

RESEARCH ARTICLE

Meeting in difference: Revisiting the therapeutic relationship based on patients' and therapists' experiences in several clinical contexts

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Abstract

Despite decades of research on the therapeutic relationship and the therapeutic alliance and their connection with therapeutic outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011), only a handful of studies have examined how they are experienced by the therapy participants. The aim of the present study is to describe the therapeutic relationship from the subjective perspective of the patients and therapists involved in 3 clinical cases: (a) a 7-year-old child diagnosed with attention deficit hyperactivity disorder, (b) a 29-year-old woman diagnosed with a personality disorder, and (c) a 22-year-old man diagnosed with schizophrenia. We conducted semistructured interviews with patients and therapists that were later analyzed following grounded theory coding procedures (Corbin & Strauss, 2008). The results obtained reveal that the constitutive elements of the therapeutic relationship are linked to 2 dimensions of the patient–therapist meeting experience: the technical and role-related dimension, characterized by relational asymmetry, and the affective exchange dimension, characterized by relational symmetry. The article discusses the possible association between the asymmetrical technical dimension, whose roles are defined by the organization of the helping relationship, and the notion of therapeutic alliance as commonly conceptualized and assessed; on the other hand, the experience of the bidirectional and symmetrical patient–therapist affective exchange is linked with concepts such as *real relationship* and *intersubjectivity*.

KEYWORDS

alliance, children, patient and therapist perspectives, qualitative methods, schizophrenia, therapeutic relationship

1 | INTRODUCTION

Decades of research on the therapeutic relationship have cemented its status as a key agent of change in psychotherapy (Gelso, 2014; Norcross, 2011). The therapeutic alliance has been the most extensively studied construct for examining the central elements of the therapeutic relationship. It has been shown to be one of the nonspecific variables that best explains psychotherapeutic change, regardless of the therapeutic approach (Horvath, 2005; Horvath, Del Re, Flückiger, & Symonds, 2011) and modality employed (Heatherington, Friedlander, Diamond, Escudero, & Pinosof, 2015; Horvath et al., 2011; Martin, Garske, & Davis, 2000).

In the present article, the therapeutic relationship will be understood in terms of what Gelso (2014) describes as the feelings and attitudes that patient and therapist experience toward each other and the ways in which they express them (verbally, nonverbally, explicitly, or implicitly). For Gelso (2014), this broad concept of therapeutic relationship includes phenomena such as the real relationship (the genuine and real part of the relationship), the therapeutic alliance, and transference and countertransference elements. Because the alliance is the most widely studied element of the therapeutic relationship in the field of psychotherapy, and because studies focused on the therapeutic relationship as a study unit are scarce, much of the literature reviewed in this section concerns the concept of therapeutic alliance, even though the interest of this article is centered on the concept of therapeutic relationship in a broad sense.

Most studies on the therapeutic alliance have adopted the pan-theoretical definition advanced by Bordin (1979), who conceptualized it as a construct made up by three interrelated dimensions: agreement between the patient and the therapist regarding therapeutic goals, the tasks that must be carried out to achieve said goals, and the emotional bond between the participants, which contains aspects such as trust and acceptance. Most of the instruments used to assess the alliance are based on this theoretical construct, which, together with other definitions derived from it, reflect the implicit assumptions of its creators. However, as several studies have underscored, it is unclear how the theoretical assumptions underlying these measures fit the perspectives of therapy participants regarding the relevant features of the therapeutic alliance (Baylis, Collins, & Coleman, 2011; Bedi, Davis, & Williams, 2005; Krause, Altimir, & Horvath, 2011). Thus, due to being based on predefined scales and questions, the existing definitions encompass certain specific domains of experience regarding the alliance phenomenon, leaving others out; for example, they emphasize collaboration toward the attainment of therapeutic tasks and goals, thus focusing on more cognitive and behavioral aspects of therapy (Krause et al., 2011).

In contrast to the theoretical perspectives, studies that consider the subjective reports of the therapy participants show that both patients and therapists identify the following essential elements of the therapeutic relationship: their emotional experience, affective reciprocity, feelings of trust, and, in the case of patients, feeling understood by the therapist (Krause et al., 2011). In addition, for some patients, the critical elements for the establishment of the alliance include contact with the therapist outside the session, therapist care provided beyond the normative requirements of his or her role, and eye contact during the session, among others (Bedi et al., 2005).

