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Javiera Duarte, Claudio Martinez & Alemka Tomicic

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EMPIRICAL PAPER

Sparks of psychotherapeutic change: How therapists understand moments of meetings' contribution to change in psychotherapy

JAVIERA DUARTE, CLAUDIO MARTINEZ, & ALEMKA TOMICIC

Center of Studies in Clinical Psychology and Psychotherapy, Universidad Diego Portales (CEPPS-UDP) and Instituto Milenio para la Investigación en Depresión y Personalidad (MIDAP), Santiago, Chile

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Abstract
Moments of Meeting (MoM) in psychotherapy are understood as shared moments between patients and therapists that allow a mutual implicit understanding about their relationship and create a new state of intersubjectivity that reconfigures the patient's procedural knowledge of "being with others." Despite ample theoretical and clinical descriptions of this phenomenon, little is known, from an empirical standpoint, about these kinds of moments in therapy.*Objective* : This study describes therapists' experience of moments of meeting with their patients in psychotherapy, and how these moments relate to the patient's change process.
Method : 13 in-depth interviews conducted with therapists from different theoretical backgrounds were analyzed using Grounded Theory.
Results Four categories were established: (1) Characteristics of moments of meeting, (2) Triggers of moments of meeting (3) Enabling conditions, and (4) Main effects of moments of meeting. A conceptual model was developed around an axial phenomenon that provides understanding on how moments of meeting contribute to the change process in psychotherapy, through the construction of shared relational knowing.
Discussion : The value of moments of meeting for the therapeutic process is discussed and reflected upon, as well as their effect on changes regarding implicit relational knowing.

Keywords: moments of meeting; psychotherapy process; therapist's subjective experience; implicit relational knowing; process research

Clinical and methodological significance of this article: This article has a clinical significance because it provides a better understanding of moments of meeting from therapists' perspective and how they contribute to psychotherapeutic change. It also has a methodological significance as it describes and highlights the relevance of qualitative methods for in-depth study of the psychotherapy process.

Research regarding relevant events or episodes in psychotherapy sessions has increasingly gained importance since it provides new understanding on how and why change occurs (Elliott, 2010; Knobloch-Fedders et al., 2014). As Duarte et al. (2019) show in their review, this interest has led to the progress of multiple theoretical and empirical conceptualizations. At first, relevant events were mainly understood and studied as a process that belonged to the patient, in which the therapist participated, but in a rather reactive role instead of a co-constructive one. As relational and intersubjective aspects of the therapeutic process started to generate interest in different researchers from different perspectives, and to be considered as a crucial aspect of the therapeutic process, other developments have emerged, such as *Moments of meeting*, proposed by Daniel Stern (2004), Stern et al.

Correspondence concerning this article should be addressed to Javiera Duarte, Center of Studies in Clinical Psychology and Psychotherapy, Universidad Diego Portales (CEPPS-UDP) and Instituto Milenio para la Investigación en Depresión y Personalidad (MIDAP), Grajales 1746, Santiago, Chile. Email: javiera.duarte@mail.udp.cl

(1998) and the Boston Study Process Change Group (BCPSG,2010).

The term *Moment of Meeting* (MoM) was coined by Stern et al. (1998) as a way to describe how shared Implicit Relational Knowledge (IRK) could be developed in psychotherapy. Intersubjective in their essence, these moments, between patient and therapist, would be co-constructed as each actively contributes with unique aspects of themselves and of their own previous relational knowledge (Stern, 2004; Stern et al., 1998). According to Stern et al. (1998), *MoM* between therapist and patient would be the result of an interactive process called *moving along*. This process refers to the natural course of the psychotherapeutic process, 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 movements*—that aren't necessarily present to our consciousness, despite being accessible to it. By becoming conscious, these relational movements could transform into present moments, which may contain a micro history that possibly captures a person's subjective style. These brief moments of consciousness are characterized as units that contain words, gestures and silences grouped in a meaningful way, and would be key breaking points that change the direction of the process of moving along (Duarte et al., 2019; Stern, 2004).

From clinical experience (Stern et al., 1998), *present moments* have been described as rich and fruitful as they condense a multiplicity of sensations, meanings, and emotions. Present moments take place often, but only some of them become intense from an affective standpoint and powerful for the therapeutic process. These characteristics would transform them into *now moments*, during which the familiar intersubjective environment of the patient-therapist relationship suddenly becomes strained, and risks being altered. This emotional intensity would pressure the therapist to respond, through an interpretation, an innovative response or even through silence. Insofar as the *now moment* is sustained and shared by both therapist and patient; as long as the therapist is able to grasp the moment and explore it, the possibility of a *moment of meeting* emerges (Duarte et al., 2020; Stern, 2004; Stern et al., 1998). 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 associated with the loss of opportunities to establish a meaningful connection between therapist and patient, i.e., to establish a moment of meeting.

The concept of moments of meeting in psychotherapy emphasizes that the experience of being in connection with others would be a fundamental aspect of psychotherapy and essential for change to take place (Stern et al., 1998). From this perspective, psychotherapeutic change, or at least part of it[1], can be understood as a relational and interactive process involving both patient and therapist. MoM are perceived as highly significant moments in which both patient and therapist connect emotionally; this can potentially modify the relationship between them and enable transformation and reconfiguration in the way patients typically relate with others. Therefore, it provides changes in their implicit relational knowledge (Boston Change Process Study Group, 2002, 2005, 2008a, 2008b, 2010; Stern, 1998, 2004).

