are not looking for solution based on coping strategies or other CBT techniques. OEST, becomes a suitable alternative, that will be better suited.

Patients with severe personality disorders, mood disorders, psychosis, suicidal ideation, or substance misuse, may require specialized interventions, but OEST can be suitable with multidisciplinary support (as seen in the following section).

Trauma assessment to distinguishing between those who suffered from PTSD and those currently experiencing active symptoms is important, as they might require specialised trauma therapy. Patients with anxiety crises may be better suited for therapies like Cognitive Behavioural Therapy (CBT) or crisis intervention.

Finally, motivation must be assessed; patients referred by others without intrinsic motivation may not benefit from therapy, though ambivalent patients can still begin treatment. Consistent studies by Lester Luborsky (Luborsky, 1984, Luborsky, Barber, & Crits-Christoph,1990) and Otto Kernberg (1984, 2019), have established that a patient without motivation to recover or to use the therapeutic process, will not benefit from it.

External Support (Multidisciplinary Approach): A multidisciplinary team can make OEST a more viable option for patients with complex needs, if there is sufficient support to address the specific needs the patient, and address potential risk, then the work is possible. In order to assess this, a clear and transparent exercise needs to be done, where the risk and support needs of the patient are reviewed and covered before the process can start, for example:

A patient, in her early thirties, arrives for consultation, she has been recently diagnosed with a bipolar disorder, and has experienced severe manic episodes, becoming impulsive and struggling to keep her job and social commitments. These periods can include anger and possible violence, followed by depressive episodes lasting a few weeks, where she becomes suicidal. She is tired of what she calls ‘classic therapy’ and wants someone to listen as she talks about her experience without trying to cure her or direct the talk back to her episodes and medication. She wants some consistency in having someone be there for her as she deals with the recent life changing diagnosis.

She has a multidisciplinary team, including a psychiatrist and a home treatment team that can send a psychiatric nurse to her house when needed. The therapist sees her in a hospital setting, ensuring she has the specialized support required to manage her symptoms safely. She will be suitable for OEST, although without these teams, it would not be safe to work with her in a private setting.

Therapist Competency: Therapists must ensure they have the necessary competencies and adequate support to handle complex cases. They need to be prepared for the worst-case scenarios based on a patient's mental health history. A safe holding environment is one where the therapist can provide support beyond just referring the patient back to their General Practitioner in a crisis. If a therapist feels unsafe starting treatment, they should reflect on why that may be and consider having an extended assessment period to ensure they are prepared for the case. If the therapist is out of their comfort zone, they will struggle

to offer support, particularly when they are anxious or unsettled by the patient's presentation.

Practitioners must be prepared to handle the unique challenges that come with OEST. This includes being aware of their own limitations, having a solid understanding of the patient's condition, and ensuring that appropriate support systems are in place. By doing so, practitioners can create a truly safe and supportive environment that fosters healing and growth. Therefore, is expected that if the patient has a particular diagnosis, the therapist is well trained in such specialty and has the required experience.

5. THE SETTING

The setting in psychotherapy involves two main components: the material framework and the psychic framework. The material framework includes the contract, the number of sessions per week, their duration, location, payment policies, holiday interruptions, and the therapist's capacity to uphold the agreement. The psychic framework encompasses the therapist's availability, neutrality, abstinence, listening, evenly suspended attention, curiosity, and overall analytical approach, consistently applied session after session.

The setting can be seen as an ongoing continuation of the therapeutic agreement. The therapist willingness to maintain clear boundaries throughout the treatment, ensuring that time, place, and roles are kept stable. With more challenging patients, who may show difficult emotions in therapy, it is crucial to establish clear boundaries that go beyond the therapeutic agreement and need to be consistently reinforced as the patient tests them. This includes setting specific conditions for the therapeutic setting, such as fixed times and places for sessions, limits on behaviour, like prohibiting destructive actions, and ensuring no physical contact between patient and therapist. These boundaries help manage intense emotional outbursts and maintain a safe therapeutic environment (Kernberg, 2003).