To date, the great majority of the studies on the therapeutic relationship have assessed the alliance through self-report instruments, analyzing them quantitatively for the most part (Horvath et al., 2011; Martin et al., 2000). These measures have established the relation between alliance and therapeutic outcomes as well as the development and evolution of the alliance; however, few studies have attempted to show how the alliance is experienced and understood by those involved in the therapeutic relationship (Bachelor & Salomé, 2000; Bedi et al., 2005). This type of research is needed, considering that the quality and level of appreciation of the alliance can vary depending on the informant and his or her characteristics (e.g., age range, role in the therapy, psychopathological state; Kazdin, Whitley, & Marciano, 2006).

Further, only a few studies have examined the therapeutic alliance in children and adolescents (Green, 2006; McLeod, 2011). In addition, the main diagnoses of the adult patients studied have been anxiety, depression, and personality disorders (Bachelor & Salomé, 2000; Bedi et al., 2005; Rozmarin et al., 2008). This tends to homogenize the characteristics of the participating population because studies on the therapeutic alliance with patients suffering from severe psychiatric disorders such as schizophrenia are much less common than those with other adult patients (Frank & Gunderson, 1990; Goldsmith, Lewis, Dunn, & Bentall, 2015).

1.1 | Therapeutic alliance in psychotherapy with children and adolescents

The existing research has shown that the therapeutic alliance is a relevant predictor of therapeutic outcomes in psychotherapy with children and adolescents (Shirk, Karver, & Brown, 2011). Even though the model advanced by Bordin (1979) has served as a starting point for understanding alliance in this population, it is affected by major applicability issues (Baylis et al., 2011), given that it is the parents who often choose to seek help, according to their own therapeutic goals for the child, which usually differ from the minor's perspective and that of the therapist (Accurso & Garland, 2015; Shirk et al., 2011). Specifically, adolescents tend to disagree with their parents with respect to the nature of the problem and the need for treatment (Shirk & Karver, 2011). All this can result in a low initial degree of child and adolescent participation in the psychotherapeutic process (Baylis et al., 2011; Shirk & Karver, 2011).

On the other hand, the bond-related aspect of the alliance seems to transcend the patient–therapist relationship because the latter must establish multiple alliances: at least one with the child/adolescent and another with his or her parents (Green, 2006; Shirk & Karver, 2011). Studies on parents–therapist alliance show that it is associated with better parenting skills and household interactions, also influencing commitment to the therapy and support for extra-session treatment, which has a direct effect on therapeutic change (Kazdin et al., 2006; Marker, Comer, Abramova, & Kendall, 2013; Shirk et al., 2011). In addition, parents' commitment, support, and alliance with the therapist can improve the quality of the alliance that children establish in the therapy (Campbell & Simmonds, 2011; Kazdin et al., 2006).

Even though these studies have yielded some information about the alliance in child–adolescent psychotherapy, they are mainly based on the views of therapists and parents, while only a few projects have taken into account the perspective of children and adolescents (Shirk et al., 2011). This issue gains relevance considering that the few existing studies reveal that children, adolescents, and parents have a more positive opinion of the alliance than therapists, who underestimate the family's level of alliance with them (Accurso & Garland, 2015; Kazdin et al., 2006).

1.2 | Therapeutic alliance in psychotherapy with patients with schizophrenia

The existing research on the therapeutic alliance with patients with schizophrenia has identified it as a key factor for adherence to treatment (both psychotherapeutic and pharmacological) and patient recovery (Misdrahi, Petit, Blanc, Bayle, & Llorca, 2012), leading to better therapeutic outcomes (Kvrgic, Cavelti, Beck, Rüschi, & Vauth, 2013), or even a decrease in medication use (Frank & Gunderson, 1990). Goldsmith et al. (2015) state that a positive therapeutic alliance is not only linked to improvement, but that it also can be the cause of the recovery of patients with early psychosis, in the same way that a poor therapeutic alliance could have a negative effect on therapeutic outcome.