Implicit Relational Knowing and Shared Relational Knowing in Psychotherapy

Implicit relational knowing refers to the knowledge about relationships with others, inferred in a procedural way from early relationships which operate outside the person's conscious attention and verbal experience (Stern et al., 1998). 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 to the knowledge regarding other people, such as showing one's affection for others, learning to call for attention or learning how to joke, it is called implicit relational knowing. This knowledge integrates not only cognitive but also affective and interactive elements and is based on implicit patterns of relational behavior that regulate our interactions with others (Lyons-Ruth et al., 1998; Stern et al., 1998). Relational learning is subject to variation, because each person'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).

The hypothesis that sustains the aforementioned is that the process of dyadic interaction would generate new emerging relationships that require learning a different form of intersubjective coordination, including not only the coordination of physical states, but also of complex psychological ones (Lyons-Ruth, 2000; Orange et al., 1997). For Sander (1965) and Lyons-Ruth (2000), knowing and being known is achieved through the process of accomplishing interactions that are coordinated or

in tune with each other. This process allows for a complex coordination of the dyadic system, where we are able to connect our internal experience to our reflective consciousness of it, as well as of others (Lyons-Ruth, 2000). It has been conceptualized in research as a process of mutual regulation.

Mutual Regulation in Psychotherapy

From the perspective of mutual regulation, both members of the therapeutic dyad display idiosyncratic affective and relational repertoires, learned in the context of significant early childhood bonds and reorganized throughout later significant relationships. The explicit and implicit attempts of each participant of the dyad to regulate the state of the relationship are influenced and affected by those of the other, in a circular, continuous, and dynamic process (Beebe & Lachmann, 2002).

In psychotherapy, mutual regulation has been mainly studied as synchrony and described from different behavior modalities such as electrodermal activity, heart rhythm, congruence between perceptions of patients and therapists, convergence of facial displays and expressions, speech rate, voice and vocal quality, silence patterns, prosody, lexical or linguistic alignment and coordination of body movement or nonverbal synchrony (see Ramseyer, 2020, for more detail). Available evidence also shows that nonverbal coordination and communicative synchrony relate to aspects such as the "success" of the interaction, rapport, and empathy, all of which are associated with regulatory processes (Cappella & Schreiber, 2006)

Mutual regulation seems to be important in psychotherapy because it allows adjustments in the therapeutic alliance and the possibility to overcome tense or difficult moments and to readjust in favor of therapeutic advancement. For example, Muntigl and Horvath's study (2018) shows that therapists and clients struggle to develop, maintain, and repair a close collaborative relationship and that this negotiation of affiliation entails the use of language and non-verbal resources.

Accumulated evidence in the field of cognitive neuroscience have come to show that human experience is processed by two co-existing systems that mutually and continuously affect each other: the symbolic and sub-symbolic. Symbolic processing is mainly manifested through verbal coding such as language and is usually perceived as intentional, explicit, and conscious. On the other hand, the sub-symbolic system is manifested mostly in nonverbal manners, housing procedural knowledge; that includes organizing principles of relational repertoires, which are implicit, automatic and nonvolitional, mainly operating at an unconscious level (Bucci, 1988). Despite the coexistence of both systems, much of the information exchanged during the therapeutic interaction is manifested tacitly, automatically and at a nonverbal level (Schore & Schore, 2008) or as Lyons-Ruth et al. (1998) states, through implicit relational knowing.

Objective

This research, based on the theoretical work of The Boston Group, seeks to offer an alternative perspective for the study of relevant episodes in psychotherapy, by proposing a *meeting* point between theory and clinical practice and adding interactive and relational elements to our understanding of change. In this way, MoM in psychotherapy can be considered as relevant relational events that can provide new understanding of how mutual regulation and implicit aspects of the therapeutic interaction stimulate changes in the implicit relational knowing of the patient.

The objective of this study is to describe therapists' experience of MoM with their patients in psychotherapy, and how these moments relate to the patient's change process. A conceptual model, based on the perspective of the therapists, is developed, demonstrating the contribution of MoM to change in psychotherapy.

Method

The study was performed using a qualitative methodology, seeking to characterize and describe MoM from therapists' point of view. In-depth interviews were conducted and qualitatively analyzed through Grounded theory open and axial coding procedures (Charmaz, 2014).

Participants

Thirteen therapists with varying levels of experience and theoretical orientation participated in the study. For the selection and recruitment of the therapists, theory-guided purposive sampling was used (McLeod, 2001).

This type of sampling allowed us to direct the selection of new participants from the emergence of relevant categories in the analysis. The criteria of emerging variation, that guides the selection of participants in theory-guided purposive sampling, allows researchers to compose a structurally representative set of interviews (Malterud et al., 2016);

these cases represent the variety of possible manifestations of therapists' understanding of MoM and their contribution to change in psychotherapy.

The researchers used personal contacts to invite 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.

For recruitment, an e-mail was sent to potential participants with an invitation and a brief explanation of the study and its objectives. Of the 20 participants who were asked to participate, 15 agreed to be interviewed, but it proved impossible to coordinate a meeting with two of them. The interviews corresponding to the 13 therapists allowed saturation of the main categories. Seven of the interviewed therapists were women and six were men, with age ranging from 31 to 70 years. Five participants had less than 20 years of experience, six participants had consolidated clinical experience (20–30 years) and two were senior psychotherapists (more than 30 years) at the moment of the interview. The therapists worked from diverse theoretical frameworks such as Cognitive Constructivist, Humanistic, Narrative Systemic, Integrative and mostly Psychodynamic. Additionally, most of the participants reported having experience in both the public health care and private practice.

