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DOCTORAL DISSERTATION:

***Episodes of meeting as relevant episodes for the study of change in
psychotherapy***

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Psychotherapy

By

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Individual neurons are separated by small gaps called synapses. These synapses are not empty spaces by any means; rather, they are inhabited by a variety of chemical substances engaging in complex interactions that result in synaptic transmission. It is this synaptic transmission that stimulates each neuron to survive, grow, and be sculpted by experience. In fact, the activity within synapses is at least as important as what takes place within the neurons themselves. We know that neurons activate and influence one another through multiple biochemical messengers. Over vast expanses of evolutionary time, synaptic transmission has grown ever more intricate to meet the needs of an increasingly complex brain.

When it comes right down to it, doesn't communication between people consist of the same basic building blocks? When we smile, wave, and say hello, these behaviors are sent through the space between us. These messages are received by our senses and converted into electrical and chemical signals within our nervous systems. These internal signals generate chemical changes, electrical activation, and new behaviors that, in turn, transmit messages back across the social synapse.

The social synapse is the space between us—a space filled with seen and unseen messages and the medium through which we are combined into larger organisms such as families, tribes, societies, and the human species as a whole. Because our experience as individual selves is lived at the border of this synapse and because so much communication occurs below conscious awareness, this linkage is mostly invisible to us....”

(The Neuroscience of Human Relationships: Attachment and the Developing Social Brain, Louis Cozolino, 2014)

“... the same evolutionary process that gave rise
to the sources of our emotional suffering
also provided us with the tools to heal:
our abilities to connect, attune and empathize with others.
Psychotherapy is not a modern intervention,
but a relation based learning environment
grounded in the history of our social brains”
(Cozolino, 2016, p.17).

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I. Contents

Acknowledgements.....	4
I. Contents	6
II. Abstract	9
III. Introduction.....	10
IV. Article 1: The study of change in psychotherapy by means of relevant events.....	20
Abstract.....	20
Keywords:.....	20
Introduction.....	21
Significant Events in Psychotherapy	22
Key Change Events.....	25
Change Episodes.....	27
Innovative Moments	30
Rupture and resolution episodes	32
Moments of Meeting.....	34
Discussion.....	37
References.....	42
V. Article 2: “I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist.....	53
Abstract.....	53
Keywords:.....	53
Introduction.....	54
The present study	57

Method.....	58
Researchers' reflexivity	59
Procedure	60
The Case of Ms. B.	63
Results.....	65
“YouTube”: The establishment of the psychotherapeutic relationship	65
“I couldn’t change the past”: The working-through of the traumatic experience ...	69
“The baby”: The therapeutic relationship as an emotional experience	73
“WhatsApp”: The continuity of the relationship	77
Discussion.....	80
References.....	87
VI. Article 3: Moments of meeting in psychotherapy: What they are and how they contribute to therapeutic change from a therapists' perspective.....	96
Abstract.....	96
Introduction.....	97
The Present Study	101
Method.....	101
Participants	101
Procedure	105
Results.....	107
Moments of Meeting as Moments of Resonance with the Other	108
Moments of Meeting as Generators of Change	115
Towards a Comprehensive Vision of the Therapists' Perspective About Moments of Meeting in Psychotherapy	120
Discussion.....	123

References.....	128
VII. Article 4: From moments of meeting to episodes of meeting in psychotherapy: The patients' perspective about their relevance and their effect on their implicit relational knowing:	133
Abstract.....	133
Key words: episodes of meeting, microanalytic interview, subjective experience, implicit relational knowing.....	134
Introduction.....	135
The present study	137
Method.....	137
Design	137
Participants	137
Data Collection	138
Procedure	140
Data Analysis.....	141
Results.....	142
From moments of meeting to episodes of meeting.....	142
Generic structure of episodes of meeting	143
Subtypes of episodes of meeting	149
Synchronic Structure of Moments of meeting.....	153
Discussion.....	155
References.....	158
VIII. Discussion and Conclusions	163
Final considerations	175
IX. Complete References	177

II. Abstract

The study of the change process in psychotherapy has advanced considerably during the last 30 years, focusing its efforts on the study of relevant intra-session episodes in order to contribute to a better understanding of psychotherapy and how change occurs. Although there are different conceptualizations of relevant episodes, up to the present, the different episodes developed and the conception of change that emerges from each one, have focused mainly on the patient, neglecting the dyadic and relational aspects of the therapeutic process, which emphasize that new experiences of relationship with the therapist would be the essence of change. In this line an approach to relevant episodes, which includes change in psychotherapy as a relational and interactive phenomenon between patient and therapist, is that of Daniel Stern and the Boston Group (1998, 2004) which propose moments of meeting in psychotherapy as central moments for reorganizing the patient's implicit relational knowing. However, despite its theoretical solidity, this approach lacks empirical systematization, which hinders its study. The aim of this dissertation was to design a procedure for identifying and outlining episodes of meeting between therapist and patient during the psychotherapeutic process and to establish the main characteristics (verbal, non-verbal and relational) of the interaction between patient and therapist during its occurrence. This descriptive-relational exploratory study was based on a qualitative methodological approach, that combined grounded theory with a phenomenological approach called the micro analytic interview. Eight therapeutic dyads, thirteen therapists, nine patients and five experts were interviewed to approach this phenomenon from different perspectives and grasp its central features. This thesis is considered relevant as it is a contribution for the investigation of the psychotherapeutic process and for clinical practice.

Keywords: Episodes of meeting, psychotherapy and change, relevant episodes, subjective experience, qualitative methods, microanalytic interview

III. Introduction

Over the past 30 years, the emphasis of psychotherapy research has gradually shifted from testing effectiveness to understanding how change takes place and what aspects are associated with patient improvement and change. In this context, the study of the psychotherapeutic process has undergone important developments and evolutions, resulting in significant advances and modifications to research.

These changes have been characterized by an intensive deepening of process research, which has extended not only to methodological approaches, by incorporating mixed research designs, micro-analytical studies, and single case studies, but also to a finer conceptualization of the study object contributing to a better understanding of the psychotherapy process (Lambert, 2013; Braakman, 2015).

In this setting, the complexity of human experience and behavior as well as the richness of the therapeutic process, have led to the realization that the therapeutic process and its effects on change are neither linear nor stable (Braakman, 2015; Kramer & Stiles, 2015) and therefore cannot be studied as such. Greenberg (1986) affirmed that the way psychotherapy process was being approached, was insufficient for achieving new and better answers in psychotherapy research, proposing that change events that occurred in session must be paid attention to, as to identify observable markers of clients' and therapists' behavior that could help us better understand the process of change. Through this work, Rice and Greenberg influenced considerably a paradigm shift in process-outcome research, by believing that groups of particular change events could lead to a positive outcome (Braakman, 2015). This work had great impact on some researchers, who begun to focus on what they considered significant events or relevant episodes within psychotherapy sessions, developing several empirically based theoretical conceptualizations (see Gonçalves Matos & Santos, 2009, 2010, 2011, 2012; Krause et al., 2005, 2006, 2007; Safran & Muran, 1996, 2000, 2006; Greenberg, 1986, 1999, 2007; Elliot, 1984, 1991, 2001, 2010; Stern, 1998 2004; Timulak, 2003, 2007).

Although these conceptualizations differ in their descriptions and understanding of significant events, they have in common several features: the temporary nature of events, that is, all significant moments during a psychotherapy session occur in minutes or less; an emphasis on the present, that is, temporality is perceived subjectively; the observation

of discontinuity in the flow of the interaction or narrative; and a focus on the significance and effect of the event on the patient. Thus, in general, significant episodes can be understood as certain moments of the psychotherapeutic process that are interlinked and have a fundamental influence on the evolution of change and the outcome of therapies (Krause, 2007).

However, understandings of relevant events and their effects on change has centered mainly on the patient, defining them as actions performed by the client and/or their impact on him or her. Although most research in this line of work has emphasized the importance of the interaction between the therapist and patient, only few studies have analyzed the therapist's actions and performance as an independent subject, not as joint actions that take place between patient and therapist (see Fernández Herrera, Krause, Perez Valdés, Vilches, & Tomicic, 2012; Valdés et al., 2010, 2011). Such perspectives have tended to neglect the relational and dyadic aspects of psychotherapy, making it difficult to understand the dynamics of a psychotherapy process as an interactive one. As Kramer and Stiles (2015) have pointed out, therapists implement therapy by responding to their client's requirements and characteristics as they emerge in the therapy process. The "problem" is that even though this is clinically relevant and even hoped for in a good therapy, a therapist who takes into account what clients present and responds to it, injects unpredictable irregularities into research designs, which makes it hard to measure.

Despite this methodological difficulty, the relational and intersubjective aspects of the therapeutic process have gained increasing importance in postmodern approaches to psychotherapy, no matter the theoretical orientation (Safran & Muran, 2000; Mearns & Cooper, 2005). These approaches stress that patients strengthen their capacity for reflective self-consciousness through new experiences of relationship with their therapists, which allows the development of new internal representations (Orange, Atwood, & Stolorow, 1997). In this way, the process of dyadic interactions creates new emergent relational organizations that require the intersubjective coordination of complex psychological states and not simply the coordination of verbal or physical acts. Knowing and being known is essentially about achieving coordinated or attuned interactions with another, which is what Sander (1965) refers to as recognition processes. These recognition processes may require extensive mutual negotiation, failure of recognition, and efforts to

repair (see Lyons-Ruth, 1999; Tronick, 1989), but it is this psychological recognition process that allows inner experiencing, and later reflective awareness of experience to be linked with the experience of other minds, permitting a complex coordination of the dyadic system (Lyons-Ruth, 2000). For most postmodern psychotherapeutic approaches, these elements are considered the basis of psychotherapy and the essence of change. However, these approaches have been developed mainly in theoretical contributions and have little empirical support.

In this rational, Daniel Stern and the Boston Change Process Study Group (BCPSG) (1998, 2002, 2004, 2005, 2008, 2010) have developed a relevant event approach for understanding change in psychotherapy, where the interactive and interrelated process between patient and therapist are an essential part of their description of these events called *moments of meeting*. Stern et al. (1998) argue that change in psychotherapy occurs precisely *in* the interaction, specifically, in certain moments of connection between patient and therapist during the therapeutic process (*moments of meeting*), which alter the course of the relationship, allowing the transformation and reconfiguration of the patient's implicit relational knowledge, which is the procedural knowledge related to interpersonal events that exists outside the focus of one's attention and conscious verbal experience and is acquired from early childhood in relationships with others. (Stern et al., 1998). The implicit relational knowings of both patient and therapist intersect to create an intersubjective field that includes a pretty accurate sensing of each of the participants of the dyads ways of being with others (Lyons-Ruth, 1998)

This process results in changes in the patient's sense of self and ways of being with others because "...this intersubjective field becomes more complex and articulated with repeated patient-therapist encounters, giving rise to emergent new possibilities for more coherent and adaptive forms of interaction. During a transactional event that we term a moment of meeting, a new dyadic possibility crystallizes when the two partners achieve the dual goals of complementary fitted actions and joint intersubjective recognition in a new form. We argue that such moments of meeting shift the relational anticipations of each partner and allow new forms of agency and shared experience to be expressed and elaborated". (Lyons- Ruth et al. 1998, p. 1)

As Lyons- Ruth (1998) clearly elaborates above, for Stern and the BCPSG (1998, 2004), *moments of meeting* are essentially intersubjective because therapist and patient make unique and personal contributions from their own subjectivity to the joint construction of these moments. It is important to consider that *moments of meeting* do not appear suddenly but are preceded by *present moments*, which emerge and enter consciousness when the routine of the interaction is disrupted, and by *now moments*, when the *present moment* becomes an affectively intense moment. Only when the therapist can seize the *now moment* and use it therapeutically does this moment transform into a *moment of meeting*, mutually recognized by both participants. These three moments are closely related and last only briefly, so in this thesis, they are considered together as a whole and are called *episodes of meeting*.

Stern et al. (1998) claim that many lasting therapeutic effects result from changes in the (inter) relational domain and that failures in therapy stem from the loss of opportunities to establish a meaningful connection between therapist and patient, that is, to establish a *moment of meeting*. However, therapeutic interaction working from this perspective has not received sufficient empirical and systematic study in psychotherapy but, instead, has been addressed theoretically and conceptually. This situation presents the challenge to develop a research model that enables observation and rigorous analysis of the intersubjective and interactive aspects of the patient–therapist relation and their association with change without losing idiosyncratic quality of these moments.

So far, studies on the psychotherapy change process have focused primarily on the technical aspects of change and how certain interventions, such as interpretation, insight, and empowerment, lead to change (Stern, 1998; Fosshage, 2003; Timulak, 2007). Perhaps due to the methodological difficulties involved, nontechnical aspects of psychotherapy, such as what takes place at the relational level between patient and therapist, have not been sufficiently described, even though several studies have indicated the high relevance of these aspects to the process of change (Safran, 2000; Asay & Lambert, 1999; Wampold, 2001). So far, there is no clarity on how to observe and study these complex episodes, how to elucidate them and make them more visible, or how to select the most suitable mechanism for the study and detection of the characteristics that make these moments

recognizable for therapists and researchers, allowing a comprehension of their relational characteristics.

This absence highlighted the relevance of conducting a thorough study of *episodes of meeting* in psychotherapy in order to contribute to a better understanding of what happens in the patient-therapist relationship at a more implicit level and of how the interaction between them and modifications in the patient's relational domain influence changes in the patient's implicit relational knowledge.

Thus, the questions that guided this research were the following: What are the characteristics or qualities of *episodes of meeting* that enable their observation and identification throughout the psychotherapeutic process? What happens during the interaction between the therapist and patient that allows the appearance of these episodes? What kind of effects do these episodes have for the psychotherapy process?

Therefore, the aim of this doctoral dissertation was to design a procedure for identifying and outlining episodes of meeting between therapist and patient during the psychotherapeutic process and to establish the main characteristics (verbal, non-verbal and relational) of the interaction between patient and therapist during its occurrence. In order to accomplish this purpose, four specific objectives were developed (1) to determine general criteria for identifying and delimiting *episodes of meeting* and its three moments during the therapeutic process, (2) to identify verbal characteristics of *episodes of meeting* during the therapeutic process, (3) to characterize the nonverbal aspects present in *episodes of meeting* during the therapeutic process and (4) to establish the characteristics of the relational dynamic between patient and therapist during *episodes of meeting*.

Also, guiding questions were developed: Regarding the general criteria for identifying and delimiting episodes of meeting, the following questions were asked: What are the main features of episode of meeting? How does an episode of meeting start and end?? How and when do episodes of meeting take place within psychotherapy sessions? What happens during the therapeutic process (between patient and therapist) before an episode of meeting? What facilitates the occurrence of these episodes of meeting? What happens after the episode of meeting? How do these episodes affect the course of the psychotherapeutic process? Do episodes of meeting always happen the same way? If not,

what are its variations? Is it possible to find certain indicators that predict the occurrence of episodes of meeting? If so what are they?

For identifying verbal qualities of episodes of meeting the following questions were asked: What verbal expressions appear during an *episode of meeting*? Is it possible to identify some appearing more frequently? How are they like? What are the themes or content appearing more frequently during *episodes of meeting*? How is the discourse of the patient structured during an *episode of meeting*? How is the patient's discourse is organized before and after? How is the discourse of the therapist structured during an *episode of meeting*? How is the therapist's discourse organized before and after? How do patient and therapist intervene at a discursive level in *episodes of meeting*? What kind of discourse prevails? Does the discourse between patient and therapist change throughout the episode, does it have certain patterns or does it stay the same?

The nonverbal aspects of episodes of meeting were approached with the subsequent questions: What nonverbal aspects such as postures and movements can be observed in therapist and patient during an *episode of meeting*? In what way do facial and vocal expressiveness reflect the significance of *episodes of meeting*? What emotional expressiveness prevails during *episodes of meeting*? What emotional expressiveness predominates before and after the occurrence of an *episode of meeting*? What role does silence play in the *episodes of meeting*? How is nonverbal expressiveness indicative of the occurrence of *episodes of meeting*?

Finally, to establish the relational dynamics between patients and therapists during episodes of meeting the guiding questions were as follows: What happens between the participants during an *episode of meeting*? What are the characteristics of the interaction within the episodes of meeting? Are there relational dynamics specific at each of the moments that make up the *episodes of meeting*? And if so what or how are they like? Is it possible to distinguish these specific dynamics to the three moments that make up the *episode of meeting*?

For a study of this nature and in order to suitably approach the aforementioned objectives and questions a flexible methodological approach was needed. A combination of qualitative methods was used aiming for a multilevel perspective that could combine therapists', observers' and experts' different perspectives with patients' subjective

experience. Thus, the study design for this dissertation consisted on a mixed qualitative and cross-sectional design, in order to characterize and understand the *episodes of meeting* during the therapeutic process. A descriptive relational analysis was accomplished through grounded theory and micro-phenomenological interview.

The data collection procedure of this study was conducted in two phases that overlapped, and gave feedback to each other. The first phase consisted on eight semi-structured interviews to patient-therapist dyads who had recently finished their therapy process (B, J, M1, M2) regarding their overall experience of the psychotherapy process and particularly significant in session moments; thirteen in- depth interviews, conducted to therapists regarding their conceptualizations thoughts and experiences of moments of meeting in psychotherapy and the conduction of five interviews to expert in the field of psychotherapy and specifically on moments of meeting to clarify the concept and contextualize the interviews theoretically. The information obtained throughout these interviews were analyzed performing open, selective and axial coding as proposed in Grounded Theory (Charmaz, 2006; Strauss and Corbin, 1999), allowing a first approach for identifying and outlining episodes of meeting and general characteristics empirically and giving us perspective on relevant aspects of episodes of meeting and future directions. The second phase consisted on the use of a first-person methodology stemming from a phenomenological approach called the micro-phenomenological interview, which was initially introduced by Francisco Varela (1996) into his neurophenomenological program for the study of consciousness under the name of elicitation or explication interview. This interview was developed by Pierre Vermersch (1994/2011) to explain the experience that takes place during certain actions, which implies that during these actions there is something implicit to discover or evidence and that this work of discovery is not as evident as one would think and therefore requires some help, which is provided by the interviewer during the conduction of the interview. This interview aims at “evoking” a specific event with the intention of integrating the pre-reflective or unrecognized experience to produce a richer apprehension of the experience (Hurlbert, 2011). Since then, this interview has been used in different contexts to study subjective experience and different research fields such as cognitive (e.g., Lutz et al. 2002), clinical (Petitmengin, Navarro & Le Van Quyen 2007), therapeutic (Katz 2011) and managerial (Remillieux 2009)

This interview attempts to guide the interviewee in recalling a given experience, examine it and describe it with great precision and detail (Valenzuela et al., 2013). Its use permits the exploration of the temporal evolution of the experience (The diachronic dimension) and the qualitative aspects of a particular moment of the experience (the synchronic dimension). For this study, the interview was conducted to nine patients of different types of psychotherapies, in order to study (the structure of) or characterize moments of meeting in psychotherapy as a lived experience. This interview centered on a specific re-lived experience that patients recalled as moments of special connection or feeling met by his therapist. This analysis contributed to establishing verbal and nonverbal characteristics of episodes of meeting; the conceptual dimensions that underlie episodes of meeting and to develop a relational model that allowed us to characterize and explain conceptually the episodes of meeting and the relational dynamics between therapist and patient during these episodes.

The whole analysis process was carried out by the researcher and other members of the research team, so that event identification, interpretation of data and generation of categories were validated by an inter-agreement process, to ensure the quality of the results (Interpreters triangulation strategies, Krause, 1995; Howe & Eisenhart, 1993; Patton, 1990). Also, the criterion of thick description (Ponterotto, 2006) was used to understand and interpret each of the interviews and observations in a contextualized way, in order to plausibly describe the different elements that gave form episodes of meeting. The present doctoral dissertation is a *dossier* of four articles that, integrates (a) the gathering and systematization of theoretical and empirical literature, which comprise the conceptual framework of relevant episodes in psychotherapy establishing moments of meeting as an alternative kind of relevant episode for the study of change in psychotherapy and contextualizes this research (article 1); (b) the presentation of a single case study that reveals a dyads comprehension and experience of certain relational aspects that contribute to therapeutic change (article 2); and (c) the results of therapists and patients perception and experience of moments of meeting in psychotherapy, which provide empirical support for the discussion of moments of meeting's characteristics and main effects for the psychotherapy process (articles 3 and 4).

The first article, titled *El estudio del cambio a través de eventos relevantes en psicoterapia* [The study of change in psychotherapy by means of relevant events] (Duarte, Martinez, Tomicic, 2017, under revision) is currently accepted with modifications in the *Revista Argentina de Psicología Clínica* [Argentinian Journal of Clinical Psychology –indexed in ISI]. This publication presents the general conceptual framework of this dissertation and its purpose was to offer an organizing view of different approaches that identify and work with relevant episodes in the context of psychotherapy process research and change, distinguishing between their different theoretical frameworks and conceptual models, their understanding of change, the definition of the events itself, and the consequent methodologies for its observation and analysis. It also discusses the implications of considering moments of meeting as relevant episodes for the study of change processes and exposes its methodological challenges.

The second article, titled: *“I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist.* (Duarte, Fishersworrning, Martínez & Tomicic, 2017) was published in the online version of *Psychotherapy Research*- indexed in ISI- on 03 Aug 2017. This publication was a single case study of a psychotherapeutic dyad and aimed at constructing an integrated understanding of the change process of a patient diagnosed with borderline personality disorder by identifying shared aspects of her own and her therapist’s psychotherapy experience that contributed to therapeutic change. This article deepens in the understanding of psychotherapy as a multilevel process, in which different themes occur and develop simultaneously, where the recovery of trust in others through corrective emotional experiences and the construction of a shared implicit relational knowledge seem to be central aspects for the progress of psychotherapy.

The third article was titled: *Moments of meeting in psychotherapy: What they are and how they contribute to therapeutic change from a therapists’ perspective.* (Duarte, Martinez & Tomicic, 2017) and is currently under preparation. This manuscript presents the analysis of the results of the first phase of the dissertation, corresponding to the experience of the therapists on moments of meeting. The aim of this study was to explore therapists’ experience of these moments of meeting with their patients, with the purpose of

identifying the essential elements and characteristics of its configuration. In this phase we were able to describe and analyze how therapists experience moments of meaningful connection with their patients during course of psychotherapy and the relevance they ascribe to these moments for the therapeutic process.

The fourth article titled *From moments of meeting to episodes of meeting in psychotherapy: The patients' perspective about their relevance and their effect on their implicit relational knowing* (Duarte, Martinez, Tomicic & Valenzuela-Moguillansky, 2017) is also under preparation and shows the results of the second phase of the dissertation. These results contribute to understanding how patients experience moments of meeting or significant connection between themselves and their therapist during their psychotherapy process as a lived experience the effect and identify its main characteristics, effects and relevance accredited to them for the psychotherapy process and its outcome.

The four articles, together as an ensemble allowed us to answer the four objectives of this dissertation, generate discussion about its relevance for clinical practice and methodological difficulties and pose future questions to be developed.

IV. Article 1: The study of change in psychotherapy by means of relevant events¹

Abstract

Scholarly interest in studying relevant events in psychotherapy sessions has increased over the last years, originating several theoretical and empirical conceptualizations. Given that research on change processes in psychotherapy has been based on a variety of theoretical perspectives, the multiple ways in which relevant events or episodes can be delimited, understood, and analyzed is often confusing and ambiguous. The aim of the present article is to provide an organizing overview of the main approaches used to identify and work with relevant events or episodes within the context of change process research. Six lines of research are reviewed (*Significant Events*; *Key Change Events*; *Change Episodes*; *Innovative Moments*; *Rupture and Resolution Episodes*; and *Moments of Meeting*), analyzing their theoretical frameworks and the conceptual models from which they derive, their conceptions of change, their definitions, and their methodologies for observing and analyzing change. Their similarities and differences as well as their contributions to the study of the psychotherapeutic process and its outcomes are discussed.

Keywords: relevant episodes in psychotherapy, significant events, moments of meeting, change process research

¹ Duarte, J., Martinez, C. & Tomicic, A. (2017). El estudio del cambio a través de episodios relevantes [The study of change in psychotherapy by means of relevant events]. Under revision *Revista Argentina de Clínica Psicológica*.

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Introduction

During the 1980s, the underlying paradigm of psychotherapy research established a clear difference between process and outcome research, with change or improvement studies being almost exclusively limited to the latter. In contrast, process research focused on trying to understand how psychotherapy works and what happens within the session (Knobloch-Fedders, Elkin, & Kiesler, 2014). In response to the separation between these research purposes and approaches, Change Process Research (CPR; Elliott, 2010) emerged in order to identify, describe, explain, and predict the processes that produce therapeutic change (Greenberg, 1986). This new development is buttressed by the progress made in process research, which includes new methods for analyzing intra-session events, more differentiated conceptualizations of the ingredients of the change process, and innovative data analysis techniques.

CPR is aimed at overcoming the process-outcome dichotomy by highlighting that research can focus on the measurement of change events occurring within the sessions and on how they affect outcomes (Knobloch-Fedders et al., 2014). Thus, process measures started being used not only to describe what takes place within a psychotherapy session or predict outcomes, but also to understand how and why change occurs (Elliott, 2010; Knobloch-Fedders et al., 2014). In this context, scholarly interest in studying relevant events or episodes in psychotherapy sessions has gained importance, leading to the generation of multiple theoretical and empirical conceptualizations (Krause, 2005).²

The study of relevant episodes in psychotherapy includes the observation and analysis of situations or moments of therapeutic work which can be greatly beneficial to the process, such as Helpful Events (Timulak, 2007). However, it can also identify moments that may negatively affect the process, which is the case of Hindering Events and Non-Helpful Events (Timulak, 2010). Regarding both types of event as relevant to the psychotherapeutic process contributes to our understanding of the mechanisms involved in the production of change and also sheds light on the processes through which such changes occur. Thus, it can be stated that research on change processes in psychotherapy has to a large extent been built on the basis of the thorough identification and description

² The terms *event* and *episode* are used interchangeably in this article.

of events that, according to certain criteria, stand out in the therapeutic process and are important for change, either by promoting or hindering it (Bastine, Fiedler, & Kommer, 1989; Elliot & Shapiro, 1992; Fiedler & Rogge, 1989; Herrera et al., 2009; Martin & Stelmaczek, 1988; Rice & Greenberg, 1984; Krause et al., 2006, 2007).

Since research on change processes in psychotherapy has adopted a variety of theoretical perspectives, multiple ways to delimit, understand, and analyze relevant events or episodes have been devised.

The aim of the present article is to provide an organizing overview of these approaches used to identify and work with relevant events or episodes within the context of change process research, differentiating their theoretical frameworks and the conceptual models from which they derive, the conceptions of change that they involve, their definitions of the event as such, and their methodologies for observing and analyzing change. To achieve this goal, this review will consist in a trawl through the six lines of research on relevant episodes with the largest presence in the literature, including an analysis of their contributions to psychotherapeutic process and outcome research. The approaches to be reviewed are: *Significant Events*, developed by Robert Elliott (1984); Leslie Greenberg's and Laura Rice's *Change Events* (1984); *Change Episodes*, advanced by Mariane Krause and her collaborators (2005, 2006, & 2007); *Innovative Moments*, proposed by Miguel Gonçalves and his team (2009, 2010, 2011, 2012); *Rupture and Resolution Episodes*, developed by Jeremy Safran and Christopher Muran (2000; 2006, 2011); and *Moments of Meeting*, proposed by Daniel Stern and the Boston Study Process Change Group (BCPSG; 1998, 2004, 2010).

Significant Events in Psychotherapy

Theoretical basis, conceptualization, and research contributions. The study of Significant Events in psychotherapy is part of a broader line of research known as “Event Paradigm”, which proposes the comprehensive analysis of certain episodes that take place throughout the psychotherapeutic process (Greenberg, 2007; Rice & Greenberg, 1984). This line of research, developed by Elliott (1984), is probably the one that grants the most importance to relevant episodes, because it constitutes a long tradition of approaches to the analysis of the change process, grouping together several studies under the general

notion of *significant event*. Although the notion of significant events emerged from experiential psychotherapy and person-centered psychotherapy (Elliott, 1984; Greenberg, Rice, & Elliott, 1993), it quickly transcended its origin, becoming an a-theoretical and empirically-based concept. Thus, in recent years, these events have been studied from several perspectives, being used to analyze multiple aspects of the psychotherapeutic process and becoming a generic model for approaching the change process through relevant episodes (e.g. Hill & Knox, 2008; Levitt, Butler, & Hill, 2006, Timulak, Belikova, & Miller, 2010).

In general, significant events can be defined as those that stand out in the psychotherapy, such as a specific answer or reaction, an utterance, an interaction, act, or phenomenon that resonates deeply in the individual's –the therapist's or the patient's– subjective experience and appears to trigger significant development in the process (Elliott & Shapiro, 1992). These events involve a specific response from the patient to the therapist's actions (Greenberg & Pinsoff, 1986). According to the authors [who coined the term] (Elliott, 1984; Elliott & Shapiro, 1992), such events continue to be remembered and reinterpreted by the participants after the psychotherapy is over. Studies on significant events focus on capturing and examining the client's perceptions regarding important moments that take place during the psychotherapeutic process, both helpful and hindering. By doing this, researchers consider that it is possible to gain access to the process of change in psychotherapy, given that such moments contain effective change ingredients and represent certain common factors for therapeutic process (Elliott, 1989; Elliott & Shapiro, 1992; Rice & Greenberg, 1984; Timulak, 2007).

Taken together, multiple studies belonging to this line of research have made it possible to recognize certain significant events that are particularly important for the process, such as insight events (Elliott, 1984) or the empowerment events described by Timulak and Elliott (2003). Given the wide variety of studies that focus on these events, Timulak (2007) sought to identify and integrate their results into a meta-summary of qualitative research. He described nine core categories of significant events in psychotherapy sessions as identified by patients: (a) insight/self-awareness/self-understanding events; (b) behavioral changes/problem-solving; (c) empowerment events; (d) relief events; (e) exploration of

feelings/emotional experience; (f) feeling understood; (g) patient involvement; (h) support/safety/certainty events; and (i) personal contact.

For their part, Martin and Stelmachzonek (1988) found that the moments of the session that patients identified as significant events were those which lead to greater levels of understanding, exploration of feelings, and expression of new behaviors. Likewise, Martin, Paivio, and Labadie (1990) examined therapeutic dialog during significant events remembered by patients, and observed that said events were characterized by a deeper, more imaginative, and more metaphorical language compared to other moments of the therapeutic session.

Detection and analysis system: Interpersonal Process Recall (IPR). Significant events can be detected through the identification of segments of the session that the patient experiences as important or the selection of fragments of the session that correspond with clinically and/or theoretically relevant concepts. In both cases, researchers tend to use a transcript of the event and/or the patient's reflections, and in some cases those of the therapist (Timulak, 2010).

Interpersonal Process Recall (IPR; Elliott, 1986; Kagan, 1975) is one of the main techniques developed for the identification of significant events. It consists in video-recording the therapeutic session to later show it to the therapist and/or the patient in order to provide them with recall cues that they can use to report the significant events experienced during it. The main advantage of this technique, compared to spontaneous recall, is that the video recording of the session enriches the interview by optimizing access to relevant experiences, making it easier for the patient to remember what happened during the process and the emotions that he/she felt. While watching the video-recorded session, participants can pause the video and re-watch segments of the interaction, which makes it simpler for them to reflect on and put into words the more subtle and transient feelings that they experienced during the session (Larsen, Flesaker, & Stege, 2008). Even though the IPR method is comprehensive, given that the session is reviewed in full, it is quite time-consuming for both the researcher and the interviewees, which tends to hinder its implementation. For this reason, an adaptation called Brief Structured Recall (BSR; Elliott, 1993; Elliot & Shapiro, 1988) was developed. BSR starts with the prior

identification of significant events –generally by the patient– through the administration of the Helpful Aspects of Therapy (HAT; Elliott, Slatick, & Urman, 2001) questionnaire, an instrument with separate versions for patients and therapists. The HAT, a brief questionnaire, is administered after the session and makes it possible to identify and describe the strongest helpful and hindering events during it. After these events are identified, they are located in the video recording and watched together with the interviewee. Apart from the time saved, another advantage of this method is that it can be very thorough: it does not only use qualitative recall procedures based on free-answer descriptions, but also incorporates rating scales that make it possible to quantify significant events (Elliott & Shapiro, 1988).

It must be noted that significant events have also been studied through retrospective narrations of important moments of the psychotherapy produced by patients or therapists. In contrast with IPR, events are not studied immediately after they occur, that is, once the therapeutic session ends, but at a later time, either after the whole process is completed or at some point of it, depending on the aims of each study (Levitt et al., 2006; Rhodes, Hill, Thompson, & Elliott, 1994; Timulak, 2010).

Key Change Events

Theoretical basis, conceptualization, and research contributions. In contrast with Significant Events, which have generally been studied using an empirical and trans-theoretical approach, research on Key Change Events, led by Rice and Greenberg (1974, 1984), originated within the context of Emotion-Focused Therapy (EFT; Elliot, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002; Greenberg & Johnson, 1988; Greenberg & Watson, 2006). This therapy belongs to humanistic and experiential approaches and adopts elements from Rogers' Client-Centered Therapy (1961), Gestalt Therapy (Perls, Hefferline, & Goodman, 1951), Emotion Theory, and a Dialectical-Constructivist Metatheory (Greenberg, Elliott, & Pos, 2008).

In order to understand the concept of key change moments more clearly, it is necessary to provide a brief explanation of some concepts of Emotion-Focused Therapy (TFE). This therapy is based on the idea that emotions have an innate adaptive potential which, when activated, can help the patient modify his/her problematic emotional states or undesired

emotional experiences. Therefore, the aim of the therapy is to help the patient identify, experience, explain, give meaning to, transform, and manage his/her emotions more flexibly. In consequence, for this therapeutic model, the central mechanisms of change are emotion processing and emergent meaning assignation processes. Change occurs when one makes sense of one's emotions by becoming aware of, expressing, regulating, reflecting on, and transforming them into an empathetically attuned patient-therapist relationship. From this perspective, as the underlying elements of the patient's problems emerge, some process markers start appearing. These markers are believed to be essential for the evolution of the therapy, since they guide the specific interventions that best suit the particular issues of each patient (Greenberg et al., 2008).

In this context, Rice and Greenberg (1974, 1984) proposed an approach to the study of change processes based on key events in which a Key Change Event is defined as a therapeutic episode containing four components: a) the patient's problem marker, which consists in one or a set of utterances by the patient that signal to the therapist that he/she is dealing with a specific problematic state or conflict; b) the therapist's operation, which refers to the set of interventions performed by the psychotherapist to promote the resolution of the problem; c) the client's response or behavior derived from the therapist's interventions; and d) immediate intra-session results, such as the integration of the patient's problematic tendencies or a cognitive reorganization. Key Change Events can vary in length: from three speaking turns involving at least one exchange or interaction between the participants (e.g. patient-therapist-patient) to an episode taking up most of the session, or even stretching across several sessions (Greenberg, 1984; Rice & Saperia, 1984).

In this approach, change occurs and is studied in the patient, with the therapist being part of the task's environment. In this regard, it is assumed that the client is the main location of change, which makes it possible to regard him/her as an active agent who is committed to the task of solving his/her set of problems (Greenberg, 2007). Thus, Key Change Events can be defined as clinically significant patient-therapist interaction sequences with a starting point, a “work” or development process, and a final point (Greenberg, 2007).

Detection and analysis system: Task Analysis (TA). Task Analysis was used for identifying and studying Key Change Events. This method was originally developed within the context of scientific management as a research strategy for identifying the steps needed to complete a task successfully. This method was initially adapted by Pascual-Leone in 1976 to analyze cognitive performance in problem solving and develop a task-based approach to the study of change in psychotherapy (Greenberg, 2007; Pascual-Leone, 1976). It was later used by Greenberg (1976, 1984) in his doctoral dissertation as an analytical approach to the study of the resolution of emotional problems in the psychotherapeutic process. In subsequent studies conducted with Rice, he became interested in capturing not only what existing measures were able to assess, but also what really occurred during change, based on the view that, in order to understand change, it was important to consider not only what the client did, but also certain particular aspects of the moment when they occurred. This led these authors to focus on an intensive observational method and develop a context-sensitive type of psychotherapeutic process research based on “events”, which resulted in the notion of Key Change Events (Greenberg, 2007; Rice & Greenberg, 1984).

Following the Task Analysis strategy, Key Events correspond with the task to be analyzed. They are defined, during an initial phase, through a discovery-oriented approach that makes it possible to specify a psychotherapeutic change process model and a procedure for measuring its components (Greenberg, 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009).

Change Episodes

Theoretical basis, conceptualization, and research contributions. The study of Change Episodes is part of the approaches that regard change as progressive meaning construction (e.g. Assimilation Model, Stiles et al., 1990; Transtheoretical Change Model, Prochaska & DiClemente, 1984). The underlying idea in these models is that change is progressively constructed upon lower-order stages and that each additional stage involves a development process with increased meaning and abstraction. Thus, initial changes involve a process of de-construction of prior or dysfunctional ways of making sense of or understanding one's problems, which allows higher-level ones to consolidate through the

establishment of new meanings and/or behaviors connected to the topics that the patient finds problematic (Krause et al., 2006).

Change Episodes, advanced by Krause and her collaborators (1992, 1998, 2005, 2006, 2007), constitute a trans- theoretical model that proposes that the progression of change is not necessarily linear and that patients can start their psychotherapeutic process at any stage; therefore, moving from one phase to another could be regarded as a therapeutic change in itself. From this perspective, change is related to the transformation of the patient's subjective theory of him/herself, his/her problems and symptoms, and his/her relationship with the context in which they occur. This entails modifications in subjective patterns of interpretation and explanation leading to the development of new subjective theories, which for their part result in emotional and behavioral changes (Krause, Pérez, Altimir, & De la Parra, 2015).

The model advanced by Krause et al. (2007) proposes the existence of 19 Generic Change Indicators (GCI) that can be observed over the course of a session and belong to three hierarchically organized levels. The first level is called “Initial consolidation of the structure of the therapeutic relationship” and contains the first seven indicators: (1) Acceptance of the existence of a problem; (2) Acceptance of one's limits and acknowledgment of one's need for help; (3) Acceptance of the therapist as a competent professional; (4) Expression of hope; (5) Challenging of one's usual ways of understanding, behaving, and feeling emotion; (6) Expression of the need to change; and (7) Recognition of one's involvement in one's “problems”. The second level, called “Increase in permeability regarding new understandings” is composed of five indicators: (8) Discovery of new aspects of oneself; (9) Manifestation of a new behavior or emotion; (10) Appearance of feelings of competence; (11) Establishment of new connections (between personal and environmental aspects or between personal and self-biographical elements); (12) Reconceptualization of one's problems and/or symptoms; and (13) Transformation of assessments and emotions regarding oneself or others. Finally, the third level, called “Construction and consolidation of new understandings” includes the five higher-level change indicators: (14) Generation of subjective constructs about oneself; (15) Anchoring of subjective constructs in one's biography; (16) Autonomy in one's management of the psychological meaning context; (17) Acknowledgment of the help

received; (18) Reduction in patient-therapist asymmetry; and (19) Construction of a subjective theory about oneself and one's relationship with the environment (Krause et al., 2006).

In this model, Change Episodes are regarded as segments of interaction within the therapeutic session in which a GCI is identified, which for its part results in a change moment that makes it possible to identify the representational processes related to the patient's change (Krause et al., 2005, 2006, 2007).

Research based on this approach to the study of the change process has yielded both quantitative and qualitative information about it. For instance, Krause et al. (2007) report that, on average, one change moment can be observed every two sessions. In addition, they detected the occurrence of extra-session changes, that is, changes taking place between sessions and which the patient ascribes to therapeutic work. On average, these changes were observed once per session. For their part, Reyes et al. (2008) found that patients' verbalizations during change moments are performative, that is, they are uttered in the first person, in the present tense, and have self-referential contents ("I, now, in my case"). Fernandez et al. (2012) observed that, during change episodes, a propositive discourse predominated in therapists, who used assertions and negations, while patients were found to be more receptive. More recently, and in line with the previous research team, Morán et al. (2016) found that, during change episodes, patients were more likely to adopt a reflective discursive position characterized by emotional distance from situations. While in this position, patients balanced their affections and their own views, managing to listen to and critically examine the other positions within themselves (Martínez & Tomicic, 2016).