Donald Winnicott (1955) theorizes that the setting is intricately linked to trust in early relationships, encompassing how the patient was cared for by their parents and whether they experienced reliability, adaptation, and consistency. Many patients exhibit unpredictable patterns in their earlier relationships, highlighting the importance of the therapist's role as being more reliable than individuals in their ordinary lives (Caldwell & Joyce, 2011).

A vivid illustration of this concept emerged when a supervisee of mine commenced work with a patient in a supportive setting. After my supervisee reassured the patient that she was offering a safe space for open conversation, the patient responded with anger: “When I was 12, my drug-addicted mother took me to a drug house so the dealers could have their way with me, because she had no money left to pay them. If my own mother, who was supposed to love me the most, did this to me, what makes you think I will trust you?”

This poignant anecdote underscores how trust is deeply rooted in past experiences and extends beyond mere therapist assurances. The patient's narrative highlights the profound impact of previous life experiences on trust-building within the therapeutic process.

From this perspective, the setting plays a crucial role in therapeutic practice. Offering a reliable setting allows the patient to regress to a state of dependency and provides the opportunity to re-live the difficulties they are facing in their relationships (Abram & Hinshelwood, 2018). As stated by Jahn Abram (1996), this process enables the integration of experiences, facilitating movement forward.

A secure base involves continuous closeness, accessibility, and intimate understanding, akin to parental and spousal love. In addition to these characteristics, a secure process is responsive, reliable, consistent, exhibits "mind-mindedness," (Holmes, 2016), and has the capability to mend disruptions in emotional connection or the capacity to manoeuvre through the complex emotions the patients bring, without falling out.

One way to understand the setting is through Winnicott's (1965a) concept of the facilitating environment, which fosters the development of the capacity to be alone and comfortable with oneself. It emphasizes the importance of being attuned to the patients' needs, creating a safe space free of judgment, that promotes the autonomy of the patient and allows for the exploration of thoughts and emotions, regardless of their perceived negativity.

Ensuring a sense of safety, clarity, consistency, affordability, and reliability are crucial, in a pragmatic way. This can be achieved through a clear contract with the patient, outlining session schedules, missed session policies, fees, and the duration of therapy. For example, I set the setting by saying the following:

"I can offer to work together in an open-ended way, meaning we don't have an end date, and we can determine when to stop based on your needs and we can talk about it as we go. I take breaks for two weeks during Christmas and Easter and a month in the summer. I also don't work on bank holidays. If you miss a session, there is a charge. If you know in advance that you can't attend, let me know, and we can try to find a different time. Sessions will be held on the same day and at the same time, and I charge X amount. I will send you the invoice at the end of each month."

After presenting the contract, it's important to ask if the patient agrees and address any questions or concerns, they may have. It's common for patients to ask about the duration of therapy, to which it's honest to respond that it can vary and may take months or even years. From the therapist's perspective, it's crucial to ensure comfort with the arrangement, including the time commitment, fees, and readiness for a potentially lengthy therapeutic process. It is the responsibility of the therapist, to ensure the contract agreed is followed by both parties, and to reinforced it in a firm but caring way, when the patient attempts to move it, putting at risk the consistency and predictability of the treatment.

Consider your patient having a difficult day mid-week: Do they know when they will see you next? Can they trust that you will listen to them and that they will be able to share whatever they want? Essentially, can they trust you and the therapeutic process to be there for them?

Now, contrast this scenario with someone who works without a set date, where the times are moved, and sessions may or may not happen, each week. Or imagine a situation where the therapist has already informed the patient that therapy will conclude in 15 sessions. In such cases, how secure is the space provided?