Several authors have noted the difficulties experienced by therapists when attempting to establish a positive therapeutic relationship with patients with schizophrenia (Easter, Pollock, Pope, Wisdom, & Smith, 2015; Kvrgic et al., 2013). This challenge is usually attributed to clinical manifestations of the disorder, which include symptom severity (Johansen, Melle, Cabral Iversen, & Hestad, 2013), thought alterations (Calvetti, Homan, & Vauth, 2016), and low patient insight about his or her symptoms (Easter et al., 2015). More recently, research has explored the negative impact of self-stigmatization and the positive effect of therapists' recovery-focused approach (Kvrgic et al., 2013).

Nevertheless, little research attention has been paid to the relational needs that may be involved in the treatment of people with schizophrenia (Penn et al., 2004). Based on the existing studies, it is clear that the relational dimension of the alliance is crucial for the establishment of a positive therapeutic relationship when working with patients with schizophrenia. For example, Easter et al. (2015) stress the value that patients ascribe to talking, feeling that they share common ground with the therapist, having a say in the planning of the treatment, and having a therapist who displays availability and flexibility. As another example, Fenton (2000) indicates that the issue ultimately depends on the therapist's ability to be attuned to the patient's clinical needs. However, this is an area of the treatment of schizophrenia patients that requires further exploration.

1.3 | Aims of the current study

The literature presented reflects the limited number of studies geared toward clarifying how the alliance—and the therapeutic relationship in general—is experienced by the therapy participants (Krause et al., 2011). It is even less common to find definitions of alliance in patients from specific age groups or with a specific pathology, whose particularities could reveal slight variations in how the therapeutic relationship is experienced. Therefore, it is relevant to examine in more depth the “idiosyncratic” definitions of the therapeutic relationship provided by patients and therapists with different problems and from dissimilar age groups. Thus, the aim of this study is to describe, from the subjective perspective of patients and therapists, the therapeutic relationship established in successful therapeutic processes, considering three cases with different characteristics.

2 | METHOD

The present study employed a multiple case design, which involves a systematic, intensive, and in-depth examination of several specific cases (Rodríguez, Gil, & García, 1999). A qualitative approach was used in order to obtain a comprehensive description and understanding of the complexity of the phenomenon upon the basis of the participants' subjective perspectives.

2.1 | Participants

The present study includes three cases with differential characteristics, in which the perspectives of patients, therapists, and the mother in the case of the child, were taken into account. This yields a total of seven participants. All participants agreed to participate voluntarily. Before conducting the interviews, the participants signed an informed consent letter. In the case of the child, apart from his own assent, the mother's consent was obtained. The study was approved by the relevant Ethics Committee (School of Psychology, Pontificia Universidad Católica de Chile)¹.

2.1.1 | Case A

The patient is a 7-year-old child, referred to psychological care by his school due to attention deficit hyperactivity disorder. The therapist is a 26-year-old man with a constructivist approach, who at the time was in his first year of psychotherapy training. This was an individual therapy conducted weekly in a university health care center. It lasted for 3 months and also included sessions with the child's parents.

2.1.2 | Case B

The patient is a 29-year-old woman. Her reason for seeking help is related to an early experience of intrafamily sexual abuse and her interpersonal difficulties with her partner and at work. She has been diagnosed with an adjustment disorder with depressed mood as well as a personality disorder. The therapist is a 45-year-old woman with a psychodynamic approach and over 20 years of experience. The therapy lasted for 3 years, with weekly sessions. It took place within a teaching context, in a one-way mirror room located in the outpatient wing of a psychiatric hospital.

2.1.3 | Case C

The patient is a 22-year-old man, diagnosed with paranoid schizophrenia. His reason for seeking help is linked to difficulties in interpersonal relationships. The therapist is a 34-year-old woman with a psychoanalytic approach and 11 years of experience. The therapy has lasted for 2 years, with weekly sessions, in a private treatment context.