Observation and delimitation method: Generic Change Indicators (GCI). Change moments can be identified either directly through the observation of therapy sessions in one-way mirror rooms or indirectly through audiovisual recordings and transcripts of sessions (Krause et al., 2015). This task is performed by pairs of independent coders who subsequently compare and discuss their coding to determine whether the criteria for defining a change moment are met (Krause et al., 2015). This process is known as intersubjective agreement (Flick, 2002). For a change moment to be recognized as such,

it must meet the following criteria: *theoretical correspondence*, that is, the event observed must match the contents of the GCIs; *verifiability*, that is, the event must be observable during the session; *novelty*, that is, the specific topic of the change moment must appear for the first time; and *consistency*, that is, the change must be consistent with nonverbal cues and not be denied later on in the session (Krause et al., 2015).

Innovative Moments

Theoretical basis, conceptualization, and research contributions. The study of Innovative Moments, developed by Gonçalves et al. (2009, 2010, 2011, 2012), originated in narrative psychotherapy and the narrative metaphor of psychotherapy. This metaphor is based on the notion that patients seek psychotherapeutic help because they possess a narrative that perpetuates their problem; thus, it is proposed that patients transform themselves by changing the stories that they tell about their lives (Gonçalves, Matos, & Santos, 2009). Understanding human life from a narrative perspective (Bruner, 1986; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986; among others) is linked to the view that people's identity results from their attempts at making sense of the infinite number of events that constitute life (Gonçalves et al., 2009). Thus, life narratives can be regarded as the result of a dialogical process of negotiation, tension, disagreement, and alliance among several voices or positions of the self, given that narratives of one's life are multifaceted and multivocal. Each voice or position of the self can tell a story from its own perspective and transform into a potential space where meaning is constructed and reconstructed while multiple positions gain or lose power. However, when these multiple voices or positions of the self are subjugated by the monologue of a single voice or position, symbolically constructing events in a different manner becomes hard or impossible. This is what the authors refer to as *problem-saturated story*, where the sensemaking or signifying of reality is characterized by redundancy and a loss of complexity, as individuals eventually reject or ignore experiential diversity (White & Epston, 1990). For a new story to develop, it is necessary for the narratives that were left out of the domain of the problem-saturated story to regain some space. The Innovative Moments (IM) approach is aimed at understanding how new narratives are constructed in a problem-saturated story or, in other words, how monological and rigid narratives

become dialogical, facilitating the emergence of new narrative identities and change in psychotherapy (Gonçalves et al., 2009).

In order to develop the IM coding system, Gonçalves et al. (2009) focused on the “unique outcomes” of narrative therapies: the emergence of something not said by the dominant story and which differs from the patient's usual way of narrating him/herself. For the authors (Gonçalves et al., 2009), these emergent and innovative moments (IMs) reflect openness to new stories and opportunities for change to occur.

IMs, then, allude to the emergent meanings that appear within the context of the problematic personal narratives of patients and possess the latent ability to promote the reconstruction of their narratives (Gonçalves et al., 2009; Matos, Santos, Gonçalves, & Martins, 2009). During therapy, an IM occurs every time a narrative challenges or deviates from the problematic narrative pattern (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). Specifically, IMs are defined by the emergence of innovative ways of feeling, thinking, and behaving in the client's narrative during psychotherapeutic conversation. These innovations can vary in complexity and scope, resulting in five types of IMs. Authors divide these IMs into two groups: low-complexity (action, reflection, and protest) and high-complexity (reconceptualization and new experiences) (Ribeiro, Bento, Gonçalves, & Salgado, 2010).

Detection and analysis methodology: Innovative Moments Coding System (IMCS).

The first version of this coding system for detecting and analyzing IMs was developed in 2006 and revised in 2009 (Santos, Gonçalves, Matos, & Salvatore, 2009; Gonçalves, Mendes, Angus, & Greenberg, 2010). The coding system requires that two raters analyze the therapy with no knowledge of its outcome (successful or unsuccessful). Coding is performed in five steps: (1) Training; (2) Consensual definition of the problem or problematic narrative by the two raters; (3) Identification of innovative moments and determination of their start and end points in order to track their salience, that is, the portion of the session taken up by each IM; (4) Categorization of the IMs identified in terms of type (i.e. action, reflection); and (5) Categorization of the IMs identified in terms of emergence, that is, the raters determine how they were introduced into the conversation; for instance, IMs may be produced by the therapist and accepted by the patient, they may

be facilitated by a question or assertion by the therapist, or they may be spontaneously produced by the patient (Gonçalves et al., 2011). Since IMs are identified in contrast with previous problematic patterns, it is necessary for raters to code full cases and not only exemplars or samples of the sessions, unless the coders become familiar with the full case before examining a particular session.

Rupture and resolution episodes

Theoretical basis, conceptualization, and research contributions. Like Innovative Moments and Key Change Moments, Rupture and Resolution Episodes have a mainly theoretical origin, given that they are based on a relational approach to self and change. In the early 1990s, Safran and Muran developed a research program for the study of alliance ruptures and therapeutic relationship impasses (Muran, 2002). The aim of these studies was to understand the role of the therapeutic alliance in the therapeutic process, with an emphasis on impasses and ruptures as critical opportunities for psychotherapeutic change in the patient (Muran, 2002). The authors (Safran & Muran, 2000) based their work on the conceptualization of the therapeutic alliance advanced by Bordin (1979), which considers patient-therapist agreement regarding the aims or goals of the psychotherapy, their agreement regarding the tasks required to attain these aims, and the positive quality of the relational bond between both. For Safran and Muran (2000), psychotherapy consists in a relational process involving a “push and pull” dynamic between self-affirmation and autonomy needs and bonding and dependence needs –those of the patient and the therapist– that configures an “intersubjective negotiation” process (Pizer, 1998). In this context, therapeutic alliance ruptures reflect a decrease in patient-therapist collaboration regarding the tasks and goals of the therapy, along with a decrease in the quality of the relationship. As a whole, this reflects a breakdown in the intersubjective negotiation process (Mitchell, Eubanks-Carter, Muran, & Safran, 2011).

According to Muran (2002), ruptures represent vicious cycles that involve the involuntary participation of the patient and the therapist; that is, they reflect maladaptive relational practices and constitute critical opportunities for making participants aware of dissociated processes and questioning or challenging pathogenic beliefs implicitly linked to a

dysfunctional schema (Muran, 2002). For the authors, this can be achieved through resolution and repair strategies, which represent a corrective emotional experience.

According to this model, ruptures can be of two types (withdrawal or confrontation) and reflect different ways of dealing with the dialectical tension between self-affirmation and autonomy needs and bonding and dependence needs (Safran & Muran, 1996; Safran & Muran, 2000). In withdrawal ruptures, the patient privileges the need to relate to the other to the detriment of his/her agency or self-definition needs (for instance, the patient withdraws from the therapist or from joint work by denying manifest and evident feelings or emotional states); in contrast, in confrontation ruptures, the patient solves the tension by privileging his/her agency or self-definition needs over his/her relatedness needs (for instance, the patient expresses negative feelings about the therapist or therapeutic work). Patients tend to adopt one of these forms of rupture, which may reflect idiosyncratic adaptation styles, even though both types may be observed during the treatment (Muran, 2002).

Although alliance rupture episodes may be characterized as “negative” events of the psychotherapeutic process because they instill tension into the relationship and make therapeutic work more difficult, the underlying notion of this approach is that ruptures are relatively widespread phenomena which constitute opportunities for change in psychotherapy if they are solved or repaired (Martínez, Tomicic, Medina, & Krause, 2004). In this regard, a number of studies suggest that the process of recognizing and referring to aspects like difficulties in the therapeutic alliance –as a way of solving and repairing ruptures– can play a major role in therapeutic success (Safran, Muran, Samstag, & Stevens, 2001; Muran, 2002; Martínez et al., 2004).

Detection and analysis systems: Rupture Resolution Rating System (3RS). Mitchell et al. (2011) developed the Rupture Resolution Rating System (3RS), a method for coding ruptures and resolutions of therapeutic alliance breakdowns that makes it possible to track rupture indicators and resolution strategies throughout therapy sessions. This system is influenced by the Task Analysis paradigm, which integrates quantitative and qualitative strategies for analyzing components involved in the performance of intrasession tasks or change events (Greenberg, 1986; Rice & Greenberg, 1984). To apply this system, a coder must watch a video recording of the full session. Then, he/she identifies ruptures in the

patient and determines their type, locates resolution strategies employed by the therapist, and assesses the degree of success of said strategies.

The analysis can be performed with or without a transcript, but this transcript cannot replace the video recording of the session because the nonverbal aspects of patient-therapist communication are relevant when detecting these episodes. The video can be stopped, rewound, and reviewed as many times as the coder requires to complete his/her work (Mitchell et al., 2011). The latter point is especially relevant considering that ruptures, according to their operationalization in the 3RS manual, are not only caused by major and evident patient-therapist arguments or conflicts: frequently, they are due to minor or subtle tensions between them (Mitchell et al., 2011).

Moments of Meeting

Theoretical basis, conceptualization, and research contributions. This proposal, developed by Stern and the Boston Change Process Study Group (BCPSG; 1998, 2002, 2004, 2005, 2008a, 2008b, 2010), addresses the change process in psychotherapy by focusing on patient-therapist interaction. This model emerged from relational psychoanalysis and is based on micro-analytical studies of mother-infant interaction (Stern, 1977; Trevarthen, 1979; Sander, 1980; Tronick, 1989; Beebe et al., 2000), focusing on moment-by-moment activity between the mother and her child. It has a phenomenological perspective and utilizes Nonlinear Dynamic Systems Theory (NDST; BCPSG, 2002). In broad terms, NDST supports the view that certain systems behave in a complicated and unpredictable manner, with nonlinearity referring to the lack of proportionality between cause and effect, which depend on the variables included in a given model or equation (Carrasco & Vivanco, 2011).

These authors hold that the psychotherapy is composed of three subsequent moments: *Present Moments*, *Now Moments*, and *Moments of Meeting*. *Present Moments* are composed of subjective time units that become conscious when the routine of everyday interaction is broken. For their part, *Now Moments* are affectively intense moments that interrupt the usual work setting –the well-known and familiar intersubjective field of the therapist-patient relationship– and cause it to suddenly alter its course. If a *Now Moment* is perceived and sustained by the therapist, it will lead to a *Moment of Meeting*, which

represents a window of opportunity for therapeutic reorganization (Stern, 2004). Moments of Meeting are jointly constructed by the therapist and the patient, as both provide unique aspects of their subjectivity.

In this model, psychotherapeutic change is understood to involve both an explicit domain –where the unconscious becomes conscious through the use of therapeutic techniques such as interpretation– and what the authors refer to as the implicit relational domain – that which is generated upon the basis of knowledge about interpersonal and intersubjective relationships acquired over one's life and through meaningful relationships, such as the psychotherapeutic one. For Stern (2004), this knowledge concerns the “way of being with” that is implicitly incorporated into our way of relating to others and the world, and integrates affective, cognitive, behavioral, and interactional dimensions. In psychotherapy, the subjective exchange of the patient's and the therapist's implicit relational knowledge makes it possible for them to develop shared relational knowledge about their relationship. This knowledge is constructed moment-by-moment within the framework of the therapeutic relationship, gaining depth and complexity in episodes that are affectively more intense, meaningful, and shared, such as Moments of Meeting (Stern, 2004).

In other words, for these authors, change in psychotherapy occurs in the intersubjective field thorough the transformation of the patient's implicit relational knowledge (BCPSG, 2010), which is achieved by experiencing moments of meeting. Thus, Moments of Meeting constitute nodal events in the psychotherapeutic process: they are essential for understanding change, given their potential for modifying the relationship between the participants and reorganizing the patient's implicit relational knowledge, that is, his/her way of being with others (Stern, 2004; BCPSG, 2008a).

Even though this proposal has a solid theoretical basis and provides a novel view of change as an interaction process –and in contrast with the other models presented– the literature review yielded no empirical studies.

Detection and analysis methodology: the microanalytic interview. Stern (2004) developed this methodological proposal for the study of Now Moments. This technique, labeled *microanalytic interview*, is aimed at eliciting a narration of an event experienced

consciously by the interviewee after it has taken place, through the construction of a narrative outline which becomes deeper via repeated revisions aimed at “correcting”, expanding, shortening, or enriching the initial narrative. The technique is referred to as *microanalytic* because the events remembered are short and are used to explore the minutest feelings, thoughts, or actions until no more content can be extracted (Stern, 2004). The narration is co-constructed by the interviewer and the interviewee, with elements being depicted in terms of time (an estimate) and intensity (subjectively assessed). This process yields a unique retelling of the event in the form of a co-constructed narrative. Stern (2004) calls this product a *composite narrative*.

Even though this interview was designed to gain access to the now moments experienced by a subject, the presence of a moment of meeting in psychotherapy could be explored in the same way in order to understand what happens intersubjectively between the patient and the therapist and how these moments affect the course of the psychotherapeutic process. However, the interview has not been described in more depth or more systematically and has thus failed to attain further empirical development, remaining at the level of clinical casuistry. The literature review conducted only revealed a qualitative study by Bertoni and Sironi (2009), who adapted the microanalytic interview to apply it to transcripts and analyzed the relational moments that precede present moments. In this study, three types of relational movements were found: intersubjectively oriented movements, movements aimed at fostering the scope of the intersubjective field, and mirroring movements. The authors sought to identify the types of now moments but did not examine them in more depth.

In brief, due to its emphasis on how to work and what to focus on during the psychotherapy process, this model represents an interesting and novel approach to relevant events in psychotherapy, shedding light on their association with change—and thus with clinical and psychotherapeutic work. However, not much has been written about how to methodologically delimit these moments or about their value as a model for observing change from the perspective of a third party.

Table 1.1: Comparison of Relevant Events in psychotherapy research

	Author(s)	Theoretical basis	Theory change	of Focus	Measures	analyzed Material	Who determines the moment
Significant events	Elliott, 1984; Elliott & Shapiro, 1992	Person-centered psychotherapy	Generic Change Model	Patient	IPR, HAT, BSR, Retrospective interview	Video and transcript	Patient, Therapist, or Observer
Key change events	Rice & Greenberg, 1974, 1984	Emotion-Focused Therapy	Modification of problematic emotional states	Patient	Task Analysis	Video and transcript	Observer
Change moments and episodes	Krause, 2005; Krause et al., 2006, 2007	Subjective change theory	Transformation of subjective theory	Patient	Generic Change Indicators (GCI)	Video and transcript	Observer
Innovative moments	Gonçalves et al., 2009, 2010, 2011, 2012	Narrative theories	Construction of new narratives based on the problem-saturated story	Patient	Innovative Moments (IMs) coding system	Transcript	Observer
Rupture and resolution episodes	Safran & Muran et al., 2000, 2009, 2011	Brief relational therapy	Changes in maladaptive relational patterns.	Patient and Therapist	Rupture Resolution Rating System (3R)	Video and transcript	Observer
Now moments and moments of meeting	Stern, 1998, 2002, 2004	Microanalytic study of mother-child interaction	Change in implicit relational knowledge	Patient and Therapist	Microanalytic Interview	Post-event interview	Therapist and Patient

Discussion

The present article reviewed six of the approaches to the research of relevant episodes in psychotherapy with the largest presence in the specialized literature. The article analyzed their contributions to the study of the psychotherapeutic process, their main results and applications, and their methodologies in order to organize and systematize these models for the benefit of psychotherapy research.

As shown throughout the article, all the approaches reviewed share the view that a central aspect of these events is their emergent nature: they are moments of the session that stand out in clinical terms and do not occur all the time. Thus, although relevant events are defined depending on what the underlying models or theories of change of each approach deem to be significant, it is interesting to note that all the approaches reviewed focus on small segments or fragments of the session in which something important for the psychotherapeutic process occurs. Each approach, based on its own reference framework, identifies a specific way in which these episodes prompt changes in the patient and/or in the therapeutic relationship, eventually leading to a larger psychotherapeutic change. These approaches attempt to answer the following questions: *What changes? In which moments of the process? and as a result of what actions?* Regarding the first question, even though the approaches reviewed identify different contents of change, they all share the view that they involve a subjective dimension of experience, either in terms of meanings or narratives (Change Episodes, Innovative Moments, and Significant Events), in experiential or emotional terms (Key Change Events, Meaningful Events, and the Moments Model), or in relational terms (Significant Events, Rupture and Resolution Episodes, and Moments Model). Also, many of these changes could be identified or detected upon the basis of several of the models presented; for instance, a significant event may also be a key change event or an innovative moment. However, few analyses have been conducted to compare these models and identify their similarities, including their potential methodological and even theoretical overlap. These studies include an exploratory attempt to validate IMs by analyzing their correlation with Krause's Change Episodes, which found a positive and statistically significant association between these two episode types and a connection between the more complex IMs and higher level change indicators (Martínez, Mendes, Gonçalves, & Krause, 2009).

Another interesting aspect of these proposals is that all of them provide a –relatively thorough– methodological device for identifying and delimiting these relevant episodes of the psychotherapy. This aspect is important for psychotherapeutic process research, because it enables scholars to make visible certain core aspects of the change process that are often implicit and/or happen outside of the patient's and the therapist's consciousness. In addition, from the point of view of clinical training and practice, the methodologies for

observing relevant events associated with the approaches reviewed may contribute to systematization and monitoring, for instance, in research-oriented practice, which is aimed at connecting clinicians and researchers so the former can take part in the design and implementation of research in their everyday practice (Castonguay & Muran, 2015; Castonguay, Barkham, Lutz & McAleavey, 2013).

Although some of the approaches reviewed –such as significant events– have a strong empirical basis demonstrating their contribution to or association with change, others – such as the model advanced by Stern et al. (1998)– lack this evidence and are instead based on a solid and highly convincing theory of change with little empirical development. These differences appear to be linked to the origin of these approaches, given that some of them were developed from and for psychotherapy research, while others emerged within a specific theoretical and clinical model, with no intentions of obtaining empirical proof. Thus, for instance, Significant Events were derived from clinical theory, but were strongly influenced by empirical research, whereas the ideas advanced by Stern et al. (1998) are on the opposite end of the spectrum, having deep theoretical roots but insufficient empirical evidence. In consequence, it is not surprising to find differences among the methodologies employed to study the episodes in each approach. The elements used include live or video-recorded sessions (e.g. Krause et al., 2015; Mitchell et al., 2011), transcripts (e.g. Santos, Gonçalves, Matos, & Salvatore, 2009), retrospective interviews (e.g. Levitt et al., 2006; Rhodes, Hill, Thompson & Elliott, 1994; Timulak, 2010), microanalytic interviews (e.g. Stern, 2004), or a combination of techniques. In addition, the person in charge of identifying relevant episodes differs among approaches: the researcher, when sessions are observed or transcripts analyzed; the patient and/or the therapist in the case of retrospective interviews or when the HAT (Elliott, Slatick, & Urman, 2001, etc.) is administered; or all three perspectives, like when the IPR (Elliott, 1986; Kagan, 1975) is used or multiple methods are combined.

In our view, this variety greatly contributes to the study of change in psychotherapy, since it affords multiple angles and perspectives for looking at and understanding what happens within the psychotherapeutic process. Each point of view yields a small piece of a complex and intricate puzzle. In this regard, the study of relevant episodes generates a major contribution to process research in psychotherapy because it is aimed at understanding the

underlying mechanisms of change, making an effort to determine what ingredients constitute change and how change occurs in the patient during the psychotherapy. These moments are remembered by patients as highly significant (see Altimir et al., 2010; Levitt, Pomerville, & Surace, 2016); this, together with the empirical contributions of each approach, makes it possible to construct hypotheses about how the presence of relevant episodes over the course of the psychotherapy mobilizes and intensifies the process, leaving tracks and laying the groundwork for increasingly complex changes that involve greater levels of understanding, exploration of feelings, and expression of new behaviors (Krause et al., 2015; Martin & Stelmachzonek, 1988). Therefore, the study of relevant episodes is doubly valuable for psychotherapy research, given that each episode brings us closer to understanding the ingredients of change (i.e. unique outcome, Gonçalves et al., 2009), while they also, as a whole, allow us to develop an understanding of both the process and the micro-process (see difference between Big “O” –Outcome– and little “o” –outcome– in Greenberg & Pinsof, 1986; Orlinsky, Ronnestad, & Willutzki, 2004).

Regarding practical implications, the study of relevant events or episodes makes it possible to bring research “down to earth” by linking it to clinical practice, because these moments take place during the session and can be identified by the therapist. Even though some approaches facilitate this task or provide clearer guidance thanks to the support afforded by a specific clinical theory (e.g. Innovative Moments, Gonçalves et al., 2011), all approaches shed light on what occurs within the process.

The limitations of this form of psychotherapy research are mainly connected to methodological difficulties regarding how to relate the presence of relevant episodes to psychotherapy outcomes. Even though the analysis of relevant episodes has extended our knowledge about what the participants of the psychotherapeutic process regard as important (Viklund, Holmquist, Zetterqvist, 2010), insufficient evidence exists for determining the link between these episodes and therapeutic outcomes. Indirect proof of this connection includes reports that, during these events, information processing levels increase or that such events are remembered by patients for a significantly long period (Martin & Stelmachzonek, 1988; Elliott & Shapiro, 1992); nevertheless, this evidence is not sufficient to draw conclusions about their impact on outcomes.

Difficulties for tracking the connection between relevant episodes and psychotherapeutic outcomes are mainly due to the fact that, as the analysis of such episodes has shown, the psychotherapeutic process does not behave like a linear model and must be regarded as a dynamic, heterogeneous, and nonlinear process (Timulak, 2010; Duarte, Fischersworing, Martinez, & Tomicic, 2017). This means that the complexity of establishing such connections lies in the difficulties inherent to “quantifying” or “weighting” episodes, which can acquire different valences in a single therapy depending on the patient, the phase of the therapy, the moment of the session when the event occurs, etc. Alternatively, different events can have a cumulative impact on the process; for instance, they can be “constructed on top of others” (Elliott, 1983; Timulak, 2010). In this regard, questions such as How many episodes are needed to generate changes? Are all episodes equally relevant and do they have the same influence on change? and Do episodes differ according to the moment of the psychotherapeutic process when they occur? have yet to be answered. As Kazdin (2009) points out, research on the change process and on how it develops during sessions requires explanations linking what happened with a more in-depth understanding of how and why it happened.

References

- Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomicic, A., Valdés, N., Echávarri, O., Vilches, O., Pérez, J.C., (2010). Clients', therapists' and observers' perspectives on moments and contents of therapeutic change. *Psychotherapy Research*, 20, 472 – 487. doi: 10.1080/10503301003705871
- Bastine, R., Fiedler, P., & Kommer, D. (1989). Was ist therapeutisch an der Psychotherapie? Versuch einer Bestandsaufnahme und Systematisierung der Psychotherapeutischen Prozeßforschung [What is therapeutic in psychotherapy? Attempt of stocktaking and codification of the psychotherapeutic process research]. *Zeitschrift für Klinische Psychologie*, 18, 3-22.
- Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, J. (2000). Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. *Infant Mental Health Journal*, 21, 99-122.
- Bertoni, M. & Sironi A. (2009). Dalla clinica alla ricerca: andata e ritorno. Per una ricerca sul processo di cambiamento: il gruppo “Kairòs” Retrieved from <http://www.psicoanalisiikairòs.joomlafree.it/2014-03-22-02-12-53/dalla-clinica-alla-ricerca.html?tmpl=component&print=1&page>
- Bordin E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy* 16, 252–260.
- Bruner, J., (1986). *Actual minds, possible worlds*. Harvard University Press, Cambridge, Mass.
- Boston Change Process Study Group. (2002). Explicating the implicit: The local level and the micro process of change in the analytic situation. *Int. J. Psychoanal.* 83 1051-1062
- Boston Change Process Study Group. (2005). The “something more” than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Japa* 693-729

- Boston Change Process Study Group. (2008). Forms of relational meaning: Issues in the relations between the implicit and reflective- verbal domains *Psychoanalytic Dialogues*, 18, 125-148. doi:10.1080/10481880801909351
- Boston Change Process Study Group. (2008). Forms of relational meaning: Reply to commentaries. *Psychoanalytic Dialogues*, 18, 197-202. doi: 10.1080/10481880801909583
- Boston Change Process Study Group. (2010). *Change in Psychotherapy: A unifying paradigm*. New York: Norton
- Carrasco, I., & Vivanco, M. (2011). ¿Sistemas dinámicos en Ciencias Sociales? [Dynamic systems in social science?] *Revista de Sociología*, 26 169-191
- Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). *Practice-oriented research: Approaches and applications*. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (6th ed., pp. 85–133). Hoboken, NJ: Wiley.
- Castonguay, L., & Muran, J. C. (2015). Fostering collaboration between researchers and clinicians through building practice oriented research: An introduction. *Psychotherapy Research*, 25 (1), 1–5.
- Duarte, J., Fischersworing, M., Martínez, C. & Tomicic, A. (2017): “I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist, *Psychotherapy Research*, DOI: 10.1080/10503307.2017.1359426
- Elliot, R. (1983). “That in your hands”: A comprehensive process analysis of significant events in psychotherapy. *Psychiatry* 46, 113-149
- Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. In L. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 249-286). New York: Guilford Press.

- Elliott, R. (1986). *Interpersonal process recall as a psychotherapy process research method*. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 503-527). New York: Guilford Press.
- Elliott, R. (1989). Comprehensive process analysis: Understanding the change process in significant therapy events. In M. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165-184). Albany, NY: SUNY Press.
- Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*, 20 (2), 12-135. doi: 10.1080/10503300903470743
- Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant events. *British Journal of Medical Psychology*, 61, 141-153.
- Elliott, R., & Shapiro, D.A. (1992). *Client and therapist as analysts of significant events*. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-186). Newbury Park, CA: Sage.
- Elliott, R., Slatick, E., & Urman, M. (2001). *Qualitative change process research on psychotherapy: Alternative strategies*. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science.
- Elliot, R., Watson, J., Goldman, R., & Greenberg, L. (2004). *Learning Emotion-focused therapy: The Process-Experiential approach to change*. Washington: American Psychological Association.
- Fernández, O., Herrera, P., Krause, M., Pérez, J., Valdés, N., Vilches, O., & Tomicic, A. (2012). Episodios de Cambio y Estancamiento en Psicoterapia: Características de la comunicación verbal entre pacientes y terapeutas. [Change and Stagnation Episodes in Psychotherapy: Characteristics of verbal communication between patients and therapists] *Terapia Psicológica*, 30(2), 5-22.
- Fiedler, P., & Rogge, K. E. (1989). Zur Prozess Untersuchung psychotherapeutischer Episoden. Ausgewählte Beispiele und Perspektiven [On the investigation process

- of psychotherapeutic episodes. Selected examples and perspectives]. *Zeitschrift für Klinische Psychologie*, 18, 45-54.
- Flick, U. (2002). *An introduction to qualitative research* (2nd ed.). New York: SAGE.
- Gonçalves, M., Matos, M., & Santos, A. (2009). Narrative Therapy and the nature of “innovative moments” in the construction of change. *Journal of Constructivist Psychology*, 22(1), 1-23. doi: 10.1080/10720530802500748
- Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotion focused therapy: The case of Lisa. *Journal of Constructivist Psychology* 23(4), 267-294. doi:1 0.1080/10720537.2010.489758
- Gonçalves, M. M., Ribeiro, P. A., Mendes, I. Matos M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The Innovative Moments Coding System. *Psychotherapy Research*, 21(5), 497-509. doi: 10.1080/10503307.2011.560207
- Gonçalves, M. M., Mendes, I. Cruz, G., Ribeiro, A., Sousa, I., Angus, L., & Greenberg, L. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research*, 22(4), 389-401. doi: 10.1080/10503307.2012.662605.
- Greenberg, L.S. (1976). *Task analytic approach to the study of psychotherapeutic events* (Doctoral dissertation, York University, Toronto, Ontario, Canada).
- Greenberg, L.S. (1984). *Task analysis: The general approach*. In L. Rice & L. S. Greenberg (Eds.) *Patterns of change: Intensive analysis of psychotherapy process* (pp. 124-148). New York: Guilford Press.
- Greenberg, L.S. (1986). Change process research. *Journal of Consulting and Clinical Psychology*, 54(1), 4-9.
- Greenberg, L.S. (2002). *Emotion-Focused Therapy: Coaching Clients to Work Through Their Feelings*. Washington, D.C: American Psychological Association.
- Greenberg, L.S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, 17, 15-30.

- Greenberg, L.S., & Pinsof, W.M. (1986). *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Greenberg, L.S.-Pinsoff, W.M. (1986): *Process research: Current trends and future perspectives*. In L.S. Greenberg & W.M. Pinsoff (Eds.), *The psychotherapeutic process. A Research Handbook*, (pp.3-20). Nueva York: Guilford Press.
- Greenberg, L.S. & Johnson, S. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.
- Greenberg, L.S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.
- Greenberg, L.S., Ford, C., Alden, L. & Johnson, S. M. (1993). In-session change in emotionally focused therapy for couples. *Journal of Consulting and Clinical Psychology*, 61, 78-84.
- Greenberg, L. & Watson, J. (2006) *Emotion-focused therapy for depression*. Washington DC: American Psychological Association.
- Greenberg, L.S., Elliott, R. & Pos, A. (2008). Emotion-focused therapy: An overview. *European Psychotherapy* 7, 19-40
- Herrera, P., Fernández, O., Krause, M., Vilches, O., Valdés, N. & Dagnino, P. (2009) Revisión Teórica y Metodológica de las dificultades en psicoterapia: Propuesta de un modelo ordenador. [Theoretical and Methodological revision of difficulties in psychotherapy: A proposal of a unifying model] *Terapia Psicológica*, 27(2), 169-179
- Hill, C. E., & Knox, S. (2008). *Facilitating insight in counseling and psychotherapy*. In R. Lent & S. Brown (Eds.), *Handbook of Counseling Psychology*, 4th ed. (pp. 284-302). Hoboken, NJ: Wiley.
- Kagan, N. (1975). Interpersonal process recall: A method of influencing human interaction. Unpublished manuscript, University of Houston, TX.
- Kazdin, A.E. (2009) Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19, 418-428.

- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Consulting and Clinical Psychology*, 67, 332–339.
- Knobloch-Fedders, L., Elkin, I., & Kiesler, D. (2014). Looking back, looking forward: A historical reflection on psychotherapy process research. *Psychotherapy Research* 1-13 doi: 10.1080/10503307.2014.906764
- Krause Jacob, M (1992). Efectos subjetivos de la ayuda psicológica - Discusión teórica y presentación de un estudio empírico. *Psyche*, 1, 41-52.
- Krause, M. (1998). Construcción y transformación de teorías subjetivas a través de la psicoterapia [Construction and transformation of subjective theories through psychotherapy] *Terapia Psicológica*, 7, 29-43.
- Krause, M. (2005). *Psicoterapia y cambio. Una mirada desde la subjetividad* [Psychotherapy and change: A view from subjectivity]. Santiago: Ediciones Universidad Católica.
- Krause, M., de la Parra, G., Arístegui, R., Tómicic, A., Dagnino, P., Echavarri, O., Ben Dov, P., Reyes, L., Altimir, C., Ramirez, I. (2006). Indicadores de cambio genéricos en la investigación psicoterapéutica [Generic change indicators in psychotherapy research] *Revista Latinoamericana de Psicología*, 38(2), 299-325.
- Krause, M., de la Parra, G., Arístegui, R., Dagnino, P., Tómicic, A., Valdés, N., et al. (2007). The evolution of therapeutic change studied through generic change indicators. *Psychotherapy Research*, 17, 673- 689.
- Krause, M., Pérez, J. C., Altimir, C., de la Parra, G. (2015). Generic Change Indicators in Therapeutic Processes with Different Outcomes. *Psychotherapy Research*, 25(5), 533-545, DOI: 10.1080/10503307.2014.935516.
- Larsen, D., Flesaker, K., & Stege, R. (2008). Qualitative Interviewing Using Interpersonal Process Recall: Investigating Internal Experiences during Professional-Client Conversations. *International Journal of Qualitative Methods*, 7(1), 18-37.
- Levitt, H. M., Butler, M., & Travis, H. (2006). What clients find helpful in psychotherapy: Principles for facilitating change. *Journal of Counseling Psychology*, 53, 314-324.

- Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. *Psychological Bulletin*. doi.org/10.1037/bul0000057
- Martin, J., & Stelmachzonek, K. (1988). Participant's identification and recall of important events in counseling. *Journal of Counseling Psychology*, 35, 385-390.
- Martin, J. Paivio, S. & Labadie, D. (1990) Memory-enhancing characteristics of client-recalled important events in cognitive and experiential therapy: integrating cognitive and experimental and therapeutic psychology. *Counseling Psychology Quarterly*, 3, 239-256.
- Martínez, C., Tomicic, A., Medina, L., & Krause, M. (2004). A Microanalytical Look at Mutual Regulation in Psychotherapeutic Dialogue: Dialogic Discourse Analysis (DDA) in Episodes of Rupture of the Alliance. *Journal Research in Psychotherapy: Psychopathology, Process and Outcome (RIPPO)*, 17(2):73-92. doi: 10.7411/RP.2014.021
- Martínez, C., Tomicic, A., & Medina, L. (2014). Psychotherapy as a discursive genre: A dialogic approach. *Culture & Psychology*, 20: 501-524. doi: 10.1177/1354067X14551292
- Martínez, C. & Tomicic, A. (2016). Discourse in psychotherapeutic interaction: Developing a Discursive Positioning Model (DPM). Manuscript sin publicar.
- Martínez, C., Mendes, I., Gonçalves, M. & Krause, M. (2009) *Exploring the Construct Validity of Innovative Moments*. Poster presented at the SPR Annual European Meeting, Bolzano, Italia.
- Matos, M., Santos, Gonçalves, M. M., & Martins, C. (2009). Innovative Moments and change in Narrative Therapy. *Psychotherapy Research*, 19(1), 68-80
doi: 10.1080/10503300802430657.
- Mc Adams, D.P. (1993). The stories we live by: Personal myths and the making of the self. New York: Morrow.

- Mitchell, A., Eubanks-Carter, C., Muran, J.C., & Safran, J. D. (2011) Rupture Resolution Rating System (3RS). *Unpublished Manuscript*
- Muran, J.C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research*, 12, 113-138.
- Orlinsky, D., Rønnestad, M., & Willutzki, U. (2004). *Fifty years of psychotherapy process-outcome research: Continuity and Change*. In M. Lambert (Ed.), Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (pp. 307-389). New York: John Wiley and Sons, Inc.
- Pascual-Leone, J. (1976). Metasubjective problems of constructive cognition: Forms of knowing and their psychological mechanisms. *Canadian Psychological Review*, 17, 110-122
- Pascual- Leone, A., Greenberg, L.S., Pascual Leone, J. (2009). Developments in task analysis: new methods to study change. *Psychotherapy Research*, 19(4-5), 527-542. doi: 10.1080/10503300902897797.
- Perls, F., Hefferline, R. y Goodman, P. (1951/1994). *Gestalt Therapy. Excitement and Growth in The Human Personality*. Highland, U.S.: The Gestalt Journal Press.
- Pizer, S. A. (1998). Building bridges; The negotiation of paradox in psychoanalysis. Hillsdale, NJ: Analytic Press.
- Polkinghorne, D. E. (1988). *Narrative Knowing and the Human Sciences*. Nueva York: State University of New York Press.
- Prochaska J, & DiClemente, C. *The transtheoretical approach*. New York: Dow Jones; 1984.
- Reyes, L., Aristegui, R., Krause, M., Strasser, K., Tomicic, A., Valdés, N., Altimir, C., Ramirez, I., De La Parra, G., Dagnino, P., Echávarri, O., Vilches, O & Ben-Dov (2008) Language and therapeutic change: A speech acts analysis, *Psychotherapy Research*, 18:3, 355-362, DOI: 10.1080/10503300701576360

- Ribeiro, A., Bento, T., Salgado, J., Stiles, W., & Gonçalves, M.M. (2010). A dynamic look at narrative change in psychotherapy: A case study tracking innovative moments and protonarratives using state space grids. *Psychotherapy Research*. doi:10.1080/10503307.2010.504241
- Rice, L., & Greenberg, L. S. (1984). Patterns of change: Intensive analysis of psychotherapy process. New York: Guilford Press.
- Rice, L. & Saperia, E. (1984) *A task analysis of the resolution of problematic reactions*. In L. Rice & L. S. Greenberg (Eds.) Patterns of change: Intensive analysis of psychotherapy process. New York: Guilford Press (pp. 29-66).
- Rhodes, R., Hill, C., Thompson, B., & Elliott, R. (1994). Client Retrospective Recall of Resolved and Unresolved Misunderstanding Events. *Journal of Counseling Psychology*, 41(4), 473-483.
- Rogers, Carl. (1961). On Becoming a Person: A Therapist's View of Psychotherapy. London: Constable.
- Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64, 447-458.
- Safran, J. D., & Muran, J. C. (2000) *Negotiating the therapeutic alliance*. New York: Guilford Press.
- Safran, J. D., & Muran, J. C. (2006). Has the concept of therapeutic Alliance outlived its usefulness. *Psychotherapy: Theory, Research, Practice, Training*, 43, 286-291.
- Safran, J. D., Muran, J. C., Samstag, L., & Stevens, C. (2001) Repairing Alliance Ruptures. *Psychotherapy*, 38(4), 406-412.
- Safran, J. D., Muran, J. C., & Eubanks- Carter, C. (2011) Repairing Alliance Ruptures. *Psychotherapy*, 48(1), 80-87. doi: 10.1037/a0022140
- Sander, L. (1980) *Investigation of the infant and its caretaking environment as a biological system*. In S Greenspan & G Pollock (Eds.), The course of life Vol. I. Washington, DC: US Government Printing Office.

- Sarbin, T. R. (1986). *The narrative as root metaphor for psychology*. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3-21). New York: Praeger.
- Stern, D. (1977). *The First Relationship: Infant and Mother*. Cambridge, MA: Harvard University Press.
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, Bruschweiler Stern, N. & Tronik, E. (1998) Non Interpretative Mechanisms in Psychoanalytic Therapy. The “something more” than interpretation. *Int. J. Psycho-Anal*, 79, 903-921.
- Stiles, W. B., Elliott, R., Llewelyn, S., Firth-Cozens, J., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy*, 2, 411-420.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative metaanalysis. *Psychotherapy Research*, 17, 305-314.
- Timulak, L. (2010) Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research and Practice*, 83 (4), 421-447
- Timulak, L., & Elliott, R. (2003). Empowerment events in process-experiential psychotherapy of depression: An exploratory qualitative analysis. *Psychotherapy Research*, 13, 443- 460.
- Timulak, L., Belikova, A. & Miller, M. (2010). Client identified significant events in a successful therapy case: The link between the significant events and outcome. *Counseling Psychology Quarterly*, 23 (4), 371-286.
- Tomicic, A., Martinez, C., & Krause, M. (2014). The Sound of Change: A study of the psychotherapeutic process embodied in vocal expression. Laura Rice’s ideas revisited. *Psychotherapy Research*, 1-14 doi: 10.1080/10503307.2014.892647

- Trevarthen, C. (1979). Communication and cooperation in early infancy: A description of primary intersubjectivity. In M. Bullowa (Ed.), *Before speech: The beginning of interpersonal communication*. (pp. 321–347). New York: Cambridge University Press.
- Tronik, E. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44, 112-119.
- Viklund, E., Holmquist, R., Zetterqvist Nelson K. (2010) Client-identified important events in psychotherapy: Interactional structures and practices. *Psychotherapy Research*, 20(2), 151-164. [dx.doi.org/10.1080/10503300903170939](https://doi.org/10.1080/10503300903170939)
- White, M. y Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: WW Norton & Company.

V. **Article 2: “I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist.³**

Abstract

Background: Qualitative research has provided knowledge about the subjective experiences of therapists and patients regarding the psychotherapy process and its results. Only few studies have attempted to integrate both perspectives, considering the influence of a patient’s characteristics and diagnosis in the construction of this experience. **Aim:** To identify aspects of psychotherapy that contribute to therapeutic change based on the experience of a patient and her therapist, to construct an integrated comprehension of the change process of a patient with BPD. **Method:** A single-case was used to carry out a qualitative analysis of follow-up interviews of the participants of a long-term psychotherapy. Two qualitative approaches were combined into a model entitled “Discovery-Oriented Biographical Analysis” to reconstruct an integrated narrative. **Results:** This method yielded an integrated narrative organized into four “chapters” that reflect the subjective construction of both the patient’s and the therapist’s experience of psychotherapy in terms of meaning. **Discussion:** The understanding of psychotherapy as a multilevel process, in which different themes occur and develop simultaneously, is discussed. From this perspective, psychotherapy can be characterized as a process that involves the recovery of trust in others through corrective emotional experiences and the construction of a shared implicit relational knowledge.

Keywords: Process Research; Qualitative Research Methods; Personality Disorders; Long-term Psychotherapy; Single Case Study; Subjectivity.