Research Team

The first researcher (JD) has experience in qualitative methods in psychotherapy process and therapeutic training from a cognitive constructivist perspective. The second (CM) has vast experience investigating therapeutic processes, and academic training in the field of psychodynamic psychotherapy. The third (AT) is an expert in qualitative research in psychotherapy processes. The first author conducted all the interviews, while the analyses were done by the three authors.

Every team member was familiar with Daniel Stern's and the Boston Group's work. Regular meetings were held to prepare interviews, analyze data, as well as discuss and reach agreements regarding codification. Also, experts in MoM and related subjects—Karlen Lyons-Ruth, Andre Saasenfeld, Jeremy Nahum, Steven Knoublach and Jeremy Safran-were contacted and interviewed during 2016 regarding the phenomena in general. Their reflections, theoretical knowledge and particular points of views were enlightening for our discussions and further analysis of the data.

Given that Grounded Theory, and Qualitative Analysis in general, is always an interpretative process, the research team chose to promote self-consciousness during the analysis, and thought about their own reflexivity (Charmaz, 2014). Therefore, we revisited the data and its comprehensive evolution in a hermeneutic way, taking into account the researcher's biases (personal background, positions, preconceptions, and values that could influence the research). To achieve this, the main researcher (JD) kept memos about her beliefs, perceptions, and theories regarding MoM during both stages of the study: interviews and analyses. This process allowed the investigator to register and cultivate her own understanding as it developed, and to take notes of the decisions she made about coding and method. Additionally, the whole team had periodic triangulation meetings in which emerging categories and their properties were discussed and refined. These considerations enabled the probing of doubts that came up during the interpretation and the explicit recognition of the team's suppositions, mitigating the effects of researcher biases (see analysis below)

Interviews

The interview protocol was initially developed by the authors based upon theoretical knowledge and the information provided by the experts on MoM. They were in-depth interviews (Kvale & Brinkmann, 2009) that aimed at collecting the participant's points of view concerning the following aspects: (a) the description of MoM or meaningful connection, (b) the different contexts for their emergence, (c) the main aspects fostering their occurrence, (d) the impact of MoM for the therapeutic process, and (e) possible effects for the patient, therapist and the therapy. Therapists were free to talk about their experience referring to one or several patients, depending on their relevance, but the interview was not focused on a particular patient, rather on their general experience along their professional trajectories as psychotherapists.

The interview began with the following open-ended question: "From your experience as a therapist, could you tell me about your perspective on MoM or meaningful connection with your patients and the importance that they may have for psychotherapy?" and then the participants were asked to elaborate on their answers. Then, therapists were asked to elaborate on their experience and if they hadn't done so, spontaneously, they were requested to share a specific moment of meeting that had taken place with a patient during his or her career as a psychotherapist. 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 with it. A common theme throughout the interviews was the question of what, in particular, made these moments relevant for the interviewee.

It is important to clarify that during the interview the conceptual aspects of MoM, as developed by Stern and BCPSG, were not explained; the issue was pursued based on the interviewee's personal conception of the term. Even though some of the individuals alluded to the term and were somewhat familiar with Stern's work, others were not acquainted with the term or its theoretical meaning. The audio recorded interviews lasted about 60 min and were transcribed verbatim.

The ethical protocol for the research was approved by the ethics committee of the faculty of Medicine of Universidad de Chile. Informed consent forms for the use of data for research purposes and related publications were signed by all the participants before the interview. Transcribers were also asked to sign a confidentiality form.

Qualitative Analysis

In order to answer the research question, Grounded Theory analysis was regarded as the method of choice. The choice of this method of analysis is consistent with the purpose of the study since it allows the development of a conceptual model for the contribution of MoMs to change in psychotherapy based on the perspective of therapists. A model that can later be discussed and contrasted with its theoretical-clinical perspective (Titscher et al., 2000).

Initially, open coding (Charmaz, 2014; Corbin & Strauss, 2008) was conducted assisted by ATLAS.ti software. The first three interview transcriptions were fully coded by the three researchers together (JD, CM, AT). The analysis of the following interviews was led by the first author and discussed with the other two authors in regular meetings every two weeks. Codes and their properties were agreed upon and classified as members of a category. Data saturation (Charmaz, 2014; Creswell, 2014) was reached with interview number 10, and the last three interviews were used to explore previously described concepts or delve into certain categories. We use the notion of saturation, which refers to a point of informational redundancy in which the collection of additional data contributes little or nothing new to the study. This particular form of saturation is called data saturation to differentiate it from the concept of theoretical saturation (corresponding to the emerging theory in qualitative analysis). Data saturation has been widely recognized as a guide or indicator that sufficient data collection has been achieved and is therefore related to the final definition of the number of participants (Gentles et al., 2015). We also used category frequency and the guidelines developed in consensual qualitative research to show the level of saturation regarding each category (Hill, 2012) (see Table I).

In a second phase, axial coding (Charmaz, 2014) was performed by linking different categories, so as to sketch an integrative diagram aimed at forming substantive theories about different features regarding the object of our study.