2.2 | Data collection technique

Individual, semistructured interviews were conducted to ensure the exploration of key topics for all participants and the examination of idiosyncratic aspects of each interviewee. The interviews were based on a common thematic script for patients, parents, and therapists, which was developed for the larger study from which the present research

derives. The scripts included open-ended questions covering several areas: assessment and description of the process, motivations for getting therapy, interventions and significant moments, therapeutic relationship, therapy termination, changes perceived, and meanings ascribed to the mental illness, diagnosis, and recovery. With respect to the therapeutic relationship, the interview explored the participants' perception of it throughout the therapy, its modifications, its characteristics, the feelings associated with the therapist or the patient, and the influence of the therapeutic relationship on the therapy process and patient change.

In the case of the interview with the child, the drawing "before and after therapy" (Capella et al., 2015) was also included. In this task, the child is instructed to draw him/herself in these two moments; afterwards, the drawings are integrated into the script to facilitate narrative production about the start of the therapy, its outcomes, and its termination.

The follow-up interviews were conducted face-to-face by members of the research team, audio recorded, and transcribed for later analyses. In case A, interviews were conducted 4 months after termination, while in case B they were conducted 6 months after termination. In case C, the interviews were conducted while therapy was still in progress, specifically in its second year, around session number 35.

2.3 | Analysis

The interviews were qualitatively analyzed, using a discovery-oriented approach based on grounded theory (Charmaz, 2006; Corbin & Strauss, 2008). The analysis included open coding followed by the axial coding of the data collected, using ATLAS.TI v7. The open coding procedure consisted in the analytic identification of emergent themes in each individual interview, which yielded several categories of relevant phenomena. Afterwards, the interviews were reanalyzed to identify emergent topics linked to the therapeutic relationship. The open coding process resulted in hierarchical classification categories associated with the multiple dimensions of the therapeutic relationship. These categories later underwent axial coding—which consisted in organizing the categories and subcategories around a central integrative phenomenon—embedded in a denser and more interpretative description and analysis process focused on emergent phenomena (Corbin & Strauss, 2008; Valles, 2003).

The drawing, on the other hand, was examined with qualitative techniques for studying visual data (Capella et al., 2015). To ensure the quality of the results, a triangulation strategy (Cornejo & Salas, 2011) was employed involving several researchers. Through intersubjective agreement, this process allowed several perspectives to be considered in the identification and interpretation of the categories generated.

3 | RESULTS

Based on the analysis conducted, a model is proposed which identified the patient–therapist meeting as the main emergent phenomenon in the therapeutic relationship. This phenomenon appears to comprise two domains of experience: the technical dimension and its associated roles, characterized by relational asymmetry; and the affective dimension, characterized by relational symmetry. These two domains are defined by and emerge from the structure and organization of the helping relationship (see Figure 1). In addition, it is important to note that the interviewees describe the therapeutic relationship, and these two constituent elements, as evolving throughout the therapeutic process. In the interviewees' description, the technical asymmetry and role-related dimension appears to remain more stable during the process, but the affective dimension gains relevance as the therapeutic process progresses, becoming more symmetric toward the end of the therapy.

According to the analysis of the participants' narrations, the structure of the therapist–patient meeting is defined upon the basis of a helping relationship that determines and organizes the roles adopted by each member of the dyad and defines their interaction throughout the therapeutic process. These roles involve an active therapist, perceived as an expert who adopts a listening position, and a more receptive patient who seeks help. This arrangement reflects a patient–therapist encounter that is, in principle, defined by asymmetry in terms of technical knowledge and the differential roles played by each member of the dyad.

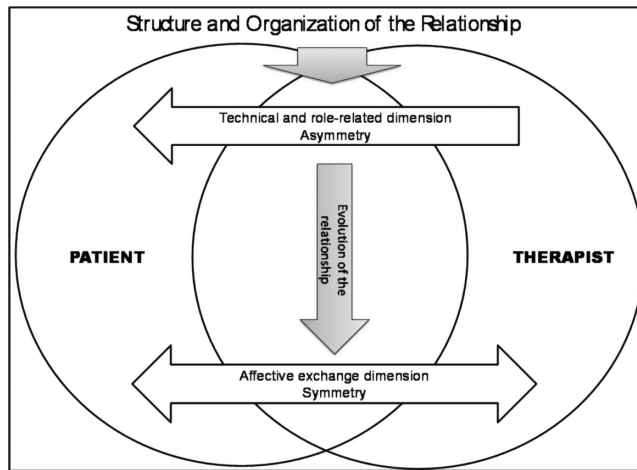


FIGURE 1 The patient–therapist meeting composed of the technical and role-related, and the affective exchange dimension of experience.