³ Duarte, J., Fischersworing, M., Martínez, C. & Tomicic, A. (2017): “I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist, *Psychotherapy Research*

Introduction

The study of the psychotherapeutic process has progressively captured the attention of researchers, given that the question of efficacy and effectiveness in psychotherapy has been positively answered in a consistent and systematic way (Braakmann, 2015). According to Kramer and Stiles (2015), process research has focused on constructing explanatory theories (i.e. Theory Building) which are meant to guide clinicians in conducting therapy. However, a large part of these studies have been conducted from a third person perspective (Fuchs, 2010), that is, creating descriptions and distinctions that objectify the observed phenomenon, making the development of theories possible by collecting observations that confirm, disconfirm, strengthen, or weaken their guiding models. (Kramer & Stiles, 2015). Complementary to this kind of research, enriching research (Stiles, 2015) and practice-oriented research (POR; Castonguay, Barkham Lutz, & McAleavey, 2013) have provided generative knowledge that not only give unitary explanations about how psychotherapy operates, but which also offer new and alternative perspectives for its interpretation. While POR has focused on creating partnerships between clinicians and researchers that allow the former to become involved in the design and implementation of research within their own clinical routine (Castonguay & Muran, 2015), enriching research has sought to draw attention to and deepen our understanding of the less frequently heard “voices”, such as the participants’ perspectives and points of view regarding the psychotherapeutic process (Levitt, Pomerville, & Surace, 2016), shifting from a third-person to a “first- and second-person” approach. That is, the first and second person approaches focus on the lived conscious experience and the subjectivity associated with a particular event (Fuchs, 2010).

Similarly, qualitative research for the study of change processes in psychotherapy has provided knowledge about the experiences of therapists and patients regarding psychotherapy and its results (Yeh & Inman, 2007; Levitt et al., 2016), contributing to the development of principles that guide therapeutic practice (Levitt, 2014). Nevertheless, the distinctions made about the meaning of such processes from the perspective of its participants are insufficient and attempts to integrate both perspectives have been scarce (Altimir et al., 2010; Kivlighan & Arthur, 2000), with the therapist’s perspective prevailing over others (e.g. Blatt, 2013; Elliott, 1984, 2008; Greenberg, 2007; Helmeke &

Sprenkle, 2000; Knox, Hess, Petersen, & Hill, 1997; Timulak, 2007; Timulak & Elliott, 2003; Westra, Aviram, Barnes, & Angus, 2010; Hill, Williams, Heaton, Rhodes, & Thompson, 1996). Even though patients are the reason for the existence of the therapy, their point of view is usually disregarded when evaluating results, due to the belief that experts know more and patients will give unreliable reports, because they are not capable of making accurate judgments, tend to provide biased information, and have difficulties expressing and articulating their experience (Elliott & Williams, 2003; Hodgetts, Wright, & Gough, 2007). However, as Bohart and Wade state (2013), patients are not mere recipients of treatment; instead, they actively intersect with therapists' interventions, which makes their contribution to therapy the most powerful determinant of change. In this context, from a research perspective, looking at therapy from the patient's side of the interaction seems to be a paradigm shift of sorts. In a similar way, patients' stories about their experiences in psychotherapy, both during treatment and after it, have been shown to be very important for them to work through and reflect on how their experience of therapy fits into different aspects of their lives. Psychotherapy is an unusual experience in life, so developing a story about it can help patients hold on to their progress and lays the foundations for the maintenance of therapeutic gains (Adler, 2013).

Psychotherapy is an interactive dialogue in which therapist and patient exchange different and multiple comprehensions about themselves and others and about the reasons that led them to this particular encounter (Martínez, Tomicic & Medina, 2014). In this scenario, change in psychotherapy consists on a transformation of the subjective relational patterns, as to contribute to the patient's wellbeing (e.g. Krause & Martínez, 2011). It is a change that occurs in the subjective space and territory of the therapeutic relationship, which is part of both the process and the results of the transformation of these relational forms.

Therefore, the description of the subjective experience of a psychotherapeutic process and its associated change must consider that it takes place in a certain interpersonal and intersubjective context. Significant in-session moments, as well as other events that occur throughout the therapeutic process, in which patients' experience transformations (Frankel & Levitt, 2008), cannot be interpreted without considering the presence of both patient and therapist and their involvement in this process (e.g. Stern et al., 1998; Stern, 2004; Martínez, Tomicic, & Medina, 2014).

Furthermore, qualitative studies tend to address the experience of psychotherapy participants in a general way, and only a few have considered the influence of a patient's singular characteristics and diagnosis on the construction of the psychotherapeutic experience (e.g. Krause, Abarzúa, Silva, Navarro & Altimir, 2016). Specifically, scarce qualitative studies involving subjective experience have been carried out on Borderline Personality Disorders (BPD). One of those rare studies was conducted by Horn, Johnstone, and Brooke (2007), where they explored patients' experiences and understandings associated with receiving a BPD diagnosis, identifying five main themes: knowledge as power, uncertainty about the meaning of the diagnosis, diagnosis as rejection, diagnosis as not fitting in, and hope and the possibility of change. In a recent study conducted by Larivière et al. (2015), the experience of recovery in women with BPD who had completed a two-year program was examined. Their findings showed that even though "recovery" was not the best term to label their experience, they all talked about a process leading towards stability and wellbeing. The authors also found that the dimensions of recovery included letting go of the past (personal dimension), being involved in meaningful activities (occupational dimension), and having healthy relationships (environmental dimension). Facilitators included social support and participation in a specialized therapy program, while the main obstacle was unstable family relationships. In another line of work, considering therapists' perspective, Rizq (2012) found that counselors in primary care have a permanent sense of failure when dealing with patients with BPD, which is consistent with the work of Bourke and Grenyer (2013) that indicates that therapists who work with patients with BPD tend to express more emotional distress and need for supervision in their clinical work compared to other therapists. Another study conducted by Araminta (2000) explored both therapists' and patients' experiences during a Dialectical Behavioral Treatment (DBT), finding that both considered the relational aspects of therapy to be particularly relevant for the treatment's success. However, only a handful of studies have examined patients' and therapists' subjective experience during the psychotherapy process considering the specific aspects connected with a BPD diagnosis and the specific intersubjective context in which the psychotherapy takes place.

Similarly, single case studies on psychotherapy with BPD patients have also been scarce and more centered on validating certain techniques or forms of intervention by comparing treatments or concentrating on certain mechanisms *of change* (e.g. Gullestad & Wilberg, 2011; Higa & Gedo, 2012; Landes, 2013; Dimaggio, Salvatore, MacBeth, Ottavi, Buonocore, & Popolo, 2017). For example, Higa and Gedo (2012) presented a brief case study highlighting the usefulness of Transference Interpretation in borderline personality disorders from the perspective of Transference Focused Psychotherapy (TFP) and Mentalization-Based Treatment (MBT). In another study, more in line with the purpose of this paper, Athanasiadou-Lewis (2016) discussed a borderline case study focusing on formulation rather than diagnosis, looking to better understand the relational and unconscious processes underlying BPD.

The present study

This study follows the principles of first- and second-person research (Fuchs, 2010); enriching research (Stiles, 2015), and practice-oriented research (POR; Castonguay & Muran, 2015; Castonguay et al., 2013), as an attempt to shed light on the daily realization of psychotherapy in its natural context, considering the case as the basic unit of analysis (Eells, 2007; Fishman, 2005; Iwakabe & Gazzola, 2009). The purpose of this study was to construct an integrated understanding of the change process of a patient diagnosed with borderline personality disorder by identifying shared aspects of her own and her therapist's psychotherapy experience that contribute to therapeutic change.

This study is part of an ongoing project on psychotherapy follow-up entitled: "Experiences of Success and Failure in Psychotherapy - Construction of a Comprehensive and Multidimensional Model of Psychotherapy" (Project FONDECYT N° 1141179). In that project, 80 patients and their therapists are being interviewed regarding their experience during psychotherapy three to six months after termination. Its aim is to establish a multidimensional conceptual model of successful and non-successful aspects of the psychotherapy process from the subjective experience of a variety of participants, considering different ages, problems and expectations, therapists' theoretical background, years of professional experience, and psychotherapy outcome.

Method

A single-case design was used to attain a qualitative analysis of follow-up interviews conducted with the participants of a long-term psychotherapy (patient and therapist), with the purpose of performing a systematic and in-depth exploration of the subjective construction of the psychotherapeutic change process from their perspectives (Elliot, 2002; Galassi & Gersh, 1993; Hilliard, 1993; Kazdin, 1999; Stephen & Elliot, 2011).

This narrative case study is based on the belief that stories of psychotherapy told by patients and therapists convey meanings in themselves, *“because a story functions as a basic human means of organizing and communicating information about life experiences”* (McLeod, 2010, p.207). In this way, psychotherapy can be understood as a life experience for the patient. This idea is sustained by evidence showing that stories about patients’ experience of psychotherapy is strongly associated with clinical improvements and may strengthen our understanding of the therapeutic actions that impact the individual (Adler, 2013).

The therapy under analysis in this article was part of a training program in Psychodynamic Psychotherapy and was used in the context of two previous research projects on the psychotherapeutic process. All sessions were observed through a one-way mirror and video recorded. The first study focused on verbal and non-verbal mutual regulation processes between patient and therapist during therapy sessions and their relation with the patient’s change process. Some of these results, which include data from the therapy used for this study, are published in Tomicic et al. (2015) and Morán et al. (2016). The second study centers on mentalization as a regulatory function of patient and therapist interactions during therapy sessions and on the way in which these interactions relate to the patient’s change process. These results have not yet been published, but are partly presented in a paper under review (De la Cerda, Tomicic, Pérez, & Martínez, 2017).

The therapy analyzed in this article was selected for an in-depth analysis among the series of cases collected within the aforementioned research project because it represents a ‘good outcome’ in terms of objective measures (OQ-45.2 RCI, Lambert et al., 1996; Jacobson & Truax, 1991), in terms of the subjective positive global evaluation of the process made by both patient and therapist, and in terms of a change process evaluation carried out using the Generic Change Indicators system (see Krause, Pérez, Altimir & De la Parra, 2015).

Also, this is an influential case within our context (McLeod, 2010) and has received special attention for research and training purposes given its usefulness for understanding the change processes that might occur with patients with BPD in public health institutions. The ethical protocol for this follow-up study was approved by the ethics committee of Pontificia Universidad Católica de Chile. Both participants of the study signed an informed consent giving their authorization for the interviews and the session videos and transcriptions to be used for research purposes and related publications.

Researchers' reflexivity

As mentioned above, the present study is part of another research project. In the present case study, eight researchers from the above-mentioned research project team analyzed the case of Ms. B. Two of the authors of this paper (AT and CM) are principal investigators in that project, both psychologists with extensive experience in qualitative methods and psychotherapy process research. CM is also a dynamically-oriented psychotherapist and professor in a psychodynamic psychotherapy training program. The other two authors of this paper (JD and MF) are PhD students and experienced clinicians with a constructivist therapeutic orientation. JD is investigating mutual regulation processes in psychotherapy with a micro-phenomenological approach, while MF's research interests involve the experiences of psychotherapists doing psychotherapy. The other members of this team are psychodynamically-oriented clinicians and have previous experience in qualitative research. It is important to clarify that not all members of the research team are psychodynamically oriented. Therefore, we tried to maintain an open and empirically guided analysis and discussion in which all participants felt that their views of psychotherapy were properly reflected in this work.

All team members participated in the coding process of both transcribed interviews. AT and CM were familiar with the full therapeutic process of Ms. B. because of their participation in a prior research project involving her case, in their role as researcher and professor/trainer respectively, in the Psychodynamic Psychotherapy training program. The follow-up interviews were conducted by two members of the research team.

Procedure

Data Collection: Interviews

Semi-structured follow-up interviews, designed for each participant in the context of the above-mentioned project were conducted separately with patient and therapist six months after termination. In general terms, the patient's interview focused on how she had experienced the therapy process, what she had found to be helpful, and the identification of significant moments in the psychotherapy, while the therapist's interview mainly addressed her view of the patient and her difficulties, her symptoms, the construction of the psychotherapeutic process, her goals and work methods during it, and her understanding of the patient's change process. Both interviews lasted around one hour.

The opening question for the interview with Ms. B. was: "Tell me about your experience during your psychotherapy treatment. I would like to pick up your general impressions, whatever comes to mind". During the interview, six topics were examined: (1) Diagnosis and illness notions (e.g. what moved you to seek help? How did you get to therapy? How did you understand what was happening to you at the time?); (2) Therapy expectations (e.g. in what way did you think therapy could help you? Was therapy what you expected? Did unexpected things happen?); (3) Therapeutic relation (e.g. How would you describe the relation you established with your therapist? How did you feel with her? Did these feelings change during the therapy?); (4) Significant moments and interventions (e.g. What did your therapist do during session? What important things do you remember? Do you remember any particularly significant moments?); (5) Outcomes (e.g. How do you evaluate your therapy process? What do you think changed for you? Were there any negative results? Were there any unexpected results?); (6) Termination process (e.g. How did your therapy come to an end? Who decided it was time to finish the process? Do you think it ended in the right moment? What implications do you think this process may have for you in the future?).

A similar opening question was formulated for the therapist "I would like to ask you about the therapy process with Ms. B. How was that experience for you?". The same six topics were addressed: (1) Diagnosis and illness notions (e.g. Why did this patient come to therapy? Why do you think she decided to ask for help?); (2) Therapy expectations (e.g. How did you think psychotherapy could help this patient? Did unexpected things happen

during therapy?); (3) Therapeutic relation (e.g. How would you describe the relation you established with Ms. B.? How did you feel with her? How do you think these feelings changed during the therapy?); (4) Significant moments and interventions (e.g. How would you describe the evolution of this therapy? What interventions or techniques did you use? Were there any key interventions in this process? Were there any significant or relevant moments?); (5) Results (e.g. How do you appraise this therapy? What changes in the patient do you ascribe to the therapy process? Were there any unexpected results?); (6) Termination process (e.g. How did the therapy process come to an end? Who decided it was time to finish the process? How did you feel about the way this therapy ended?). Throughout the interview, both the patient and the therapist were encouraged to share anything they felt had been relevant for them or for the change process and to exemplify their reflections through specific events that had occurred during the therapy.

Analysis procedure

To better fulfill the purpose of this case study and construct an integrated understanding of the change process of a patient diagnosed with borderline personality disorder, we used a triangulation strategy (Patton, 1999). We combined two different analytic operations, described by two qualitative approaches, into a new model that we have called “Discovery Oriented Biographical Analysis”.

The first analytic operation used was the open coding procedure of the Grounded Theory approach (Charmaz, 2006; Corbin & Strauss, 2008). This procedure consists in developing the concepts and categories obtained from the data analysis. In order to do this, we approached the interpretation of the different fragments of the interview transcript with two analytic questions: ‘What is the text talking about?’ and ‘What does it say about the topic?’ The answer to the first question makes it possible to generate a concept or category (for example, the category “Context of the psychotherapy”, because in a certain fragment of the transcript, the therapist or the patient [or both] make references to the material or abstract circumstances in which the psychotherapy was conducted). The answer to the second question (i.e. What does it say about the topic?), applied to the same fragment of the transcript, allows us to develop the concept or category in terms of its properties or dimensions. For example, when the patient or therapist refer to the “Context of the

psychotherapy”, they might say it is a psychiatric institution or that it took place in a one-way mirror room.

For the first stage (open coding procedure), the team was divided into two sub-groups. Both groups coded both interviews separately in regular meetings (once a week) to conduct analyst triangulation (see Patton, 1999) of the data. After both interviews were coded by both groups, the whole research team held meetings to reach an intersubjective agreement regarding the emergent categories and their properties (Flick, 2002). As a result of this work, ten main categories emerged regarding how the patient and the therapist had experienced the psychotherapy: (1) Context, (2) Conditions for conducting the psychotherapy, (3) Reasons for consultation, (4) Expectation of change, (5) Transformation of change and attainment expectations, (6) Forms of therapeutic work, (7) Facilitators of psychotherapeutic change, (8) Therapeutic relationship, (9) Termination process of the psychotherapy, and (10) Representations. Each category contains several properties, some specific to one participant and some mentioned by both.

The purpose of the second analytic operation was to describe the narrative organization of the emergent categories identified during the open coding procedure. This was done using the “Construction of the Self in Biographical Narration Model” (Piña, 1988, 1989). This analysis model understands narratives as the product of the *subjective I*, which organizes, interprets, and signifies life events. To reconstruct the subject’s narrative, this model suggests the identification of contexts, stages, milestones, causality attributions, motivations, and references to moral orders throughout the interview narrative. Once this was done, the second step was to organize these categories in a way that allowed the research to reconstruct a new narrative for both participants. Afterwards, by identifying convergences between both reconstructed narratives (the patient’s and the therapist’s), an integrated narrative emerged which contained the particular and subjective view of each participant. This procedure finally led to the development of an integrated therapist-patient narrative that we organized into “chapters”, labeled according to relevant themes that reflected the therapeutic process with Ms. B. As a result of this second phase of analysis, four chapters were defined: “YouTube”, “I couldn’t change the past”, “The baby”, and “WhatsApp”.

In the third stage, we traced the transcript excerpts and passages of the therapy sessions where the themes described in the chapters occurred or were mentioned. This final stage was not central for the analyses but helped us to contextualize and corroborate the themes presented in this integrated narrative. The tracing of these sessions was conducted by AT due to her familiarity with Ms. B.'s psychotherapeutic process.

The Case of Ms. B.

Ms. B.'s therapy was a long-term process that lasted three years (88 weekly sessions). This therapy took place in a public psychiatric hospital of Santiago de Chile, in a Psychodynamic Psychotherapy Outpatient Unit. It was performed in a one-way mirror room and observed in full by psychologists in psychotherapeutic training, with all sessions being video recorded. The patient, by giving her informed consent, expressed her full awareness and acceptance of the setting conditions.

Ms. B. was 29 years old at the beginning of therapy. She was of low-income status and lived with her mother, her brother, her sister, and a little niece. She had pursued technical studies and worked in a call center as a supervisor. She had previously received psychiatric treatment when she was 17, due to her father's death. She was very close to him: as she recalls, she was the "apple of her daddy's eye", so her mother suggested treatment to prevent a breakdown. She received pharmacological treatment for two years. Later, at the age of 27, Ms. B. consulted a psychiatrist again, who gave her pharmacological treatment and recommended therapy, which she did not take at that time. Two years later, she decided to seek help again. This time she was diagnosed with a borderline personality disorder, with dependent personality traits, and a mixed adjustment disorder, for which pharmacological treatment and psychotherapy were indicated. Both diagnoses were made through clinical interviews conducted by psychiatrists in charge of receiving new patients in the psychiatric hospital. The personality disorder diagnosis was justified by her history of interpersonal instability and emotional overreactions related to frustrations and feelings of abandonment.

The patient started her current treatment thinking she was only going to receive pharmacological treatment, which she did not want. Even though she did not know very well how psychotherapy worked, she was pleased to have a space where she could talk about her difficulties and feel that someone would listen. During the first psychotherapy

session, she reported having suffered sexual abuse at the age of five. The perpetrator was her father's brother, with whom she occasionally stayed when her father was out of town due to his work obligations. She remembers telling her parents about this traumatic experience, but they did nothing at that time. Just before seeking professional help, she ran into her offender on the street. This encounter triggered flashbacks and vague memories about the episode. She was still suffering flashbacks when she started attending therapy, and felt she needed to repair something regarding this experience. She had tried to reach her uncle through Facebook, but did not receive a response. She also reported having problems at work, specifically with her superiors, with whom she was very confrontational. In the realm of social relationships, she was usually mistreated and was having problems with her couple or "friend with benefits", as she referred to him. Additionally, she had difficulties with separations and felt she had low self-esteem. The possibility of talking to someone who was empathetic, interested in what she had to say, and who paid real attention to her was fundamental for her to start working through her traumatic experiences.

Initially, Ms. B. did not associate her traumatic childhood experiences with her current disturbances. The treatment helped her link these difficulties to her past traumatic experiences, which had never been validated, and which were therefore always present. During therapy, she ended her romantic relationship and eventually found a new partner who was very kind and caring with her. After some time, she got pregnant and they had a baby. The termination of the psychotherapy process was worked through for about two months before the last session. The patient maintained sporadic contact with the therapist after the end of her psychotherapy.

The therapist, a 45-year-old woman, is a trained psychoanalyst with more than 20 years of experience. At the time of the therapy, she was working in her private practice and teaching at a psychodynamic trainee program at a psychiatric hospital. She treated Ms. B. in the context of this program. The psychotherapy was fully recorded and the therapist received feedback from the group that was watching and listening on the other side of the mirror.

Results

By reconstructing an integrated patient-therapist narrative, we identified four milestones mentioned as significant by both. These milestones allowed us to identify relevant and recurrent themes that were addressed and worked through during the therapy. Considering this, we decided to organize the reconstructed narrative into chapters, because they give a better account of the multilevel nature and the circularity of a psychotherapy process.

In each chapter, the main categories derived from the open coding procedure were arranged to form a narrative that accounts for the subjective construction of change in this case. These four chapters are “YouTube”, referring to the establishment of the psychotherapeutic relationship within a specific research context; “I couldn’t change the past”, referring to the working-through of the traumatic experience; “The baby”, denoting the therapeutic relationship as an emotional experience which includes extra-therapeutic events; and “WhatsApp”, indicating the continuity of the relationship beyond the end of the therapy.

“YouTube⁴”: The establishment of the psychotherapeutic relationship

This chapter is about the process of establishing the therapeutic relationship and how both patient and therapist had to overcome personal and professional issues to be able to create a psychotherapeutic relationship. The main categories used to construct this chapter are: context of the psychotherapy, conditions for conducting the therapy, and representations of the psychotherapy and of mental illness (see table 2.1).

Table 2. 1. Main Categories of the “YouTube” Chapter

Main Categories	Properties	Mentioned by
Context	Psychiatric Hospital	The patient recognizes the presence of other patients with serious mental disorders, which doesn’t match her perception of her own psychological problems.

⁴YouTube is a website where users can upload and share videos. It contains a variety of movie clips, television shows, and musical videos, as well as amateur contents such as videoblogs and gaming footage.

	Teaching	At times, the patient and the therapist feel that they are part of a “show” and the therapist mentions that the therapy may have been imposed by teaching objectives.
	Research	The patient mentions her mistrust due to the possibility of being exposed, and the therapist mentions her discomfort due to the cameras and the one-way mirror.
Conditions for conducting therapy	Setting	The therapist mentions the importance of a flexible setting.
	Demands on the therapy process – goals and tasks	The therapist mentions that the interventions were adapted to the context where the therapy was conducted, and she recognizes differences compared to her usual private practice.
	Relation of trust between patient and therapist	The patient and the therapist acknowledge how much the process benefited from the construction of a trust-based relationship between them.
Representations (a) Psychotherapy	Psychotherapy as an intimate relationship	The therapist regards the psychotherapeutic relationship as one of an intimate nature that can be affected in situations where the participants feel exposed, such as when the therapy is conducted in a room with a one-way mirror.
Representations (b) Mental Illness	Mental illness as a severe disability	The patient mentions that her psychological problems are not typical of psychiatric patients, who she associates with severe mental diseases that require incapacitating pharmacological treatments.

At the beginning of the psychotherapy process, the patient expressed her concerns about the future use of the recordings of the sessions and her fantasy that they may be uploaded to YouTube, even though she had previously been informed that the information collected

was confidential and would be used with discretion. In the same way, the therapist expressed her concerns about the teaching and research context of the psychotherapy and how “other” interests rather than the patient’s might guide this process. The therapist had the feeling, at times, of sharing with the patient the experience of being part of a “show”. During the follow-up interview, regarding the recordings, the patient said:

Well, at first everything was very strange, because looking at yourself with cameras, mirrors, with people behind a glass (...) in fact I even asked her [the therapist], “are you sure this won’t end up on YouTube?”. (Patient's Follow-up Interview)

Regarding the same topic, the therapist said:

I thought of the benefits this situation had for her, as a way to compensate for the feeling that being observed actually generated a certain conflict (...) that maybe she wouldn't have felt if we'd been in a more private setting, a more protected place. (Therapist's Follow-up Interview)

In this case, the therapeutic context seemed to be important in the process of constructing the subjective notion of psychotherapeutic change, because it modeled the patient’s expectations regarding the therapy, the difficulties that led her to seek help, and the initial quality of the therapeutic relationship. In other words, the “YouTube” chapter explains how the context—as both a shared cultural framework and a specific one where this particular encounter took place— contributed by shaping the establishment of the psychotherapeutic bond.

As shown in table 2.1, both interviewees make reference to how the psychotherapeutic situation (a research and teaching context in a psychiatric hospital) generated specific conditions for the fulfillment of the psychotherapy and the establishment of a therapeutic relationship. Therefore, the particular context in which the psychotherapy took place shaped the preliminary conditions of the process, such as the therapeutic setting, the goals and tasks expected from the therapist and the patient, and mainly the establishment of a relationship based on trust and safety. Likewise, the way the context affected and

generated the conditions for the psychotherapy was mediated by representations related to therapy and illness. For example, the therapist conceived psychotherapy as a private and intimate process, so the fact that this therapy took place in a one-way mirrored room and that all the sessions were recorded greatly affected her as a person and her experience of bonding with the patient. As illustrated below, the research and teaching context made this psychotherapy process especially difficult for her.

It was a good experience, but it was heavy because of its difficulty, it was an intimate situation, feeling like it was public and that somehow people would give their opinion, you came out of the room and that was followed by a discussion on what you'd done in the session, so there were some moments when you felt like telling people to "go to hell" so to speak, the ones behind the mirror, not the patient. I mean, you felt like grabbing the patient and taking her to a private space (...) so it was a presence that somehow probably made me behave a bit differently compared to a situation where nobody was looking. (Therapist's Follow-up Interview)

For the patient, being in a Psychiatric Hospital strained the representation that she had of her own problems and her ideas or images of mental illness. She perceived this context as menacing:

I was at a friend's house and when I got here, to my house I; in fact if I remember correctly, they brought me home because I wasn't okay and there I decided, I decided and said "No, I have to do this", but it was complicated when they told me that the therapy would be in the psychiatric hospital... and watching all those sick people, drooling and walking through the halls where I was. I said "I am not like that, then why am I here?" (Patient's Follow-up Interview)

Despite the initial difficulties and the fact that the theme of being observed by others was present throughout the process, it became less and less important as therapy progressed, allowing patient and therapist to work together and establish a trust-based relationship.

“I couldn’t change the past”: The working-through of the traumatic experience

Ms. B.’s traumatic experience in early childhood was a central theme of her therapeutic process. This chapter summarizes her transformation, showing how her original understanding of the problems and difficulties that motivated her to seek professional help gave way to a change in her perspective on what she had lived, allowing her to distinguish past from present and integrate both periods. During her therapeutic process, Ms. B. was able to understand that digging into the past and trying to change it would not necessarily allow her to “get better”. Instead, she had to integrate her traumatic experience and work it through in light of the present. The main categories used for the construction of this chapter are: representation of the problem, expectations of change, reasons for seeking help, and transformation of change and attainment expectations (see table 2.2).

Table 2.2. Main Categories of the “I couldn’t change the past” Chapter

Main Categories	Properties	Mentioned by
Reason for consultation	Explanations for the past	The patient states that her reason for seeking help is to find an explanation for her traumatic childhood experiences, in order to understand why her aggressor had sexually abused her.
	Resolve actual difficulties	The therapist mentions that the patient’s initial reason for seeking help was her need to solve some problems in her current interpersonal relationships (at work and with her partner).
Expectations of change	Results validated by the therapist	The patient mentions that she expected her changes resulting from the therapy to be validated and confirmed by her therapist: <i>“You have now completed a degree in your disease”</i> .

	Concrete, tangible results	The patient mentions that she expected concrete and tangible results from the therapy; for example, that the therapist would erase her traumatic experience and its effects.
	Fast change	The patient mentions that she expected a brief psychotherapeutic process in which her problems would be swiftly solved.
Transformation of change and attainment expectations	Being the same as before... but a little better	The patient mentions, as part of the transformation of her expectations regarding the therapy, that she sees her change as the preservation of a sense of continuity in terms of identity, but reinforcing its positive aspects.
	Finding a way to move forward	The patient mentions, as part of the transformation of the changes and achievements she expects from the therapy, her wish to continue living her life using the therapist's encouragement but without needing it later on.
	Self regulation through reflection	The patient and the therapist mention that one change in the therapy is the patient's ability to self-regulate negative affects, not denying them but rather reflecting on them.
	Accepting the non-changing past	The patient mentions that a relevant transformation of her change expectations involved realizing that it was not possible to erase the traumatic events of her past –she understood that the answer to her problems was not there.

	Working on updating the conflict in the present	The therapist mentions that a change in the patient's change expectations concerned her willingness to work, in the present, on the current manifestations of her past conflicts.
Representations (c)The psychological problem	Dysfunctional relational patterns and re-actualization of conflicts	The therapist regards psychological problems as the reemergence of dysfunctional relational patterns formed in response to early traumatic experiences.

These categories were important in the process of constructing the subjective notion of psychotherapeutic change because they helped us understand what underlies the process of transformation of the participants' expectations and representations of change.

"I couldn't change the past" discusses the origin and permanence of the patient's initial psychological problems and the future possibilities of resolving them. It is a past that makes itself present or a present trapped in the past. This idea was in Mrs. B.'s narrative from the first session onwards, when she told the therapist that after accidentally bumping into her offender on the street she started having flashbacks of the abuse:

Yes, that's when I started, I started to have some flashbacks, in fact I was dating at the time and I was with my boyfriend and I saw him [the offender], and my boyfriend was a little violent and had his smile, some gestures like him, so this shocked me because I had him every day here in my head. (...) I want to close this chapter, that's what I wrote to him in an email: "I want to close this and forget you", and put it behind me, like he never existed. (Therapy Session 1)

The idea of the present trapped in the past can also be recognized in the therapist's follow-up interview, when she was asked about the patient's reason for seeking help:

What I remember about her reasons for seeking help is that she wanted to be able to have a relationship, and at the time she was in love with a guy did not love her and treated her badly,

he was like her friend with benefits (...) he always told her that if she were prettier or skinnier, then maybe he could love her. So it was a sadomasochistic relationship, she kept him close (...) she was very good at her job, she worked in a call center and was doing great (...) and she made tons of money and she used that money to invite him to concerts, buy him expensive sneakers, but she was fully aware of what she was doing. So one thing was that she knew the relationship wasn't going anywhere (...) and as a backdrop to this, chasing guys that kept running away and running away from guys who wanted to be with her, the issue of sexual abuse came up, that an uncle had abused her. She told a story of trauma, of how her family reacted, and how dealing with this in her family became a major issue, I mean the recognition of this trauma. (Therapist's follow-up interview).

The main category, “Transformation of change and attainment expectations”, contains the notion that therapeutic change implies a repositioning of what is in the past and cannot be modified and the possibilities for a re-appropriation of this experience in the present. This idea could be identified in both the patient's and the therapist's follow-up interviews:

I think they made me realize that I couldn't change things, that they were the way they were and that I couldn't keep looking for explanations where there weren't any. So realizing that this was not going to happen and that I had to find a way to move on without that answer that I wanted so much (...) I kept looking for the answer, but she made me understand that the answer wasn't there. (Patient's Follow-up Interview).

This was part of the working-through process, you see? To be able to give the traumatic theme its own place, which was in the past, and not see it as something that was always present. It was present for her the whole time and I think that through a more interpretive work that theme could be placed in the past, so it wouldn't be here and now all the time (Therapist's follow-up interview).

As expressed in the above quotations, although the reasons for consulting recalled by the patient and the therapist differ in terms of the problem identified, in more abstract terms they were both embedded in a specific moment in time: the patient was trying to resolve a traumatic experience from the past, while the therapist was identifying difficulties of the

patient that persisted in the present, picturing their resolution in the future, and finally discovering the relationship between her present difficulties and the traumatic event in the patient's childhood.

In the therapeutic encounter, these initial reasons for seeking help were shaped by the therapist's representations of the psychological problem –the problematic relationship between past and present and its permanence in the present and the future– and the patient's expectations regarding how psychotherapy could be helpful for her. In this process of negotiation and reformulation of the patient's reason for consulting, her representations and expectations of change were transformed from *“forgetting”* and *“looking for explanations”* into *“leaving things in the past”* and *“becoming the same as before... but a little bit better”* (Patient's Follow-up Interview); in other words, untying the knot that bound her to the past and kept her from *“following her own path”* (Patient's Follow-up Interview).

“The baby”: The therapeutic relationship as an emotional experience

This chapter describes how the disruption of what the patient expected from the therapist and the psychotherapeutic process gave both participants the opportunity to meet on a different level of their relationship and allowed the patient to explore a new form of relating to others.

The main categories used to construct this chapter refer to the therapeutic interventions conducted and to emotionally significant moments. These categories are: forms of therapeutic work, facilitators of therapeutic change, and therapeutic relationship (see table 2.3).

Table 2.3. Main Categories of “The baby” Chapter

Main Categories	Properties	Mentioned by
Forms of therapeutic work	Adapting interventions	The therapist mentions the use of specific intervention techniques (e.g. interpretation of transference, working on the patient's dreams) but highlights the importance of

		adapting her interventions to the patient's needs, thus flexibilizing the therapeutic setting.
Therapeutic listening		The patient mentions that a relevant aspect is the feeling that the therapist listens to her, an activity characterized as judgment-free and soothing.
Facilitators of therapeutic change	Therapist's spontaneous and close style	The therapist mentions that, in her opinion, her spontaneity and closeness with the patient was an aspect that facilitated her change process, because it contributed to the construction of a positive bond and helped her convey her affection to the patient.
	Unconditional acceptance	The therapist mentions that an aspect that facilitated the patient's change was her attitude of unconditional acceptance, neither judging nor evaluating her actions.
	Emotional experience	The patient and the therapist both mention that an important facilitator of the patient's change was that the therapeutic relationship constituted an intense and positive emotional experience.
Therapeutic relationship	Mutual affection	The patient and the therapist note that they really cared for each other and that this was a particular characteristic of their therapeutic relationship.
	Containment	The patient and the therapist mention that the therapeutic relationship they established provided containment to the patient.

Mutual confidence	The patient and the therapist both mention their mutual trust (that of the patient in the therapist's genuineness and that of the therapist in the patient's resources) as a relevant characteristic of their relationship.
Genuine relationship	The patient and the therapist reveal their feeling that this therapeutic relationship was a "real" relationship, mainly due to the genuineness of their mutual affection and the therapist's concern for the patient's needs.

These categories were important in the process of constructing subjective notions of psychotherapeutic change because they model the process of change itself. "The baby" allowed us to reflect on the nature of psychotherapeutic interventions, their scope, their singularity, and their emotional power.

The patient's desire to become a mother was confronted with her fears of repeating relational patterns and being neglectful and abusive to her baby, in the same way her mother had been with her. This conflict was present since the beginning of therapy and became a thematic axis throughout the therapy process. At the end of the first year of psychotherapy, Ms. B. became pregnant. Although in several of the previous sessions she had expressed her desire to have a baby, once she was pregnant she started showing regret. These feelings were expressed by the patient in-session:

I always said "I would like to have a baby", because I thought that if I had a baby, I could give her the things they didn't give to me (...), but I have this thing where I imagine I'll touch the baby, I'll do things (...), and perhaps the baby will feel all I'm feeling and that would be awful.

As seen above, it seems that her pregnancy connected her with all her fears about being a bad mother, incapable of protecting her baby from others or even herself, which resembles her experience with her own mother, who did not recognize the sexual abuse suffered by

her own daughter. Due to these circumstances, the therapist seemed to realize that this issue was greatly relevant for the patient, so when the baby was born she decided to visit her at the hospital. This decision to move out of her ordinary form of intervention and make a spontaneous gesture created a highly significant moment for both, changing the course of the therapy and their relationship. This moment was preserved in their memories as something special; as the follow-up interview shows, the therapist recalled this visit in the following way:

You know, compared with other patients I treated at the hospital in all my years there, this patient was stronger. Perhaps because I wasn't working in the [psychiatric] hospital anymore [as a psychotherapist] ... it was a special situation for her and for me. So I thought: "she is the only patient I have visited when she was having a baby. Why?" Well partly because hospitalization had never been so traumatic for any other patient. I mean, I felt it was a therapeutic need. (...) It was beautiful... I also talked a lot with the patient's partner, I met her mother, I got to see the baby, somehow, I felt like I was part of this family. (Therapist's follow-up interview).

For the patient, this visit also stood out as an important experience. She reflected on it during the follow-up interview:

I saw her as a professional like any other, and I'm a loving person, I give a lot to others and so I said to myself, "why so much love? She is only doing her job" (...) when I had my daughter and she came to the hospital with a little bouquet of flowers, I said "she is here", and I did not expect such displays of affection in a therapy; I always dreamed of these things (...) she is not only a doctor or a professional, I'd always waited for this. At least from the other psychologists and psychiatrists that I had; I didn't expect these things now, because I thought they just did not happen. (Patient's follow-up interview).

"The baby" led us to reflect upon the therapeutic actions that both the patient and the therapist identified as a contribution to psychotherapeutic change, in their own subjective experience. Seemingly, the therapist's visit at the hospital resulted in the consolidation of

some aspects previously worked on during therapy, mainly the issue of trust and the therapist's genuine interest in the patient's wellbeing.

Although the therapist referred to the use of specific techniques in her job, she emphasized the importance of adapting her interventions to the specific needs of the patient. On the other hand, the patient had the feeling that the therapist listened to her, and recognized the action of being listened to as therapeutic in itself. Both the patient and the therapist recognized the value of these therapeutic actions embedded in a particular relationship; a relationship characterized by mutual manifestations of affection and unconditional acceptance, where the therapist did not judge the patient, where the patient could trust the therapist, and where the therapist could rely on the patient's own resources. A relationship that could soothe the patient.

In this interplay between forms of therapeutic work and the construction of a positive therapeutic relationship, several references to facilitators of change emerged. These mentions revealed the importance of the “person-to-person” encounter beyond the participants' roles, characterized by spontaneity and the genuine manifestation of emotions and affections. The hospital encounter became a powerful intervention in its own right because it gave its participants the possibility of experiencing the therapeutic relationship as an emotional experience.

“WhatsApp⁵”: The continuity of the relationship

This chapter is about the termination process and the maintenance of the relationship over time. The main categories converging in “WhatsApp” are the termination process and the participants’ representations of therapeutic change. These categories were important in the process of construction of the subjective notion of psychotherapeutic change because they gave a perspective of the achievements of the psychotherapy (see table 2.4).

5 WhatsApp is an instant messaging application for smartphones that sends and receives messages through the Internet complementing email, instant messages, short message service, and multimedia message systems. Besides being able to send text messages, users can create groups, send images, videos, and audio recordings.

Table 2.4. Main Categories of the “Whatsapp” Chapter

Main Categories	Properties	Mentioned by
Termination process	It is a therapeutic action	The therapist mentions that, for her, the termination process was an additional therapeutic action because it demanded a working-through process.
	It is negotiated	The therapist mentions that the termination of the therapy was a consensual decision, made together with the patient.
	It is multidetermined	The patient and the therapist mention that the reasons for terminating the therapy were varied and concerned both practical issues and others involving the patient’s ability to go on without the therapist’s aid.
	It is an evaluative instance	The patient and the therapist regard the termination process as a time when they were able to put into perspective the patient’s achievements and changes, along with the issues that they did not manage to fully solve.
	The therapy finishes, the relationship remains	The patient and the therapist mention that the termination process involved the end of the psychotherapeutic process but not of the relationship, which allows the participants to stay in touch and initiate a new therapy if necessary.
Representations (d)Therapeutic change	Autonomy in handling problems	The therapist mentions that the patient’s autonomy in handling problems, not a lack of them, is a therapeutic change that she thinks the patient attained.

Gratification	The patient mentions that the feeling of well-being and satisfaction with herself was indicative of her therapeutic change.
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Both participants described the termination process as a therapy that comes to an end, but also as a relationship that remains. The decision to end the therapy was suggested by the patient, because she had started a new job that made it difficult for her to keep attending therapy. Two months passed between the first time they discussed the possibility of terminating the therapy and the last session. The therapist gave her telephone number to the patient, allowing her to get in touch via “WhatsApp” even after the end of the therapy. This situation, mentioned by both in the follow-up interviews, gave us the chance to think about the termination process and about what really ends when a psychotherapeutic process is over, as these fragments of both follow-up interviews suggest:

She sent me a “whatsapp” message during the holiday period and I answered her by “whatsapp”, and later she told me that she expected a call (...) so I think that separations were problematic for her, and I have the fantasy that the final separation was also difficult for her (...) the therapy was to end after the holidays (...) she found a very good job, and she suspended the therapy because of this job, because our schedule was no longer suitable for her. We had talked about the discharge, but perhaps there wasn't enough time to work it through. So I think that her clinginess, the necessity to call me, suggests a premature discharge (...) [but the idea of ending the process was introduced] because she started feeling well, thinking by herself (Therapist's follow-up interview).