6. ATTENTIVE LISTENING AND NONVERBAL CUES

Attentive listening entails actively engaging with the patient's moment-to-moment experiences and being attuned to subtle shifts in their states of mind. These shifts are often communicated indirectly through metaphorical language or nonverbal cues such as posture and tone. By closely attending to the patient's narrative, including their words, tone, body language, and the emotional impact on the therapist, a deeper understanding of their internal world and relational dynamics can be gained, thereby informing the therapeutic process (Lemma, Target, & Fonagy, 2011).

A clear example of this occurred when a patient insisted that they were fine, despite the room feeling sombre. During a session, the patient recounted their day as normal, while the therapist sensed underlying sadness in their demeanour. Sensing this discrepancy, the therapist gently probed, suggesting that the patient might be avoiding discussing something significant. Eventually, the patient confessed, "What is the point of keep crying? I keep saying how bad I feel, and what is the point of all these tears, I just want to move on." This revelation demonstrated the patient's attempt to maintain composure and suppress their emotions, despite their evident distress. The key takeaway here is that effective listening goes beyond the patient's words alone, it encompasses the totality of their experience.

While words are not insignificant, they often only scratch the surface of our experiences. In everyday conversation, words serve as vessels to convey our thoughts and emotions. However, when we struggle to articulate our innermost feelings, the search for the right words becomes more than mere semantics, it becomes a quest to capture the essence of our experiences. In finding the precise language to articulate our experiences, we dive deeper into the richness of our emotions and thoughts, experiencing authenticity and self-awareness. This phenomenon, described by Winnicott (1965b) as "going-on-being," fosters deeper self-reflection and self-examination.

In the case described the patient's resistance to feeling emotional pain hindered their ability to express themselves authentically. Instead of using language to describe their experience, words became a shield against acknowledging their pain, serving as a façade of emotional detachment. In OEST, we would not challenge the patient’s defensiveness, or explore the reason behind it, instead we would use the formulation to understand how they are working and how this might affect the relationship. In the case above, it might affect the relationship if the therapist pushes on their defences and scares the patient away.

7. FREE ASSOCIATION AND OTHER APPROACHES

Holmes (2016) explores how most therapists today adopt an integrative approach, for instance, even in NHS settings with a psychoanalytic or psychodynamic frameworks, questionnaires such as Core-10 are commonly used to measure patients' progress and emotional well-being. This utilization of a CBT approach is a clear merger of different approaches.

Similarly, many different therapeutic approaches prioritize the therapeutic relationship, drawing from psychodynamic principles. However, when employing supportive interventions, it's crucial not to mix approaches indiscriminately, as this can undermine the effectiveness of the chosen modality. For example, if a patient is struggling with emotional pain and the therapist finds it challenging to tolerate their suffering, resorting to a strategy-based approach is not advisable. This underscores the importance of understanding the role of free association and its benefits and offering the correct intervention from the beginning. The therapist might suggest a referral to other professional and further assessment, without changing their way of working, but finding way to cover their needs.

Free association serves as a vital tool for exploration within supportive therapy. Patients may initially present with a specific reason for consultation, but through the process of free association, new themes and insights emerge. For instance, a patient sought therapy due to the death of his sister years ago, but in subsequent sessions, his discussions about his mother became recurrent. By simply observing and mentioning this pattern, it became evident that he was also grieving the loss of his mother, who had fallen into a severe depression and never recovered after his sister's death. Using free association, the

patient redirected the therapeutic focus on a different aspect they haven't appreciated before. This creates a particular atmosphere where the patient is being listen to in a way that reflects what matters to them, and not the particular agenda that an approach can have.

This is way, in this modality, we refrain from selecting specific topics for exploration or guiding the session. Instead, we allow the natural flow of the patient's associations to guide us. Our active role lies not in steering the conversation but in ensuring the patient feels safe to explore their thoughts and emotions freely.