This asymmetry is necessary for initiating therapeutic work and building trust because it allows the patient to experience a freer relationship that requires less care than other meaningful relationships in his or her life: the therapist is “prepared” to provide support without faltering or compromising the helping relationship. In this regard, asymmetry can help establish the distance required to differentiate the roles present in the helping relationship. This is reflected in the words of the therapist of case B:

It was funny, because I addressed her quite informally ... and she was very formal. She called me “doctor” while I called her [the patient’s name].... So it was like, like she was keeping her distance in a way, keeping the ... the professional distance so to speak....

In addition, this asymmetry allows the patient to embrace the language and clinical tools provided by the therapist. The patient adopts the role of someone who must deal with a problem and requires the therapist’s help; thus, she receives the interventions implemented by the latter: “It’s like I need someone to listen to me, because I can’t really tell this to anyone” (patient, case C).

For her part, the therapist adopts the role of an expert. The patients ascribe this expertise to their therapists, perceiving them as professionals or describing their feeling of being in the hands of someone who “knew what she was doing”:

But with her [the therapist], it’s like she saw the importance of the problem. I mean, I thought, Well, they must be right [referring to psychologists in general]. And when I do that [what the therapist suggests], it actually works. (patient, case C)

These patient and therapist roles are also in line with traits that each participant brings from his or her own subjective world to the therapeutic meeting: their roles are organized according to the personal characteristics of each participant, the therapist’s interest in the case that the patient represents, and the patient’s motivation and openness toward the process. Based on these roles and the aspects brought to the session by the participants, other elements emerge from the encounter with the other.

Among these elements is a phenomenon derived from technical asymmetry: the task of articulating therapeutic work taken up by the therapist that will be constitutive of the organization of the relationship. The therapist deploys a set of attitudes, actions, techniques, and interventions based on his or her understanding of the patient that guide and shape therapeutic work. This understanding of the patient entails an attitude that goes beyond establishing a categorical diagnosis. Instead, the professional seeks to comprehend the patient’s personal and biographical characteristics, which should help consolidate the relational world shared by the participants.

Even though the therapist, in his or her role as articulator, organizes and guides the therapeutic work conducted, he or she is also sensitive to the rhythms and needs that he or she perceives in the patient and tries to make him/her participate in the process, which is regarded as a collaborative effort.

The patient's response to the tools and attitudes deployed by the therapist, in his or her role as articulator of therapeutic work, constitutes another emergent element of the organization of the relationship. The interviewees note that patients often respond in a constructive manner, displaying their willingness to collaborate in the therapeutic activities and their motivation to be part of the process.

The interviewees agree that the therapist's commitment to the patient is one of the most relevant elements that he or she displays in his or her articulating role, which is manifested through an attitude of genuine concern and interest in the patient: "Regarding him [the child], he [the therapist] is strongly committed to the case ... because he saw that my husband and I came to all the sessions, because we really cared" (mother, case A).

As an articulator, and in an expression of his or her commitment to the case, the therapist adopts a flexible approach to the therapeutic frame on some occasions, when he or she considers that this approach will help the patient and the treatment process. The therapist's flexibility may entail carrying out actions that differ from the patient's expectations considering his or her role and the treatment context, which in turn makes the therapist appear closer and more available to the patient. These actions may include making contact outside the session (e.g., using the phone, e-mail, or WhatsApp®). In addition, the therapist may contact other health professionals or institutions linked to the patient (e.g., a school) to intercede on the patient's behalf, waive an institutional procedure, extend sessions beyond their set duration, or lower the cost of his or her professional services:

We ignored every rule ... I mean, I pampered her as much as I could. I gave [case B patient] really preferential treatment that included getting her medical appointments outside the set schedule, changing doctors, discussing her medication with the psychiatrist, getting medical leaves for her. I mean, I gave her everything she asked for. In fact, she never took that document ... I think, Why was that? Because of the one-way mirror context ... because she was in a special situation, I gave her special treatment... I mean, I thought, how can I treat her like a common patient if I put her in a special situation? (therapist, case B)