First, when we finished the therapy, the therapist gave me her telephone number. Then at one point I felt super bad and I called and went to her office and talked. But later I analyzed that I did it to know if she was still there (...) It was not like we finished the therapy and said “bye-bye, I don't know you anymore”. So, for me it was that (...) it was an excuse to know if she was there or not. Indeed, sometimes I send her a “whatsapp”, something like “hello, how are you?”, “fine, and you?”, and “bye” (...), to know that she is there, that I have her on “whatsapp” and I can contact her (Patient's follow-up interview).

In the follow-up interviews with the participants, the termination process of the psychotherapy was regarded as one more therapeutic action and as a negotiation involving issues related to the concrete conditions for conducting the therapy and evaluative issues about the patient's process of change. On the latter point, it seems that the ideal closing process was different for each participant. The therapist expected a formal closing process, while the patient expected it to meet her own needs. However, it is interesting to note that, in the subjective experiences of both participants, this process involved a reconfiguration of the therapeutic relationship: as mentioned above, the therapy ends, but the relationship remains.

On the other hand, the closing process helped to account for what had changed in the patient: a change experienced as a new subjective position that enabled her to handle her problems with autonomy, leaving her with a feeling of gratification for who she is now and integrating this new view into her identity. Regarding this aspect, Ms. B. said in the interview: “remembering how you used to be and thinking about how you are now... it is very gratifying”.

Discussion

The patient says, “I couldn’t change the past, the answer wasn’t there”. Where was the answer, then? We think this question can be approached from different viewpoints that can contribute to a better understanding of how certain aspects of a psychotherapy process could affect therapeutic change in a patient with BPD.

Firstly, the answer seems to lie somewhere in the patient-therapist relationship, where the experience of change is embodied: in the establishment of the therapeutic relationship, in the working-through of the traumatic experience within this relation, in the experience of emotionally significant moments within it, and in the continuity of the relationship.

In this case, the fact that Ms. B. progressively relaxed her state of vigilance regarding signs of hostility and threat in others (i.e. the therapist, the team behind the mirror, and her romantic partner) seems to be both a condition for her change and change in itself. This can be observed, for example, in Ms. B.’s ability to establish a positive romantic relationship and have a healthy motherhood (Fonagy, Luyten, Campbell, & Allison, 2014).

As Fonagy and Allison (2014) state, change in psychotherapy consists in the possibility of recovering epistemic trust; in other words, psychotherapy seems to work because we learn to trust those who help us learn about ourselves. Epistemic trust is trust in the authenticity and personal relevance of the information transmitted in an interpersonal space, which contains aspects that facilitate the patient's adoption of a confident attitude of openness towards the exploration of the self and others, and is promoted by a secure environment. Therefore, in the psychotherapeutic context, the recovery of this trust is what allows a patient to learn from new experiences and accomplish changes in his/her way of understanding social relationships and his/her own behaviors and actions (Fonagy & Allison, 2014).

The four-chapter sequence that provides a narrative organization for the subjective construction of this case reveals the process through which Ms. B. recovered her trust in others. In "YouTube", we can see how she moves from mistrust, expressed in her doubts about a potentially abusive therapeutic context, to trusting the therapist and the therapy, opening up a space for learning and reflecting upon herself and others. In "I couldn't change the past", the abuse experienced by the patient as a child and her reasons to mistrust others are updated in her frustration due to not getting the answer she so desperately wants, which is followed by her attempt to move on without it. In "The baby", it seems that a trust-based relationship is finally consolidated, because the patient is certain that her therapist's feelings towards her are genuine and that she really cares for her. The patient's reflective exploration is protected in a safe relationship. Lastly, in "WhatsApp", we can see that the therapist remains present, as does trust, which allows the patient to apply the knowledge built through this specific experience to other contexts and relational experiences. These findings are consistent with Larivière et al.'s (2015) work, where letting go of the past and having healthy relationships are considered fundamental dimensions of recovery for patients with BPD. Our findings are also in line with Araminta's (2000), which show that both therapist and patient seem to highlight the relevance of relational aspects of therapy as strongly contributing to a positive outcome. We stress the importance of a therapist who proves through actions that she is reliable, genuine, thoughtful, and responsive to her patient's needs. In line with Winnicott's (1960) work, it is possible to say that the trustworthiness of the therapist is essential: as the patient

did not experience trust in her early relationships with primary caretakers, she had to find it in the therapeutic relationship to be able to use it for the first time.

Similarly, we must also underline the importance of the flexibility of the therapist's interventions. These interventions, adapted to the patient's needs, are what both participants remember the most. The therapist's flexibility allows her to be positively influenced by the emergent context of the psychotherapy, which is in line with Kramer and Stiles' (2015) notion that "therapists deliver therapy by responding to clients' requirements and characteristics as they emerge in the therapy process, using the principles and tools of their approach" (p. 278). From this perspective, psychotherapy is more likely to be understood as a non-linear, dynamic, and heterogeneous phenomenon rather than as a simple linear process. So, in metaphorical terms, instead of thinking of the psychotherapeutic process as if it were a race track, would it not be more suitable to regard it as a chessboard? What is the range of movements that these boards allow us? How do we construct different game styles? What are the patterns and variations that we can use for a certain type of match? And in what way do the answers to these questions describe or indicate the expertise of the player, regarding not only the game in general but also each individual match? Therefore, considering the cumulative knowledge available about therapy, it becomes fundamental to ask ourselves one question: how do the therapist and the patient learn to be with each other? This issue can be assessed upon the basis of the reflections put forward by Stern et al. (1998, 2002) and Lyons-Ruth et al. (1998) on implicit relational knowledge, which is procedural knowledge about interpersonal and intersubjective relations that shows us how to 'be' with someone. In therapy, each member of the dyad has his/her own relational histories, but the context of psychotherapy and its affectively charged moments become the perfect potential space for the patient to generate new forms of shared experiences that are constructed in that particular process and in that particular encounter as shared implicit knowledge.

The therapeutic moments depicted in the analysis of Ms. B.'s case are experienced by both the patient and the therapist as *something more* than just making the unconscious conscious (Stern et al., 1998). As the Boston Change Process Study Group states in its work, "[s]omething more has taken the form of psychological acts versus psychological words (...) of a mutative relationship with the patient versus mutative information for the

patient” (Stern et al., 1998, p. 903). In this regard, change in psychotherapy occurs precisely *in* the interaction, specifically, in certain moments of connection between the patient and the therapist during the therapeutic process. These moments can alter the course of the relationship, allowing the patient’s implicit relational knowledge to be transformed and reconfigured (Stern et al., 1998, 2002; Stern, 2004).

In “The baby”, the patient refers to the therapist’s visit to the hospital by saying “I did not expect this”. This “unexpected” quality is introduced as a core aspect of the subjective experience of psychotherapeutic change. But how is this quality introduced? We think that it enters the process as a corrective emotional experience. This term, in its original sense (Alexander & French, 1946), refers to the possibility of thinking about the change process outside the field of insight and consciousness and placing it in the field of the therapeutic relationship and action, that is, within the patient’s ability to interact with the therapist in a way that is different from what he/she knows, which is grounded on early relations with significant others (Goldfried, 2012). In a more current definition, corrective experiences in psychotherapy lead to the disconfirmation of patients’ expectations (conscious or unconscious) as well as to an emotional, interpersonal, cognitive, and/or behavioral shift. In these experiences, patients can re-encounter not only previously unresolved conflicts, as Alexander & French (1946) state, but also previously feared situations, reaching different outcomes in terms of their own responses, the reactions of others, or new ways of dealing with them (Hill et al., 2012). In the case of Ms. B., the unexpected visit of her therapist seems to have been a way of crystallizing something they had been working on throughout the therapy process, allowing her to see others differently for the first time in a very long time. Ms. B. is not only able to see others as genuine and trustworthy: in this same light, she is also able to see herself as a person who can receive the affection of others.

It is interesting to consider the fact that two of four significant events mentioned by the patient and her therapist regarding the psychotherapy took place in an extra-therapeutic setting (referenced in ‘The Baby’ and ‘WhatsApp’). In this case, that of a woman diagnosed with borderline personality disorder, a major factor of change perceived by the patient and her therapist is their encounter within a psychotherapeutic relationship. The establishment and maintenance of this relationship could be understood as a corrective

emotional experience (Hill et al., 2012) that provides a sense of being accompanied in life by the therapist. Considering the characteristics of corrective emotional experiences, the notion of being in therapy could be extended beyond the therapeutic setting and the significance of encounters in extra-therapeutic settings could be highlighted. Particularly in a long-term psychotherapeutic process, the sense of accompanying and being accompanied in life is part of the therapeutic experience, and it could be posited that changes in therapy and in life are part of a reciprocal dynamic.

As we stated in the introduction, this study was conducted following the principles of first- and second-person research (Fuchs, 2010), generative research (Stiles, 2015), and Practice-Oriented Research (POR; Castonguay, Barkham Lutz, & McAleavey, 2013), addressing the day-to-day concerns of clinicians and recognizing that therapists' actions and interventions are influenced by patients' characteristics and behaviors, which are more or less constantly changing (Stiles, 2009) and thus require permanent mutual regulation. In other words, what happens in psychotherapy is influenced by the emergent context, and so research should attempt to consider this issue at least to some extent (Orlinsky, Ronnestad, & Willutzki, 2004). We consider that the above-mentioned forms of research offer evidence that can be applied to clinical practice in a flexible way, giving clinicians the possibility of tailoring research findings to their particular context and to each individual patient. In this line of work, the present research design enriches psychotherapy research through a single case study focused on the subjective experience of a patient and his/her therapist, considering a specific diagnosis. The reconstruction of an integrated narrative, organized around milestones that represent central themes –chapters– worked on through the psychotherapy, sheds light on those aspects that appear as marking the course of this specific psychotherapy process from the perspective of both participants and the researchers.

The latter is compatible with the understanding that life is a recursive experience rather than a linear one (Salvatore & Tschacher, 2012), which includes psychotherapy if it is conceived as a life experience. This recursiveness is results from the act of meaning (Bruner, 1990) or signification of the lived experience, connecting present with past and future and with subsequent changes in the narrative. Thus, the organization of the narrative

into so-called chapters, rather than into events or key moments, could be a meaningful distinction reflecting the recursive nature of human change processes.

As Castonguay, Barkham, Lutz, and McAleavey (2013) point out, these lines of research help to construct a more robust knowledge base in the field of psychotherapy by complementing evidence-based research (Barkham & Margison, 2007; Barkham, Stiles, Lambert, & Mellor-Clark, 2010) with additional methods that have unique strengths and with convergent observations derived from different methodologies and epistemologies (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Understanding the singular experience of the participants of this psychotherapy, as well as observing and studying this dynamic and constantly changing process, constitutes a challenge for empirical psychotherapy research. In this regard, the present study has several limitations.

A first limitation of this study is that the analysis may heighten the common aspects of the experiences of the patient and her therapist and the coincidences between their perspectives in the reconstruction of an integrated narrative. This means giving an account of only some aspects of the subjective experience of the therapeutic process –in our opinion, a highly relevant approach, but one that fails to fully account for the phenomenon. This analytical decision, however, results from the fact that a striking feature in this case is the strong resemblance between the individual narratives of both participants. In future case analyses, it would be interesting to select cases in which patients and therapists differ in their overall evaluation of the therapeutic process or provide similarly negative opinions. In such cases, we should pay close attention not only to points of convergence, but to divergent elements as well.

Regarding methodological issues, a single case study design contributes to a deeper understanding of a specific psychotherapy process, but is also limited in terms of its power to approach the object of study in a broader way. In order to address this issue, it is necessary to conduct other single case studies with patients with this or other diagnoses, which would make it possible to analyze the convergences and divergences between these cases and identify the core aspects of change processes.

Conducting retrospective interviews about a psychotherapy three to six months after termination can elicit doubts regarding the fidelity of the participants' memories.

Regarding this point, even though it is true that this temporal distance entails a cost in terms of the richness of the participants' account, it is a choice that results in a much broader perspective on change and gives participants the opportunity to reflect on how the experience of therapy fits into other aspects of their lives (N. Midgley, personal communication, August 2, 2014). In this context, it seems important to mention that both participants were asked (at the end of the retrospective interview) about their feelings regarding the interview, and both agreed that it was a useful moment to give their experience a new meaning. This is congruent with the idea that every act of meaning (by recalling and narrating) transforms the lived experience into a new one (Bruner, 1990; Fuchs, 2010; Piña, 1999).

Another limitation has to do with the possibility that the emergent relevance of the therapeutic encounter could have been influenced and biased by the therapeutic orientation of the researchers despite their different theoretical orientations (psychodynamic and constructivist). It is important to acknowledge that, in this study, interpersonal understanding helped us guide our reflections and thoughts for the discussion. Nevertheless, it was based on generic ideas that are shared by different psychotherapeutic approaches. For example, even though the original notion of corrective experience is psychodynamic, we based our discussion on literature in which the concept is discussed trans-theoretically.

Finally, we can conclude that research on the subjective experiences of psychotherapy must consider both patient and therapist as privileged but always complementary witnesses of their interaction. In addition, it should be noted that the experience of studying this biographical reconstruction generates a space where research and practice converge. The analysis of participants' narratives provides fascinating windows into their perceptions of psychotherapy and the process of change (Safran, 2013); here, the researcher is not merely a privileged observer or a good summarizer: he/she has the chance to imbue the psychotherapy with a new meaning by connecting it with a common set of knowledges and a body of socially shared experience.

References

- Adler, J. (2013). Clients' and therapists' stories about psychotherapy. *Journal of Personality*, 81 (6), 595-605.
- Alexander, F. & French, T. (1946). *Psychoanalytic Therapy*. New York: Ronald Press.
- Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomicic, A., Valdés, N., ..., & Pérez, J.C., (2010). Clients', therapists' and observers' perspectives on moments and contents of therapeutic change. *Psychotherapy Research*, 20, 472 – 487. doi: 10.1080/10503301003705871
- Araminta, T. (2000). Dialectical behavior therapy: A qualitative study of therapist and client experience. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 61(1-B), 520.
- Athanasiadou-Lewis, C. (2016). My subdued ego: A psychodynamic case study of borderline personality disorder following relational trauma. *Psychodynamic Practice*, 22 (3), 223-235. doi: 10.1080/14753634.2016.1198274
- Barkham, M. & Margison, F. (2007) Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In C. Freeman and M. Power (Eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 443-476). Chichester: Wiley.
- Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge-base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence: A guide for the psychological therapies*. (pp. 21–61). Chichester: Wiley.
- Blatt, S. (2013). The Patient's Contribution to the Therapeutic Process: A Rogerian – psychodynamic Perspective. *Psychoanalytic Psychology*, 30, 139– 166 doi 10.1037/a0032034
- Bohart, A. C. & Wade, A. G. (2013) The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behaviour change* (6th ed., pp. 219-257). Hoboken, NJ: Wiley.

- Bourke, M. & Grenyer, B. (2013) Therapists' accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of Personality Disorders*, 27(6), 735-745. doi: 10.1521/pedi_2013_27_108
- Braakmann, D. (2015) Historical Paths in Psychotherapy Research. Foundations, Process and Outcome. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 39-65). New York: Springer-Verlag.
- Bruner, J. (1990). *Acts of Meaning*. Harvard University Press.
- Castonguay, L. & Muran, J.C. (2015) Fostering collaboration between researchers and clinicians through building practice-oriented research: An introduction. *Psychotherapy Research*, 25:1, 1-5. doi: 10.1080/10503307.2014.966348
- Castonguay, L.G., Barkham, M., Lutz, W., & McAleavey (2013). Practice-oriented research: Approaches and applications. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (6th ed., pp. 85-133). Hoboken, NJ: Wiley.
- Castonguay, L.G., Boswell, J.F., Constantino, M.J., Goldfried, M.R., & Hill, C.E. (2010). Training Implications of Harmful Effects of Psychological Treatments. *American Psychologist*, 65, 34-49.
- Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. Los Angeles, CA: Sage.
- Corbin, J. & Strauss, A. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (3rd ed.). Thousand Oaks, CA: Sage
- De la Cerda, C., Tomicic, A., Pérez, C., & Martínez, C. (2017). Mentalizing in the psychotherapeutic process: The reflective functioning of patient and therapist in psychotherapy. *Paper under review for publication*.
- Dimaggio, G., Salvatore, G., MacBeth, A., Ottavi, P., Buonocore, L., & Popolo, R. (2017). Metacognitive interpersonal therapy for personality disorders: A case study series. *Journal of Contemporary Psychotherapy*, 47(1), 11-21. <http://dx.doi.org.uchile.idm.oclc.org/10.1007/s10879-016-9342-7>

- Eells, T. D. (Ed.). (2007). *Handbook of psychotherapy case formulation (2nd ed.)*. New York: Guilford Press.
- Elliott, M. & Williams, D. (2003). The client of counselling and psychotherapy. *Counselling Psychology Review*, 18 (1), 34-38.
- Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. En L. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 249-286). New York: Guilford Press.
- Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1): 1-21.doi: 10.1080/713869614
- Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research*, 18, 239-242. doi: 10.1080/10503300802074513
- Fishman, D.B. (2005). Editor's introduction to PCSP- from single case to database: a new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy*, 1(1): 1-50.
- Flick, U. (2002). *An introduction to qualitative research* (2nd ed.). New York: SAGE.
- Fonagy, P. & Allison, L. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, 51(3), 372-380.doi: 10.1037/a0036505
- Fonagy, P., Luyten, P., Campbell, C., & Allison, L. (2014). Epistemic trust, psychopathology and the great psychotherapy debate. [Web Article]. Retrieved from <http://www.societyforpsychotherapy.org/epistemic-trust-psychopathology-and-the-great-psychotherapy-debate>
- Frankel, Z. F. & Levitt, H. M. (2008). Clients' experiences of disengaged moments in psychotherapy: A grounded theory analysis. *Journal of Contemporary Psychotherapy*, 39, 171-186.doi: 10.1007/s10879-008-9087-z
- Fuchs, T. (2010). Subjectivity and Intersubjectivity in Psychiatric Diagnosis. *Psychopathology*, 43, 268-274. doi: 10.1159/000315126

- Galassi, J. P. & Gersh, T. L. (1993). Myths, misconceptions, and missed opportunity: Single- case designs and counselling psychology. *Journal of Counselling Psychology*, 40, 525-531.doi: 10.1037/0022-0167.40.4.525
- Goldfried, M. (2012). The Corrective Experience: A Core Principle for Therapeutic Change. In L. Castonguay & C. Hill (Eds.), *Transformation in Psychotherapy. Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches* (pp. 13-28). Washington D.C.: American Psychological Association.
- Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, 17, 15-30. doi:10.1080/10503300600720390
- Gullestad, F. & Wilberg, T. (2011). Change in reflective functioning during psychotherapy—A single-case study. *Psychotherapy Research*, 21(1), 97-111. <http://dx.doi.org.uchile.idm.oclc.org/10.1080/10503307.2010.525759>
- Helmeke, K. & Sprenkle, D. (2000). Client's perceptions of pivotal moments in couples' therapy: a qualitative study on change in therapy. *Journal of Marital and Family Therapy*, 26, 69-483.
- Higa, J. & Gedo, P. (2012). Transference interpretation in the treatment of borderline personality disorder patients. *Bulletin of the Menninger Clinic*, 76(3), 195-210. doi: 10.1521/bumc.2012.76.3.195
- Hill, C. E., Williams, E. N., Heaton, K. J., Rhodes, R. H., & Thompson, B. J. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counselling Psychology*, 43, 207-217.doi: 10.1037/0022-0167.43.2.207
- Hill, C., Castonguay, L., Farber, B., Knox, S., Stiles, W.B., Anderson, T., ...& Beck, J. G. (2012). Corrective Experiences in Psychotherapy: Definitions, Processes, Consequences and Research Directions. In L. Castonguay & C. Hill (Eds.), *Transformation in Psychotherapy. Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches* (pp. 355-370). Washington D.C.: American Psychological Association.

- Hilliard, R.B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology*, 61, 373-380. doi: 10.1037/0022-006X.61.3.373
- Hodgetts, A., Wright, J., & Gough, A. (2007). Clients with borderline personality disorder: Exploring their experiences of dialectical behavior therapy. *Counselling and Psychotherapy Research*, 7(3), 172-177. doi: 10.1080/14733140701575036
- Horn, N., Johnstone, L., & Brooke, S. (2007) Some service user perspectives on the diagnosis of Borderline Personality Disorder. *Journal of Mental Health* 16(2): 255 – 269. doi:10.1080/09638230601056371
- Iwakabe, S. & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research* 19, 601 – 611. doi: 10.1080/10503300802688494
- Jacobson, N.S & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy-research. *Journal of Consulting and Clinical Psychology*, 59, 12-19.
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Consulting and Clinical Psychology*, 67, 332–339. doi: 10.1037/0022-006X.67.3.332
- Kivlighan, D. M. & Arthur, E. G. (2000). Convergence in client and counsellor recall of important session events. *Journal of Counselling Psychology*, 47, 79-84.
- Knox, S., Hess, S., Petersen, D., & Hill, C. (1997). A Qualitative Analysis of Client perceptions of the Effects of Helpful Therapist Self-Disclosure in Long-Term Therapy. *Journal of Counselling Psychology*, 44, 274-283.
- Kramer, U. & Stiles, W. B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice*, 22, 277-295. doi: 10.1111/cpsp.12107
- Krause, M, Abarzúa, M, Silva, M, Navarro, D, Altimir, C (2016). Psychotherapie aus der Sicht von Klienten mit Schizophrenie. *Verhaltenstherapie & psychosoziale Praxis*, Volumen 48 Issue 1 (p. 83)

- Krause, M. & Martínez, C. (2011). Dynamics of subjective change in psychotherapy. A comment on the Paper "Dynamics of sense-making and development of the narrative in the clinical exchange" by Alessandro Gennaro, Miguel Gonçalves, Inês Mendes, António Ribeiro, & Sergio Salvatore. *Research in Psychotherapy*, 14(2), 14-12.
- Krause, M., Pérez, J. C., Altimir, C., & de la Parra, G. (2015). Generic Change Indicators in Therapeutic Processes with Different Outcomes. *Psychotherapy Research*, 25, 5, 533-545, DOI: 10.1080/10503307.2014.935516.
- Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., ... & Yanchar, S. C. (1996). The Reliability and Validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy*, 3, 249-258.
- Landes, S. (2013). The Case: Treating Jared Through Dialectical Behavior Therapy. *Journal of Clinical Psychology*, 69(5), 488-489. doi: 10.1002/jclp.21984
- Larivière, N., Couture, E., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S., ... & St- Cyr- Tribble, D. (2015). Recovery, as experienced by women with borderline personality disorder. *Psychiatric Quarterly*, 86 (4), 555-568.
- Levitt, H. M. (2014). Qualitative Psychotherapy Research: The Journey So Far and Future Directions. *Psychotherapy*. Advance online publication. doi: 10.1037/a0037076
- Levitt, H. M., Pomerville, A., & Surace, F. I (2016) A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. *Psychological Bulletin*. doi: org/10.1037/bul0000057
- Lyons-Ruth, K., Bruschweiler- Stern, N., Harrison, A., Morgan, A., Nahum, J., Sander, L., Stern, D., & Tronick, E. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19 (3), 282-289.
- Martínez, C., Tomicic, A., & Medina, L. (2014). Psychotherapy as a discursive genre: A dialogic approach. *Culture & Psychology*, 20: 501-524. doi: 10.1177/1354067X14551292

- McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy*. London: Sage.
- Morán, J., Martínez, C., Tomicic, A., Pérez, J.C., Krause, K., Guzmán, M.... de la Cerda, C. (2016). Verbal and nonverbal expressions of mutual regulation in relevant episodes of psychotherapy *Studies in Psychology*, 37, 2-3.
- Orlinsky, D., Rønnestad, M.H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed., pp.307-389)*. New York: Wiley.
- Patton, M. Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Service Research*, 5, 1189-1208.
- Piña, C. (1998). La construcción del “sí mismo” en el relato autobiográfico [The construction of the self in the autobiographical narrative]. *Documento de Trabajo* 383. Santiago: Programa FLACSO-Chile.
- Piña, C. (1999). Tiempo y memoria. Sobre los artificios del relato autobiográfico [Time and memory. About the artifices of the autobiographical narrative]. *Proposiciones*, 29, 1-5.
- Rizq, R. (2012) “There’s always this sense of failure”: An interpretative phenomenological analysis of primary care counsellors’ experience of working with the borderline client. *Journal of Social Work Practice*.26 (1), 31-54. doi.org/10.1080/02650533.2011.579695
- Safran, J.D. (2013). Windows into clients’ perspectives on psychotherapy. *Psychotherapy*, 50 (4), 535-536.
- Salvatore, S. & Tschacher, W. (2012). Time dependency of psychotherapeutic exchanges: the contribution of the theory of dynamic systems in analyzing process. *Front. Psychol.* 3:253.doi:10.3389/fpsyg.2012.00253
- Stephen, S. & Elliott, R. (2011). Developing the Adjudicated Case Study Method. *Pragmatic Case Studies in Psychotherapy*, 7(1), 230-241. doi: 10.14713/pcsp.v7i1.1079

- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, B,... & Tronik, E. (1998). Non Interpretative Mechanisms in Psychoanalytic Therapy. The “something more” than interpretation. *Int. J. Psycho-Anal*, 79, 903-921.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, Bruschweiler Stern, N., & Tronik, E. (2002). Explicating the implicit: The local level and the microprocess of change in the analytic situation. *Int. J. Psychoanal.* 83, 1051-1062.
- Stiles, W. B. (2009). Responsiveness as an Obstacle for Psychotherapy Outcome Research: It's Worse Than You Think. *Clinical Psychology Science and Practice*, 16(1), 86 – 91. doi: 10.1111/j.1468-2850.2009.01148.x
- Stiles, W. B. (2015). Theory-building, enriching, and fact-gathering: Alternative purposes of psychotherapy research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 159-179). New York: Springer-Verlag.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305-314. doi:10.1080/10503300600608116
- Timulak, L., & Elliott, R. (2003). Empowerment events in process-experiential psychotherapy of depression: An exploratory qualitative analysis. *Psychotherapy Research*, 13, 443- 460. doi: 10.1093/ptr/kpg043
- Tomicic, A., Martínez, C., Pérez, J. C., Hollenstein, T., Angulo, S., Gerstman, A., ... & Krause, M. (2015). Discourse-voice regulatory strategies in the psychotherapeutic interaction: a state-space dynamics analysis. *Front. Psychol.* 6:378. doi: 10.3389/fpsyg.2015.00378.
- Westra, H.A., Aviram, A., Barnes, M., & Angus, L. (2010). Therapy Was Not What I Expected: A Grounded Theory Analysis of Discordance between Client

Expectations and Experience of Cognitive Behavioural Therapy. *Psychotherapy Research*, 20, 436-446. doi:10.1080/10503301003657395

Winnicott, D. (1960). The theory of the parent-child relationship. *Int. J. Psychoanal.*, 41, 585-595.

Yeh, C. J. & Inman, A. G. (2007). Qualitative data analysis and interpretation in counselling psychology: Strategies for best practices. *The Counselling Psychologist*, 35, 369-403.

VI. Article 3: Moments of meeting in psychotherapy: What they are and how they contribute to therapeutic change from a therapists' perspective⁶

Abstract

Experiences of profound connection between patient and therapist have been conceptualized in many different ways, such as “real relationship” (Gelso, 2011; 2009), “relational depth” (Mearns and Cooper, 2005), “synchronicity” (Jung, 1973/2010), “analytic third” (Ogden, 1994) and “moments of meeting” (Stern et al., 1998; 2004). The latter have been defined by Daniel Stern and the Boston group (1998; 2004) as shared moments, understood implicitly by both therapist and patient simultaneously, that allows a mutual implicit understanding about their relationship. These moments create a new state of intersubjectivity that reconfigures the patient's procedural knowledge of “being with the other.” Despite ample theoretical investigation and clinical description of these phenomena, little is known, from an empirical standpoint, about these moments, their features and their relationship with the psychotherapeutic process. **Objective:** This study explores therapists' experience of these moments of meeting with their patients, with the purpose of identifying the essential elements and characteristics of its configuration. **Method:** 13 qualitative interviews conducted to therapists of different theoretical orientations are analyzed through the open coding and axial coding procedures of grounded theory. **Results:** A comprehensive model is developed around two axial phenomena that relate to those features central to moments of meeting from the therapists' point of view. A distinction between high-impact moments of meeting and others of less reach, is made. The effects these moments can have in therapy are described and analyzed. **Discussion:** The value of moments of meeting for the therapeutic process is discussed and reflected upon, as well as their effects implicit relational knowing as a central axis of change.

Keywords: Moments of meeting, psychotherapy, therapist's subjective experience, implicit relational knowing, Process research

⁶ Duarte, J., Martinez, C., & Tomicic, A. (2017). Moments of meeting in psychotherapy: What they are and how they contribute to therapeutic change from a therapists' perspective *Manuscript under preparation*.

*It is as if two waves were breaking at the beach
at different speed, height and place,
and suddenly, fuu... (...).
Both of them meet and then each of them goes on
with its own speed, its own rhythm. (T8)*

Introduction

Interest about relational and intersubjective aspects in the therapeutic process has increased within the theoretical framework of postmodern psychotherapy (Safran & Muran, 2000; Mearns & Cooper, 2005). Most of these approaches emphasize the fact that the self-reflexive capacity of the patient is heightened through new experiences of relation with the therapist, allowing for the development of new, internal forms of representation. This because, the process of dyadic interaction would generate new, emerging relationships that would require learning a different form of intersubjective coordination; that of complex psychological states, as opposed to just the coordination of physical states (Orange, Atwood & Stolorow, 1997; Lyons-Ruth 2000). For Sander (1965) and Lyons-Ruth (2000), to know and to be known is mainly the process of achieving interactions that are coordinated or in tune with an other. Sander (1965) calls this the recognition process, which requires extensive mutual negotiation, recognition of failures and attempts to repair them (see Lyons-Ruth, 1999; Tronick, 1989). And it would be precisely within that process that the internal experience would be able to connect with the reflexive conscience of that experience and those of other minds, allowing for a complex coordination of the dyadic system (Lyons-Ruth, 2000). For these psychotherapeutic theories, the described aspects would form the basis of psychotherapy, and would therefore constitute the essence of change (Orange, Atwood & Stolorow, 1997). It is in this context that the existence of moments of a particular significance, has been proposed, in which both patient and therapist connect emotionally, and deepen in their relationship, creating strong feelings for each other. For many therapists, these are at the heart of their clinical practice (e. g. Friedman, 1985; Mearns & Cooper, 2005; Stern, 2004). Said experiences of profound connection have been conceptualized in different ways, such as “real relationship” (Gelso, 2011; 2009), “relational depth” (Mearns & Cooper, 2005), “Synchronicity” (Jung,

1973/2010), “analytical third” (Ogden, 1994) and “moments of meeting” (Stern et al., 1998, 2004), to mention just a few.

The work of Daniel Stern and the Boston Change Process Study Group (BCPSG) (1998, 2002, 2004, 2005, 2008a, 2008b 2010) about moments of meeting in therapy holds particular interest because, under this perspective, the experience of being in connection with an other would be a fundamental condition in psychotherapy, for change to occur. The theory proposed by the BCPSG would allow, then, to understand change (or, at least, part of it) as a relational and interactive process involving both patient and therapist.

At the root of this proposition resides the concept of *implicit relational knowing* (IRK), understood as the knowledge about relationships with others that is inferred in a procedural way from early relationships, and that operates outside of the subject's attention focus and his conscious verbal experience (Stern et al., 1998). The procedural knowledge itself is based on a set of implicit rules about how to proceed or how to achieve certain tasks, such as riding a bicycle or learning how to dance. When procedural knowledge is applied in the domain of knowledge about *other people*, such as showing one's affection for another, learning to call for attention or learning how to joke, it is called implicit relational knowing (IRK). This knowledge integrates not only affective, but interactive and cognitive elements, and is based on implicit patterns of relational behavior that regulate our interaction with others (Stern et al., 1998; Lyons-Ruth, 1998). Relational learning is subject to variation, because each subject's contribution changes from each moment to the next, and is co-created through both explicit and implicit interactions in relational contexts. Repetitive and/or intense affective relational experiences thus establish patterns of primary organization (Fosshage, 2011).

In psychotherapy, the IRK expresses itself through the process of subjective exchange that gradually transforms into a *shared implicit relational knowing* (SIRK) about the relationship between patient and therapist. In that sense, even though the implicit knowledge each participant has about the relationship is unique to that individual, the overlap between the implicit knowledge of both participants generates an implicit shared knowledge (BCGPS, 2008a). It is in the context of the construction of a SIRK that Stern describes moments of meeting. Intersubjective in their essence, these moments are built

in conjunction between patient and therapist, each actively contributing aspects unique to themselves and to their own relational knowledge (Stern, 1998; BCPSG, 2004).

This perspective, then, locates change in psychotherapy *within* interaction itself, precisely because moments of meeting imply a meaningful connection among participants that modifies the relationship between them, allowing for a transformation and reconfiguration of the IRK of the patient and, as a consequence of that, of his sense of self and his way of “being with others.” In that same way, moments of meeting signal changes in the implicit relational knowing of the patient through the procedural knowledge being shared, coupled with the felt experience of mutual affection and recognition, allowing access to dissociated aspects of the patient's self (Rappaport, 2012; BCPSG, 2008, Levenkron, 2009).

According to this theory, moments of meeting between therapist and patient would not occur in an isolated way, but rather would be the result of an interactive process. Stern et al. (1998) call this process moving along, in reference to the natural course that the psychotherapeutic process takes, a movement towards the goals of the therapy, which are managed and defined explicitly or implicitly by its participants. This process of moving along would be constituted by a succession of moments—*relational moves*—that aren't necessarily present to our consciousness, despite being accessible to it. By becoming conscious, these relational moves would transform into *present moments*, which would contain a micro history that captures a person's subjective style. These brief moments of consciousness would be characterized as units that contain words, gestures and silences grouped in a meaningful way, and would constitute keys or breaking points that change the direction of the process of moving along.

From the starting point of clinical experience, present moments have been described as rich, in the sense that they condense a multiplicity of sensations, meanings and emotions, and they take place often. Stern et al. (1998) posit that when these moments become intense from an affective standpoint and potent for the therapeutic process, they become *now moments*, moments during which the familiar intersubjective environment —of the patient-therapist relationship— would suddenly become tensioned, and at risk of being altered. This emotional potency would pressure the therapist to respond in some way, through an interpretation or an innovative response or even through silence. Insofar as the *now moment* can be sustained and shared by both therapist and patient, that is to say, as

long as the therapist is able to grasp the moment and explore it, it is possible that a *moment of meeting* can take place (Stern et al., 1998; Stern, 2004). Another way to explain this is that a moment of meeting takes place when each participant feels the experience of the other, and both of them feel their mutual participation in this experience: an interpenetration of minds that creates a new state of intersubjectivity, or *now moment*, that can be therapeutically taken advantage of and mutually recognized. In this sense, the *moment of meeting* is understood to be the emergent property of the process of *moving along*, which alters the intersubjective environment and, as a consequence of that, the shared implicit relational knowing. Stern et al. (1998) argue that many of the positive, long-lasting effects of therapy are the direct result of changes in the relational domain, and that failures in therapy are related with the loss of opportunities to establish a meaningful connection between therapist and patient, that is to say, to establish a moment of meeting.

Despite the importance that these moments of meaningful connection between therapist and patient are given, and even if many therapists recognize that such moments have occurred in their work, these moments of meeting have not been studied from a systematic and empirical point of view, but rather only from a conceptual and clinical standpoint. Therefore, a gap exists, between this plausible speculation in the theoretical domain and the possibility of scientifically studying the implicit level of therapeutic interaction and as such, moments of meeting. Moreover, most of the studies into meaningful moments in psychotherapy have, so far, focused on analyzing the patient, even when they emphasize the importance of the interaction between both agents (see Gonçalves Matos & Santos, 2009, 2010, 2011, 2012; Krause et al., 2005, 2006, 2007; Safran & Muran, 1996, 2000, 2006; Greenberg, 1986, 1999, 2007; Elliot, 1984, 1991, 2001, 2010; Stern, 1998, 2004; Timulak, 2003, 2007). Only a few studies have incorporated the actions of the therapist, but they have focused on her actions as an independent subject, and not in her participation in joint action (see Fernández et al., 2012; Valdés et al., 2010, 2011), neglecting the dyadic and relational aspect of psychotherapy. At the same time, studies regarding the process of change in psychotherapy have focused, so far, in technical aspects of change and in the association between particular interventions and their effects on said process (Timulak, 2007; Stern, 1998; Fosshage, 2003). More implicit and less technical aspects, however,

have not yet been sufficiently described, even though they seem to have high relevance for the process of change in psychotherapy (Safran, 2000; Asay & Lambert, 1999; Wampold, 2001). In this sense, the model proposed by Stern and the Boston group offers an alternative perspective for the study of relevant episodes in psychotherapy, by offering an articulation point between theory and clinical practice, that considers interactive elements to our understanding of change.

The Present Study

This study is framed within a broader investigation that seeks to develop an observational coding system that helps identify and outline moments of meeting between therapist and patient during the therapeutic process, determine their verbal features and analyze the connection between their different components. The study has been divided into three phases, focused towards collecting the experience of therapists, patients and the researcher, the three of them using different methodologies that can then be integrated into a common system.

In this article, the results of the first phase are presented. This corresponds to therapists' experience of moments of meeting. The objective is to describe and analyze the way in which therapists experience moments of meeting or meaningful connection with their patients during psychotherapy, and the relevance that they ascribe to them within the therapeutic process.

Method

Thirteen in-depth interviews were conducted during this study, all of them of Chilean therapists with varying levels of experience and theoretical orientation. To ensure a descriptive and relational understanding of the data, these interviews were qualitatively analyzed through both open and axial coding processes, according to grounded theory.

Participants

Thirteen Chilean therapists participated in the study. Sampling was purposive, theory-guided (McLeod, 2001) and used the maximum variation strategy (Patton, 1990). The distribution of the participants was as follows: seven women and six men; five participants

with less than 20 years of experience, six participants with consolidated clinical experience (20 to 30 years) and two senior psychotherapists (more than 30 years). Even if the selected therapists declare a preference in their theoretical orientation, most of them also declare that they combine different approaches in their work. Additionally, most of the participants report experience in both the public and private domain.

Table 3.1: Sociodemographic Information of the Interviewees

Identification of the Therapist	Gender	Age	Years of experience	Therapeutic orientation
T1	Male	65	40	Cognitive constructivism
T2	Male	70	45	Psychoanalysis
T3	Female	63	34	Humanism
T4	Female	33	13	Humanism
T5	Male	34	10	Post- rationalism
T6	Female	49	24	Relational psychoanalysis
T7	Male	51	21	Relational contemplative psychoanalysis
T8	Female	60	38	Corporal-relational psychoanalysis
T9	Female	31	5	Constructivism
T10	Male	37	14	Psychoanalysis
T11	Female	52	30	Narrative systemic
T12	Male			Psychoanalysis
T13	Female	34	11	Cognitive relational behaviorism

Ethical Considerations

The participation in this study was voluntary, and the research's ethical protocol was approved by the ethics committee of the faculty of Medicine of Universidad de Chile (Comité de Ética en Investigación en Seres Humanos (CEISH)). Informed consent forms were signed by all the study's participants before each interview was conducted, in which they gave their express permission for the use of the interviews for research purposes and related publications. Furthermore, a demographic questionnaire was filled with relevant information about each therapist.

Research Team

The research team was composed by two psychologists with vast experience investigating therapeutic processes (CM and AT), one of them with academic training in the field of psychodynamic psychotherapy, and a PhD candidate (JD) with a constructivist therapeutic orientation with experience using qualitative methodology. This article is part of the doctoral thesis of the first author (JD). Interviews were conducted by her, and the analysis was done by the three authors in conjunction.

Given that the analysis of grounded theory is frequently considered an interpretative process, the research team chose to promote self-consciousness during the analysis, and thought about their own reflexivity (Charmaz, 2014), trying to revisit the data and its comprehensive evolution in a hermeneutical way, taking into account the researchers' biases (personal background, positions, preconceptions and values that could influence the research). To achieve this, the main researcher kept memos about her beliefs, perceptions and theories regarding moments of meeting during both stages of the study: interviews and analysis. This process allowed the investigator to register and cultivate her own understanding as it developed, and to take note of the decisions she made about coding and method. Additionally, it enabled the probing of doubts that came up during the interpretation and the explicit recognition of her suppositions, mitigating the effects of researcher bias.