8. EMOTIONAL AVAILABLE

Being emotionally available in therapy means being receptive to the patient's experience. In therapy, emotional availability is crucial for the therapist to provide a supportive environment for the patient. It involves being open to listening to the patient's experiences and being emotionally prepared to engage with them. This requires the therapist being in a stable emotional state, ready to empathize and support the patient without being overwhelmed by one's own emotions.

To illustrate the importance of emotional availability, consider the following exercise based on a real case: A patient discovers their partner is having an affair. In this scenario, the patient may have numerous family members, friends, and coworkers in their life. However, upon closer examination, many of these individuals may not be able to offer the consistent emotional support the patient needs. For instance, the children may not be an option due to their involvement in the situation, and the partner is the cause of the problem. In-laws and parents may be too emotionally involved, unable to provide effective support, as they are struggling handling their emotions. Siblings may also have their own emotional struggles or may overwhelm the patient with their reactions.

Even among friends and coworkers, finding someone who can truly listen without trying to solve the problem, undermined the seriousness of it, somehow turn the conversations to talk about themselves or them becoming overly emotional, can be challenging. If the patient has good friend, we also need to consider that constantly talking about their problems, for many months, might change the dynamic of the friendship in a negative way. A safe space, where the patient doesn't need to worry for any of these elements and have someone who can focus on their emotions, can make a strong difference in their life.

9. EXPLORATORY NATURE OF THERAPY

A key characteristic of psychodynamic practices, that is link to its efficiency, is the exploratory nature of it. As Jonathan Shedler's 2010 article, The Efficacy of Psychodynamic Psychotherapy, suggest, psychodynamic therapy is effective and often produces benefits comparable to, or exceeding, other evidence-based therapies like cognitive-behavioural therapy (CBT). The reason behind this, as explore by Shedler, is the focus on deeper, underlying psychological issues, that leads to lasting improvements, even after treatment ends.

Carrere (2008) proposes that therapy is essentially an exploratory journey, focusing on researching into the depths of the patient's unconscious dynamics. By fostering a safe environment, patients feel empowered to share even negative feelings towards the therapy, overcoming barriers such as deeply ingrained beliefs, criticism, sexual or sadistic fantasies, sense of guilt and blame, among many other emotions. In supportive interventions, this is

not always useful, as it can bring more distress to the individual. Therefore, exploration is not the aim, and although is important for the patient to overcome their problems, it should not come at the expense of their feeling of comfort and trust. For example, avoiding the negative transference, becomes a fundamental approach of supportive therapy. In contrast, traditional psychodynamic therapy, negative transference is foster so when is expressed in the room, the therapeutic couple can think about it and explore it.

Psychoanalytic theory and thinking can be highly valuable tools for understanding patients and their underlying unconscious dynamics. However, if psychoanalytic theory is overused or applied rigidly as the sole framework for interpreting patients, it can become a significant obstacle in the therapeutic process. As Steiner (1993) stated, feeling understood is more important than understanding, and in some cases, we prioritize our theoretical pursue of understanding to simply being present in the room.

The process of understanding oneself and being understood within therapy is not solely about reaching a conclusion, rather, it holds significance due to the trust cultivated through this process (Allison & Fonagy, 2016). As Bion (1965) noted, patients' emotional experiences can be transformed through interaction with the therapist and the therapeutic environment. An optimal supportive process becomes a method that can have a level of exploration, through inquiry rather than interpretation. Many other interventions, usually referred to as "noninterpretative interventions," such as clarification, mirroring, and various other responses aimed at helping the patient think about themselves and their feelings (Hollinger, 1999), and can be more fruitful.

Here is where the flexibility to the traditional practices and techniques is really important. Ablon and Jones (1998) and Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) conducted an outcome study comparing Cognitive Behavioral Therapy (CBT) and brief psychodynamic therapy. They found that therapists' adherence to psychodynamic methods correlated with better treatment outcomes, suggesting that a positive therapeutic alliance and the ability of therapy to address previously avoided emotions were key factors in achieving positive outcomes. Interestingly, the focus on cognitive distortions, a core aspect of CBT, was associated with poorer treatment outcomes.