Results

The open coding analysis (Corbin & Strauss, 2008) yielded four categories: (1) Characteristics of MoM, (2) Triggers of MoM, (3) Enabling conditions, and 4) Main effects of MoM. These categories, their properties and descriptions are presented in Table I, along with a quote as an example.

As shown in Table I in the category *Characteristics of Moments of Meeting*, *MoM* were described by therapists as emergent, non-verbal, embodied, and emotionally intense shared experiences, idiosyncratic to a particular dyad. These moments seem to generate an initial feeling of surprise, followed by a sense of genuine connection and closeness between the participants that enabled the construction of a common history. The emotional connection that emerged from MoM had a sense of resonance and complicity for the therapists, and primarily referred to their own relationship but went beyond the therapeutic relationship, having the potential to impact the patient's relationship with others.

Participants identified different ways in which MoM were triggered. Most of these *triggers* had in common that they stopped, interrupted or disrupted the course of the interaction, and were identified in forms of silence, a sustained pause in the conversation, a joke or funny situation, and ruptures or impasses caused by certain misunderstandings or tense situations. Other types of triggers emerged from ordinary situations and seemed to enhance a sense of connection and synchrony or empathic attunement on behalf of the therapist.

Therapists also identified certain *enabling conditions* that create an intersubjective field for the emergence of MoM, such as therapists' and patients' openness to connect, the patient's capacity to trust the therapist, the process and the therapist's authenticity as well as the ability to recognize the patient's rhythms. They also mentioned the formation of a

Table I. Open coding: categories and properties of therapists' experiences of moment of meeting.

Categories	Properties	Description of the category	Therapist quote	Frequency
Characteristics of Moments of meeting	1. Emergent nature 2. Genuine experience 3. Shared experience 4. Embodied experience 5. Idiosyncratic 6. Surprising 7. Implicit process 8. Emotionally intense 9. Intimate and deep bond 10. Emotional synchrony 11. Resonance 12. Attunement	Moments of meeting were described by all therapists as co-constructed moments that take place during the process through therapist-patient interaction. These moments are spontaneous and lived as a genuine and unplanned experience. They are creative, unique and singular experiences that produce feelings of emotional synchrony that can take different forms and levels of intensity. Even though moments of meeting are often felt, they are not always discussed between patient and therapist.	It's 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 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).	General
Triggers of Moments of meeting	1. Humor 2. Ruptures or impasse 3. Ordinary situations 4. Silences 5. Connectedness and synchrony 6. Empathic attunement	Most therapists agreed that moments of meeting develop and materialize in different ways, such as funny situations, a sense of connectedness, empathy and synchrony with the patient but also through misunderstandings and difficult moments during the process. Even moments of silence or surprise could lead to a moment of meeting, because they defy the original movement of the psychotherapy process	I think that there are a lot of moments of emotional connection … positive … but also some that are not so positive that can be very powerful for the relation. They can be very relevant and well, if you can identify them some of them and bring them to the session, then maybe it's even better because sometimes you just miss them (T10) If I stop a little, and start recalling, many, many, many scenes come to mind, many situations of different types, some more subtill, some funny ones, others difficult, because as I was saying, the novelty or the unexperienced challenges you (T11)	Typical
Enabling conditions	1. Openness (T and *P*) 2. Emotional disposition (T and *P*) 4. Personal features (T and *P*) 5. Awareness of oneself (T) 6.Therapeutic flexibility (T) 7. Authenticity (T) 8. Recognition of the patient`s rhythms (T) 9. Trust in the therapist (*P*) 10. "Perfect fit" (REL) 11. Knowledge of the relationship (REL) 12. Established alliance or relation (REL)	Most interviewed therapists recognized the importance of certain conditions for moments of meeting to take place. Some of these conditions were identified as dependent of the therapist, and some were recognized as part of the relationship. The therapists identified a central condition from both partners which was openness and emotional disposition to meet. But most conditions were attributed to the therapists, such as authenticity, technical flexibility and to be able to recognize the patient's tempos and rhythms. They also referred to the importance of the therapeutic relationship and to have an established alliance that could come from previous knowledge of their relationships. Complimentary and having a "perfect fit" were also recognized as enabling conditions for moments of meeting. Only one condition was seen as coming from the patients and it was the capacity to have trust in the therapist and the process.	I have come to realize that emm … the faster I can pick up when something is stuck, or that we are detained righ? when we are not being able to interact … then I am more active and usually more things happen (T6) I think that before anything the patient has to validate you, the patient has to trust who he is with … it's like a dance in the end … you have to dance to the same rhythm. The patient picks the rhythm and you have to follow … the patient directs … and of course, you as the therapist have to connect. The patient directs in terms of the emotional tone, but it's the therapist who gives direction to the encounter (T9)	Typical

(*Continued*)

Table I. Continued.