Interviews

The interview protocol was initially developed by the authors based upon theoretical knowledge about moments of meeting in therapy. The interviews conducted were in-depth qualitative interviews (Kvale & Brinkman, 2009). The following opening question was used: "From your experience as a therapist, could you tell me about your perspective on the importance that moments of meeting or meaningful connection with your patients during psychotherapy?" Later, if the therapist didn't do it spontaneously, it was requested of him or her to share a moment of meeting that had taken place with a patient during his or her career as a psychotherapist. For each of these moments, an exhaustive description was requested, seeking to explore in detail the context in which said moment took place within the therapy, what were the elements that led to its occurrence, what was the impact that these moments had in the process and what were the possible effects for both the patient and the therapist, and the therapy as a whole. Once the moment of meeting had been adequately described, the therapist was encouraged to remember gestures, postures, words, phrases or entire dialogs, sensations, feelings and images that he or she associated to it. A common theme throughout the interviews was the question of what, in particular, made these moments relevant in terms of the encounter, in the eyes of the interviewee.

It is important to make clear that at no point was it mentioned that we were working with moments of meeting as were conceptualized by Stern and the BCPSG, but rather, the issue was pursued from the interviewee's personal conception of the term. As we will further analyze when we discuss the results, even though some of the participants alluded to the term and were familiar with Stern's work in some degree, others did not know the term or its general meaning. To ensure that everyone was, up to a certain point, on the same page, definitions of now moment and of moment of meeting were presented to them at the end of the interview, so that the therapists could reflect on their own construction of meeting and its relation to one, both or neither of the definitions. Coinciding and differing aspects regarding their own views about meaningful connection with their patients were discussed during the interview.

This interviewing protocol was maintained along all conducted interviews. However, it was also enriched and fine-tuned by the material that the participants brought to each interview. In a sense, even though the interview's structure and objective were maintained,

it nurtured from each new participant, becoming unique according to the vision and experience of each therapist.

Procedure

Enlisting of Interviewees

Interviewees were selected by maximum variation sampling, because the researchers were interested in investigating all possible forms of the experience of meeting, and to account for the fact that a particular form could be more prevalent in a certain group of therapists (for example: therapists with a lot of experience or therapists belonging to a certain theoretical doctrine). This is why it was sought that the participants had varying levels of experience, that they had worked in both public and private institutions, with different kinds of patients and with patients with varying levels of complexity. The researchers utilized personal contacts to invite Chilean colleagues to participate, using the following selection criteria: psychotherapists with formal training in either psychiatry or psychology, willing to speak openly about their work in therapy, and especially feelings that come about from their patients and from therapy itself. Their experience could refer to one or several patients, depending upon their significance, but the interview was not focused on a particular patient, rather on their general experience along their professional trajectory as psychotherapists.

For recruitment, an e-mail was sent to the potential participants with an invitation and a brief explanation of the study and its objectives. Of the 20 participants who were asked, 15 agreed to be interviewed, but it proved impossible to coordinate a meeting with two of them. 13 participants were interviewed and were enough for the saturation of the sample, in terms of the criteria that were determined for its maximum variation. Of the other five people invited, two declined participation for lack of time or interest and three of them never replied to the invitation (no further e-mails were sent).

Conduction of the Interviews

All interviews were conducted and recorded (audio only) by the first author. The interviews had a running time of between 50 and 70 minutes and were conducted in person. After each interview, the researcher took field notes, in which she recorded her

general impressions during the interview, those aspects she deemed relevant or that called her attention and commentary about what information could be significant in further interviews. Afterwards, the interviews were transcribed as thoroughly as possible, including non-verbal aspects, such as pauses or laughter. The transcriber had previously signed a confidential form in which he or she committed not to share the information within the audio files, and to get rid of them as soon as the transcription work was finished. The transcribers eliminated any information that could identify the participant, replacing their names with a numerical code.

Analysis Procedure

Every team member was familiar with Stern's and the Boston Group's work. To prepare the interviews and the data analysis, meetings were established to discuss and reach an agreement on the central points. Meetings were also arranged with experts in moments of meeting and similar subjects. Karlen Lyons-Ruth, Andre Saasensfeld, Jeremy Nahum, Steven Knoblach and Jeremy Safran were contacted and willing to participate in the research. Their reflections, theoretical knowledge and particular points of views were very enlightening for the analysis of the results and the development of the discussion.

Analysis of the material was conducted through a rigorous application of grounded theory to each interview. Initially, an open coding (Charmaz, 2014; Corbin & Strauss, 2008) was conducted through the ATLAS.ti software. The first three interviews were carried out by the three researchers as a team. The following ones were led by the first researcher and triangulated with the remaining two in periodical meetings, in which concepts and categories were agreed upon and in which a coding system was developed according to a Hierarchical Classification System (HCS). At this stage, concepts and categories were named following as closely as possible the wording put forth by the interviewee, so as not to betray their central ideas.

During the analysis stage, the conduction of the interviews went on simultaneously, and these were gradually incorporated into the hierarchy until saturation was achieved (Glaser & Strauss, 1967).

Data saturation (Charmaz, 2006; Creswell, 2014) was reached with interview number 10, and the last three interviews were used to explore certain previously described concepts

or deepen in certain categories. At this point, all three researchers checked the HCS and coincided in that the level of saturation of the information was acceptable.

All discussions among members within the research group were audio recorded, and the main considerations regarding methodological decisions, reflections, discussions, emergent categories, doubts, emphasis and connections were written on the record and archived to be later considered, in order to be more conscious about possible biases.

This open coding procedure (Strauss & Corbin, 1999) gave rise to six main categories: Characteristics of the Encounter, Encounter Indicators, Origins of the Encounter, Encounter Effects, Conditions that Facilitate the Encounter and Obstacles to the Encounter.

In a second stage, axial coding (Charmaz, 2014; Corbin & Strauss, 2008) was used to work with the central categories and their subcategories, seeking to compare, distinguish and establish relationships among them, in order to create models of understanding for the conditions in which, in the experience of the interviewees, moments of meeting take place, and especially the consequences that these moments give rise to (McLeod, 2001). During this analysis, two instances of axial coding and one of selective coding—which seeks to integrate the proposed axes—were developed. In the first axial proposal, the central phenomenon is called a “moment of resonance with the other”, a concept that alludes to one of the main characteristics of moments of meeting in psychotherapy and one of the fundamental aspects that were highlighted by the therapists themselves. In the second axial proposal, the central phenomenon was named “moments of meeting as generators of change,” and it tries to explain the therapists' perception of these moments and the way in which they affect the therapeutic process.

Results

The process of analyzing the data was guided by the pretense of developing an understanding of the phenomenon: moments of meeting in psychotherapy from the therapists' perspective based upon empirical data (Henretty, Levitt & Matthews, 2008). The process that guided the analysis was that of inductive categorization, which works by decomposing the interviews into main ideas as they relate to moments of meeting that came up in the therapists' narration. After that, these ideas were organized into categories

that reflect their common elements, which were later compared and ordered by the researchers to create broader categories that encompass those of a lower level. From this work, it was possible to infer certain relations between the categories (both between upper-level categories and between upper and lower level ones), a fact that allowed for the creation of two different axial coding frameworks and a selective one that encompasses both axes.

Moments of Meeting as Moments of Resonance with the Other

The first emerging phenomenon (Figure 3.1) responds to the query of how do the interviewees understand moments of meeting in psychotherapy. The central category was denominated “moment of resonance with the other” because it was described in a similar way by the interviewees. This category references the fact that therapists experience moments of meeting as being within an experience that is shared with the patient, in which both connection and complementarity are felt. This shared experience is defined by them as the sensation of being with another—in physical terms, but also both mental and emotionally. It is an intimate and profound bond, characterized by a feeling of emotional synchrony with the patient and which maintains its intensity during the whole process. However, they also acknowledge that, even if this sensation is often felt, it is not always discussed between patient and therapist.

I guess this kind of attunement that takes place, even when one has to respect in silence something one is not listening to or sharing, the encounter there has to do with making room for... maybe everything I've been saying starts there... It is not very verbal at all, at least from my side, I don't give too much importance to the words that are used, because of course there is talking, but it is what happens, it happens in another level, it happens somehow through words, it is so strange, what I'm saying, haha. (T7)

Central Characteristics/Properties

The most important properties pertaining to moments of meeting are five: first, their **emergent character**; that is, they are described as moments that appear in a spontaneous, surprising or unpredictable way during the therapeutic process and, for that same reason,

tend to occur in an unplanned and unexpected way. For therapists, this characteristic implies that only when these moments occur can they truly decide what to do with them and how to react, which is a process generally lived as an experience that rests beyond the normal therapeutic dialog.

Another property, related to the previous ones, is that moments of meeting tend to be felt by the therapists as a **genuine experience**, understood as a unique and singular moment that pertains just to that dyad and particular situation, but is also genuine in terms that their reaction or response to the moment tends to be associated more with their own person than their role as therapists, even though, sometimes, this difference can lead to some inner conflict.

I think that's important. It is not a technical moment that emerges from a... from a preparation of something, rather, it is spontaneous (...). And that, then, has to do with being submerged in a space where you are not thinking that the other person is the patient and you are the therapist, where there is a... I mean, that is within the scene, within the frame that I work with, but in that moment of cont... of closeness, I think one has to lose that to allow these spontaneous things to emerge, because spontaneity is... it is essential in these kinds of movements (T7).

Elsewhere, therapists mention the fact that moments of meeting tend to be **embodied experiences**, which means they are felt physically and materialize in the body. In that sense, many of these experiences maintain themselves in that pre-reflexive level and are only remembered when an effort is made, whereas others are made explicit and talked about with the patient, be it during the moment itself or in later sessions. Following this, a fourth property could be defined: the moment of meeting is a **sensorimotor experience**, in the sense that physical perceptions and non-verbal features are of the utmost important during these moments.

And the therapist, like... I... it's like the thera... I feel that the therapist, like, a... approaches, like, a lot with his body... the experience of the other person, it's like I am there, I... living it with that person, almost. (T9)

Um... look something, something that happened there and its... its ... interesting to think about it is... is that a sensorimotor coordination occurs ¿No? You look at each other and you adopt a similar face... I would say you start to resonate with the other um... pre... pre-reflectively... um like on a common theme ¿no? (...) Well first I feel it... first I feel I am in the same synch with the other. (T5)

Finally, the fifth property reported by the therapists is the **idiosyncratic** character that these resonating moments have. It means that this described “resonance with the other” is unique to that particular moment, and even to that specific relationship. Following this, what could constitute a meeting with one patient could not be valid for another. Thus, an encounter with the patient could be lived in different ways, such as a synchronized state of emotion, a shared laughter, a conversation or even a disagreement.

It has to do, it could be that we said a word at the same (...). And we laughed... Or, um... we went into a very synchronized state of similar emotions. In relation to something, it could even be something that is happening, um... or a space opens... with certain features of... of... special features, so to speak. (T8)

Additionally, several therapists have emphasized the fact that the connection does not necessarily need to be made explicit; it could remain implicit and still constitute a shared experience.

I think many moments of meeting take place, even in silence. Sometimes an encounter takes place that you know is... and the other is having a personal moment of building that... it's like... like went down the slide, he went off on his own... and my job is to accompany him in silence, there are moments in which one also feels, but there are no words. (T7)

Basal Condition

All interviewees mention, at some point, the idea that resonance with the other (or the meeting itself) can only happen when there is a certain emotional intensity. This kind of basal condition could be any kind of emotion, as long as it is intense and felt by both individuals.

In a way, it's like something took place that was similar to what had happened in... um... I don't know, um... like, the situation or the characteristics of that situation were similar, right?, and he felt very, like, um... swept, emotionally, and I think it was the first time that i saw him like that, and I also felt very emotionally charged, i fel... I became very emotionally charged, in fact I had to restrain myself not to ... not to shed any tears, because there was a very strong emotional bond, in which I felt I could take him in, and he could let himself be taken. (T10)

It is hard for me to imagine a meaningful moment where only I felt called upon, for example... no... no, no, I feel there is something... of couse, I don't... I wouldn't call it meaningful, you know? I mean, I would only say: "damn, a patient got mad" or "or a patient... disagrees", or "a patient...", I don't know. I don't know, I... can't, like I can't... I wouldn't understand it, really, if it wasn't mutual. (T11)

From this follows that, even though moments of meeting are lived by therapists as a sort of emotional, cognitive or even physical resonance with their patients, this resonance is sustained by an atmosphere of high emotional intensity and by certain preconditions that allow for its emergence.

Facilitators or Preconditions

This category defines the necessary conditions so that resonance with the other can take place. These conditions are divided by therapists into three types: the "conditions of the relationship," the "conditions of the therapist" and the "conditions of the patient."

With regards to the "conditions of the relationship," the interviewees indicate that it is necessary to be in tune with the patient, an aspect that can be facilitated if there is a relatively consolidated bond and a historical relationship between patient and the therapist.

With regards to previous history, I think that, well, the bond that we've established has been... it hasn't been an easy bond, but it has been very... like: "OK, we lose each other, then we return... we lose each other and we return", a lot of reparation happening constantly, so I think that also um... it allowed us, now that I think about it, it allowed us both to take risks.
(T4)

Two participants specifically mention the importance of the therapeutic framework to be able to establish this condition.

In this next quote, when T4 references the structure, she alludes to the idea that the framework allows both participants to know the conditions of the relationship and of the therapeutic process, and that his knowledge would work as a sort of minimum condition on which it is possible to build the therapeutic work. In this sense, moments of meeting could only develop if both individuals understand the limits of the space that contains them.

Yes? Um... It's like that... that structure, I feel like it also gives the... um... like what you said about technique, also, we give the conditions or the space so that the person can, like, venture a little further and also so I can be more daring, because we... we know we have that space.
(T4)

The *conditions of the therapist*, on the other hand, are also mentioned as facilitators. Here, the interviewees allude to many factors: technical aspects, such as expertise, but also personal features such as their curiosity, their ability to “observe” and “listen” well, the capacity to detach from their role when it proves necessary and of offering a safe space to the patient, their disposition to meet with him or her and to generate complicity and, finally, knowing his or herself properly, in the sense of being able to recognize their own sensations and emotions and identify their own intuitions.

I think that the meeting is that one goes to meet another, like, I feel... I feel that me, for example I... I wanted to meet with that girl (...) and I feel that... that happened, like, it was...

it was intentional, of course it... it was intentioned, but I didn't know what I was going to find. (T9)

Lastly, according to the interviewed therapists, the *characteristics of the patient*, be they understood as personality features, for example, or previous experiences, would also contribute to the possibility of this resonance, in the sense that they could allow the patient to be available to the experience or, on the contrary, lead him or her to avoid it.

T3 specifically mentions that the openness of one of her patients and her positive disposition towards being in the relationship and to learn new things was, in some degree, what facilitated her own disposition and availability as a therapist.

Well, I think that... in general terms, I think that her openness and her trust in me... I feel like she, she is very thirsty, it's like she always comes to drink something different, so I have the symbolic feeling that I need to... I need to have a lot of glasses for her to drink from them (laughter). (T3)

In the opposite spectrum, when this openness or availability of the patient is not present, therapists also give an account of their difficulty to establish this kind of connection, their own openness notwithstanding, and even though it is in these situations that therapists often feel that the patient needs urgently to meet with the therapist. T6, for example, makes reference to a patient with which it was very hard to connect, and describes how the patient couldn't even manage to perceive his own efforts to connect with him.

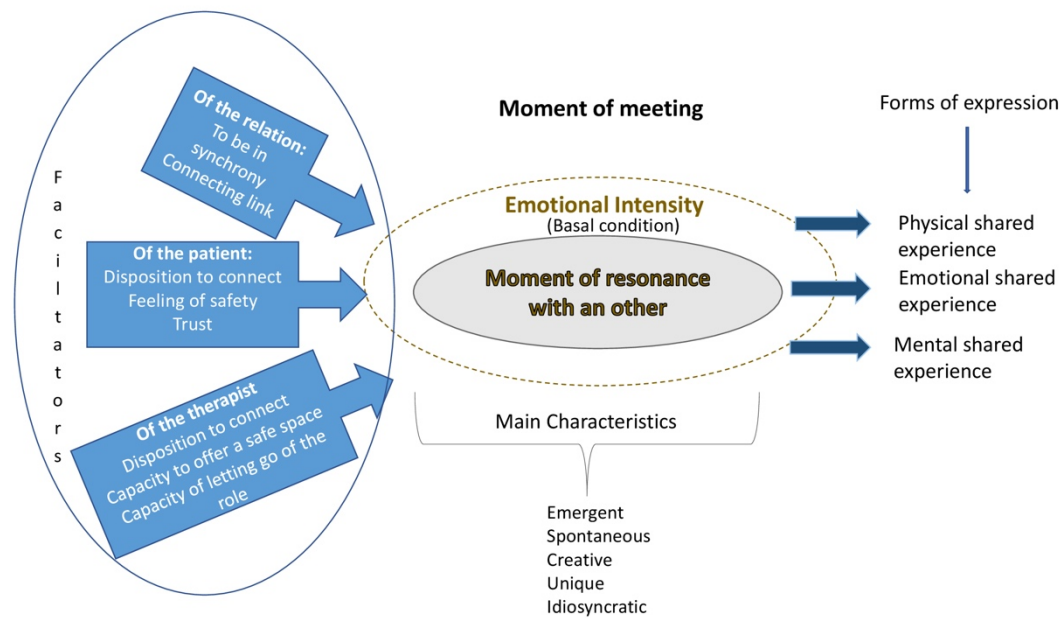
Yes, so he told me: "no, it's not... no, it's not that you're knocking and I don't want to open the door, or... I don't know, I don't see it, I don't feel it. (T6)

In that same vein, T10 references certain experiences that the patients have; in this case, traumatic experiences that impact them in such a way that they refuse emotional bonding with another, or anxiously seek it.

I was telling you about trauma, I think... of course, um... patients are... um... traumatized, on one side, one encounters many that are... that are very reticent to connect and others that seek connection in a very... intense way, you know? (T10)

Even though in some ways these three ways to express the meeting are connected and probably occur in a complimentary way, the fact is that, for the different therapists, one of these kinds of experiences usually proves easier to recognize. In the final part of this essay, a few hypotheses are ventured as to the reason behind this fact.

Figure 3.1: How do therapists understand moments of meeting?



In this way, as shown in figure 3.1, all the mentioned aspects intertwine to give a fuller picture of the way in which therapists understand moments of meeting in psychotherapy. This knowledge helps us isolate those aspects that, for them, are central for the manifestation and recognition of these moments.

Moments of Meeting as Generators of Change

The second axial phenomenon that is relative to moments of meeting from the therapists' point of view relates to the effect that these moments can have, in patients and therapists, but also in the development of the psychotherapy itself. Thus, we have established “moments of meeting as generators of change” as a central category in which the main observable changes, from the therapist point of view, are conceptualized. These changes present themselves in two different temporal dimensions that often intertwine: immediate changes and long-term changes (Figure 3.2).

Moments of Meeting as Generators of Immediate Change

Starting from the therapist's experience, these changes appear as an effect of the occurrence of a moment of meeting. The therapists mention observable immediate changes in **themselves**, in their **patients** and in the **session**, itself. These changes find expression on a physical, emotional or even cognitive level. About changes observed in their patients after a moment of meeting, therapists say that a sensation of decompression, relief and vitality is felt, where bodies relax, rigidity decreases and more fluid movement takes place. They also observe changes in the patients' body posture and facial expression, and in some cases even laughter or a similar spontaneous gesture that signals the emergence of new emotions. Some of the interviewed therapists (T3, T4, T7) have perceived a feeling of rest and freedom in their patients as a consequence of the moment of meeting, and understand that their patients “feel met,” that is, they feel accompanied by the therapist, even in silence (T7, T8, T9). The idea that the patient recovers a part and regains control of his or herself also appears; new possibilities of “learning and becoming more complex” appear (T5, T9, T10).

In my experience, these moments hold a lot of affective potency, both for the therapist and the patient, and... and it's often in those moments that the patient feels that something is happening, right? the encounter with the other that helps them to... to understand themselves, to be well, to... to be accompanied or whatever. (T10)

Regarding effects on themselves, therapists describe that, after a moment of meeting, they feel more relieved. The emotional tension that sustained the moment relaxes, and some of them even report relaxation in their own bodies. Some describe these moments as a gap in time in which it would seem that “something fits” and, at the same time, in which they achieve as special understanding and complicity with the patient. Others (T4, T6, T8) describe it as an experience of being present or as a moment of great vitality. Specifically, they explain that they also live these moments as an intense emotional experience, using terms such as “getting emotional,” “being marveled” or “being surprised” at what happens in that instant.

Well, I think that, um... that those are the moments in which I, um... I as a therapist discover new things about the patient, and the patient discovers new things about his or herself, when that synchrony takes place, I think there was a meeting (...). It's like, um... when these things happen, for me the patient is... an other appears before my eyes (...). And I feel that the patient feels it, too, not with my, but with himself. (T9)

According to the interviewees, meeting with an other has an immediate effect in the session, which expresses itself in its “atmosphere”; the emotional climate changes, and an intense shared emotionality appears. The therapists point out that moments of meeting suffuse life and perspective into the session, letting it to unlock, lose tension or rearrange itself, allowing the process to continue along (Stern et al., 1998 calls this process moving along). Therapists emphasize, following this argument, that the changes in the session and its participants strengthen the therapeutic bond: therapist and patient come closer and a “more real” relationship, according to the therapists' words, emerges, opening space for an emotional depth and a new code of relations that wasn't there before.

Also when there's, like... there have been moments of... of like, of like a r... of a more genuine form of recognition, right?, as if one has recovered parts of oneself that weren't visible before... or weren't experimented, right?, like all those kinds of experiences, of patients that speak through images, no?, of moments feeling like... of feeling more alive, more vital, um... um... for me, they are very significant, and have been very significant, they have come up like that, in... in the therapeutic situation, in a very spontaneous or unexpected way for both of us, in a way, right? (T6)

Long-term Changes

It is noteworthy that the therapists highlight the fact that these moments can generate change without being talked about in the session.

Therapists describe that, besides the immediate effects, moments of meeting produce long-term changes in two relevant areas: within the therapeutic **process** and in the **patient** himself.

In the therapists' view, changes within the process make it more potent and solid, which can give rise to an inflection point in the therapy.

I feel like these moments are moments in which... um... like, a possibility opens, of... like a possibility opens... of, um... of evolving a little, maybe the relationship or, um... what happens to the patient. (T9)

The interviewees thus explain that a moment of meeting can denote a before and after in the therapy process, generating changes in the logic of the relationship and, as a consequence, in the way in which the therapy was being conducted. It is because of these that some therapists (T4, T7, T9, T10) propose that moments of meeting allow for the advancement of the therapeutic process, often constituting milestones in the therapy. However, those same therapists and others (T1, T3) emphasize the fact that there is not a linear relationship between moments of meeting and advancement in the process, that is to say, they don't always give way to immediate change nor give an accurate account of the process, but could also just take place and then acquire unexpected relevance with the passage of time.

Despite this, most interviewed therapists agree upon the fact that these moments are necessary so that change can occur in psychotherapy, because the break in the logic of the relationship, as it was being sustained until that moment, and the need to do something to give it a new direction opens unforeseen possibilities. These possibilities could affect the evolution of the process, strengthen a relationship or change the therapist's perspective, broadening their understanding of the patient. In this sense, change, from the therapist's perspective of his or her patient, could be understood in multiple ways, from the possibility of discovering something new about oneself, to changes in thinking, feeling or seeing, connecting with unforeseen emotions or even changes in behavior or relational patterns of the patients.

Yes, I think they [moments of meeting and therapeutic change] go hand in hand (...), I think they go hand in hand, um... because, I will say it again... I can think of it as many meaningful moments, only some are much subtler... and they guide the way you're going. (T11)

...or to understand a mechanism, understand why that happened to you, explanations more, explanations less, but finding yourself, that intimate experience, as I told you earlier, that's an experience that is strong and transformative. (T5)

Therapists also highlight that one of the most important aspects of moments of meeting is that patients can be “*found by the other*” (T8) through them, and in that process, find themselves. This would imply that they can acquire new notions, recognize or learn something fresh about themselves, discovering attributes that they did not know they had.

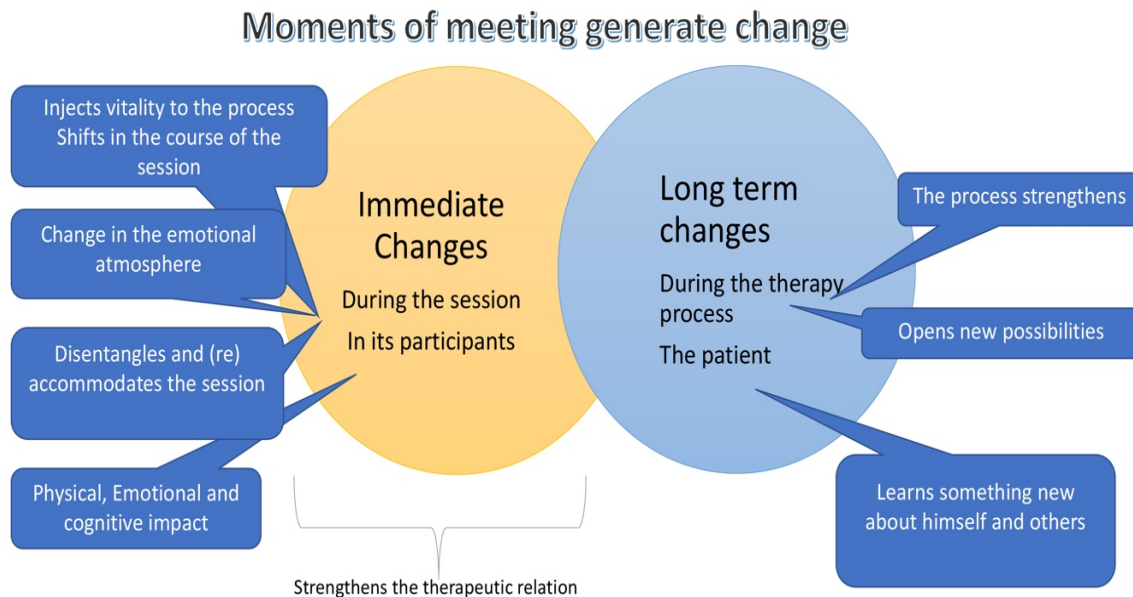
That would mean... it would mean that the patient can start to see himself from a different perspective or with new eyes, I think that is very therapeutic and, as a change, that the patient can see himself as the therapist... with the eyes of the therapist, haha, also... (...) So, the encounter between therapist and patient in emotional synchrony, in, um... I think that already creates change. (T9)

For many of the interviewed therapists, the acquisition of these new notions of the self allows for the patient to learn, at the same time, something new about his way of relating with others. Some even describe it as a laboratory to create new experiences outside of the session, where the meeting with the therapist takes place and then expands outwards, towards the patient's other relationships.

And we go into this sort of shared tenderness or whatever, um... it kind of allows for that... that process of change in which she no longer experiences it as abandonment, so it's no longer an abandonment, it's someone that could be, that exists, we have a bond and many of the things that were at stake there (...), but it's also a change at the level of... at the level of the experience that the patient can have of others (...). Those moments are sort of transformative. (T4)

I think that [a patient's name] is a person that has been deprived of affection, of tenderness, of truly meaningful encounters with other people, very deprived, and so what ha... what happened in the end was like... as an example, an... a laboratory, because the fact that he has married and everything, is a thing that, way back, we wouldn't have even begun to, um... (T3)

Figure 3.2: How do moments of meeting affect psychotherapy?



Towards a Comprehensive Vision of the Therapists' Perspective About Moments of Meeting in Psychotherapy

The axes that give an account of the therapists' vision of what they consider to be the central characteristics of moments of meeting, and how they influence changes in psychotherapy, can be linked together by a central category, called moments of meeting. The researchers discussed and examined the theoretical memos, integrating ideas about the general structure of the model, which allowed for a reemergence of the moment of meeting as a central category, capturing, in this way, the essence of the processes described by the psychotherapists in a meta-level. Figure 3.3 allows us to understand how moments of meeting unfold from the perspective of the therapists. Thus, moments of meeting, as a central category from which all other categories unfold, would have certain properties, as was discussed in the explanation of the first axial phenomenon. These properties are related to the idea that these moments are spontaneous and hold a great

affective charge, which generates the possibility of establishing a resonance with the other. Besides, moments of meeting would be clearly defined within the framework established by the therapists and, because of that, proved relatively easy to explain, despite having been described in different words and expressions. As an example, T4 remarks:

OK, yes, of course, a lot of meaningful encounters, um... moments of meeting like, in a broader sense, have been moments... in general, moments in which... at least, what I have experienced is that we find ourselves before something that is like, alive, like... something that we find... we can find it in laughter, or we can find it when we understand what we are thinking, where we are going, um... or that, um... we go into a conversation, like... like a profound, but new conversation, I don't know how else to say it, it rests a little bit outside of classical therapeutic dialog. (T4)

At the same time, moments of meeting would be immersed in a particular context, that generally relates to a therapy's medium phase in which, according to the interviewees, the participants would already have some knowledge of each other, the therapeutic alliance is consolidated, and both therapist and patient would find themselves particularly predisposed towards the meeting.

[There is] a bond of... in which there is... a basic expectation of sustenance and containment and, from that, a place where one can, um... um... put the pieces back together, or... (T8)

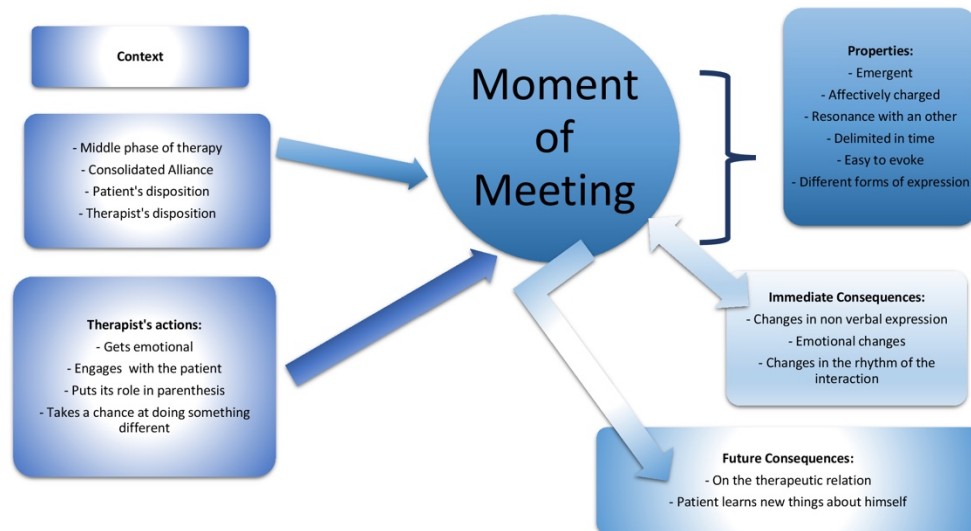
Although all therapists say that moments of meeting come up spontaneously during therapy, they still reference the need for the therapist to be available for them to happen and, in this sense, to carry out certain actions that could allow for their emergence, such as becoming emotional towards the patient or engaging with him or her in some other way. As it was described in the first axial phenomenon, for many therapists this has to do with being open to place the therapist's role between brackets and taking risks by trying something different. Therapist 7 and Therapist 5 reflect on this idea and say:

*(...) so the fun thing was... I had the idea that this could spin towards something useful...
(...) and I think I let him go for that reason, I didn't interrupt him, I participated a little in
the scene (...), despite the fact that I was already seeing it, I let him go on. (T7)*

*However, I think that the... being completely into it, this is my case, being completely involved
in someone else's story (...). Um... it makes the distinction easier, between, um... when...
when we are... when we are meeting and resonating with something that is mine or the other
person's. (T5)*

Lastly, even though it is impossible to establish a direct and unequivocal relation between moments of meeting and the process of change in psychotherapy, all the interviewed therapists emphasize the fact that these moments would seem to hold the possibility of producing certain effects in its participants, both in immediate and long-term ways. In the immediate sense, therapists say they observe, both in themselves and in their patients, a physical sensation of relief or decompression, changes in nonverbal expression, transformations at an emotional level and in the rhythm of interaction, which would influence the relationship's further development. Regarding long-term consequences, they highlight the fact that these moments would, by generating more emotional depth and more trust between both participants, impact the therapeutic relationship in a positive way. Additionally, they would allow for the patient to recognize new aspects of their self and to generate changes in their relational pattern.

Figure 3.3: How do moments of meeting deploy during psychotherapy



Discussion

This paper's goal was to describe and analyze the way in which therapists' experience moments of meeting with their patients during psychotherapy, and to understand the relevance that these moments have towards developing the therapeutic process itself.

In general terms, and as a sort of panoramic conclusion, the first thing that almost every interviewee highlights, with independence from their theoretical orientation or amount of clinical experience, is that they recognize these significant moments and report having encountered them during the practice of therapy. From this experience, they emphasize that certain conditions exist in order for a moment to be considered this kind of meeting, such as their emerging character, the fact that they happen outside of the normal therapeutic dialog, and that they constitute genuine and strongly embodied moments, which is reflected at a sensorimotor level.

It is interesting, at this point, to mention the fact that, despite these similarities, different therapists value different elements, putting more emphasis in one over the others. While reviewing these observations in greater detail, the question came up of whether biases in the recognition of this "meeting" would be influenced by their theoretical orientation,

among other factors; as an example, a post-rational therapist defines the meeting as a meeting of minds (T5), while a humanist therapist emphasizes the importance of a heart-to-heart connection (T3). This element strikes us as relevant for future inquiry, because it allows for the conception that, with independence of the therapist's formation, the meeting with the patient could be a common or transversal aspect that is felt by most therapists, but recognized and identified by them with the language borne from their conception and understanding of psychotherapy. Following this reasoning, it is remarkable that, even though not all interviewees were familiarized with Stern and the Boston Group's concept of moments of meeting, after having read the concept's definition following the interview, there seemed to be a consensus in recognizing that the experience they had described was indeed contained in said definition. It is notable also that some of the interviewees have pointed out that certain words do not entirely fit, or that they prefer one definition over another; for example, some therapists identify the definition of now moment as the one that suits the described situations best, while others identify the concept of moment of meeting as the most adequate to represent their experiences but, nevertheless, almost all the interviewees agree upon the fact that the definitions complement each other, and tend to see their narrations as containing aspects of both.

The recognition, on the part of the therapists, that there are certain common features to these moments, even though they present themselves in a very varied fashion, is also remarkable. The main properties detected by the interviewees are their emerging character, the spontaneity with which they come up, the creativity or originality of their manifestation, their uniqueness and their idiosyncratic nature. The data shows a phenomenon recognized by all interviewees, even though it is described in different variations of theoretical language.

All these features would be complemented by the an emotionally intense experience shared by both patient and therapist which, in a way, sustains/envelops the meeting itself; what has been called the moment of resonance with the other. This would prove particularly relevant for the therapeutic experience because, as Rappaport points out (2012), affective resonance in the space between therapist and patient would give birth to a sensation of security and containment.

Likewise, even though moments of meeting are understood by all therapists as spontaneous and unplanned moments, these don't seem to happen in a random way; on the contrary, they would have to do with something that has already been happening (“cooking”) over time in the therapeutic relationship. That which “emerges,” “lands,” “appears” or “fits” is, however, spontaneous, and the vehicle in which it arrives is more or less circumstantial, like intense emotion, a phrase, a look, a silence or a laugh. For some therapists, it is possible to identify some elements that maximize the encounter's effect, such as a history of mutual knowledge, the therapist's ability to listen, the openness and disposition of both participants and, therefore, their capacity to synchronize. The therapists were also able to identify with considerable precision certain indicators regarding their immersion into a moment of meeting, such as sensations, emotions or attitudes they recognized in themselves, besides changes in posture, body language and physical expression in their patients.

Another of this study's finds relates with certain distinctions and elaborations that contribute to the Boston Group's and Daniel Stern's original model, and their understanding of moments of meeting in psychotherapy. In this respect, it was possible to observe that multiple of the interviewed therapists (T3, T4, T6, T7, T8, T9, T11, T13) made a difference between big meetings (Big M) and little meetings (Little m). Even though descriptions of moments of meeting, as developed in this article, allude to the characteristics and properties of big moments of meeting, the interviewed therapists did also reference the existence of moments of meeting that they characterize as *little*, in the sense that they are not remembered as clearly delineated events, but as moments that register themselves in the level of the body and sensations. These *little* moments of meeting would come from a sort of “state” of connection and rapport with the patient, but they would not have the disruptive or surprising character that *big* moments of meeting share. These *little* moments of meeting tend to be more frequent than the *big* ones, and also occur with most patients, but they apparently have a lesser emotional impact, in contrast to *big* moments of meeting, which are much less frequently and take place with only a fraction of patients. In this regard, it would be possible to hypothesize that, in order for a therapeutic process to take place, it would be a necessary condition for the therapist to feel like he can meet with the patient and that the patient feels met by his therapist.

However, this can also happen constantly throughout the process, with a moderate affective load, without necessarily altering the course of the session. This makes these moments much harder to remember in detail, and they are often recalled by the therapists as a succession of internal sensations. *Big* moments, on the contrary, as they present themselves with a big emotional charge and in a surprising way, would tend to destabilize the rhythm and the order of the session and would, for that same reason, register themselves in the mind of the therapists as specific episodes. Thus, *little* moments of meeting could be thought of as being created in accordance with the continuity of psychotherapy, whereas *big* moments could be understood as protuberances or swellings inside the therapeutic process. This meditation would, for the time being, open more doubts than it answers, such as, what could be the connection/relation between these two kinds of moments? How would these moments interact between themselves (if they do)? Would they be completely different phenomena, or can a little meeting give rise to a big one? Would little moments of meeting be a sort of preparation for big ones or, rather, are they complimentary forms of connection?

Finally, it is relevant to discuss the place and the effects in the therapeutic process that the interviewees tend to attribute to moments of meeting. All interviewed psychotherapists, except for one of them (with a more classical psychoanalytic training) recognize moments of meeting as central events in the therapeutic process; some of them go as far as saying that, without meetings, there cannot be a process of psychotherapy (T3, T8, T11).

Therapists, in general, tend to value and treasure these moments of meaningful connection with their patients, feeling that they contribute in different ways and different levels to the process of change. Broadly, moments of meeting could be understood as corrective emotional experiences (Hill et al., 2012) which provide patients with the sensation of being accompanied by their therapist (Duarte et al., 2017). This accompaniment, however, would seem to be the beginning to a relationship that transforms through time and gives the patient the possibility of learning new things about himself and of relating to other people, which could be understood as a change in implicit relational knowledge (Lyons-Ruth, 1998). This relational knowledge is accessible through somatic and sensitive experiences, before they are recognized and verbalized (Levine & Frederick, 1997; Levine, 2010; Schore, 2002). In this sense, as Fosshage (2011) points out, psychotherapy

would seem to work through two interconnected paths: the word and the reflexive work that happens in a more explicit level and, also, through both implicit and explicit relational experiences. This, given that the implicit knowledge that comes forth in psychotherapy, along with the felt experience of affection, would help the patient recognize and integrate different aspects of his or herself (Rappaport, 2012; BCPSG, 2008; Levenkron, 2009). To say it in a different way: moments of meeting, by changing *the* therapeutic interaction itself, would allow for a transformation and reconfiguration of the relational knowledge implicit in the patient; as a consequence, of his or her feeling towards the self.

References

- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC: American Psychological Association.
- Beebe, B., & Lachmann, F. M. (1988). The contribution of mother-infant mutual influence to the origins of self- and object representations. *Psychoanalytic Psychology*, 5, 305-337.
- Beebe, B., & Lachmann, F. M. (1998). Co- Constructing Inner and Relational Processes: Self and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology*, 15, 480-516.
- Beebe, B., Knoblauch, S., Rustin, J., & Sorter, D. (2005). *Forms of Intersubjectivity in Infant Research and Adult Treatment*. New York: Other Press
- Boston Change Process Study Group. (2002) Explicating the implicit: The local level and the micro-process of change in the analytic situation. *Int. J. Psychoanal.* 83 1051-1062
- Boston Change Process Study Group. (2005) The “something more” than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Japa* 693-729
- Boston Change Process Study Group. (2008a) Forms of relational meaning: Issues in the relations between the implicit and reflective- verbal domains *Psychoanalytic Dialogues*, 18, 125-148. doi: 10.1080/10481880801909351
- Boston Change Process Study Group. (2008b) Forms of relational meaning: Reply to commentaries. *Psychoanalytic Dialogues*, 18, 197-202. doi: 10.1080/10481880801909583
- Boston Change Process Study Group. (2010) *Change in Psychotherapy: A unifying paradigm*. New York: Norton
- Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. Los Angeles, CA: Sage.
- Charmaz, K. (2014) *Constructing grounded theory. A practical guide through qualitative analysis* (2nd ed.). Thousand Oaks, CA: Sage.

- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Los Angeles, CA: Sage.
- Creswell, J. W. (2014) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (4th ed.). Los Angeles: Sage
- Duarte, J., Fischersworing, M., Martínez, C., & Tomicic, A. (2017): “I couldn’t change the past; the answer wasn’t there”: A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist, *Psychotherapy Research*, Advance online publication. DOI: 10.1080/10503307.2017.1359426
- Fernández, O., Herrera, P., Krause, M., Pérez, J., Valdés, N., Vilches, O., & Tomicic, A. (2012). Episodios de Cambio y Estancamiento en Psicoterapia: Características de la comunicación verbal entre pacientes y terapeutas. *Terapia Psicológica*, 30 (2)5-22.
- Fosshage, J. (2003). Fundamental pathways to change: Illuminating old and creating new relational experience. *Int. Forum Psychoanal*, 12, 244-251. doi: 10.1080/08037060310018247 .
- Fosshage, J. (2011) How do we “know” what we “know”? and change what we “know”? *Psychoanalytic Dialogues*, 21: 55-74 doi: 10.1080/10481885.2011.545328
- Friedman, M. S. (1985). *The healing dialogue in psychotherapy*. New York: Jason Aronson
- Gelso, C.J. (2009). The real relationship in psychotherapy in a postmodern world. *Psychotherapy Research*, 19 (3), 253- 264.
- Gelso, C.J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. Washington, D. C.: American Psychological Association.
- Glaser, B. y A. Strauss (1967). *The discovery of grounded theory: strategies for qualitative research* . New York: Aldine Publishing Company
- Henretty, J. R., Levitt, H. M., & Mathews, S. S. (2008). Clients’ experiences of moments of sadness in psychotherapy: A grounded theory analysis. *Psychotherapy Research*, 18, 243–255. doi:10.1080/10503300701765831

- Hill, C., Castonguay, L., Farber, B., Knox, S., Stiles, W.B., Anderson, T., ...& Beck, J. G. (2012). Corrective Experiences in Psychotherapy: Definitions, Processes, Consequences and Research Directions. In L. Castonguay & C. Hill (Eds.), *Transformation in Psychotherapy. Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches* (pp. 355-370). Washington D.C.: American Psychological Association.
- Jung, C. G. (1973/2010). *Synchronicity – An Acausal Connecting Principle*. The Collected Works of C. G. Jung. Vol. 8. Bollingen series XX. New Jersey: Princeton University Press
- Kvale, S., & Brinkmann, S. (2009). Interviews. Learning the craft of qualitative research interviewing. Los Angeles: Sage.
- Levenkron, H. (2009). Engaging the implicit. Meeting points between the Boston Change Process Study Group and Relational Psychoanalysis. *Contemporary Psychoanalysis* 45 179-217.
- Levine, P & Frederick, A. (1997) *Waking the tiger: Healing trauma*. California: North Atlantic Books
- Levine, P. (2010). In an unspoken voice: How the body releases trauma and restores goodness. California: North Atlantic Books
- Lyons- Ruth, K. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health*, 19 (3), 282-289.
- Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanal. Inq.*, 19, 576-617.
- Lyons Ruth, K. (2000) "I sense that you sense that I sense...": Sander's recognition process and the specificity of relational moves in the psychotherapeutic setting. *Infant Mental Health Journal*, 21 (1-2), 85-98 doi: 10.1002/(SICI)1097-0355(200001/04)21:1/2<85::AID-IMHJ10>3.0.CO;2-F
- McLeod, J., & Balamoutsou, S. (1996). Representing narrative process in therapy: Qualitative analysis of a single case. *Counselling Psychology Quarterly*, 9, 61-76.
- McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. Thousand Oaks: Sage

- Mearns, D. and Cooper, M. (2005) *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.
- Ogden, T. (1994), The analytic third: Working with intersubjective clinical facts. *Internat. J. Psycho-Anal*, 75:3-19.
- Orange, D.M., Atwood G. E., & Stolorow R. D. (1997). *Working Intersubjectively: Contextualism in psychoanalytic practice*. The Analytic Press: Hillsdale, NJ.
- Patton, M. Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Service Research*, 5, 1189-1208.
- Rappoport, E. (2012) Creating the umbilical cord: Relational knowing and the somatic third) *Psychoanalytic Dialogues* 22:3, pages 375-388.
- Safran, J. D., & Muran, J. C. (2000) *Negotiating the therapeutic alliance*. New York: Guilford Press.
- Schore, A. (2002) Advances in neuropsychoanalysis, attachment theory, and trauma research: implications for self psychology. *Psychoanalytic Inquiry*, 22, 433-484.
- Sander, L. (1965) Interaction of recognition and the developmental processes of the second eighteen months of life. Paper presented at Tufts University Medical School, Boston, MA.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, Bruschweiler Stern, N. & Tronik, E. (1998) Non Interpretative Mechanisms in Psychoanalytic Therapy. The “something more” than interpretation. *Int. J. Psycho-Anal*, 79, 903-921.
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.
- Stolorow, R., Brandchaft, B., & Atwood, G. (1987). *Psychoanalytic treatment, an intersubjective approach*. Hillsdale, N.J: Analytic Press.
- Strauss, A., & Corbin, J. (1999). *Basics of qualitative research. Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Thousand Oaks: Sage.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305-314.

- Tomicic, A., & Martinez, C. (2011). Voice and Psychotherapy: Introduction to a line of research on mutual regulation in Psychotherapeutic dialog. *Praxis*, 13(20), 109-139
- Tomicic, A., Martinez, C., & Krause, M. (2014). The Sound of Change: A study of the psychotherapeutic process embodied in vocal expression. Laura Rice's ideas revisited. *Psychotherapy Research*, 1-14 doi: 10.1080/10503307.2014.892647
- Tronik, E. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44, 112-119.
- Tronik, E. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19, 290-299.
- Tronik, E., & Weinberg, K. (1997). Depressed mothers and infants: the failure to form dyadic states of consciousness. In L. Murray & P. Cooper (Eds.), *Postpartum depression and child development* (pp. 54-85). New York: Guilford Press.
- Valdés, N., Krause, M., & Álamo, N. (2011). Qué dicen y cómo lo dicen: Análisis de la comunicación verbal de pacientes y terapeutas en episodios de cambio [What do they say and how do they say it: Analysis of patients and therapists verbal communication during change episodes] *Revista Argentina de Clínica Psicológica*, 20, 15-28.
- Valdés, N., Tomicic, A., Perez, J.C., & Krause, M. (2010). Sistema de codificación de la actividad terapéutica (SCAT- 1.0): Dimensiones y categorías de las acciones comunicacionales de pacientes y psicoterapeutas. [Therapeutic activity coding system (SCAT-1-0): Dimensions and categories of patients' and psychotherapists' communicational actions]. *Revista Argentina de Clínica Psicológica*, 19, 117-130.
- Wampold, B. E. (2001). The great psychotherapy debate: Models, Methods and findings. Mahwah, NJ: Lawrence Erlbaum.

VII. Article 4: From moments of meeting to episodes of meeting in psychotherapy: The patients' perspective about their relevance and their effect on their implicit relational knowing:⁷

Abstract

Background: Moments of meeting in psychotherapy or of special connectedness between patient and therapist have been addressed from different theoretical perspectives in different terms (e.g.: Ogden, 1994; Jung, 1998, 1973; Mearns & Cooper, 2005; Stern et al., 1998, 2004). Daniel Stern and the Boston Study Group (1998, 2004) coined the term moments of meeting and described them as shared moments between patient and therapist that create a mutual implicit knowledge about the relationship, because each one feels the experience of the other and both feel the other's participation in the experience. These shared moments create a new intersubjective state that modifies the relation and reconfigures the patient's procedural knowledge about relationships, this is, the way of "being with others". However, empirically, little is known about these moments and their association with the psychotherapeutic process, and less yet about the patients' perspective regarding this subject. **Aim:** The aim of this paper was to explore and understand moments of meeting in psychotherapy as a lived experience by the patient and identify its main characteristics, effects and relevance accredited to them for the psychotherapy process and its outcome.

Method: A first person methodology stemming from a phenomenological approach called the micro-phenomenological interview was conducted to nine psychotherapy patients regarding their experiences of moments of meeting. **Results:** A general diachronic structure of episodes of meeting was developed, to better understand how these episodes unfold, what their main characteristics are and what triggers them. Three subtypes of diachronic structures were found for episodes of meeting. Also, the synchronic

⁷ Duarte, J., Martinez, C., & Tomicic, A. & Valenzuela- Moguillansky (2017). *From moments of meeting to episodes of meeting in psychotherapy: The patients' perspective about their relevance and their effect on their implicit relational knowing: Manuscript under preparation.*

aspects of one of the phases (moment of meeting) was analyzed, where their particular properties emerged.

Discussion: We discuss similarities and differences regarding the patients experience and possible implications of these moments for the psychotherapy process and patient-therapist relation.

Key words: episodes of meeting, microanalytic interview, subjective experience, implicit relational knowing

Introduction

The interest in relational and intersubjective aspects within the therapeutic process has become increasingly relevant throughout different theoretical approaches of postmodern psychotherapy (Safran & Muran, 2000; Mearns & Cooper, 2005), placing particular emphasis on the idea that it is through new experiences of relationship with the therapist that the patient's capacity for reflexive self-awareness increases, allowing the development of new internal representations, which would represent the essence of change (Orange, Atwood & Stolorow, 1997). More specifically, the idea of particularly significant moments within the therapy, in which patient and therapist are emotionally connected to one another or in other terms, generate deeper feelings of connectedness and relatedness is for many therapists at the heart of their clinical practice (ie Friedman, 1985; Mearns & Cooper, 2005; Stern, 2004). Such experiences of deep connectedness have been conceptualized in different ways such as "real relationship" (Gelso, 2011) "Relational depth" (Mearns & Cooper, 2005) "Synchronicity" (Jung, 1973/2010) "analytic third" (Ogden, 1994) and "moments of meeting" (Stern, 1998, 2004) just to mention a few.

Within these definitions, the work of Daniel Stern and the Boston Change Process Study Group (BCPSG; 1998, 2002, 2004, 2005, 2008, 2010) on moments of meeting in psychotherapy is particularly significant, as they understand that change (or at least part of it) is a relational and interactional phenomenon that takes place between patient and therapist. This proposal is based on Karlen Lyons-Ruth's concept of *implicit relational knowledge* (Lyons-Ruth, 1998), defined as knowledge that is procedurally acquired in relationships with others and that operates outside the attentional focus and the conscious verbal experience of the self. This knowledge of interpersonal events is registered since the earliest childhood (Stern et al., 1998). Longitudinal attachment research has also provided support for the understanding that relational behaviors are grounded in relational history (Lyons-Ruth, 1999).

Meaning systems are organized to include implicit or procedural forms of knowing (knowing how to do something and how to behave adaptively for example), but the organization of memory and meaning in the implicit domain only become visible during the doing (action).

Knowing how to do develops and changes by processes that are intrinsic to the representation system, so they do not rely on the translation of the procedures into reflective or symbolized knowledge. Even though, it is important to mention that procedural systems are influenced by as well as influence symbolic systems through multiple cross-system connections (Lyons- Ruth, 1999)

In psychotherapy, implicit relational knowledge is expressed through the process of subjective exchange that becomes a shared implicit knowledge about the relationship. This work is grounded on the belief that relational aspects and specifically emotional connection between patients and therapists are fundamental for change processes to take place during psychotherapy (Lyons – Ruth, 1998; Stern et al., 1998).

With this in mind, it can be said that for Stern et al. (1998), change in psychotherapy resides precisely *in the interaction*, that is, in moments of meeting between patient and therapist, because these moments of significant connection during the process would modify the relationship between both, allowing a transformation and reconfiguration of the patients' implicit relational knowledge and as an effect, of his sense of himself and his way of "being with others". Stern and the BCPSG (1998, 2004) point out that these moments of meeting in psychotherapy are essentially intersubjective, because they are constructed jointly by therapist and patient, with the contribution of something unique and particular of each of their subjectivity. In other words, the therapist-patient relation facilitates change, specifically around constructing new possibilities for adaptive regulation of intersubjective experiences. The therapist must then be able to deconstruct already established, but unsatisfying ways of "being with", while simultaneously helping the patient move towards new and satisfying ways (Lyons- Rut, 1999) and it would be through the significant connection provided by moments of meeting in therapy that this process could partially take place.

Even though the concept of moment of meeting has been theoretically described and analyzed in detail by the authors, little empirical work has been done to understand how it is that these moments take place in the subjective experience of its participants.

The present study

This paper is framed in the context of the first author's doctoral dissertation which seeks to design a procedure to identify and outline *episodes of meeting* between therapist and patient during the psychotherapeutic process and establish the main characteristics (verbal, non-verbal and relational) of the interaction between patient and therapist during its occurrence. The dissertation has been divided in two phases focused on gathering therapists', patients' and experts understand and experience of moments of meeting, with different methodological approaches in order to merge them into a common procedure.

In this article, the results of the second phase are presented. These results correspond to patients subjective experience of meeting in psychotherapy. The aim of this paper in particular, was to explore and understand moments of meeting in psychotherapy as a lived experience by the patient and identify its main characteristics, effects and relevance accredited to them for the psychotherapy process and its outcome

Method

Design

A first-person methodology stemming from a phenomenological approach called the micro-phenomenological interview was conducted to nine psychotherapy patients, in order to study (the structure of) moments of meeting in psychotherapy as a lived experience. The data was analyzed according to the micro-phenomenological interview analysis procedure.

Participants

For selecting the participants of this study, purposive sampling using the strategy of maximum range (Patton, 1990) was followed. As criteria of heterogeneity we considered: gender of the participants, therapeutic orientation of the therapist, different lengths of therapy and if the processes were currently on going or already finished

All patients were 18 years or older

Table 4.1: Interviewees Demographics

Interviewee id code	Gender	Age	Therapist orientation	Length of psychotherapy	Status of therapy	Reasons for consulting
Pe1	Female	26y	Cognitive	6 months	Ongoing	Normative crisis
Pe2	Female	25y	Humanistic	3 months	Finished	Eating disorder
Pe3	Male	39y	Gestalt	96 months (8y)	Ongoing	Divorce
Pe4	Female	37y	Psychodynamic	24 months (2y)	Finished	Relationship difficulties
Pe5	Female	30y	Psychodynamic	12 months (1y)	Finished	Relationship difficulties
Pe6	Female	23y	Post -rationalist	4 months	Ongoing	Sexual problems
Pe7	Female	36y	Eclectic	60 months (5y)	Finished	Normative crisis
Pe8	Female	40y	Eclectic/ DBT	12 months (1y)	Ongoing	Substance abuse
Pe9	Female	41y	Relational/psychodynamic	72 months (6y)	Finished	Anxiety disorder and depression
Total	1 male 8 females	33y	Wide-ranging	32 months (2,7 y)	55,5% finished 44,4% ongoing	Multiple

Data Collection

The Micro -Phenomenological Interview

For data collection, the micro-phenomenological interview was conducted (Vermersch, 2011; Valenzuela et al., 2013). This interview stems from a phenomenological approach and was first introduced by Pierre Vermersch (1994/2011) and later developed by Claire Petitmengin (1999, 2006) for cognitive science studies. Originally designed to study the cognitive processes involved in learning, this technique was then incorporated into the neurophenomenological program proposed by Francisco Varela (1996) and has been used since then in a growing number of researches in cognitive (e.g., Lutz et al. 2002), clinical (Petitmengin, Navarro & Le Van Quyen 2007), therapeutic (Katz 2011) and managerial (Remillieux 2009) fields.

A central notion underlying this technique is that all experience is initially grounded in the body's direct sense, experience which is consequently brought to the mind's attention (Aron, 1998; Cozolino, 2002; Siegel, 2007; Wallace 2006; Katz, 2011). This experience is the heart of a subjective experience, so in order to truly understand an experience as it unfolds, it is essential to access this pre-reflective dimension of human experience. Accessing the reflective dimension of human experience provides information about *why* actions are taken but not *how* they are taken. Felt experience in bodily dimensions and in pre-conceptual dimensions often remain pre-reflective and pre-conceptual and so does meaning. However, when felt meaning and experience remain pre-reflective and pre-conceptual, knowledge in this dimension of experience remains hidden and unavailable for us to use in making sense of our experience.

The micro-phenomenological interview concentrates on the *how* instead of the *why* of that lived experience. This technique attempts to guide the interviewee in recalling through evocation a given experience (Valenzuela- Moguillansky et al., 2013; Valenzuela-Moguillansky, personal communication, 2017)

This interview allows us to explore the temporal evolution of the experience (The diachronic dimension) and the qualitative aspects of a particular moment of the experience (the synchronic dimension).

This interview is performed in three steps. The first step has the purpose to lead the interviewee in evoking a past experience- to evoke means recalling a given experience as if re-enacting it-. This is accomplished by asking the person to identify a single experience and then exploring the sensory atmosphere, facilitating a description from an "embodied position" (Vermersch, 1994/2011). The state of evocation can be recognized by the extent to which the person is "in contact with" the experience that he or she is describing. A number of non-verbal, verbal and para-verbal signs have been identified that indicate the interviewee's level of connection with an experience (Hendricks 2009; Vermersch 1994/2011; Petitmengin 2006). Once the person is in a state of evocation, the actions (physical or mental actions) that the person performs throughout the specified situation are used as an axis of questioning (Vermersch 1994/2011; Petitmengin 2006). We can then ask about the temporal evolution of the actions and establish an outline of their sequence, accessing what has been called the "diachronic dimension" of the

experience. Depending on the research question, the diachronic dimension of the experience can be explored at different levels of detail. Thus, once a coarse sequence of events or actions is established, the interviewer may guide the interviewee to direct attention to finer levels of the experience. Using the sequence of actions as an axis, the qualitative aspects of the experience for a particular moment, or its “synchronic dimension,” can then be explored. Usually interviewees glide into general descriptions of condensed situations that make it difficult to produce precise descriptions. Therefore, it is important to continually bring the interviewee back to the chosen particular situation (Valenzuela- Moguillansky, et al. 2013).

Procedure

As the purpose of this particular research was to explore and understand moments of meeting in psychotherapy as a lived experience by the patient, the interviews concentrated on a specific relived experience that the patient recalled as a moment of special connection or feeling met by his therapist.

Nine patients were interviewed (see table 4.1). All the participants were interviewed between October 2016 and May 2017. The interviews were conducted face to face and audio recorded for future transcription. The interviews lasted between 40 to 80 minutes. A sociodemographic questionnaire regarding relevant information of the participants was applied at the end of each interview

Interviews were conducted in Spanish and all the extracts of interviews reported in this article were translated into English by the authors. The interviewees’ identification codes are placed in parenthesis at the end of each quotation as noted in table 4.1. Questions from the interviewer and key parts of the descriptive statements are in italics.

The interview began with the following opening question “If you agree, I would like to ask you to take your time and let a moment of your psychotherapy process with (therapist name) were you felt a significant connection, a special moment of meeting, come to mind... when you have found it, please let me know”

Once the interviewee was able to identify that particular moment, the interviewee was asked for a general description of that moment as if he/she were reliving or evoking it. To help the interviewee complete this task, different techniques offered by the microphenomenological interview method were used to situate the person in time, space

and sensorial memories of the event. If evocation was interrupted, the interviewee was led gently back to the event.

Once the situation was described the event was revised in detail in order to clearly understand the sequence of actions of that particular event and how it occurred in terms of emotions, physical sensations or thoughts that emerged.

Every certain while the event was recapitulated by the interviewer as to confirm that the sequences and sensations were being correctly described and once the interview was finished the description was corroborated with the interviewee.

The ethical protocol for this research was approved by the ethics board of the faculty of Medicine of Universidad de Chile and informed consent forms were signed by all the participants of the study before the interview was conducted, giving their permission for the use of the interview transcripts for research purposes and related publications.

Data Analysis

The information obtained was analyzed using the micro- phenomenological analysis procedure, which suggests an individual and group (generic) analysis of both diachronic and synchronic aspects of the researched experience. The interviews were transcribed for the analysis was the transcription of the interviews. After reading each interview, general anecdotal descriptions were set aside and all the information regarding the experience itself was selected. In this study, *moments of meeting* were identified through “events”, most likely interviewees’ or their therapists’ actions, that marked different stages or phases of the experience, allowing the identification of the diachronic structure of the interviewee’s experience. This procedure was repeated for each of the nine interviews, which allowed the recognition of nine individual representations of the (diachronic) structure of the experience. Then the individual structures of each interview were compared, looking for invariants across different experiences. Based on the invariants a generic diachronic structure of the experience of moments of meeting was constructed and in a second analysis, this structure was regrouped into three subtypes according to their main characteristics. Once the generic diachronic structure was identified, the experiential categories that characterize each phase were revised, looking to identify synchronic aspects of the interviewees experience of meeting. As will be shown in the results section,

only one of the phases constructed in the generic diachronic structure allowed a generic analysis of the synchronic dimension of all nine interviews.

The analysis process was carried out by the all the authors so that the event identification, interpretation of data and generation of categories were validated by an inter-agreement process, to ensure the quality of the results (Interpreters triangulation strategies, Krause, 1995; Howe & Eisenhart, 1993; Patton, 1990). Also, the criterion of thick description (Ponterotto, 2006) was used to understand and interpret each of the interviews in a contextualized way, in order to plausibly describe the different elements that gave form to the experience of moments of meeting

Results

From moments of meeting to episodes of meeting

As an overview of the general description of moments of meeting and its impact in the interviewees psychotherapy process (as lived by them) these moments are described by the interviewees as a part of a larger event or episode during the psychotherapy session, in which these moments of meeting or feelings of connectedness are contained. This has lead us to think that the term “episode of meeting” describes better the patients’ recollection of the whole event, where moments of meeting are specific instants, that allude to that particular moment of “feeling met” or feeling connected to the therapist. This finding is consistent with the findings of the first phase of this research (Duarte, Martinez & Tomicic, 2017, under preparation) where the interviewed therapists also tended to identify moments of meeting as part of a bigger interaction during the therapy session.

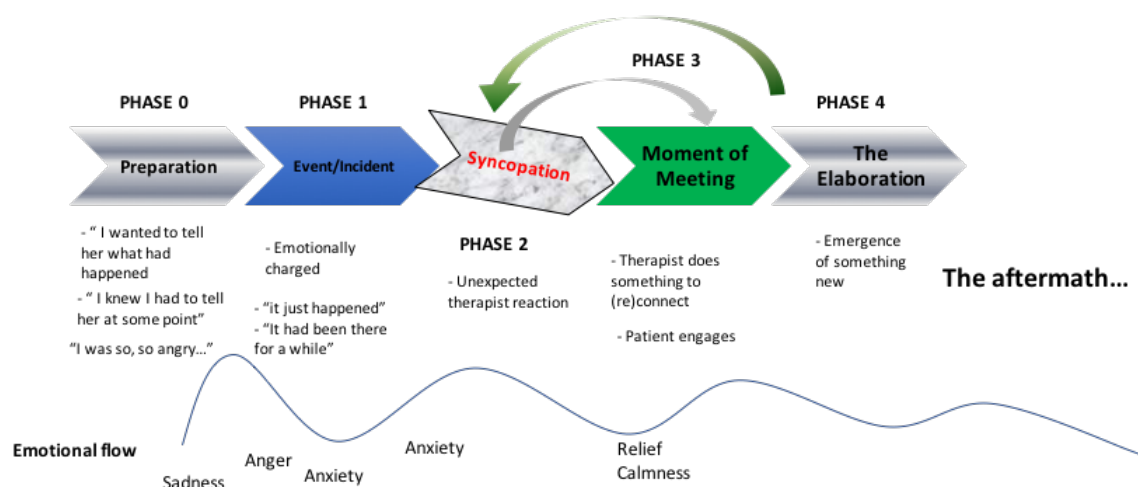
It is important to highlight that episodes of meeting during therapy unfold, like most of our experience, as a part of a continuum and as such do not have a clear beginning or ending, nor can be easily divided in a clear-cut fashion into different “phases” (Valenzuela- Moguillansky et al., 2013). The phases that have been identified during the diachronic analysis are temporal delimitations of the experience in order to allow a more didactic comprehension and a formulation of its general structure. Therefore, when trying to separate or divide the individual experiences in this way, it is difficult to establish a

clear criterion on where to cut. That being said, during the analysis procedure, a generic diachronic structure integrating the nine cases was developed, due to its similarities regarding the process of occurrence. However, in a second reanalysis of the structure of the episodes of meeting, three subtypes were identified in terms of their quality and how they evolved. The first type was named **unexpected episode of meeting** (PE1, PE2, PE9), the second type was named **feeling met episode** (PE4, PE5, PE6, PE8) and the third kind of episode of meeting was named **familiar meeting** (PE3, PE7).

Generic structure of episodes of meeting

The generic structure of the experience of patients' moments of meeting was created by integrating the diachronic structure or temporal characterization of these moments with the synchronic structure or qualitative characterization of the different stages or phases. Through the analysis of the interviews, five phases were identified as making up the diachronic structure of episodes of meeting (Figure 1). An extra phase which took place after the episode was also included in the analysis, because of the effect this phase had for the patients. Some phases were described in more detail than others by some of the interviewees while other interviewees concentrated their description on only one or two of the phases.

Figure 4.1: Generic Diachronic Structure of “Episodes of meeting”



Phase 0 “The Preparatory Phase”

This phase contains patients’ descriptions of what they were experiencing before the episode of meeting took place and how they prepared themselves to tell something to their therapists or to talk about a special subject. Some patients describe that they were troubled by something, feeling something very strongly or thinking about sharing something with the therapist, before they decide to act on it. It is important to state that in some cases this phase took place just before “phase 1”, while in other cases there was a longer preparation from the patient’s part, going back to several weeks before “phase 1” actually takes place. This phase is clearly present in only 2 of the 9 cases, but in all the other cases, the content of the event had been around in previous sessions, even if they did not describe this phase and started their evocation in “phase 1”.

...so a long time went by (...) before...I... I couldn’t even mention the word rape (...) until I started treatment and told T128 about it... I felt the need to talk about it in therapy. (PE8)

I got there that day and was very stuck with what had happened and I was very angry... I was very angry, angry, angry, angry... and I got there [to the session] and the first thing I wanted to do was tell her what had happened. (PE1)

Phase 1 “The event Phase”

This phase concentrated on the description of the interaction that took place during the moment the patient chose as a moment of meeting or of feeling special connectedness with their therapist. This phase is present in all the interviews and tends to be very detailed and descriptive. In some cases, the episode was regarding something the patient was telling the therapist or in other cases it was about something that was happening between them. This moment is described by all interviewees as emotionally charged, due to the content of the event, the atmosphere of the session or both. Even though this phase did not turn out to be the moment of meeting itself, it was very important because it was around this particular interaction that the meeting took place and therefore articulated the episode as such. However, it is important to mention that in many cases it was not easy for the

interviewer to clearly understand why this particular moment was chosen as a moment of meeting and only made itself clear by the end of the interview or in some cases during the analysis procedure. Some reflections regarding this issue will be resumed in the discussion section.

So, I was telling her about S' [patient's husband] mom... that she has Alzheimer and, and can be very unpleasant, she is very categorical with her ideas, so like... how do I say it... it's hard when you don't think the same way as she does and she says "you are wrong", or "people who do that are stupid..." (PE7)

Like I started telling her that like I went to see my dad and there she started to... and she said "Oh" because it had been like a year and a half since I last saw him. (PE6)

Phase 2 "The Syncopation Phase"

The predominant feature corresponding to this phase was that the therapist did or said something that took the patient by surprise or confused him/her. Something happened that the patient was not expecting, a spontaneous gesture of the therapist such as laughter or a non-verbal reaction such as a pause, silence or a gesture of support. In some cases, the syncopation was the product of a technical move on the therapist's behalf that the patient was not expecting.

This unexpected action generated a shift in the rhythm and synchrony of the session and an emotional arousal/impact in the patient who didn't seem to understand what was going on. The emotions that arose from this moment were quite different, such as confusion, anger or astonishment, but were very strongly felt, even if they were not immediately communicated to the therapist. The patients described this phase as a moment where there seemed to be a mismatch or miss-attunement between them and that they didn't know very well how to process or go on during the session. Even though this phase seems to be short and happen very quickly, they described having many thoughts and emotions simultaneously, and feeling initially very thrown off or disoriented while trying to make sense of what was happening. It was described as a confusing moment where the patient

tried to organize this flood of information into something more manageable. This phase was mentioned in three of the nine the interviews, so it's presence marked one of the subtypes of episodes of meeting that will be described further on in this section.

...so, I explained the situation to her, just like it had happened and she [the therapist] had a fit of laughter... but really... a fit of laughter... I think I was a little thrown off by her reaction, I wasn't expecting that. (PE1)

[the patient is describing the moment she returned to therapy after holidays] ...she opened the door... and she leaned over to kiss me...and I... it was a millisecond, very silly really... but she leans over... after 4 years of therapy we had never greeted ourselves with a kiss! ... so, she leans over and I respond automatically and then came a certain discomfort at least I felt it like "oh! This is weird" (...) It was very small but very tense... internally, I'm not sure what happened with her...and then we went inside, I was very uncomfortable like a little disturbed and the session began... I thought she was going to say something, I decided that I wasn't going to say anything about it and the crazy thing is that nobody said anything. (PE9)

Phase 3 "The moment of meeting"

This phase was present in all the interviews and represented the actual moment (instance) when the patient felt emotionally connected with the therapist. This phase was also described as emotionally intense, but with the emergence of different kinds of emotions than the ones in phase 2. These emotions were defined in a more positive way such as feeling met, supported, comforted, understood or even feeling hugged (metaphorically) by their therapist. Patients also reported the prevalence of sensations of relief, calmness, peace and warmth. These sensations in some cases lasted very briefly and were the interrupted by the emergence of other emotions or reemergence of previous ones or in other cases were maintained throughout the rest of the episode

Um... like she had shown me that... I don't know... like from the moment she said that I was the one that had been abandoned and not the other way around it was like... when she said that I felt hugged by her (PE6)

And I said to her "I don't want to be like my mother... and she said, don't worry, you won't... and in that moment, it's not like she leaned over to hug me or anything, but I felt relieved... relieved that somebody could say that to me, that validated my efforts... like she really saw me... and then maybe I felt a little anxious...like how am I going to do that? (PE4)

We were talking about not doing anything and my mom... like I had a sensation like, like in my heart, like my chest was very tight and I couldn't verbalize, and she said something... I don't remember well what it was, but she said just the right word, it was like pressing the button and like, like I clicked and started crying, because it was just that...I felt she understood me so well... something I couldn't put into words... (PE5)

Patients that reported having experienced phase 2 described this phase as the moment when the previous miss attunement was resolved. Here it seems to be that the therapist noticed the change in the rhythm of the interaction and specifically did or said something as an attempt to reconnect with the patient. This action tended to pull the patient out of his/her self-absorption and back into the relationship, providing them the possibility to recouple and resynchronize. With this action the patient felt met, understood and connected to the therapist, the initial negative emotion tended to fade away, turning the disorientation or confusion into a strong feeling of connection.

She noticed I was disoriented and she said something like "I'm sorry, sorry for laughing" ... and I said no, it's fine... it is actually very funny... she insisted "Really, I'm sorry... I'm not laughing at you" ... but I understood, that she wasn't laughing at me but at the situation I was telling her (...) so I started laughing too... and we both laughed for a while. (PE1)

... and there I think there was a silence... I remember looking at my drawing again and expanded my attention to the whole picture and when I saw it, in that moment I realized...

that yes... she was right, my drawing looked like the picture of a boy [referring to the therapist's reflection that her drawing of herself didn't have the shape of a woman]. (PE2)

...I had a feeling that we were both sustaining the scene...like...neither her or me... we implicitly decided not to talk about it... in fact we talked about it many sessions later, when I couldn't stand it anymore and there she recognized that she had felt uncomfortable too... that we made a mistake... that we missed each other and it was like spontaneous. (PE9)

It is important to mention that in this phase patients described very precisely certain actions and attitudes the therapist had, regarding the emotionally charged moment, that made them feel their therapist really understood them and was connected with their emotions. It seems that this phase is actually the moment of meeting as such.

Phase 4 "The elaboration or consequence Phase"

This phase took place after the moment of meeting had passed and was lived by the patients in different forms. The main characteristic of this phase is that there is a further reflection about what happened which helps the patient understand something about him or herself that was not accessible before. In other words, a new understanding emerged and new emotions about the event took place. Some of the interviewed patients described that this reflection took place right after the moment of meeting while still in session, while others described it as something that occurred much later in the process, where they connect that episode with something else in their therapy. Likewise, some of the interviewees described this phase as something that took place privately, this is as a personal reflection that they did not necessarily share with their therapists, while others elaborated and reflected on the moment of meeting together with the therapist. This phase was described by all the patients but with different levels of deepness. For some patients, this phase was very important for them due to the new understanding, while for others it is very brief and trivial.

In fact, after that, I understood a lot about why he [the person that had offended her] had said that to me... (PE1)

And there I understood that yes... more than the distortion that I had about my body at that time, I drew what I really saw every time I looked at myself... a skinny person, even though every time I looked at the mirror I felt fat or found any flaw in my body (PE2)

Phase 5 “The aftermath or long-term effect Phase”

During the analysis of the interview material we also found what we called the aftermath or long-term effect phase, which is a retrospective view of the described episode, where the patient analyses in the present how that episode could have affected/impacted the psychotherapy process. Even though this phase was not mentioned spontaneously by all patients, in some cases it came up as a product of the micro-phenomenological interview and provided good insight about how the patients perceived that experience. Most of the interviewees related the episode of meeting with a shift in the way the relation with the therapist was developing until that moment and/or as a catalyzer for the development of a new perspective about how they related with others or their selves.

I felt much more freedom, in fact, I feel that since that moment I can say things to her more freely, more spontaneously (...) I also feel that she has also relaxed more after that... (PE1)

Now that I think about it that was an important moment for me because it opened a chapter that I had shut down and it allowed me to talk about those things, that I had kind of buried. For me it was easier to talk about other things, but not my mom... it allowed us to talk about it again, in different sessions and it was much easier... (PE6)

Subtypes of episodes of meeting

As previously mentioned above, even though all interviewees were able to describe a certain sequence of events that lead to a moment of meeting and its implications for them and for the therapy process. In a second analysis, it was possible to classify these descriptions into three groups according to their quality. The first category was named **Unexpected episode of meeting** and was described by three interviewees (PE1, PE2,

PE9). This type of episode of meeting was explained as an emergent, surprising or unexpected moment, that took place when the therapist did or said something that the patient was not expecting, which astounded and confused the patient. This group of interviewees all include phase 2 in their description and is described very vividly, almost anecdotally. However, this unexpected moment was later followed by a moment of meeting as the therapist attempts to repair the previous miss-attunement. It seems that the therapist's intention to resolve and re-synchronize with the patient transforms, what initially could be lived as a negative event, into a moment of meeting. In other words, in this category, the meeting seems to be a consequence of the previous disconnection and can be felt as such because the therapist was in some way able to notice the syncopation and emotionally available for dealing with it spontaneous and genuinely even when using a technical intervention.

The second type of episode was named as a **Feeling met episode**, and was described by four interviewees (PE4, PE5, PE6, PE8). This episode was described as less abrupt or surprising than the previous one, mainly because it doesn't contain phase two, this is, the moment of meeting was not preceded by some a syncopation or a miss-attunement. After describing the event phase (phase 1), the interviewees passed directly to the description of the moment of meeting (phase 3), or in which they felt met by the therapist. In these descriptions, patients felt that the therapist so immersed in what is happening between them, either what the patient was telling him or what is happening in the session, that the patients literally feels met or connected with their therapist. They describe feeling attuned with the therapist, and understood by them, that the therapist knew exactly what he/she needed in that particular moment and with his actions is able to sustain this encounter and generate a space of deep intimacy. While this type of moment does not contain a phase of previous disagreement or dysregulation of the rhythm of the session, the emotional connection is equally powerful and felt by the patient. This suggests that moments of meeting need not happen after something unexpected, but can also take place as part of the regular rhythm of the session, where due to different reasons, such as the topic that is being discussed or the high involvement of both participants in the session, the emotional

intensity of the session increases and the therapist is able to synchronize with the patient making him/her feel met by him.

The third type of episode was named as **familiar meeting** and was mentioned by two interviewees (PE3, PE7) these episodes were the hardest to analysis, because even though the patients were able to identify a specific situation of feeling met, it seems that their feeling met has to do with a certain familiarity or a certain relational understanding that has already been established between them and not due to a particular experience or to an emotional arousal. For example, PE7 describes a situation where she is having trouble dealing with her mother in law and feels met when the therapist explains to her the clinical characteristics of her mother in-laws' diagnosis and offers some advice on how to handle her better. Apparently, this is not an emotionally charged situation and the patient is not overwhelmed by the situation, but having the therapist explain and offer a solution was just what she needed, so her feeling met by her therapist has more to do with the therapist knowing just what to do to calm her than with a particular emotional impact

In that moment I left the session thinking “wow, she really gets me”... now I am thinking about the advice she gave me and how it still works for me... That session is still useful for me today. (PE7)

And then she deepens on her reflection

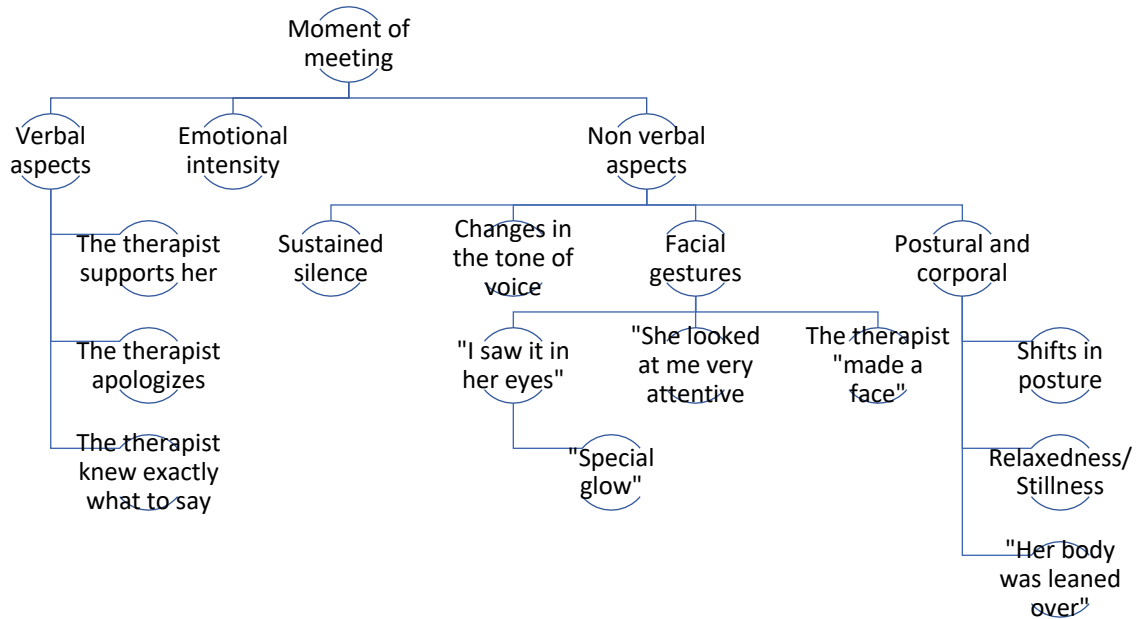
I think the connection I felt there was like two things... I felt that the process was very fast, like I had this uneasiness and quickly V [Therapist] was able to take it away from me... so in that sense... looking back I think that could have been a connection, we were able to connect, she gave me the two things I needed, like theory and practice...that's the way I sense the connection. (PE7)

Both interviewees that described this type of episode had been in therapy for a long time and the recollection process was very difficult for them, because they remembered the feeling of being met or having had an emotional connection with their therapist and even report having felt it often during their therapy, but they were not able remember a specific moment. Their descriptions seem more like a regular condition of that process that was already established as part of their particular interaction and in that way, it was harder for

them to put it in one single event. In this sense, even though they were able to describe shifts in their emotional states and having felt different after the moment of meeting, it was less intense than the other types previously described. This makes us wonder if this could be product of a long-term psychotherapy, where new implicit relational knowledge is already established and shared by both participants or more related to certain patient characteristics, where they have more difficulties in evoking particular situations.