3.1 | The affective meeting as the core of the relationship: Symmetry in the affective dimension

Based on the technical and role-related dimension, an affective dimension of the encounter emerges throughout the process, to which the interviewees ascribe great importance. This affective dimension emerges out of the asymmetrical arrangement, and in a way it is aligned with that organization, however, at the same time it adopts a more symmetrical aspect inasmuch as a bidirectional affective exchange is experienced. Even though this exchange is not equivalent, it puts patient and therapist at the same level of emotional and relationship experience, because both feel genuine emotions in their interaction with the other, which in turn makes the relationship more intimate and committed.

3.2 | The therapist's genuine affection and interest: Connection, concern, and care

The therapeutic relationship begins taking shape and developing at the same time as the therapy starts. This process is characterized by an initial stage in which patient and therapist get to know each other, aided by a fundamental element of connection between both: as one of the interviewees puts it, an initial "feeling."

However, as the relationship evolves, a more affect-based exchange emerges and grows between patient and therapist, which is expressed through the feelings of care, concern, and emotional closeness that the therapist experiences toward the patient. Such feelings are experienced as genuine and spontaneous, and as elements that go beyond what the therapeutic contract implicitly establishes as part of the helping relationship. In this process, the real dimension—the feelings that lie outside the defined role—begins to gain importance in the relationship; however, the relationship is safeguarded by the asymmetrical roles described above, which define the relationship as therapeutic.

This therapist's genuine concern for the patient stands out in the participants' reports of the study. This is a valued element in the relationship that makes it possible to build trust beyond technical competences:

Sometimes people come and say "Right, he's doing his job, but he doesn't really care or doesn't show much interest, you can't really see his commitment." So I think that factor has some influence on parents' perception, whether they think one's doing a good job...In this case, I think they saw I cared because I sent them reports, I called them and everything. (therapist, case A)

Oh, yes, um, I mean I felt like she was truly interested. For instance, sometimes she sent me emails asking how I was, if I needed an additional appointment, things like that. I mean, I felt the relationship wasn't so cold...I mean, it wasn't friendship or anything, but I saw she cared. I mean, it wasn't a really cold relationship, like I went to the session and then said goodbye, that's it, if I didn't call her there wasn't any contact or anything else. Yes, I felt some concern coming from her, like she really wanted me to get better and overcome this. (patient, case C)

As the therapeutic relationship evolves, the therapist's concern for the patient becomes linked to the emergence of genuine feelings of care and the wish to adopt a protective role: "Yes, because it's something, like experiencing love ... Yes, something like that, wanting to care for him, yes. I don't know, it's like an experience of love" (therapist, case C).

A noteworthy element in the case of the child patient is that the therapist's relational offer—involving play-related aspects—is regarded as loving and friendly, which allowed the patient to have a good attitude toward the therapy, viewed as a different type of relational experience with the adult world. In this regard, the patient states:

I: And if you had to describe [the therapist], how would you describe him?

P: Well ... um, kind ... affectionate.

I: Affectionate, okay.

P: And, um... and he shares.

I: And he shares, shared things with you. And, for example, in what sense was he affectionate? Can you give me like an example?

P: He used to lend me—he lent me his pencils.

The therapist, as she listens, experiences real emotions; she is moved, feels attached, and connects to the patient on an affective level, which the patient sees as a positive element when she perceives that she can generate affective states in her therapist that extend beyond the roles in their relationship:

P: When I told things to her and she was moved, she was moved and I think that's why I felt so strongly that, yes, her affection was real. Maybe it's bad for a psychologist to get involved, the psychologist can't get involved, but when she made me feel that.

I: How could you perceive that she was moved?