Categories	Properties	Description of the category	Therapist quote	Frequency
Main effects	1. Relief (T and *P*) 2. Decompression (T and *P*) 3. Physical changes (*P*) 4. Laboratory for new experiences (*P*) 5. New knowledge of himself and others (*P*) 6. Opens new possibilities (*P*) 7. Sense of connectedness (T) 8. Injects vitality to the session (PR) 9. Disrupts the regular flow (PR) 10. Changes in the emotional atmosphere (PR) 11. Gives new directions (PR) 12. The process strengthens (PR)	All therapists agreed that moments of meeting have a very powerful effect for the therapy process that can be seen immediately during the session but also have a long-term effect that expresses later during the process. The immediate effects of moments of meeting for the patient and the therapist were described as relief and decompression, which therapists identified in their patients through their facial expressions and changes in their posture and body movements. Therapists also identified in themselves feeling more connected to the patient, and that many sensations occur at an implicit level that are not necessarily verbalized. During the session the normal flow was interrupted, and certain vitality was injected producing change in the emotional atmosphere. The session disentangled and readjusted. As a long-term effect, therapists recognized that these moments gave them clarity on how to proceed and allowed the therapy to move forward. They also felt the process strengthened and understood moments of meeting as opening new possibilities for the therapy but also for the patient. Some called them a laboratory for new experiences that can take place outside of therapy, because the patient had learned something new about himself and others.	What I think is significant … it has to do with like a felt experience of … of relief (…) that I also perceive in myself … I mean in that moment it stopped being such a big effort for us, we were no longer uncomfortable, right? we were no longer stuck, and it was a relief no? Of not having to do all that effort … the patient, his expression, basically, his physical expression of surprise and relief" (T6) I think that [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 is now married, has a family and everything, is something that, way back, we wouldn't have even begun to, um … imagine (T3) 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)	General

Note: General, 13–14 cases; typical, 8–12 cases; variant, 2–7 cases (labeled following Hill, 2012).

positive bond between patient and therapist, a therapeutic relationship characterized by its flexibility as an important condition for MoM to emerge.

Finally, the immediate *main effects* of MoM indicated by therapists had a cross effect related to the regulation of arousal or emotional intensity of the session, where both patient and therapist felt relieved and connected afterwards; more long-term effects referred to the patient's possibility of achieving new internal states and a new form of relating within the therapeutic relationship.

How Moments of Meeting Contribute to Therapeutic Change: MoM as Sparks of Change

In a further analysis, axial process coding was performed. *Process coding*, according to Strauss and Corbin (1998), seeks to understand and develop a conceptual model regarding how and why a sequence of actions or interactions evolve and change; it also includes what allows permanence. This analysis was done by linking interactions between categories and their properties. They are presented in a tentative conceptual model of how MoM contributes to therapeutic change, grounded in the therapists' perspective. In this coding, the phenomenon of the main idea represented through the categories (Strauss & Corbin, 1998) was named *Sparks of change* and is illustrated in Figure 1.

The sparks of change represent the relational and intimate connection that serves to ignite the process of change. It simultaneously alludes to something that sets change in motion as well as a flash of change, something that leaves an imprint on the individual or on both participants and that can be traced over time. The spark is expressed in the MoM itself

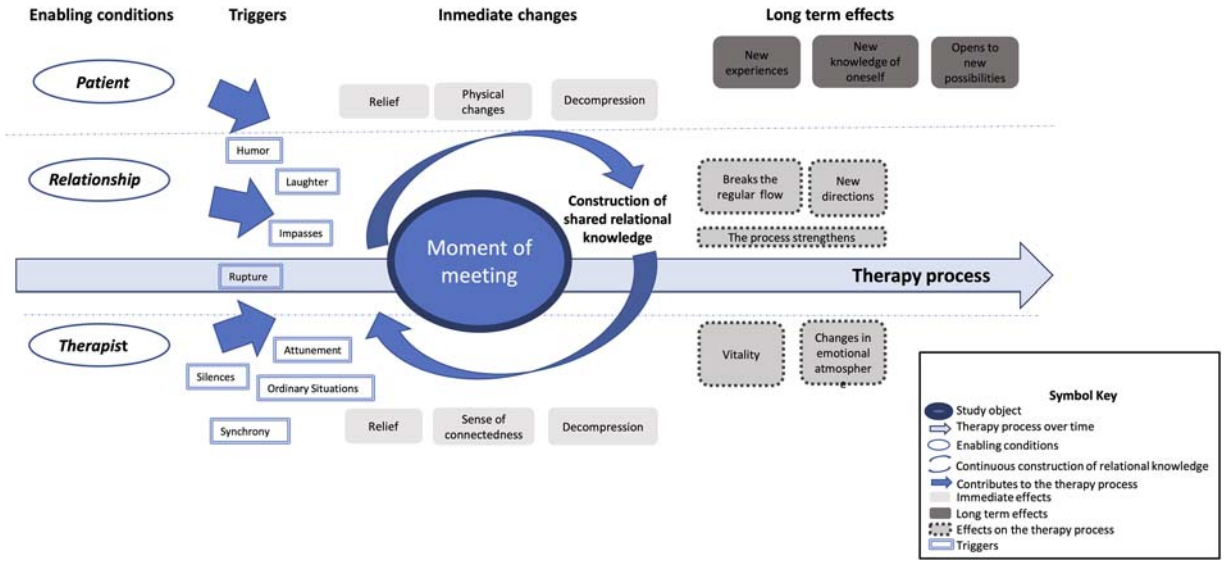

Figure 1. Phenomenon: moments of meeting as sparks of change.

as the twinkling of a light that indicates an immediate effect and, at the same time, allows us to trace the change that takes place in the long term.

The process of sparks of change can be depicted as follows (see Figure 1). The interviewed therapists identified three types of preexisting conditions for MoM to take place: (a) enabling conditions of the relationship; (b) enabling conditions of the therapist and (c) enabling conditions of the patient. Regarding the relationship, interviewees indicated that both *openness* and *emotional disposition* from both parties were necessary for the emergence of MoM. They also indicated that these conditions were facilitated by the existence of a *consolidated bond* or *previous knowledge* about their relationship, for which aspects such as the therapeutic frame, boundaries and a proper setting were important. However, most participants were emphatic to state that these aspects must be properly combined with the singularity and particular demands of that particular relationship for certain intimacy to develop; this is what some of them called "a perfect fit."