The key point for me is how crucial it is to focus on the relationship and the patient over any intellectual aspect. Connecting with the patient is more important than any technique or theoretical rationale. Feeney and Van Vleet (2010) suggest that for a successful therapeutic relationship, it is crucial to be available, non-intrusive, and encouraging. These are the key functions of supportive roles, superseding any strategy or potential formulation. As Winnicott (1955) explained, psychoanalytic technique needs to adapt from traditional interpretation to prioritize the importance of the setting, which is crucial in supportive interventions.

It’s also important to recognize the role of validation as a therapeutic intervention in supportive therapy. In psychodynamic psychotherapy, therapists typically maintain a neutral stance, refraining from validating or reassuring the patient to avoid colluding with their defensive narratives. However, in supportive therapy, validation becomes a key tool for building trust and helping the patient feel heard. Something as simple as acknowledging the patient's emotions—saying, "What you’re going through sounds difficult," or, "It seems like it has been a painful experience for you"—can go a long way in making the patient feel their emotions are justified and that the therapist genuinely cares.

That said, it's essential to strike a balance between validation and avoiding collusion with the patient's defensive narratives. For example, while you might validate the patient’s emotional experience, it would be problematic to say, "It sounds really painful the way your mother treated you." We don't know how the mother actually behaved, and, as we

understand from psychodynamic theory, patients often project their own unpleasant aspects onto maternal or authority figures. If the therapist blindly validates such narratives, the patient may externalize blame and avoid confronting their own shortcomings, casting ohers as a villain in the process.

The goal is to validate the patient's right to feel a certain way without reinforcing a distorted or defensive interpretation of events. By navigating this delicate balance, therapists can provide the support necessary to foster emotional growth without inadvertently encouraging maladaptive coping mechanisms, such as victimization or externalizing blame.

In essence, while the therapist may have the capacity to identify internal object relations and interpret them, the goal is to use these tools to support the therapeutic alliance rather than for analysis. The therapist avoids focusing on minor details or interpretative possibilities that may lead to patient paranoia or feeling misunderstood. Instead, the therapy is about allowing the patient to use the space for their needs, with less intervention being more effective.

10. CLINICAL CASE

10.1. Case Study 1: A Mother Navigating Her Child's Mental Health Diagnosis

The patient was a mother of a young child suspected of having a serious mental health condition that could not be diagnosed yet. Initially, she was uncertain about seeking help, and it was unclear whether she needed support for herself, her child, or was navigating denial about the situation. When she first contacted me, her ambivalence about therapy and inconsistency in seeking help made it challenging to initiate treatment. She was not ready to commit to a meaningful process and felt unsure whether she needed ongoing support.

After a year, the patient returned, emotionally transformed. She was heartbroken, isolated, and angry, primarily because her husband denied there was any problem with their child. She felt alone and struggled to accept her child’s condition, while comparing her situation with that of other children’s progress, which intensified her feelings of isolation.

I offered Open-Ended Supportive Therapy (OEST) to provide a safe, consistent space where the patient could explore her emotions freely. The aim was to create a sense of future stability, allowing her to confront complex feelings without feeling pressured to defend against painful thoughts. We clearly established break dates and fees, ensuring that appointments would be predictable. For the patient, having this structure was the first step in building trust and allowing her to engage emotionally.

As the therapy progressed, sessions were filled with sadness, crying, and anger. The focus was on providing a space for the patient to express her feelings without trying to "solve" her problems. Her child’s condition required acceptance, not negotiation, and I avoided stepping into the role of a healer, knowing that other people in her life were already trying to help in that way.

Over time, the patient became more introspective, moving from emotional release to deeper reflections about how her life would change. This transition opened the door to exploring unconscious emotions, such as guilt and resentment toward her husband, which were expressions of her profound grief over her child’s condition. By allowing her to express these emotions freely, we contained the conflict within the therapeutic process, providing an outlet for her ambivalence.