Synchronic Structure of Moments of meeting

Figure 4.2: Synchronic structure of phase 3: “moment of meeting”



As this phase was described by all nine interviewees, and seemed to be the moment of meeting or special connection as such, an analysis of its synchronic structure was performed, with the objective to better understand what the main components of the phase moment of meeting were and to identify experiential categories that could allow us to characterize the experience in synchronic units of different levels of abstraction. In other words, the objective of this analysis was to represent the main components of the experience of meeting.

As shown in figure 2, three main categories emerged from this analysis. These categories were described by all interviewees as relevant aspects of feeling met by their therapists.

The first category called **verbal aspects**, was described as the verbal actions the therapists performed to show their interest and commitment with their patients and made the patient feel this genuinely from the therapist's behalf. Here the main themes are related with the therapist verbally supporting the patient in some way such as the case of PE8 that says *"She told me um, if you don't want to you don't have to tell me... at your own time, when*

you feel its ok... um... no rush... if you want to tell me now do it, if not, whenever you feel its ok and want to talk about it (...) that made me feel trustful and that I could tell her and that's why I did". These verbal actions also include the therapist being able to apologize when he/she realizes they have gone off track or had contributed to the patient's confusion, like in the case of PE1 who remembers that when her therapist started laughing she said *"I'm sorry, really, it's not that I'm laughing at you (...) but I understood that she wasn't laughing at me but at the situation"* And the idea of the therapist knowing exactly what to say in moments where the patient feels helpless or in need of reassurance. Such as the case of PE4 when her therapist says, *"You are not like your mother"*.

The **emotional intensity** category was very variable and described very differently by the patients, according to the moments they were evoking or personal characteristics. However, every interviewee while describing this phase, was able to recognize in themselves (and some in their therapists) very strong emotions of connection and the substitution of negative emotions for more positive ones. Such as PE6 says *"It's like we both knew... I felt her... I thought that it wasn't something to talk about because she wasn't going to do anything but I felt her close"*

Finally, the third category named **nonverbal aspects/cues** was also very powerful and described with detail. In this category patients mentioned that the nonverbal aspects of what was happening at that moment was very important to identify or interpret what was going on between them and their therapists, even if they were very small or initially insignificant. The main nonverbal aspects described were changes in the tone of voice of their therapists. Like PE2 recalls *"Her tone of voice was different, it was like naïve, like that really caught her attention... that's how I remember it... and that's how I received it"* their facial gestures or expressions, like in the case of PE3 he remembers *"Like his facial gestures... I don't know, smiling, interested... um... I don't know... yea... well he is always sitting in front of me... um ... he doesn't move much, but yes sometimes I can feel his curiosity"* and postural and corporal cues, as PE8 remembers *"I realized she was connected from her physical way of being, relaxed, paying attention, not moving her hand, she didn't do anything that could distract me, she was serene, sitting...um... listening and looking at me. Her whole body was connected and available to what I was talking about"*. In this way moments of meeting seem to be enhanced not only by explicit signs of meeting,

such as the therapist verbalizing that they understand or are present for their patients, but are more fully felt moments, which have an emotional impact in the patient and can also be recognized in nonverbal cues that create a special atmosphere of connection.

Discussion

The aim of this study was to explore and understand moments of meeting in psychotherapy as a lived experience by the patient and identify its main characteristics, effects and relevance accredited to them for the psychotherapy process and its outcome. It allowed us to deepen and to better understand how these moments unfold, what triggers them, and what characteristics these moments have that make patients perceive them as special moments of meeting.

A first finding shows that moments of meeting seem to be part of a larger sequence of moments, or as we called them, part of an *episode of meeting*, where the meeting in itself is a consequence of a series of previous (inter)actions and affects the course of the session. Even though all the episodes of meeting described had a similar sequence, they also had differences regarding how the moment of meeting developed. This allowed us to group them in 3 types of episodes of meeting. The unexpected episode of meeting is quite similar to the description developed by Daniel Stern and the Boston group, where they point out that moments of meeting are usually preceded by now moments (moments of high emotional intensity) and are only possible when the therapist is able to grasp them and respond in a unique and genuine way (Stern et al, 1998). However, patients also described other types of episodes of meeting (felt meeting and familiar meeting) that shed some light on different forms of meeting that have more to do with an intersubjective experience and reflect how subjective and unique these moments of meeting can be. For example, during the familiar meeting what seemed to happen to the participants was a sort of confirmation of the shared relational knowledge they had with their therapists, which produced the effect of a re- cognition of one with the other

It was very interesting to see how moments of meeting were evoked by patients very vividly and with great detail, which is probably a reflection of the impact these moments had on them and for their personal processes. Even though all patients were able to recall a moment of meeting, the interviewees that were in an ongoing process tended to recall better than those who had already finished their therapeutic processes for a while. In other

words, patients with an ongoing therapy remembered better specific moments of feeling connected to their therapists, they had much more clarity of how and when they occurred, the emotional impact it had on them and how the sequence of events unfolded, while patients who had finished therapy had a harder time remembering an isolated event of this nature and tended to go back to general descriptions.

Another finding is that episodes of meeting seem to have an idiosyncratic nature that is particular for every process/dyad and influenced by different aspects such as patients and therapists' personal characteristics, how the relationship has been constructed, how they generally interact and what patients value or need more. However, the intensification of the emotional and nonverbal cues is mentioned by all interviewees, which could be understood as important markers of the emergence of these moments.

In methodological terms, the micro-phenomenological interview provides the necessary configuration for studying less reflective conscious events such as these, because they allow the interviewee to concentrate on a particular event and relive it. As this interview concentrates on the experience instead of the representation we may have elaborated about said experience, it operates at a pre-reflective, implicit level, connecting our implicit memories with their emotions and allowing it to become conscious as we put it in words. This process is what facilitates the interviewee not only to recall the experience, but to relive it. As Petitmengin (2006) states, in order to study pre-reflective experiences, we cannot limit research to observable data, but it is essential to take into account their subjective dimensions as they are lived from the inside.

Also, in terms of methods for approaching moments of meeting in psychotherapy, it seems that *episodes of meeting* could be easier to work with empirically, than moments of meeting because they provide the context of how the "meeting" was accomplished and the results of this meeting. Patients as well as therapists (Duarte, Martinez, Tomicic, 2017 under revision), tend to recall *episodes of meeting* in which moments of meeting are understood as the moment when therapist and patient not only feel connected, but also feel each other's connection. The idea of *episodes of meeting* could help identify moments of meeting from a third person perspective, due to the possibility to observe a wider range of interaction. In this same line, we consider that as future guidelines it would be important to complement these second- person studies with a third person study as to complement

these observational perspectives and generate more precise indicators of moments of meeting and how they arise during the psychotherapy process

As for clinical implications, we consider this study to be a contribution to Stern et al. (1998), Lyons-Ruth (1999) and the Boston Group's thinking, as it reinforces the idea that change in psychotherapy not only occurs in explicit forms but also through implicit mechanisms. As Lyons-Ruth (1999) state, implicit procedural forms of relational knowing may come about through different mechanisms than change in conscious declarative forms of knowing. In our study, these implicit mechanisms were clearly perceived by the patients and reported during the interviews even if they did not refer to it in a spontaneous way to their therapists when these moments occurred. For example, regarding the significance of the recalled episode, PE5 says during the interview "... *a lot of internal changes...Yes. I think that when I started therapy I got there knowing that I wanted to work on certain contents and it was the tip of the iceberg, like what I knew and therefore were easier for me to talk about and work but (...) other things that I hadn't explored and I really didn't know if I wanted to go there...so that moment unlocked that a little*".

This work is also consistent with developmental studies, as pointed out by Siegel (2012) that assert that the experience of expressing one's emotional state and having others perceive and respond to those signals appears to be of vital importance in the development of the brain "Such sharing of primary emotions does not merely allow the child to feel "good"; it allows the child to "feel felt" and to develop typically" Siegel, 2012, p.46). In this line, we consider that moments of meeting in psychotherapy could work in a similar way, where the therapist's attunement with the patient and its inner world could help him "feel felt" and regulate their emotional states.

Although these results are not generalizable to every psychotherapy patient, given the small sample, and due to the singularity of the experience and the study object, these results provide interesting insight on how these moments can depict during a psychotherapy process and furthermore, the capacity of patients of detecting and describing moments of meeting in such a clear and distinct way. It also provides useful information on the importance of these moments for the psychotherapy process, as lived by the patients and how they affect their change processes and an empirical view for a

theory that has been enlightening in the comprehension of the process of change in psychotherapy

References

- Aron, L. (1998). The clinical body and the reflexive mind. Aron, L. and Anderson, F. S. (ed.). *Relational Perspectives on the Body*. Hillsdale, N.J.: The Analytic Press, pp 3-38
- Boston Change Process Study Group. (2002). Explicating the implicit: The local level and the micro process of change in the analytic situation. *Int. J. Psychoanal.* 83 1051-1062
- Boston Change Process Study Group. (2005). The “something more” than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Japa* 693-729
- Boston Change Process Study Group. (2008a). Forms of relational meaning: Issues in the relations between the implicit and reflective- verbal domains *Psychoanalytic Dialogues*, 18, 125-148. doi:10.1080/10481880801909351
- Boston Change Process Study Group. (2008b). Forms of relational meaning: Reply to commentaries. *Psychoanalytic Dialogues*, 18, 197-202. doi: 10.1080/10481880801909583
- Boston Change Process Study Group. (2010) *Change in Psychotherapy: A unifying paradigm*. New York: Norton
- Cozolino, L. J. (2002). *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*. New York: W.W. Norton and Company
- Duarte, J., Martinez, C., & Tomicic, A. (2017). Moments of meeting in psychotherapy: What they are and how they contribute to therapeutic change from a therapists’ perspective *Manuscript under preparation*.
- Friedman, M. S. (1985). *The healing dialogue in psychotherapy*. New York: Jason Aronson.

- Gelso, C.J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. Washington, D. C.: American Psychological Association
- Hendricks, M. (2009) Experiencing level: An instance of developing a variable from a first-person process so it can be reliably measured and taught. *Journal of Consciousness Studies* 16 (10–12): 129–155.
- Howe, K. & Eisenhart, M. (1993) Criterios de investigación cualitativa (y cuantitativa). Prolegómenos. *Revista de Educación*, 300, 173-189.
- Jung, C. G. (1973/2010). *Synchronicity – An Acausal Connecting Principle*. The Collected Works of C. G. Jung. Vol. 8. Bollingen series XX. New Jersey: Princeton University Press.
- Katz E. (2011). *Attending to clinical practice: A phenomenological study exploring the structure of clinical attention and its relationship with holistic competence* (Doctoral thesis, University of Toronto, Toronto, Canada).
- Krause, M. (1995). La investigación cualitativa: Un campo de posibilidades y desafíos [Qualitative research: A field of possibilities and challenges]. *Revista Temas de Educación*, 7, 19-40.
- Lutz A., Lachaux J. P., Martinerie J. & Varela F. J. (2002) Guiding the study of brain dynamics using first person data: Synchrony patterns correlate with on-going conscious states during a simple visual task. *Proceedings of the National Academy of Sciences United States of America* 99: 1586–1591
- Lyons Ruth, K. (2000) “I sense that you sense that I sense...”: Sander's recognition process and the specificity of relational moves in the psychotherapeutic setting. *Infant Mental Health Journal*, 21 (1-2), 85-98 doi: 10.1002/(SICI)1097-0355(200001/04)21:1/2<85::AID-IMHJ10>3.0.CO;2-F
- Lyons- Ruth, K. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health*, 19 (3), 282-289.
- Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanal. Inq.*, 19, 576-617.

- Lyons-Ruth, K., Bruschweiler- Stern, N., Harrison, A., Morgan, A., Nahum, J., Sander, L., Stern, D., & Tronick, E. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19 (3), 282–289.
- Mearns, D. and Cooper, M. (2005) *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.
- Ogden, T. (1994), The analytic third: Working with intersubjective clinical facts. *Internat. J. Psycho-Anal*, 75:3-19.
- Olivares, F.A., Vargas, E., Fuentes, C., Martínez-Pernía, D., & Canales-Johnson, A (2015) Neurophenomenology revisited: second-person methods for the study of human consciousness. *Front. Psychol.* 6:673. doi: 10.3389/fpsyg.2015.00673
- Orange, D.M., Atwood G. E., & Stolorow R. D. (1997). *Working Intersubjectively: Contextualism in psychoanalytic practice*. The Analytic Press: Hillsdale, NJ.
- Patton, M. Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Service Research*, 5, 1189-1208.
- Petitmengin C. (1999) The intuitive experience. *Journal of Consciousness Studies* 6 (2–3): 43–47.
- Petitmengin C. (2006) Describing one’s subjective experience in the second person. An interview method for the science of consciousness. *Phenomenology and the Cognitive Sciences* 5: 229–269.
- Petitmengin C., Navarro V. & Le Van Quyen M. (2007) Anticipating seizure: Pre-reflective experience at the center of neurophenomenology. *Consciousness and Cognition* 16: 746–764.
- Ponterotto, J. G. (2006). Brief note on the origins, evolution, and meaning of the qualitative research concept “thick description”. *The Qualitative Report*, 11, 538-549. Extraído de <http://www.nova.edu/ssss/QR/QR11-3/ponterotto.pdf>

- Remillieux, A. (2009). Explicitation et modélisation des connaissances de conduite de changement à la SNCF: Vers une gestion des connaissances pré-réfléchies. (Doctoral Thesis. Institut national des telecommunications d'Evry, Évry, France)
- Safran, J. D., & Muran, J. C. (2000) *Negotiating the therapeutic alliance*. New York: Guilford Press.
- Siegel, D.J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. New York: W.W. Norton & Company.
- Siegel, D.J. (2012). *The developing mind. How relationships and the brain interact to shape who we are* (2° ed.). New York Guilford Press
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, B,... & Tronik, E. (1998). Non Interpretative Mechanisms in Psychoanalytic Therapy. The “something more” than interpretation. *Int. J. Psycho-Anal*, 79, 903-921.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, Bruschweiler Stern, N., & Tronik, E. (2002). Explicating the implicit: The local level and the microprocess of change in the analytic situation. *Int. J. Psychoanal*. 83, 1051-1062.
- Valenzuela-Moguillansky, C. (2012). *The Relation between Pain and Body Awareness: An Investigation Using Experimental and Experiential Methods* (Doctoral Dissertation, Université Pierre et Marie Curie du Paris, Paris, France).
- Valenzuela- Moguillansky, C., O' Regan, K., & Petitmengin, C. (2013). Exploring the subjective experience of the “rubber hand” illusion. *Frontiers in human neuroscience*, 7 Art 659. doi: 10.3389/fnhum.2013.00659
- Varela F. J. (1996) Neurophenomenology: A methodological remedy for the hard problem, *Journal of Consciousness Studies* 3(4): 330–349.
- Varela, F.J., & Shear, J. (1999). First-person methodologies: what, why, how? *J. Conscious. Stud.* 6, 1–14.

Vermersch P. (1994/2011). *L'entretien d'explicitation* [The elicitation interview] (7th ed.).
ESF éditeur, Issy-les-Moulineaux.

Wallace, B.A. (2006). *The Attention Revolution: Unlocking the Power of the
Focused Mind*. Boston: Wisdom Press

VIII. Discussion and Conclusions

This dissertation was inspired and guided by moments of meeting in psychotherapy, a concept theoretically developed by Daniel Stern and the Boston Change Process Study group (Stern et al., 1998; Stern, 2004), but experientially lived by most therapists and patients who have undergone a psychotherapy process. The premise that during these moments, something unique happens between patient and therapist, that mark points of inflexion during the therapeutic process, and that these moments have such a significant potential for change -so well-articulated and described in the concept of moment of meeting- raised our interest to better understand how this process takes place for its participants from an empirical perspective.

In line with Stern et al.'s (1998) description of moments of meeting, how they arise in the interaction of its participants, and due to the briefness of the experience, we decided, for this research to consider, the whole sequence of moments described by the authors (present moment, now moment and moment of meeting) as an *episode of meeting*, to be able to grasp the complete phenomenon and give us a wider margin for its analysis and description. This research then, intended to respond to three main questions: What are the characteristics or qualities of *episodes of meeting* that enable their observation and identification throughout the psychotherapeutic process? What happens during the patient- therapist interaction that allows the appearance of these episodes? And What kind of effects do these episodes have for the psychotherapy process?

Therefore, the aim of this dissertation was to design a procedure for identifying and outlining episodes of meeting between therapist and patient during the psychotherapeutic process and to establish the main characteristics (verbal, non-verbal and relational) of the patient-therapist interaction during its occurrence. To answer these questions and fulfill our aim, a combined qualitative methodological approach was used, based on grounded theory and the micro-analytic interview to access patients', therapists' and experts' experiences and perspectives, and four specific objectives were developed.

In this section I will discuss each specific objective connecting them with different contributions from the articles of this dossier, the clinical and research implications of this work and future questions that have come up during this process.

The first objective was to determine general criteria for identifying and delimiting *episodes of meeting* and its three moments during the therapeutic process. To achieve this objective, preliminary work was developed, to give account of the study object and get familiar with the research field, mainly, the tradition of studying relevant moments in psychotherapy, and its relation with the change process and the therapist-patient interaction. The first thing we realized after a thorough review of empirical literature regarding relevant episodes in psychotherapy was that even though there are many systematic approaches that have provided understanding for what goes on during relevant episodes in psychotherapy, all of them focus their attention on the patient's actions or the effects these episodes may have on them. However, we did not find a measure for relevant episodes that attended to the interaction between patient and therapist, which has been firmly suggested to be a central aspect the psychotherapeutic change (Safran & Muran, 2000; Kramer & Stiles, 2015; Cozolino, 2016, Siegel, 2012). In this respect, the revision of the existing approaches on relevant episodes evidenced a gap between empirical and theoretical knowledge from an interactional and dynamic perspective. Our revision also found that methodologically there have been two kinds of approaches for relevant episodes: an observational approach, centered on the patients' actions and verbalizations during the episode, that is generally identified by the researcher. And a more subjective approach that attempts to understand relevant episodes from patients' and therapists' perspectives. This second approach gives account of more covert processes that can be elucidated through different methods such as IPR or retrospective interviews.

We also realized that even though the concept of moment of meeting was very well described by the Boston Group, emphasized the importance of patient- therapist interaction (Stern, et al., 1998) and very clinically accurate according to clinicians from different theoretical perspectives, there had only been some suggestions on how to study these moments empirically but very few and non-systematic studies were found (e.g. Bertoni & Sironi, 2009). As mentioned above, this also made us consider that moments of meeting seemed to be too brief to study on their own, so integrating present moments, now moments and moments of meeting in what we called *episode of meeting* could allow a wider time frame and better memories of them as well as a better chance of being able to apprehend them from a third person perspective. This allowed us to position episodes

of meeting as relevant episodes, for studying aspects that underlie therapist-patient interaction and their contributions to the change process in psychotherapy.

One of our first decisions and conclusions was that due to the characteristics of the study object, that is, a therapeutic exchange phenomenon, characterized by its implicit and procedural form, a methodological approach that combined both a third -person method with a first-person method was necessary. *Episodes of meeting*, being mainly lived and felt experiences, that are not of easy access to our consciousness, needed a mixed methodological approach to capture its essence, and to visualize a relevant aspect of psychotherapy that occurs at an implicit level, and is not only difficult for a third party to grasp but also difficult for the participants to spontaneously bring them to consciousness. As a result of this conclusion, we combined grounded theory, used for our interviews with dyads and therapists, with the microphenomenological interview (Vermersch 1994/2011; Petitmengin 2006), used for our interviews with patients, to enrich the data gathering and deepen in their experience of episodes of meeting.

Our first findings allowed us to grasp some of the most salient features of *episodes of meeting*, establish relations among its facilitating conditions, understand how therapists recognize the presence of these moments and their possible immediate and long-term effects.

Four central identification criteria emerged from this work. The first was the **novelty or uniqueness** of episodes of meeting. This criterion refers to the way in which these episodes unfold and explains these experiences as different from the usual experience of psychotherapy, because they seem to stand out from the process. The second criterion was the distinction therapists made between a continuous experience of meeting, which was a common feeling for therapists and related with a basal condition of the therapy process, and episodes of meeting which were felt and described as “bigger” and more intense moments that are usually surprising and emotionally charged. We named them **big M and little m** (in reference to Greenberg & Pinsof ,1986; Orlinsky, Ronnestad, & Willutzki, 2004 big O and little o during the change process) as an attempt explain how most interviewed therapist, no matter their theoretical orientation, conceive psychotherapy as being in relation with another, where little m construe the day to day psychotherapeutic relationship, while big M seem to stand out from little m due to its particular features.

Therapists described, little m as brief moments of connection or attunement with their patients, that happen frequently but fade quickly and do not necessarily disrupt the course of the psychotherapy. Therapists mentioned that they tended to feel these moments with most of their patients in a stronger or less stronger way, but remember the feeling or general impressions more than a specific moment or event. Big M on the other hand were defined as memorable moments, highly emotionally charged, surprising and unexpected, that disrupt the everydayness of the psychotherapy process and with great potential for modifying the course of the process depending on how the therapist decides to deal with its appearance. (unexpected answer versus an expected one). These moments are much easier to remember and for most therapists occurred in a more advanced phase of the process, but didn't always occur with all their patients.

The third criterion for identifying episodes of meeting, were its **non-verbal aspects**. Both patients and therapist refer to the importance of non-verbal elements such as tone of voice, pauses, facial and body gestures, corporal shifts and an increase in the emotional arousal as key aspects for identifying these episodes as such. Thus, episodes of meeting seem to be enhanced not only by explicit signs of meeting, such as the therapist verbalizing that they understand or are present for their patients, but are more fully felt moments, which have an emotional impact on the patient and can also be recognized in nonverbal cues that create a special atmosphere of connection.

The fourth criterion was the **idiosyncratic nature** of this phenomenon, which means that episodes of meeting are relationship specific and to be recognized as such there must be some previous understanding about that particular relational dynamic.

Regarding the delimitation of episodes of meeting, the use of the microphenomenological interview allowed us to apprehend these episode as a progression instead of an instance, where we could distinctly see how patients evoke a sequence of moments that are interconnected and how the episode of meeting unfolds through patient and therapists' interactions. In this way, we concluded that episodes of meeting are not static moments, they develop over time where beginning and end dilute easily. This discovery reinforced our initial idea of considering episodes of meeting as a sequence of present, now and moments of meeting. From this perspective moments of meeting seem to be the consequence of a previous instant that, in some cases, could be identified as a now moment

(according to the Boston Group description), but we also found other kinds of moments that preceded moments of meeting which were subtler, but even so, had great impact in the patient. This finding is in line with more recent work of the group as Nahum (personal communication, 2017) mentions "...that puts more of the emphasis on a patient feeling the Dr. is 'in sync' with him/her, on the same wave length", and not only on the state of discomfort as a product of their interaction. From this analysis of patients' experience we also found that moments of meeting as such are brief, implicit but strongly felt, and sustained in the interaction. In some cases that feeling was kept to themselves and in others it was brought up by the patient or by the therapist. But in a few cases, the feeling of being met was only made explicit for the patient when it was re-lived during the interview. In other words, it was initially not clear for the interviewer or the interviewee why he had chosen that particular event to explore, it seemed almost as if the selection, occurred at a preconscious or pre-reflective level and it was through the evocation of the experience that the interviewee could give it a conscious or reflective form. This made understanding the election of that particular event possible and gave us access to comprehending how the patient was able to feel met. In that sense, one of the elements that seems to give these events the quality of "meeting" may not be the moment itself, but what happens throughout the episode that finally culminates in a moment of meeting.

Objectives two and three, they were initially thought of as two different and separate dimensions of episodes of meeting: to identify verbal characteristics of *episodes of meeting* during the therapeutic process and to characterize the nonverbal aspects present in *episodes of meeting* during the therapeutic process. However, during this research, we realized that in this case, the question is actually one: How is what's being said, said, during that particular moment of connectedness? What we mean by this is that episodes of meeting are verbally and non-verbally intertwined, we speak with words, with the "explicit", but we also speak with the "implicit" with our body, our gestures and our emotions, these are metacommunications that are expressed to the other without words. So, explicit and implicit dimensions are not synonyms for verbal and non-verbal and what is said in between lines can be communicated very explicitly as what is said through words can communicate very implicitly.

Therefore, another finding from this work is that verbal- non-verbal distinctions, especially in processes that are guided by implicit relational knowledge, are not applicable in the same way as for other phenomena. The Cartesian dichotomy mind- body does not apply for studying this kind of events. In these episodes, the experience is communicated to and through the body, the body “talks” and sometimes what is said with words is communicated with the body, but sometimes it is not, and it can even be contradictory for the listener, who must ask himself, what do I listen to? What the other is saying with words or what his body is saying? In episodes of meeting when this inconsistency appeared, a subtle arrhythmia during the patient-therapist interaction took place. This arrhythmia marks the relation and slightly disrupts its path.

Another finding related to these objectives was that the content in itself seems to be irrelevant for episodes of meeting to take place, that means that almost any content brought by its participants can be a potential episode of meeting. The content is turned into something relevant according to the specific interaction dynamics and depending on who the participants are. In this study, patients that evoked certain contents as relevant during their experience of meeting remembered them because the theme was important to that patient in particular, and the therapist was able to notice this and work through it. The feeling of connectedness seems to be related to this ability of the therapist more than the content itself. Therefore, all verbalizations related to contents, semantic elections, and things that are being said provide the context of possibilities for something more to take place (something more than interpretation?), something that seems to go beyond words, through a bodily experience and acquire a different meaning for that specific and singular relational context. Many of our interviewees, when asked to put these experiences into words expressed things like “I couldn’t quite say...” or “it was something like...” We think that “not knowing how to say” is a verbal expression that translates a non-verbal experience and reflects how these two processes are profoundly intertwined. This is not surprising if we consider that implicit and explicit memories are interconnected in the construction of memories, especially autobiographical ones (Siegel, 2012; Conway, Justice, & Morrison, 2014; Köhler, 2014). What did surprise us, was how we could see these two processes combine during our interviews, especially during the microphenomenological interview, where much of the evoked memories were from an

implicit level: sensations, feelings and bodily experience. In this interview process, the interviewee had to find the proper words to express these sensations, often finding that his/her repertory of words was not accurate enough. What is interesting about this phenomenon, is that in many of these cases it was only in the re-lived moment that the interviewee attempted to find these words, to make explicit something that had been stored in an implicit way, as an intention to make sense of this experience and give it a form of story. This made us ask ourselves how many episodes of meeting stay in a pre-reflective state, in the body, but only when asked about do they turn from implicit into explicit memories and the patient can integrate these experiences into his autobiography. It seems that in this effort to make explicit an implicit experience, through the use of language and words the explicit and implicit tie together, because the patient inserts this experience into his own biography.

If we think about memories and episode of meeting, the procedural memory could be understood as the implicit relational knowledge that each participant brings to the therapy. The semantic knowledge, as a more general and universal knowledge of what it means to go to therapy, a general average of memories regarding that experience, while episodic memories of therapy would be based on specific memories, emotionally charged, and that have a reconstructive subjective and autobiographic character, for the construction of our identity. It is in this last kind of memory that the microphenomenological interview acts upon. So, in some way, we think it is probable that episodes of meeting are constructed in the experience with others for example in therapy, but also during the interview. We think that to be able to tell it, talk about it, re-live it can also be part of feeling met. We also found that not everything transpires in that precise evoked episode and that the meeting may not be only with another but also with the own experience, the own history, even when this may never be explicit for the therapist, and he may never know how he helped the patient find himself.

In some cases (PE7, PE3, PE5) it was difficult to identify what made the event evoked by the patient an episode of meeting. What seemed to occur in these cases was that the patient had a necessity or was troubled by something in that particular moment and the therapist's response to it provided the perfect fit, creating a particular experience that took place in this verbal scene but was non-verbally felt. In those case the *experience* the patient

had during that episode, in relation to the response to his needs provided the feeling of being understood or feeling met. As PE7 expressed during the interview *“when I left [the therapy session] I remember thinking, she really gets me... and now that I think about it, the advice she gave me is still useful until today”*

Episodes of meeting take place in an implicit communicational dimension, that has verbal and non-verbal implications, the bodily experience is transversal, the sensation of being met is what the patient feels. Episodes of meeting occur in an implicit level, but can be made explicit, this is where the shared implicit relational knowledge emerges: you know what I need, I know you know because you know me. We think that one of reasons that made it hard to understand the “meeting” part of the aforementioned episodes, was because episodes of meeting acquire their own shape and form due to this shared knowledge that can only be understood by them, therefore they were not evident to the researchers because they stood out in that particular relational context to which we did not have complete access to. This brought us to ask ourselves, who decides what an episode of meeting is? The researcher or the interviewee?

This question brought us to reflect upon the first- second and third person methods. While first- person methods emphasize the importance of collecting data directly from the person who has lived the phenomenon we are investigating, second- person perspective (Varela & Shear, 1999), uses interviews that are mediated by a trained interviewer to help the participants describe their experience accurately, “an interviewer or mediator with the “attitude” for reporting first-person data” (Olivares et al., 2015, p. 2), Third- person methods on the other hand understand the data gathering as an external process that is made from a neutral outsider of the experience, therefore depends on observable data for recollecting information.

Due to the characteristics of our study object and how little we still know about implicit processes in general, we consider that first and second person data collection seem to be more fitting, in this stage of our work, for understanding the constitutive processes that build up subjective experiences, such as the formation of perceptual meaning, temporal continuity or implicit bodily actions (Fuchs, 2010). In this way, we understand that the chosen episode is picked for some reason out of a whole process of psychotherapy, this

means that even if it is not directly and immediately accessible to the interviewer or researcher, it was accessible at least at a pre-reflective level for the interviewee.

As a recapitulation of our findings regarding objectives two and three, it's possible to say that one of the characteristics of episodes of meeting is that they can eventually be verbalized, but its occurrence takes place analogous to discourse, in a non-verbal dimension. Sometimes these feelings are not even mentioned by the patient and they stay as a bodily felt sensation. Maybe this is one of the reasons, we couldn't trace regularities regarding certain contents or themes, as they seem to be relation and even episodically specific. Even though no regularities were found, we could find a specific verbal form in the evocation of episodes of meeting, which seems to be more reflective, with less words, full of pauses, as if looking for the right words, changes in the rhythm (slower or faster) and emotionally charged.

Our findings, that verbal aspects are not what mainly characterize episodes of meeting, are consistent throughout the research and with the work of Stern et al. (1998). However, it is important to remember that it is in a specific verbal context such as psychotherapy, that this phenomenon occurs and probably its contrast with its non-verbal features are what enable these moments to stand out from the rest of the process. In this sense, this phenomenon does not reveal itself in verbal terms, but in non-verbal ones such as the intention of what is being said, expressivity of the discourse, tone, prosody or a discursive position that may be related to verbal structure, such as repeating a phrase or emphasizing certain words in the discourse. Verbalization and non-verbalization come together in this phenomenon, what is said with words and what is said with the body, not only what is said but how are things said: with words, with the body, with prosody, with nonverbal speech.

In personal communication Lyons- Ruth (2016) reflects on the work of the Boston Group and thinks that initially their work may have been oversimplified as a distinction between verbal and non-verbal. She sustains that the idea was more in line with distinguishing relational understanding from explicit interpretation and to establish that there are more ways to know oneself and learn about relationships than simply through verbal understanding. This implies not only interpreting non-verbal cues but also the multiple levels of communication that are communicated in a verbal message. This supposes not

only knowing what a word means but also how it is said, what words are put around it, the tone of voice, the inflexion and the context in which that word is said. “Every verbal syllable you utter is embedded in this enormous context, so it absolutely is about that whole envelope around every word, but it is a very complex surround...” (Lyons- Ruth, personal communication, 2016)

Episodes of meeting seem to take place in a non-verbal dimension, but they don’t have regularities either, because feelings, sensations, gestures and bodily communication can be so diverse. Even so during the research process we found certain keys to the non-verbal aspects of these moments. One of them was the **shift in the emotional, physical, facial or gestural state**, produced when these episodes occur. Both patients and therapists mention that they were able to feel in their selves and see in the other certain changes of state that in some way evidenced the appearance of these episodes. In some cases, it could be during the episode itself and in others it was after the episode ended, but this shift was observable and noticed from both parties even if they decided to leave it there. In other words, episodes of meeting are felt experiences, the body feels it and expresses it in some way such as relief, relax, astonishment, laughter, calmness, feeling hugged, or feeling understood. This is also consistent with what was mentioned above that the felt sensation seems to be what allows us to recognize an episode of meeting and give it a meaningful value.

Finally, the fourth objective of this dissertation was to establish the characteristics of the relational dynamic between patient and therapist during *episodes of meeting*. As a first approximation to this objective, our single case study confirmed that relational aspects of the psychotherapy process are of great relevance for both patient and therapist and that these aspects seem to be fundamental for the continuity of the process and for change to take place. It also revealed how some events in particular, seem to be significant in the memories of both participants due to its emotional intensity and its profound impact on them, which made us think of them as episodes of meeting. We also considered that in a way, episodes of meeting seem to be a type of what Castonguay & Hill (2012) call corrective experiences which are understood as events that challenge the patients fear or expectations and lead to new outcomes. These authors define corrective experiences as

experiences in which a person comes to understand or experience affectively an event or relationship in a different and unexpected way. This means they are not typically helpful events but are surprising or disconfirming of past experiences and often have a profound effect. They also mention that this kind of events often take place in psychotherapy and we add that this happens in many different ways and many different levels, for example in explicit and implicit domains. This concept is very in line with episodes of meeting as it also suggests that a client's ability to interact with a therapist in a way that is different from how they interacted with earlier significant figures in their lives could, in itself, produce therapeutic change.

Other findings regarding the relational dynamics of patient and therapist during episodes of meeting are their idiosyncratic and unique nature, due to the particular patient and therapist features and how that particular dyad interacts. As such, and as analyzed regarding the other objectives, episodes of meeting are very substantially different from one patient to another, from one therapist to another, they do not share the same content, do not appear during the same time, for the same reasons or in the same way, during different psychotherapy processes and the aspects that make these episodes special for one process may not necessarily do the same for another. However, despite its variability, the use of the micro-analytic interviewee to apprehend patients experience on episodes of meeting helped us identify certain regularities regarding their general form and how they unfold. What triggers the encounter, this is the event that takes place between patient and therapist that initiates the sequence of meeting can be identified retrospectively from the sensation of feeling met. In other words, the triggering event and the feeling met give each other feedback and enhancement each other during the evocation, this means that the event turns into something significant because the patient felt met, but at the same time, it is this event that opens the possibilities of being met. We state that it is not event that make the patient feel met, but mostly how the therapist responds to this event.

Once the episodes were identified, it was possible to perceive that there is a certain relational code and previous understanding, that sustained the episodes, a previous mutual knowledge of each other, a representation where many elements contribute to this knowledge. It does not necessarily have to be a long relationship, but when the therapist is able to understand and perceive what elements of the patient are put at stake, it is then

that the possibilities for the emergence of an episode of meeting increase. As Lyons-Ruth (2000) says, as energy is invested in a new complex dyadic therapeutic system, the system will give rise to spontaneous emergent properties, that are forms of organization that are not specified a priori but emerge in the interaction between the dyad. This is shared relational knowledge which allows episodes of meeting to take place. In other words, there is a structure of that psychotherapy process, a previous shared relational knowledge of how to conduct and conceive this relationship which is disrupted by that particular event, by something that happens or even by something the therapist does. Initially this generates the sensation in the patient that they have wandered off, for some it was felt like a miss-attunement, for others it was more of a surprise or perturbation or simply feeling a little thrown off or puzzled by what is happening, when the therapist is able to capture this is when the possibility to re-attune, repair, and move on appears. Only then can the therapy and the relationship move forward. As mentioned before, this can occur in a very subtle and non-verbal way, but is understood by both of them through gestures, gazes, pauses, a language. But there seems to be a second type of moment of encounter that also appears a lot in the investigation, which has to do with the fact that this moment of surprise, disagreement, displacement does not take place, but that it moves more smoothly without so much fright. Here the therapist seems to confirm in some way the relational history of both, the knowledge that they have of each other and with that what it does is that it sustains the patient, which also produces the sensation of being felt or being found. This feeling is described by patients as they know me, know what I need, etc.

As described in article 4, it seems that episodes of meeting, no matter how different they can be, have a generic diachronic structure that contains five phases and ends when the event is resolved or the familiar pathway is retaken. However, this doesn't mean that the felt experience disappears, because the feeling of being met is enduring and can be elaborated over time.

Stern et al., (1998) described other fates for now moments such as missed, failed, repaired, flagged and enduring now moments. We think that much of the episodes of meeting recollected in this work, from both therapists and patients can, in some way, reflect the last three fates of now moments because, even if the episode is evoked as a continuum, many of these episodes were not continuous in a minute to minute way, but took more

time for the phase of meeting to emerge. In some cases, therapists were able to repair the miss-attunement and that was what generated the phase of meeting, in other cases the sense of meeting was perceived by the therapist, the patient or both, but not talked about until a new opportunity arose and in other cases it took more than one session to turn into a meeting.

As Stern says about moments of meeting, it's a universe contained in a grain of salt, these episodes condense so much information about the patient, about the therapist and about the relationship that is thick and tightly tied. These episodes give us the possibility to look inside the therapy process and get a glimpse of how each unique process unfolds.

Final considerations

To end our analysis, we consider important to discuss some of the reflections that emerged while accomplishing this work.

A first thought concerning our results has to do with the value episodes of meeting have for the process of change in psychotherapy and how we can understand change as an ongoing process and not only as a final result. In this line, it seems to be that episodes of meeting rescue the singularity and the idiosyncratic aspects of change, that are particular to a specific person, a specific dyad and a specific relation, and as such can only be understood in this particular context. This makes us ask ourselves many questions such as: Is an episode of meeting enough to generate change? Do these episodes of meeting summarize in some way the experience of the psychotherapy process? Are episodes of meeting the climax of therapy or are they the starting points? Are they the core of change or do the set conditions for change to take place? Where we stand today, and at this initial point of our work we can say that it is probably all of the above but at the same time none of them in their selves, because their idiosyncratic nature allows them to take a form of their own in every psychotherapeutic experience. The question that follows is how can we approach them empirically while respecting their particularities, and not falling in reductionism. We think that this work is a first step in this direction, but much work is still to be done.

A second relevant aspect is that even though the emergent theory that has been empirically constructed along this dissertation and validated through the observation of patients and clinicians is an approach to dialog with the work of Stern and the Boston Group we do not

know, and cannot say if it corroborates their thinking. This, mainly because we cannot know if the episodes of meeting lived by the patients and described by the therapists are the same of the Boston Group, since inner experience is not entirely accessible from a third person perspective. What we have been able to observe is that at least part of what has been theoretically described by the Boston Group is easily recognizable for the all participants of the psychotherapy process and the sensation of feeling met is something that occurs across most psychotherapy experiences.

It is important to mention, that this perspective and in particular this dissertation does not intend to respond how change takes place, rather put under discussion that in the production of therapeutic change there are multiple dimensions that interact. In this line of thought, there are approaches that concentrate on observable and explicit moments that take place in psychotherapy such as change episodes (Krause, 20065, 2006. 2007) or innovative moments (Gonçalves, 2009, 2010, 2012) that are focused on representational process of change or approaches that attend more technical and explicit dimensions of psychotherapy, such as the importance of interpretation or the therapeutic framework, the definition of therapeutic focus or adequate elaboration of therapeutic goals (Dagininio 2012). We do not disavow these relevant contributions, but look to complement this approach by focusing on a process that has a subconscious register and that may take place outside of our conscious awareness, but nevertheless seem to have an impact on its participants, that can be evocated afterwards, due to its intensity and strength.

It is important to consider that integrating these implicit aspects in our clinical work and reflection, and decreasing our apprehension of what happens outside the technical, predictable and planed aspects of therapy can turn them in favor of our clinical work. As Nahum (1994, p3) reflects, “Sander (1983) has called this disjoin an ‘open space’ in which the infant can be alone, briefly, in the presence of the other, as they share the new context (Winnicott, 1957). Here an opening exists in which a new initiative is possible, one freed from the imperative of regulation to restore equilibrium. The constraint of the usual implicit relational knowledge is loosened and creativity becomes possible” We think that in a similar way these moments in psychotherapy open new spaces for change, and reflect on how the “intensity” the “detail”, the “accidental” or the “spontaneous” aspects of the interaction, the unplanned, but yet decided actions, give vitality to the therapeutic process.

