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EMPIRICAL PAPER

"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

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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, and to construct an integrated comprehension of the change process of a patient with Borderline Personality Disorder. **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

Clinical or methodological significance of this article: 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 advantaged 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 knowledge and a body of socially shared experience.

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

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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 (Levitt et al., 2016; Yeh & Inman, 2007), 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; Hill, Williams, Heaton, Rhodes, & Thompson, 1996; Knox, Hess, Petersen, & Hill, 1997; Timulak, 2007; Timulak & Elliott, 2003; Westra, Aviram, Barnes, & Angus, 2010). 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 (2013) state, 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 well-being (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, 2009), cannot be interpreted without considering the presence of both patient and therapist and their involvement in this process (e.g., Stern, 2004; Stern et al., 1998; Martínez et al., 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, 2015). Specifically, scarce qualitative studies involving subjective experience have been carried out on Borderline Personality Disorders (BPDs). 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 well-being. 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., Dimaggio et al., 2017; Gullestad & Wilberg, 2011; Higa & Gedo, 2012; Landes, 2013). For example, Higa and Gedo (2012) presented a brief case study highlighting the usefulness of Transference Interpretation in BPDs 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 POR (Castonguay et al., 2013; Castonguay & Muran, 2015), 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 BPD 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 3–6 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 (Elliott, 2002; Galassi & Gersh, 1993; Hilliard, 1993; Kazdin, 1999; Stephen & Elliott, 2011).

This narrative case study is based on the assumption 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 Reliable Change Index, Jacobson & Truax, 1991; Lambert et al., 1996), 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 using 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 1 hr.

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: (i) 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?); (ii) Therapy expectations (e.g., in what way did you think therapy could help you? Was therapy what you expected? Did unexpected things happen?); (iii) 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?); (iv) 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?); (v) 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?); (vi) 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: (i) Diagnosis and illness notions (e.g., Why did this patient come to therapy? Why do you think she decided to ask for help?); (ii) Therapy expectations (e.g., How did you think psychotherapy could help this patient? Did unexpected things happen during therapy?); (iii) 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?); (iv) 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?); (v) 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?); (vi) 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 BPD, 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 (e.g., 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, 2004/2007). As a result of this work, 10 main categories emerged regarding how the patient and the therapist had experienced the psychotherapy: (i) Context, (ii) Conditions for conducting the psychotherapy, (iii) Reasons for consultation, (iv) Expectation of change, (v) Transformation of change and attainment expectations, (vi) Forms of therapeutic work, (vii) Facilitators of psychotherapeutic change, (viii) Therapeutic relationship, (ix) Termination process of the psychotherapy, and (x) 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, 1999). 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 BPD, 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.

"YouTube[1]": 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 I).

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.

Table I. Main categories of the "YouTube" chapter.

Main categories	Properties	Mentioned by
Context	Psychiatric Hospital	The patient acknowledges the presence of patients with serious mental disorders, which does not match her perception of her own psychological problems.
	Teaching	At times, the patient and the therapist feel that they are part of a "show" and the therapist says 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.

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 I, 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 II).

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:

Table II. Main categories of the "I couldn't change the past" chapter.

Main categories	Properties	Mentioned by
Reason for consultation	Explanation for the past	The patient states that her reason for seeking help is to look for 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: "You have now completed a degree in your disease."
	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 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-change of the 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 reactualization of conflicts	The therapist regards psychological problems as the reemergence of dysfunctional relational patterns formed in response to early traumatic experiences.

> 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 III).

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

Table III. 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.

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 a 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.

"WhatsApp[2]": 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 IV).

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

Table IV. 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.

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 Aramínta'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, "something 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, 2004; Stern et al., 1998, 2002).

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 and 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 BPD, 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 POR (Castonguay et al., 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, Rønnestad, & 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 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 et al. (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, 2 August 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 advantaged 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 knowledge and a body of socially shared experience.

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Notes

[1] YouTube 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.

[2] 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.

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