The therapists' enabling conditions, as mentioned by the interviewees, alluded to some general factors such as technical aspects and expertise, but also *personal features* such as their curiosity, their ability to observe and listen, the capacity to detach from their role when it proves necessary and to offer a safe space to the patient. Therapists also believed that their *authenticity*, *disposition to engage* with their patients and *therapeutic flexibility* were important aspects that allowed the emergence of MoM. Also, *knowing themselves* properly, being able to recognize their own sensations and emotions and identify their own intuitions were indispensable. In that sense, therapists must be able to generate complicity and *attunement* with their patients, understand and accompany them, but at the same time to be able to recognize that the process belongs to the patient and therefore respect their *rhythm*s and *pauses*.

The patients' enabling characteristics were understood mainly as *personality features* or previous experiences which could contribute to the possibility of resonance, because they would allow the patient's availability for the experience or, on the contrary, lead him or her to avoid it. In this way *openness*, *emotional disposition* towards being in the relationship and *trust* in the therapist were also mentioned as important conditions for the patient to feel the therapist's presence. All these conditions combined were described as enabling conditions for the emergence of MoM; they set the space and atmosphere for them to take place.

The MoM was described as an *emergent and genuine experience*, co-constructed with the patient, in which both connection and complementarity are felt. This *shared experience* was defined by the therapists as a *sense of resonance* with others at a physical, mental and emotional level. During this moment, therapists had the sense of physical coordination with their patients, where the rhythm was regulated and synchronized as a sort of internal and external dance. Mental connection was described as thinking about the exact same thing or feeling they completely understood each other, while emotional connection was described as an emotionally *intense moment*, an *intimate and deep bond*, characterized by a feeling of *emotional synchrony* with the patient. However, therapists acknowledged that, even if this sensation is often felt, it is not always discussed between patient and therapist.

Therapists also explained that MoM have an *idiosyncratic nature*, which means they are particular to the dyad and therefore dependent on the participants' specific characteristics, the relationship they have established and the moment of therapy they are at. They were also recognized as moments that stand out from the ordinary therapeutic dialog because they were *spontaneous, surprising, and unpredictable.* The interviewed therapists stated that they could only decide what to do and how to react when the MoM were occurring.

Another relevant aspect described by the therapists was that MoM are *embodied experiences*, which means they are felt physically and materialize in the body. In that sense, many of these experiences are kept in a *pre-reflective level* and are only remembered when an effort is made, whereas others are made explicit and talked about with the patient, be it right away or in later sessions. This means that *implicit physical sensations* and *nonverbal aspects of communication* are predominant, leaving other aspects of communication, such as the contents, in the background.

As previously mentioned in open coding analysis, interviewees also held that MoM could be triggered by different pervious events such as a *synchronized state* of emotions, a *shared laughter*, saying the *same word at the same time*, having *similar thoughts*, *through a particular conversation or even disagreements, impasses or ruptures in the working alliance.* These triggers seem to be key aspects to identify if a MoM will take place and understand how it will develop.

Finally, the presence of MoM was described by the interviewees as having a direct impact on both participants of the therapy process and the process itself. These effects presented themselves in two different temporal dimensions that are intertwined: *immediate changes* and *long-term effects*. Therapists mentioned observable immediate changes in themselves, in their patients and in the session, associated with MoM. These changes find expression in *physical*, *emotional* and even *cognitive* levels. Regarding their patients, therapists perceived sensations of *decompression*, *relief* and *liveliness*, which were signaled by the patients' bodies relaxing, decrease in their rigidity and more fluid and fluent movements. They also observed *changes in* their patients' *body posture* and *facial expression*, and in some cases even laughter or some sort of spontaneous gestures that signaled the emergence of new emotions. Some of the interviewed therapists said they could also perceive feelings of *relief* or *freedom* in their patients as a consequence of the moment of meeting. They interpreted these signs as patients feeling accompanied by their therapists, or as one therapist said, as their patients *feeling met*.

Therapists also described that, after a moment of meeting, they *felt relieve*d. The emotional tension that sustained that moment decreased, and some of them even reported that their own *bodies relaxed*. Other therapists described it as a moment when "something fits," allowing them to achieve a special understanding and complicity with their patient.

According to the interviewees, MoM also had immediate effects in the session, which was expressed in its atmosphere, where the *emotional climate changed*, and a *shared emotional intensity* took place. The therapists pointed out that MoM suffuse *vitality* and *perspective* into the session, allowing the process to continue by unblocking the emotional flow and decreasing in tension. Therapists emphasized that these changes in the session and in its participants *strengthened the therapeutic relationship*; therapist and patient became closer and a more genuine relationship emerged, opening space for *emotional depth* and *new relational codes*.

For therapists, MoM give *salience* to the session and *disrupt the regular flow*, injecting *vitality into* the process and giving *direction on how to go on*.

Therapists also stated that these changes could contribute to long term changes, because what takes place in a particular session impacts that particular moment, but can also be sustained in time, causing the process to strengthen and generate changes in a long-term scenario.

Long-term changes were mainly recognized in two relevant areas: within the therapeutic process and in the patient.