IX. Complete References

- Aron, L. (1998). The clinical body and the reflexive mind. Aron, L. and Anderson, F. S. (ed.). *Relational Perspectives on the Body*. Hillsdale, N.J.: The Analytic Press, pp 3-38
- Adler, J.M. (2013). Clients' and therapists' stories about psychotherapy. *Journal of Personality*, 81 (6), 595-605.
- Alexander, F., & French, T. (1946). *Psychoanalytic Therapy*. New York: Ronald Press.
- Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomicic, A., Valdés, N., ..., & Pérez, J.C., (2010). Clients', therapists' and observers' perspectives on moments and contents of therapeutic change. *Psychotherapy Research*, 20, 472 – 487. doi: 10.1080/10503301003705871
- Araminta, T. (2000). Dialectical behavior therapy: A qualitative study of therapist and client experience. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 61(1-B), 520.
- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC: American Psychological Association.
- Athanasiadou-Lewis, C. (2016). My subdued ego: A psychodynamic case study of borderline personality disorder following relational trauma. *Psychodynamic Practice*, 22 (3), 223-235. doi: 10.1080/14753634.2016.1198274
- Barkham, M., & Margison, F. (2007). Practice-based evidence as a complement to evidence-based practice: From dichotomy to chiasmus. In C. Freeman and M. Power (Eds.), *Handbook of evidence-based psychotherapies: A guide for research and practice* (pp. 443-476). Chichester: Wiley.
- Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge-base for the psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering*

- practice-based evidence: A guide for the psychological therapies.* (pp. 21–61). Chichester: Wiley.
- Bastine, R., Fiedler, P., & Kommer, D. (1989). Was ist therapeutisch an der Psychotherapie? Versuch einer Bestandsaufnahme und Systematisierung der Psychotherapeutischen Prozeßforschung [What is therapeutic in psychotherapy? Attempt of stocktaking and codification of the psychotherapeutic process research]. *Zeitschrift für Klinische Psychologie*, 18, 3-22.
- Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, J. (2000). Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. *Infant Mental Health Journal*, 21, 99-122.
- Beebe, B., Knoblauch, S., Rustin, J., & Sorter, D. (2005). *Forms of Intersubjectivity in Infant Research and Adult Treatment*. New York: Other Press
- Beebe, B., & Lachmann, F. M. (1988). The contribution of mother-infant mutual influence to the origins of self- and object representations. *Psychoanalytic Psychology*, 5, 305-337.
- Beebe, B., & Lachmann, F. M. (1998). Co- Constructing Inner and Relational Processes: Self and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology*, 15, 480-516.
- Bertoni, M. & Sironi A. (2009). Dalla clinica alla ricerca: andata e ritorno. Per una ricerca sul processo di cambiamento: il gruppo “Kairòs” Retrieved from <http://www.psicoanalisiikairos.joomlafree.it/2014-03-22-02-12-53/dalla-clinica-alla-ricerca.html?tmpl=component&print=1&page>
- Blatt, S. (2013). The Patient’s Contribution to the Therapeutic Process: A Rogerian – psychodynamic Perspective. *Psychoanalytic Psychology*, 30, 139– 166 doi 10.1037/a0032034
- Bohart, A. C., & Wade, A. G. (2013). The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin & Garfield’s handbook of psychotherapy and behavior change* (6th ed.) (pp. 219-257). Hoboken, NJ: Wiley.

- Bordin E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy* 16, 252–260.
- Boston Change Process Study Group. (2002). Explicating the implicit: The local level and the micro process of change in the analytic situation. *Int. J. Psychoanal.* 83 1051-1062
- Boston Change Process Study Group. (2005). The “something more” than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Japa* 693-729
- Boston Change Process Study Group. (2008a). Forms of relational meaning: Issues in the relations between the implicit and reflective- verbal domains *Psychoanalytic Dialogues*, 18, 125-148. doi:10.1080/10481880801909351
- Boston Change Process Study Group. (2008b). Forms of relational meaning: Reply to commentaries. *Psychoanalytic Dialogues*, 18, 197-202. doi: 10.1080/10481880801909583
- Boston Change Process Study Group. (2010). *Change in Psychotherapy: A unifying paradigm*. New York: Norton
- Bourke, M., & Grenyer, B. (2013) Therapists’ accounts of psychotherapy process associated with treating patients with borderline personality disorder. *Journal of Personality Disorders*, 27(6), 735-745. doi: 10.1521/pedi_2013_27_108
- Braakmann, D. (2015). Historical Paths in Psychotherapy Research. Foundations, Process and Outcome. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 39-65). New York: Springer-Verlag.
- Bruner, J., (1986). *Actual minds, possible worlds* Cambridge, Mass: Harvard University Press.
- Bruner, J. (1990). *Acts of Meaning*. Cambridge, Mass: Harvard University Press.
- Carrasco, I., & Vivanco, M. (2011). ¿Sistemas dinámicos en Ciencias Sociales? [Dynamic systems in social science?] *Revista de Sociología*, 26 169-191

- Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.) (pp. 85–133). Hoboken, NJ: Wiley.
- Castonguay, L.G., Boswell, J.F., Constantino, M.J., Goldfried, M.R., & Hill, C.E. (2010). Training Implications of Harmful Effects of Psychological Treatments. *American Psychologist*, 65, 34-49.
- Castonguay, L., & Muran, J.C. (2015). Fostering collaboration between researchers and clinicians through building practice-oriented research: An introduction. *Psychotherapy Research*, 25(1), 1-5. doi: 10.1080/10503307.2014.966348
- Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. Los Angeles, CA: Sage.
- Charmaz, K. (2014). *Constructing grounded theory. A practical guide through qualitative analysis* (2nd ed.). Thousand Oaks, CA: Sage.
- Conway, M.A., Justice, L.V., & Morrison, C.M. (2014). Beliefs about autobiographical memory. *Psychologist*, 27(7), 502–505.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.
- Cozolino L. (2002). *The Neuroscience of Psychotherapy*. New York: W.W. Norton
- Cozolino L. (2014). *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain*. New York: Norton Series on Interpersonal Neurobiology
- Cozolino, L., (2016). *Why Therapy Works. Using our minds to change our brains*. New York: Norton Series on Interpersonal Neurobiology.
- Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (4th ed.). Los Angeles: Sage.
- Dagnino, P. (2012) *Focus in Psychotherapy: Characteristics and trajectories through the therapeutic process* (Doctoral thesis Heidelberg University in cooperation with the Pontificia Universidad Católica de Chile)

- De la Cerda, C., Tomicic, A., Pérez, C., & Martínez, C. (2017). Mentalizing in the psychotherapeutic process: The reflective functioning of patient and therapist in psychotherapy. *Paper under review for publication.*
- Dimaggio, G., Salvatore, G., MacBeth, A., Ottavi, P., Buonocore, L., & Popolo, R. (2017). Metacognitive interpersonal therapy for personality disorders: A case study series. *Journal of Contemporary Psychotherapy*, 47(1), 11-21. <http://dx.doi.org.uchile.idm.oclc.org/10.1007/s10879-016-9342-7>
- Duarte, J., Fischersworing, M., Martínez, C., & Tomicic, A. (2017): "I couldn't change the past; the answer wasn't there": A case study on the subjective construction of psychotherapeutic change of a patient with a Borderline Personality Disorder diagnosis and her therapist, *Psychotherapy Research*, Advance online publication. DOI: 10.1080/10503307.2017.1359426
- Eells, T. D. (Ed.). (2007). *Handbook of psychotherapy case formulation (2nd ed.)*. New York: Guilford Press.
- Elliot, R. (1983). "That in your hands": A comprehensive process analysis of significant events in psychotherapy. *Psychiatry* 46, 113-149
- Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. En L. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 249-286). New York: Guilford Press.
- Elliott, R. (1986). Interpersonal process recall as a psychotherapy process research method. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 503-527). New York: Guilford Press.
- Elliott, R. (1989). Comprehensive process analysis: Understanding the change process in significant therapy events. In M. Packer & R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 165-184). Albany, NY: SUNY Press.

- Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research*, 12(1): 1-21. doi: 10.1080/713869614
- Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research*, 18, 239-242. doi: 10.1080/10503300802074513
- Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research*, 20(2), 12-135. doi: 10.1080/10503300903470743
- Elliott, R., & Shapiro, D. A. (1988). Brief structured recall: A more efficient method for studying significant events. *British Journal of Medical Psychology*, 61, 141-153.
- Elliott, R., & Shapiro, D.A. (1992). Client and therapist as analysts of significant events. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-186). Newbury Park, CA: Sage.
- Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science.
- Elliot, R., Watson, J., Goldman, R., & Greenberg, L. (2004). *Learning Emotion-focused therapy: The Process-Experiential approach to change*. Washington: American Psychological Association.
- Elliott, M. & Williams, D. (2003). The client of counselling and psychotherapy. *Counselling Psychology Review*, 18(1), 34-38.
- Fernández, O., Herrera, P., Krause, M., Pérez, J., Valdés, N., Vilches, O., & Tomicic, A. (2012). Episodios de Cambio y Estancamiento en Psicoterapia: Características de la comunicación verbal entre pacientes y terapeutas. [Change and Stagnation Episodes in Psychotherapy: Characteristics of verbal communication between patients and therapists] *Terapia Psicológica*, 30(2), 5-22.
- Fiedler, P., & Rogge, K. E. (1989). Zur Prozess Untersuchung psychotherapeutischer Episoden. Ausgewählte Beispiele und Perspektiven [On the investigation process of psychotherapeutic episodes. Selected examples and perspectives]. *Zeitschrift für Klinische Psychologie*, 18, 45-54.

- Fishman, D.B. (2005). Editor's introduction to PCSP- from single case to database: a new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy*, 1(1): 1-50.
- Flick, U. (2002). *An introduction to qualitative research* (2nd ed.). New York: SAGE.
- Fonagy, P. & Allison, L. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, 51(3), 372-380. doi: 10.1037/a0036505
- Fonagy, P., Luyten, P., Campbell, C., & Allison, L. (2014). Epistemic trust, psychopathology and the great psychotherapy debate. [Web Article]. Retrieved from <http://www.societyforpsychotherapy.org/epistemic-trust-psychopathology-and-the-great-psychotherapy-debate>
- Fosshage, J. (2003). Fundamental pathways to change: Illuminating old and creating new relational experience. *Int. Forum Psychoanal*, 12, 244-251. doi: 10.1080/08037060310018247
- Fosshage, J. (2011). How do we “know” what we “know”? and change what we “know”? *Psychoanalytic Dialogues*, 21, 55-74. doi: 10.1080/10481885.2011.545328
- Frankel, Z. F. & Levitt, H. M. (2008). Clients' experiences of disengaged moments in psychotherapy: A grounded theory analysis. *Journal of Contemporary Psychotherapy*, 39, 171-186. doi: 10.1007/s10879-008-9087-z
- Friedman, M. S. (1985). *The healing dialogue in psychotherapy*. New York: Jason Aronson
- Fuchs, T. (2010). Subjectivity and Intersubjectivity in Psychiatric Diagnosis. *Psychopathology*, 43, 268-274. doi: 10.1159/000315126
- Galassi, J. P., & Gersh, T. L. (1993). Myths, misconceptions, and missed opportunity: Single- case designs and counselling psychology. *Journal of Counselling Psychology*, 40, 525-531. doi: 10.1037/0022-0167.40.4.525
- Gelso, C.J. (2009). The real relationship in psychotherapy in a postmodern world. Theoretical and empirical explorations. *Psychotherapy Research*, 19(3), 253- 264. doi.org/10.1080/10503300802389242

- Gelso, C.J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. Washington, D. C.: American Psychological Association.
- Glaser, B. y A. Strauss (1967). *The discovery of grounded theory: strategies for qualitative research* . New York: Aldine Publishing Company
- Goldfried, M. (2012). The Corrective Experience: A Core Principle for Therapeutic Change. In L. Castonguay & C. Hill (Eds.), *Transformation in Psychotherapy. Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches* (pp. 13-28). Washington D.C.: American Psychological Association.
- Gonçalves, M. M., Mendes, I. Cruz, G., Ribeiro, A., Sousa, I., Angus, L., & Greenberg, L. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research*, 22(4), 389-401. doi: 10.1080/10503307.2012.662605.
- Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotion focused therapy: The case of Lisa. *Journal of Constructivist Psychology* 23(4), 267-294. doi:1 0.1080/10720537.2010.489758
- Gonçalves, M., Matos, M., & Santos, A. (2009). Narrative Therapy and the nature of “innovative moments” in the construction of change. *Journal of Constructivist Psychology*, 22(1), 1-23. doi: 10.1080/10720530802500748
- Gonçalves, M. M., Ribeiro, P. A., Mendes, I. Matos M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The Innovative Moments Coding System. *Psychotherapy Research*, 21(5), 497-509. doi: 10.1080/10503307.2011.560207
- Greenberg, L.S. (1976). *Task analytic approach to the study of psychotherapeutic events*. (Doctoral dissertation, York University, Toronto, Ontario, Canada)
- Greenberg, L.S. (1984). Task analysis: The general approach. In L. Rice & L. S. Greenberg (Eds.) *Patterns of change: Intensive analysis of psychotherapy process* (pp. 124-148). New York: Guilford Press.
- Greenberg, L.S. (1986). Change process research. *Journal of Consulting and Clinical Psychology*, 54(1), 4-9.

- Greenberg, L.S. (2002). *Emotion-Focused Therapy: Coaching Clients to Work Through Their Feelings*. Washington, D.C: American Psychological Association.
- Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, 17, 15-30. doi:10.1080/10503300600720390
- Greenberg, L.S., Elliott, R. & Pos, A. (2008). Emotion-focused therapy: An overview. *European Psychotherapy* 7, 19-40
- Greenberg, L.S., Ford, C., Alden, L. & Johnson, S. M. (1993). In-session change in emotionally focused therapy for couples. *Journal of Consulting and Clinical Psychology*, 61, 78-84.
- Greenberg, L.S., & Johnson, S. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.
- Greenberg, L.S., & Pinsoff, W.M. (1986). Process research: Current trends and future perspectives. In L.S. Greenberg & W.M. Pinsoff (Eds.), *The psychotherapeutic process. A Research Handbook* (pp.3-20). Nueva York: Guilford Press.
- Greenberg, L.S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: Guilford Press.
- Greenberg, L. & Watson, J. (2006). *Emotion-focused therapy for depression*. Washington DC: American Psychological Association.
- Gullestad, F. & Wilberg, T. (2011). Change in reflective functioning during psychotherapy. A single-case study. *Psychotherapy Research*, 21(1), 97-111. <http://dx.doi.org.uchile.idm.oclc.org/10.1080/10503307.2010.525759>
- Helmeke, K. & Sprenkle, D. (2000). Client's perceptions of pivotal moments in couples' therapy: a qualitative study on change in therapy. *Journal of Marital and Family Therapy*, 26, 69-83.
- Hendricks, M. (2009) Experiencing level: An instance of developing a variable from a first-person process so it can be reliably measured and taught. *Journal of Consciousness Studies* 16 (10–12): 129–155.

- Henretty, J. R., Levitt, H. M., & Mathews, S. S. (2008). Clients' experiences of moments of sadness in psychotherapy: A grounded theory analysis. *Psychotherapy Research*, 18, 243–255. doi:10.1080/10503300701765831
- Herrera, P., Fernández, O., Krause, M., Vilches, O., Valdés, N. & Dagnino, P. (2009) Revisión Teórica y Metodológica de las dificultades en psicoterapia: Propuesta de un modelo ordenador. [Theoretical and Methodological revision of difficulties in psychotherapy: A proposal of a unifying model] *Terapia Psicológica*, 27(2), 169-179
- Higa, J. & Gedo, P. (2012). Transference interpretation in the treatment of borderline personality disorder patients. *Bulletin of the Menninger Clinic*, 76(3), 195-210. doi: 10.1521/bumc.2012.76.3.195
- Hill, C., Castonguay, L., Farber, B., Knox, S., Stiles, W.B., Anderson, T., ...& Beck, J. G. (2012). Corrective Experiences in Psychotherapy: Definitions, Processes, Consequences and Research Directions. In L. Castonguay & C. Hill (Eds.), *Transformation in Psychotherapy. Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches* (pp. 355-370). Washington D.C.: American Psychological Association.
- Hill, C. E., & Knox, S. (2008). Facilitating insight in counseling and psychotherapy. In R. Lent & S. Brown (Eds.), *Handbook of Counseling Psychology*, (4th ed) (pp. 284-302). Hoboken, NJ: Wiley.
- Hill, C. E., Williams, E. N., Heaton, K. J., Rhodes, R. H., & Thompson, B. J. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counselling Psychology*, 43, 207-217. doi: 10.1037/0022-0167.43.2.207
- Hilliard, R.B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology*, 61, 373-380. doi: 10.1037/0022-006X.61.3.373

- Hodgetts, A., Wright, J., & Gough, A. (2007). Clients with borderline personality disorder: Exploring their experiences of dialectical behavior therapy. *Counselling and Psychotherapy Research*, 7(3), 172-177. doi: 10.1080/14733140701575036
- Horn, N., Johnstone, L., & Brooke, S. (2007) Some service user perspectives on the diagnosis of Borderline Personality Disorder. *Journal of Mental Health* 16(2): 255 – 269. doi:10.1080/09638230601056371
- Howe, K., & Eisenhart, M. (1993) Criterios de investigación cualitativa (y cuantitativa) [Qualitative (and quantitative) research criteria]. *Revista de Educación*, 300, 173-189.
- Hurlbert, R. (2011). *Investigating Pristine Inner Experience: Moments of Truth*. Cambridge, Cambridge Press
- Iwakabe, S. & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research* 19, 601 – 611. doi: 10.1080/10503300802688494
- Jacobson, N.S & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy-research. *Journal of Consulting and Clinical Psychology*, 59, 12-19.
- Jung, C. G. (1973/2010). *Synchronicity – An Acausal Connecting Principle*. The Collected Works of C. G. Jung. Vol. 8. Bollingen series XX. New Jersey: Princeton University Press
- Kagan, N. (1975). *Interpersonal process recall: A method of influencing human interaction*. Unpublished manuscript, University of Houston, TX.
- Katz E. (2011). *Attending to clinical practice: A phenomenological study exploring the structure of clinical attention and its relationship with holistic competence* (Doctoral thesis, University of Toronto, Toronto, Canada).
- Kazdin, A. E. (1999). The meanings and measurement of clinical significance. *Journal of Consulting and Clinical Psychology*, 67, 332–339. doi: 10.1037/0022-006X.67.3.332

- Kazdin, A.E. (2009) Understanding how and why psychotherapy leads to change. *Psychotherapy Research*, 19, 418-428.
- Kivlighan, D. M. & Arthur, E. G. (2000). Convergence in client and counsellor recall of important session events. *Journal of Counselling Psychology*, 47, 79-84.
- Knobloch-Fedders, L., Elkin, I., & Kiesler, D. (2014). Looking back, looking forward: A historical reflection on psychotherapy process research. *Psychotherapy Research* 1-13 doi: 10.1080/10503307.2014.906764
- Knox, S., Hess, S., Petersen, D., & Hill, C. (1997). A Qualitative Analysis of Client perceptions of the Effects of Helpful Therapist Self-Disclosure in Long-Term Therapy. *Journal of Counselling Psychology*, 44, 274-283.
- Köhler, L. (2014). On the Development of the Autobiographical Self and Autobiographical Memory—Implicit and Explicit Aspects, *International Journal of Psychoanalytic Self Psychology*, 9(1), 18-34, DOI: 10.1080/15551024.2014.857748
- Kramer, U. & Stiles, W. B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice*, 22, 277-295. doi: 10.1111/cpsp.12107
- Krause, M. (1992). Efectos subjetivos de la ayuda psicológica - Discusión teórica y presentación de un estudio empírico. *Psykhé*, 1, 41-52.
- Krause, M. (1995). La investigación cualitativa: Un campo de posibilidades y desafíos [Qualitative research: A field of possibilities and challenges]. *Revista Temas de Educación*, 7, 19-40.
- Krause, M. (1998). Construcción y transformación de teorías subjetivas a través de la psicoterapia [Construction and transformation of subjective theories through psychotherapy] *Terapia Psicológica*, 7, 29-43.
- Krause, M. (2005). *Psicoterapia y cambio. Una mirada desde la subjetividad* [Psychotherapy and change: A view from subjectivity]. Santiago: Ediciones Universidad Católica.

- Krause, M., Abarzúa, M., Silva, M., Navarro, D., Altimir, C (2016). Psicoterapia aus der Sicht von Klienten mit Schizophrenie. *Verhaltenstherapie & psychosoziale Praxis*, Volumen 48 Issue 1 (p. 83)
- Krause, M., de la Parra, G., Arístegui, R., Dagnino, P., Tómicic, A., Valdés, N., et al. (2007). The evolution of therapeutic change studied through generic change indicators. *Psychotherapy Research*, 17, 673- 689.
- Krause, M., de la Parra, G., Arístegui, R., Tómicic, A., Dagnino, P., Echavarri, O., Ben Dov, P., Reyes, L., Altimir, C., Ramirez, I. (2006). Indicadores de cambio genéricos en la investigación psicoterapéutica [Generic change indicators in psychotherapy research] *Revista Latinoamericana de Psicología*, 38(2), 299-325.
- Krause, M. & Martínez, C. (2011). Dynamics of subjective change in psychotherapy. A comment on the Paper "Dynamics of sense-making and development of the narrative in the clinical exchange" by Alessandro Gennaro, Miguel Gonçalves, Inês Mendes, António Ribeiro, & Sergio Salvatore. *Research in Psychotherapy*, 14(2), 14-12.
- Krause, M., Pérez, J. C., Altimir, C., & de la Parra, G. (2015). Generic Change Indicators in therapeutic processes with different outcomes. *Psychotherapy Research*, 25(5), 533-545, DOI: 10.1080/10503307.2014.935516..
- Kvale, S., & Brinkmann, S. (2009). *Interviews. Learning the craft of qualitative research interviewing*. Los Angeles: Sage.
- Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. En M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.) (pp. 169–218). Hoboken, NJ: Wiley.
- Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., ... & Yanchar, S. C. (1996). The Reliability and Validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy*, 3, 249-258.
- Landes, S. (2013). The Case: Treating Jared Through Dialectical Behavior Therapy. *Journal of Clinical Psychology*, 69(5), 488-489. doi: 10.1002/jclp.21984

- Larivière, N., Couture, E., Blackburn, C., Carbonneau, M., Lacombe, C., Schinck, S., ... & St- Cyr- Tribble, D. (2015). Recovery, as experienced by women with borderline personality disorder. *Psychiatric Quarterly*, 86(4), 555-568.
- Larsen, D., Flesaker, K., & Stege, R. (2008). Qualitative Interviewing Using Interpersonal Process Recall: Investigating Internal Experiences during Professional-Client Conversations. *International Journal of Qualitative Methods*, 7(1), 18-37.
- Levenkron, H. (2009). Engaging the implicit. Meeting points between the Boston Change Process Study Group and Relational Psychoanalysis. *Contemporary Psychoanalysis* 45, 179-217.
- Levine, P & Frederick, A. (1997). *Waking the tiger: Healing trauma*. California: North Atlantic Books
- Levine, P. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. California: North Atlantic Books
- Levitt, H. M. (2014). Qualitative Psychotherapy Research: The Journey So Far and Future Directions. *Psychotherapy*. Advance online publication. doi: 10.1037/a0037076
- Levitt, H. M., Butler, M., & Travis, H. (2006). What clients find helpful in psychotherapy: Principles for facilitating change. *Journal of Counseling Psychology*, 53, 314-324.
- Levitt, H. M., Pomerville, A., & Surace, F. I (2016) A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. *Psychological Bulletin*. doi: org/10.1037/bul0000057
- Lutz A., Lachaux J. P., Martinerie J. & Varela F. J. (2002) Guiding the study of brain dynamics using first person data: Synchrony patterns correlate with on-going conscious states during a simple visual task. *Proceedings of the National Academy of Sciences United States of America*, 99, 1586–1591.
- Lyons- Ruth, K. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health*, 19(3), 282-289.

- Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanal. Inq.*, 19, 576-617.
- Lyons Ruth, K. (2000) "I sense that you sense that I sense...": Sander's recognition process and the specificity of relational moves in the psychotherapeutic setting. *Infant Mental Health Journal*, 21(1-2), 85-98 doi: 10.1002/(SICI)1097-0355(200001/04)21:1/2<85::AID-IMHJ10>3.0.CO;2-F
- Lyons-Ruth, K., Bruschweiler- Stern, N., Harrison, A., Morgan, A., Nahum, J., Sander, L., Stern, D., & Tronick, E. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19(3), 282–289.
- Martin, J. Paivio, S. & Labadie, D. (1990) Memory-enhancing characteristics of client-recalled important events in cognitive and experiential therapy: integrating cognitive and experimental and therapeutic psychology. *Counseling Psychology Quarterly*, 3, 239-256.
- Martin, J., & Stelmachzonek, K. (1988). Participant's identification and recall of important events in counseling. *Journal of Counseling Psychology*, 35, 385-390.
- Martínez, C., Mendes, I., Gonçalves, M., & Krause, M. (2009) *Exploring the Construct Validity of Innovative Moments*. Poster presented at the SPR Annual European Meeting, Bolzano, Italia.
- Martínez, C. & Tomicic, A. (2016). *Discourse in psychotherapeutic interaction: Developing a Discursive Positioning Model (DPM)*. Unpublished manuscript
- Martínez, C., Tomicic, A., & Medina, L. (2014). Psychotherapy as a discursive genre: A dialogic approach. *Culture & Psychology*, 20, 501-524. doi: 10.1177/1354067X14551292
- Martínez, C., Tomicic, A., Medina, L., & Krause, M. (2004). A Microanalytical Look at Mutual Regulation in Psychotherapeutic Dialogue: Dialogic Discourse Analysis (DDA) in Episodes of Rupture of the Alliance. *Journal Research in Psychotherapy*:

- Psychopathology, Process and Outcome (RIPPPPO)*, 17(2), 73-92. doi: 10.7411/RP.2014.021
- Matos, M., Santos, M., Gonçalves, M. M., & Matins, C. (2009). Innovative Moments and change in Narrative Therapy. *Psychotherapy Research*, 19(1), 68-80 doi: 10.1080/10503300802430657.
- Mc Adams, D.P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: Morrow.
- McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. Thousand Oaks: Sage
- McLeod, J. (2010). *Case Study Research in Counselling and Psychotherapy*. London: Sage.
- McLeod, J., & Balamoutsou, S. (1996). Representing narrative process in therapy: Qualitative analysis of a single case. *Counselling Psychology Quarterly*, 9, 61-76.
- Mearns, D. and Cooper, M. (2005) *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.
- Mitchell, A., Eubanks-Carter, C., Muran, J.C., & Safran, J. D. (2011). Rupture Resolution Rating System (3RS). *Unpublished Manuscript*
- Morán, J., Martínez, C., Tomicic, A., Pérez, J.C., Krause, K., Guzmán, M.... de la Cerda, C. (2016). Verbal and nonverbal expressions of mutual regulation in relevant episodes of psychotherapy *Studies in Psychology*, 37, 2-3.
- Muran, J.C. (2002). A relational approach to understanding change: Plurality and contextualism in a psychotherapy research program. *Psychotherapy Research*, 12, 113-138.
- Nahum, J. (1994). New theoretical vistas in psychoanalysis: Louis Sander's theory of early development. *Psychoanalytic Psychology*, 11, 1-19.
- Ogden, T. (1994), The analytic third: Working with intersubjective clinical facts. *Internat. J. Psycho-Anal*, 75,3-19.

- Olivares, F.A., Vargas, E., Fuentes, C., Martínez-Pernía, D., & Canales-Johnson, A (2015) Neurophenomenology revisited: second-person methods for the study of human consciousness. *Front. Psychol.* 6:673. doi: 10.3389/fpsyg.2015.00673
- Orange, D.M., Atwood G. E., & Stolorow R. D. (1997). *Working Intersubjectively: Contextualism in psychoanalytic practice*. The Analytic Press: Hillsdale, NJ.
- Orlinsky, D., Rønnestad, M.H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed., pp.307-389)*. New York: Wiley.
- Pascual-Leone, J. (1976). Metasubjective problems of constructive cognition: Forms of knowing and their psychological mechanisms. *Canadian Psychological Review*, 17, 110-122.
- Pascual- Leone, A., Greenberg, L.S., Pascual Leone, J. (2009). Developments in task analysis: new methods to study change. *Psychotherapy Research*, 19(4-5), 527-542. doi: 10.1080/10503300902897797.
- Patton, M. Q. (1999). Enhancing the Quality and Credibility of Qualitative Analysis. *Health Service Research*, 5, 1189-1208.
- Perls, F., Hefferline, R. y Goodman, P. (1951/1994). *Gestalt Therapy. Excitement and Growth in The Human Personality*. Highland, U.S.: The Gestalt Journal Press.
- Petitmengin C. (1999) The intuitive experience. *Journal of Consciousness Studies*, 6(2–3), 43–47.
- Petitmengin C. (2006) Describing one's subjective experience in the second person. An interview method for the science of consciousness. *Phenomenology and the Cognitive Sciences*, 5, 229–269.
- Petitmengin C., Navarro V. & Le Van Quyen M. (2007) Anticipating seizure: Pre-reflective experience at the center of neurophenomenology. *Consciousness and Cognition* 16, 746–764.

- Piña, C. (1998). La construcción del “sí mismo” en el relato autobiográfico [The construction of the self in the autobiographical narrative]. *Documento de Trabajo* 383. Santiago: Programa FLACSO-Chile.
- Piña, C. (1999). Tiempo y memoria. Sobre los artificios del relato autobiográfico [Time and memory. About the artifices of the autobiographical narrative]. *Proposiciones*, 29, 1-5.
- Pizer, S. A. (1998). *Building bridges; The negotiation of paradox in psychoanalysis*. Hillsdale, NJ: Analytic Press.
- Polkinghorne, D. E. (1988). *Narrative Knowing and the Human Sciences*. Nueva York: State University of New York Press.
- Ponterotto, J. G. (2006). Brief note on the origins, evolution, and meaning of the qualitative research concept “thick description”. *The Qualitative Report*, 11, 538-549. Extraído de <http://www.nova.edu/ssss/QR/QR11-3/ponterotto.pdf>
- Prochaska, J., & DiClemente, C. (1984). *The transtheoretical approach*. New York: Dow Jones.
- Rappoport, E. (2012) Creating the umbilical cord: Relational knowing and the somatic third. *Psychoanalytic Dialogues* 22:3, pages 375-388.
- Remillieux, A. (2009). Explicitation et modélisation des connaissances de conduite de changement à la SNCF: Vers une gestion des connaissances pré-réfléchies. (Doctoral Thesis. Institut national des telecommunications d'Evry, Évry, France)
- Reyes, L., Aristegui, R., Krause, M., Strasser, K., Tomicic, A., Valdés, N., ... Ben-Dov (2008) Language and therapeutic change: A speech acts analysis, *Psychotherapy Research*, 18:3, 355-362, DOI: 10.1080/10503300701576360
- Rhodes, R., Hill, C., Thompson, B., & Elliott, R. (1994). Client Retrospective Recall of Resolved and Unresolved Misunderstanding Events. *Journal of Counseling Psychology*, 41(4), 473-483.
- Ribeiro, A., Bento, T., Salgado, J., Stiles, W., & Gonçalves, M.M. (2010). A dynamic look at narrative change in psychotherapy: A case study tracking innovative

- moments and protonarratives using state space grids. *Psychotherapy Research*. doi:10.1080/10503307.2010.504241
- Rice, L., & Saperia, E. (1984). A task analysis of the resolution of problematic reactions. In L. Rice & L. S. Greenberg (Eds.) *Patterns of change: Intensive analysis of psychotherapy process*. New York: Guilford Press (pp. 29-66).
- Rizq, R. (2012). “There’s always this sense of failure”: An interpretative phenomenological analysis of primary care counsellors’ experience of working with the borderline client. *Journal of Social Work Practice*. 26 (1), 31-54. doi.org/10.1080/02650533.2011.579695
- Rogers, C. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.
- Safran, J.D. (2013). Windows into clients’ perspectives on psychotherapy. *Psychotherapy*, 50 (4), 535-536.
- Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64, 447-458.
- Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance*. New York: Guilford Press.
- Safran, J. D., & Muran, J. C. (2006). Has the concept of therapeutic Alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, 43, 286-291.
- Safran, J. D., Muran, J. C., & Eubanks- Carter, C. (2011). Repairing Alliance Ruptures. *Psychotherapy*, 48(1), 80-87. doi: 10.1037/a0022140
- Safran, J. D., Muran, J. C., Samstag, L., & Stevens, C. (2001) Repairing Alliance Ruptures. *Psychotherapy*, 38(4), 406-412.
- Salvatore, S., & Tschacher, W. (2012). Time dependency of psychotherapeutic exchanges: the contribution of the theory of dynamic systems in analyzing process. *Front. Psychol.* 3, 253. doi:10.3389/fpsyg.2012.00253

- Sander, L. (1965). Interaction of recognition and the developmental processes of the second eighteen months of life. Paper presented at Tufts University Medical School, Boston, MA.
- Sander, L. (1980). Investigation of the infant and its caretaking environment as a biological system. In S Greenspan & G Pollock (Eds.). *The course of life Vol. I*. Washington, DC: US Government Printing Office.
- Sander, L. (1983). Polarity, Paradox, and the Organizing Process in Development. In Call, Galenson and Tyson (Eds.), *Frontiers of Infant Psychiatry*, New York: Basic Books. pp. 333-346.
- Santos, A, Gonçalves, M., Matos M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 449– 446.
- Sarbin, T. R. (1986). The narrative as root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3-21). New York: Praeger.
- Schore, A. (2002) Advances in neuropsychoanalysis, attachment theory, and trauma research: implications for self psychology. *Psychoanalytic Inquiry*, 22, 433-484.
- Siegel, D.J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. New York: W.W. Norton & Company.
- Siegel, D. (2012). *The developing mind. How relationships and the brain interact to shape who we are* (2^o ed.). New York: Guilford Press.
- Stephen, S. & Elliott, R. (2011). Developing the Adjudicated Case Study Method. *Pragmatic Case Studies in Psychotherapy*, 7(1), 230-241. doi: 10.14713/pcsp.v7i1.1079
- Stern, D. (1977). *The First Relationship: Infant and Mother*. Cambridge, MA: Harvard University Press.
- Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.

- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, B, ... Tronik, E. (1998). Non Interpretative Mechanisms in Psychoanalytic Therapy. The “something more” than interpretation. *Int. J. Psycho-Anal*, 79, 903-921.
- Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons- Ruth, K., Morgan, ... Tronik, E. (2002). Explicating the implicit: The local level and the microprocess of change in the analytic situation. *Int. J. Psychoanal.* 83, 1051-1062.
- Stiles, W. B. (2009). Responsiveness as an Obstacle for Psychotherapy Outcome Research: It's Worse Than You Think. *Clinical Psychology Science and Practice*, 16(1), 86 – 91. doi: 10.1111/j.1468-2850.2009.01148.x
- Stiles, W. B. (2015). Theory-building, enriching, and fact-gathering: Alternative purposes of psychotherapy research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 159-179). New York: Springer-Verlag.
- Stiles, W. B., Elliott, R., Llewelyn, S., Firth-Cozens, J., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy*, 2, 411-420.
- Stolorow, R., Brandchaft, B., & Atwood, G. (1987). *Psychoanalytic treatment, an intersubjective approach*. Hillsdale, N.J: Analytic Press.
- Strauss, A., & Corbin, J. (1999). Basics of qualitative research. Techniques and Procedures for Developing Grounded Theory (2nd ed.). Thousand Oaks: Sage.
- Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, 17, 305-314. doi:10.1080/10503300600608116
- Timulak, L. (2010) Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research and Practice*, 83 (4), 421-447
- Timulak, L., Belikova, A. & Miller, M. (2010). Client identified significant events in a successful therapy case: The link between the significant events and outcome. *Counseling Psychology Quarterly*, 23(4), 371-286.

- Timulak, L., & Elliott, R. (2003). Empowerment events in process-experiential psychotherapy of depression: An exploratory qualitative analysis. *Psychotherapy Research, 13*, 443- 460. doi: 10.1093/ptr/kpg043
- Tomicic, A., & Martinez, C. (2011). Voice and Psychotherapy: Introduction to a line of research on mutual regulation in Psychotherapeutic dialog. *Praxis, 13*(20), 109-139
- Tomicic, A., Martinez, C., & Krause, M. (2014). The Sound of Change: A study of the psychotherapeutic process embodied in vocal expression. Laura Rice's ideas revisited. *Psychotherapy Research*, 1-14 doi: 10.1080/10503307.2014.892647
- Tomicic, A., Martínez, C., Pérez, J. C., Hollenstein, T., Angulo, S., Gerstman, A., ... & Krause, M. (2015). Discourse-voice regulatory strategies in the psychotherapeutic interaction: a state-space dynamics analysis. *Front. Psychol.*, 6, 378. doi: 10.3389/fpsyg.2015.00378.
- Trevarthen, C. (1979). Communication and cooperation in early infancy: A description of primary intersubjectivity. In M. Bullowa (Ed.), *Before speech: The beginning of interpersonal communication* (pp. 321–347). New York: Cambridge University Press.
- Tronik, E. (1989). Emotions and emotional communication in infants. *American Psychologist, 44*, 112-119.
- Tronik, E. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal, 19*, 290-299.
- Tronik, E., & Weinberg, K. (1997). Depressed mothers and infants: the failure to form dyadic states of consciousness. In L. Murray & P. Cooper (Eds.), *Postpartum depression and child development* (pp. 54-85). New York: Guilford Press.
- Valdés, N., Krause, M., & Álamo, N. (2011). Qué dicen y cómo lo dicen: Análisis de la comunicación verbal de pacientes y terapeutas en episodios de cambio [What do they say and how do they say it: Analysis of patients and therapists verbal communication during change episodes]. *Revista Argentina de Clínica Psicológica, 20*, 15-28.

- Valdés, N., Tomicic, A., Perez, J.C., & Krause, M. (2010). Sistema de codificación de la actividad terapéutica (SCAT- 1.0): Dimensiones y categorías de las acciones comunicacionales de pacientes y psicoterapeutas. [Therapeutic activity coding system (SCAT-1-0): Dimensions and categories of patients' and psychotherapists' communicational actions]. *Revista Argentina de Clínica Psicológica*, 19, 117-130.
- Valenzuela-Moguillansky, C. (2012). *The Relation between Pain and Body Awareness: An Investigation Using Experimental and Experiential Methods* (Doctoral Dissertation, Université Pierre et Marie Curie du Paris, Paris, France).
- Valenzuela- Moguillansky, C., O' Regan, K., & Petitmengin, C. (2013). Exploring the subjective experience of the “rubber hand” illusion. *Frontiers in human neuroscience*, 7 Art 659. doi: 10.3389/fnhum.2013.00659
- Varela F. J. (1996). Neurophenomenology: A methodological remedy for the hard problem, *Journal of Consciousness Studies*, 3(4), 330–349.
- Varela, F.J., & Shear, J. (1999). First-person methodologies: what, why, how? *J. Conscious. Stud.* 6, 1–14.
- Vermersch P. (1994/2011). *L'entretien d'explicitation* [The elicitation interview] (7th ed.). ESF éditeur, Issy-les-Moulineaux.
- Viklund, E., Holmquist, R., & Zetterqvist Nelson K. (2010). Client-identified important events in psychotherapy: Interactional structures and practices. *Psychotherapy Research*, 20(2), 151-164. dx.doi.org/10.1080/10503300903170939
- Wallace, B.A. (2006). *The Attention Revolution: Unlocking the Power of the Focused Mind*. Boston: Wisdom Press
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, Methods and findings*. Mahwah, NJ: Lawrence Erlbaum.
- Westra, H.A., Aviram, A., Barnes, M., & Angus, L. (2010). Therapy Was Not What I Expected: A Grounded Theory Analysis of Discordance between Client Expectations and Experience of Cognitive Behavioural Therapy. *Psychotherapy Research*, 20, 436-446. doi:10.1080/10503301003657395

- White, M. y Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: WW Norton & Company.
- Winnicott, D. W. (1957). *El niño y el mundo externo* [The child and the outside world: Studies in developing relationships]. Buenos Aires: Paidós
- Winnicott, D. (1960). The theory of the parent-child relationship. *Int. J. Psychoanal.*, 41, 585-595.
- Yeh, C. J. & Inman, A. G. (2007). Qualitative data analysis and interpretation in counselling psychology: Strategies for best practices. *The Counselling Psychologist*, 35, 369-40