Throughout therapy, I avoided imposing interpretations or directing the narrative. It was important not to dictate what the patient should talk about or explain her feelings through theoretical frameworks. Instead, I offered emotional support by suggesting possibilities, without intruding on her experience. After 18 months, we ended therapy when it became clear that there was no longer a specific need to continue. Addressing her fear of losing the therapeutic space allowed her to feel vulnerable, ultimately helping her come to terms with ending therapy.

This case highlighted the advantages of OEST's open-ended approach, where the absence of fixed timelines enabled the patient to set her own pace in exploring emotions. The primary challenge lay in maintaining therapeutic neutrality while providing emotional availability, especially for patients needing time to trust the process. The flexibility of OEST allowed the patient to move from a place of grief to one of introspection and acceptance without the pressure of resolution.

10.2. Case Study 2: A Failed Application of Time-Limited Therapy

In this case, the patient had recently gone through a difficult breakup. Her long-term partner had left her suddenly, causing significant emotional distress. At her workplace, she had become visibly upset, prompting her manager to arrange for 11 free therapy sessions through the company I was working for at the time.

The primary goal of therapy was to provide the patient with a space to process her grief and emotional distress. However, this time-limited framework posed a challenge from the beginning. While such frameworks can be effective when applied thoughtfully, in this case, it felt like a rigid arrangement designed to fit within corporate guidelines rather than addressing the patient's specific needs.

Feeling pressured to deliver insights quickly, I shifted the focus of our session to her family dynamics, noticing parallels between her submissive role in her relationship and her dynamics with her sister. While the patient agreed with my observations, her reaction showed annoyance rather than thoughtful reflection. Instead of providing her with a supportive space to process her grief, I had inadvertently imposed an agenda that wasn't aligned with her immediate emotional needs.

The time-limited nature of the therapy left little room for the patient to explore her grief at her own pace. After just two sessions, she emailed me to say she wouldn't be returning, feeling that I wasn't what she was looking for in a therapist. Reflecting on this case, I realized that I had allowed my discomfort with the time constraints to interfere with the therapeutic process. Instead of offering the emotional support she needed, I focused on trying to provide something meaningful within the limited number of sessions.

This case illustrates the disadvantage of time-limited therapy when applied without careful consideration of the patient's needs. The rigid framework led me to prioritize offering insights over creating a supportive space for the patient's emotions. In contrast to the open-ended therapy described in the first case, this time-limited approach resulted in premature termination, with the patient feeling that her needs had not been met.

In both cases, the key difference lay in the flexibility of the therapeutic approach. The first patient benefited from OEST's adaptability, which allowed her to engage emotionally at her own pace. In contrast, the time-limited nature of the second case, imposed constraints that hindered the therapeutic process, ultimately leading to a failure in providing adequate support.

11. CONCLUSION

The heart of effective therapy lies not just in the application of techniques or adherence to theoretical models, but in the relationship itself, the profound connection between therapist and patient. While theories and methodologies offer invaluable frameworks for understanding and guiding therapeutic work, they are mere tools in the hands of the therapist. The real healing emerges from the trust, empathy, and safety cultivated within the therapeutic relationship. In order to provide supportive therapy effectively, it is important to re-direct, the technique element from exploratory or problem solving into a supportive role.

The principles discussed highlight the critical need for a therapeutic environment that is safe, empathetic, and supportive, where patients feel free to express their innermost thoughts and emotions. Therapy is both an art and a science, requiring therapists to maintain a delicate balance of empathy, clinical skill, and humility. By embracing these core principles, therapists can foster meaningful connections that provide patients with the necessary support to navigate difficult times. Ultimately, the cornerstone of a successful therapeutic process lies in the therapist's consistency, reliability, and emotional presence, ensuring that the patient feels truly seen and understood when they need it most.

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