From the therapists' view, changes within the process were understood as watershed events that *changed the logic and dynamics of the relationship* and, consequently, the way in which the therapy was being conducted. Some therapists stated that MoM contributed to the advancement of the therapeutic process, often constituting milestones in the therapy. Most interviewed therapists agreed upon the fact that these moments are necessary for change to take place in psychotherapy, because the break in the dynamic of the relationship and the demand to "do something" 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 of the patient, from the therapist's perspective, 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. Therapists also highlighted that one of the most important aspects of MoM was that patients could be *found by*

the other and in that process, find themselves. Patients acquired new notions, recognized or learned something new about themselves, discovering attributes that they did not know they had. For many of the interviewed therapists, the acquisition of these new notions of themselves allowed patients, at the same time, to learn something new about their way of relating with others. The therapists described the therapy as a "laboratory" for creating *new experiences* and expanding them outwards, towards the patient's other relationships. However, therapists also stated that for some patients, just being found (by the therapist) was a goal in itself.

All therapists understood MoM as fundamental for the therapeutic process, and for change to take place, but also highlighted the fact that MoM can generate change without ever being talked about and that other MoM impact a particular session but then fade over time. Therapists also emphasized that there seems to be no linear relationship between MoM and progression in the therapy process. This means that MoM do not necessarily 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.

Discussion

MoM in psychotherapy, as experienced by clinicians, have been commendably described by Daniel Stern et al., (1998), but difficult to grasp from an empirical perspective due to their complexity and implicit nature. The aim of this study was to describe therapists' experience of MoM with their patients in psychotherapy, and how these moments relate to the patient's change process.

Our findings show that, in the experience of our interviewees, MoM seem to be more a process than a single and isolated event; even though their expression is usually spontaneous and emergent, certain conditions of possibility must exist. These conditions mainly refer to the characteristics of a good working alliance, but for a moment of meeting to take place, a good alliance is not enough; *something* must trigger it. This may be what Stern et al. (1998) call "now moments," which are described as affectively charged moments that strain the patient-therapist relationship and questions its nature.

From our study, these triggers are mostly provided with sensations and spontaneity rather than a rational construction of what is taking place. We also found that triggers can be related to positive emotions such as connection and synchrony, or negative ones, such as misunderstandings and rupture. This is also consistent with Stern et al.'s (1998) elaboration/ideas on *now moments*; they affirm that some *now moments* can turn into a failed *now moment*, when there is a failure to meet intersubjectivity, and a repaired *now moment*, when failed *now moments* are mended. However, positive or negative, all these triggers have in common that they produce an increment in the emotional arousal of the therapeutic dyad that must be worked out. We think that possibly the increment in emotionality related to connection and synchrony could be triggered because it deepens the good quality of the relationship and the attunement between the dyad. In the case of misunderstanding or ruptures, they may act as a contrast of those same enabling conditions. Either way, it is the trigger that generates a MoM between patient and therapist, characterized by co-construction, synchrony, embodiment and surprise, and an emotionally intense experience shared by both patient and therapist that is not thought, but felt. This experience described by the therapists as resonance with their patient, seems to be what sustains the meeting itself. This is relevant for the therapeutic experience because, as Rappaport (2012) points out, affective resonance in the space between therapist and patient would give birth to a sensation of security and containment, which is an important quality of a good outcome in psychotherapy. This finding is also consistent with our own previous findings regarding patients' experience of meeting where we found that, although unique to each participant, central aspects of MoM included the enhancing of emotional and nonverbal cues, feeling connected, but also feeling each other's connection (Duarte et al., 2020).

Another interesting finding was the identification of some aspects 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 capacity to tune in to each other, which seems to be an important element for the reorganization of intrapsychic and relational processes. This reminds us of Beebe's (2017) thoughts on bidirectional exchange between partners in a relational system, understood as a continuous process that gives rise to a greater complexity to the system and to the possibility of elaborating emergent properties of this process. In this regard, Stern (2004) highlights aspects such as dyadic synchronization and essential dyadic coordination of intersubjectivity: "When people move synchronously or in temporal coordination, they are participating in an aspect of the other's experience" (p. 81).

Our results show that, in general, therapists tended to value and treasure moments of meaningful connection with their patients, feeling that they contribute in different ways and different levels to the

process of change. MoM could be understood as what Hill et al. (2012) describe as corrective emotional experiences that provide patients with the sensation of being accompanied by their therapist, which is also in line with our previous work (Duarte et al., 2017). This accompaniment, however, would seem to be the beginning of a relationship that transforms over time and gives the patient the possibility of learning new things about him/herself and of relating to other people, which could be understood as a change in implicit relational knowledge (1998). And just like Levine and Frederick (1997), Levine (2010) and Schore (2002) mention, this relational knowledge would be accessible through somatic and sensitive experiences, before they can be recognized and verbalized.

Overall, this study seems to confirm clinicians' perspective that a MoM could have an important effect on patient *and* therapist both at an immediate level by relieving tension in the therapeutic relationship, or injecting vitality into a somewhat dormant relationship; it also has more permanent or long-term effects, such as something that is just beginning or opening up. These effects are what we have called "spark of the change," in the sense of imprinting something in the present relationship, specifically relational learning. At the same time, a process of change is ignited that is also relational but related to the patient`s implicit learning about his own relational knowledge. How permanent and long-term this change is escapes the objective of this study, but leaves the question installed for a continuation of this study. For example, this change could be translated into modifications in explicit relational schemas, which could be perceived through different bonding or relational expressions such as attachment.

Clinical Implications

Even though MoM were understood by all therapists as spontaneous and unplanned moments, these didn't happen in a random way; on the contrary, they had to do with something that had already been happening, or as a therapist mentioned, "cooking" for some 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 an intense emotion, a phrase, a gaze, a silence or a laugh. We consider this to be a relevant clinical implication, because even though it seems impossible to plan a MoM, this study shows the importance of generating conditions and possibilities for them to take place. It also gives clinicians a notion of certain markers of moment of meeting, such as the recognition of their own bodily sensations, emotions or attitudes and changes in posture, body language and physical expression observed in their patients. These markers may help clinicians identify when they are immersed in these moments and use this knowledge to turn implicit experiences into explicit ones. The aforementioned is consistent with our conclusions from a previous study on patients' experience of MoM, who identified that their "emotions and sensations are produced by the therapist's move—something the therapist says or does- and have an impact that goes beyond words, as they feel these actions as bodily sensations" (Duarte et al., 2020, p. 62).

As Fosshage (2011) formulates, psychotherapy would seem to work through two interconnected paths: through words and the reflective work that happens in a more explicit level and, also, through both implicit and explicit relational experiences. Our findings suggest that given the implicit knowledge that takes place in between patient and therapist along with the felt experience of affection, psychotherapy would help the patient recognize and integrate different aspects of his or herself and articulate explicit language with the implicit experience. These findings are consistent with Rappaport's (2012), BCPSG's (2008a) and Levenkron's (2009) work.

In terms of therapeutic interventions, our findings suggest the importance of including attention to sensory processes, the body, visual images, language in the present, in addition to the non-verbal aspects of the relationship. Rather than simply relying on interpretation leading to insight, this perspective seeks to highlight new experiences and their new meanings. Focusing on direct experiences, as opposed to just the meaning of experiences, allows interventions beyond interpretation. This is what Stern (2004) calls the present moment. Inquiry about the sensory aspect of a situation—what is seen, what is heard, what is felt to the touch, what is smelled and what is tasted—often leads to overlooked memories. Bucci (1997) describes several characteristics of discourse that have a high degree of connection between the sensory and symbolic systems: concreteness, specificity, clarity and images. Sensory experiences are directly connected to physiological responses, but it is language that helps access these experiences while imagination, body postures, and movements further enhance emotional recall and give it the symbolic place it requires to establish a new narrative.

Methodological Advantages and Limitations, and Guidelines for Future Research

The main merit of this study is its exploration of a clinical concept that has little empirical evidence and great clinical value, and the possibility to revise from the therapists' perspective what a moment of meeting looks like for them. We also think that the diverse sample, regarding their clinical background allows us to think of this concept as a generic aspect of psychotherapy practice. Even though not all interviewees were familiar with Daniel Stern and the Boston Group's concept of MoM and had different ways of referring and conceptualizing that experience, there seemed to be a consensus in recognizing certain common aspects of the described experience.

Therefore, the description articulated in this article is a way of naming and delimiting a phenomenon that appears with similar forms in the experience of therapists with different theoretical backgrounds that seem to fit to the descriptions originally made by Stern and the BCPSG.

As a limitation of this study, it is important to mention that although therapists were from different traditions, there seems to be a rather similar background, with an interest for the therapeutic relationship and for constructivist models. There were no cognitive or CBT therapists or classic psychoanalysts, which could limit the possibility of grasping divergent perspectives. Another limitation is the fact that all interviews were conducted by the same person, which can produce a biased effect in how the interviews were conducted and the way questions were stated. Also, despite the explanation and description of how a moment of meeting was understood for the purpose of this research, it is unclear that all therapists referred to this in exactly the same matter. The definition and descriptions provided by Stern and the BCPSG do not allow an operationalization of the concept, so this work is based on the spontaneous consensus of the therapists and how they seem to understand this description. Additionally, although the sample size of 13 therapists was large enough for data saturation, the study might have been strengthened by adding more diverse participants.

Despite similarities in the description of MoM, different therapists valued different aspects and emphasized some over others. This element strikes us as relevant for future inquiry because it can be hypothesized that regardless of the therapist's training, MoM with patients could be understood as a generic aspect that is felt by most therapists but recognized and identified by them with the language borne from their conception and understanding of psychotherapy and influenced by their theoretical approach, among other factors.

Another interesting area for further research is the effect that MoM may have on the therapists and if it is possible to understand them as therapeutic for the therapist as well as the patient. We hypothesize that through these reminiscences and experiences we can also see a profound psychological effect on the therapist that may influence and reinforce their work and their role.

Future studies should also focus on deepening the study of the individual and relational aspects of MoM and their connection with changes in the patient's implicit relational knowledge. Further research ought to explore a mixed method approach, as to combine data obtained from external observers, participants and objective measure for a better understanding of the advancement of MoM during therapy processes.

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Note

[1] The Boston Group described a different set of processes that contribute to therapeutic change but operate at an enactive rather than an interpretive level, i.e., at the level of relational acts between patient and therapist (Lyons-Ruth, 2000).

ORCID

Javiera Duarte http://orcid.org/0000-0002-7569-0048
Claudio Martinez http://orcid.org/0000-0001-7866-9124
Alemka Tomicic http://orcid.org/0000-0003-3272-1198

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