P: Because she got teary and started like looking the other way. (patient, case B)

For her part, the therapist actively seeks to establish emotional contact with the patient, allowing herself to display spontaneous gestures of affection, genuinely expressing her emotions, and revealing personal experiences connected to those of the patient. The matching of these common interests establishes biographical bridges that take the relationship to a more intimate plane:

The first time that he managed to talk to me more fluently was when he told me he liked to read books about the middle ages and medieval knights. So, I knew a few things about the knights templar, we talked about castles, we talked about...Actually, the hard thing is that, especially with psychosis, or with, with autistic children, the hardest thing is to show something that you're feeling. It's not like I could say, "Oh, that's interesting." If I don't feel it, they'll notice. So, I, my dad loves the knights templar and what allowed me to make a connection was this love for the middle ages, I mean, what I love about the middle ages. Yes, I'd say that's what made the connection possible...Revealing something that I knew would be perceived as something I loved. (therapist, case C)

3.3 | Constructing more intimacy based on relational trust

The patient–therapist meeting, characterized by positive and genuine affection in the bond with the other, makes it possible to experience the domain of relational trust in more depth. It is an element that patients value greatly and that allows the participants to achieve new and deeper levels of collaborative work in the therapy:

So now I really feel like I trust her. I mean, it's like I can go and tell things to her—it's quite easy...But it was like gradual. Like, I gradually added trust to our bond. (patient, case C)

Trust appears to be gradually constructed during the therapy, and the patient may even feel mistrust in the first encounters with the therapist. The gradual construction of trust fosters the generation of a stronger and more intimate patient–therapist bond. This is especially noticeable in long-term processes:

I: And did this, um, vary throughout the therapy?

P: Yes, because at the beginning, we weren't, but later on we were already friends. I mean, I felt we were friends. I could tell her whatever I wanted. (patient, case B)

3.4 | The end of the meeting: The therapy is over but the bond remains

The termination process is a relevant moment in the therapeutic relationship. In the two cases in which the therapy had already ended (A and B), termination was agreed on by both participants and resulted from the patient's improvement and the fulfillment of therapeutic objectives. This phase is marked by the emergence of several feelings, especially difficulties linked to separation. For instance, in case B, the patient finds it hard to finish the therapy and separate from the therapist: "So it's like I feel that, that separations were difficult [for the patient] and I have the fantasy that the final separation was also difficult" (therapist, case B).

In the same case, it is relevant to observe that termination is also experienced ambivalently by the therapist: She wishes the therapy were over, but feels the termination process could have been different, with more working through on the patient's part.

Another element that stands out toward the end of the therapeutic process is the assessment made of the therapeutic relationship in connection with psychotherapeutic outcomes and change. Furthermore, when the therapeutic relationship reaches a higher level of affective connection, the patient's changes are, partly, visualized as a product of this encounter.

Um, her relationships improved. All those changes, I think they had to do with, with things that ... support her emotional experience with me, um, and the ability to reflect and become aware of the things that she was going through...It's a combination of those two things. (therapist, case B)

An aspect that stands out is the importance of the therapeutic relationship, especially the building of trust with the therapist, not only for therapeutic success but also for the continuity of the patient's attendance to therapy:

I: Which of all these factors would you say had the strongest influence on your therapy process? Which would you say was the most important?

P: Building trust, I think. I think that's the most important one by far. Because if I hadn't generated that trust with her, I would never have opened up at all. I mean, first of all, I'm extremely private and I find it very hard to share these things. And if I hadn't had a positive attitude, I would never have told her anything. And I wouldn't have opened up, and maybe I wouldn't have gone to therapy, and I probably would've dropped out after 4 weeks. (patient, case C)

After the end of the intervention, patient–therapist contact is maintained, which shows that the therapeutic bond appears to extend beyond the end of the therapy. Interaction is initiated by the patient, but the therapist is open to being contacted, which generates a sense of relief in the patient. This leaves open the option of resuming the therapy if necessary or allows the therapist to schedule follow-up measures:

P: At first, when we terminated the therapy with [the therapist] she gave me her number. So one day I was feeling terrible and I called her and I went to see her to her office and we talked, but it was actually—I analyzed it later—just to know if she was still there....It's not like we finished the therapy and said that's it, bye bye, I have no idea who you are. So for me it was ... not like I was feeling so overwhelmed by the problem I had—it was like I found an excuse to find out whether she was there. Actually, sometimes I send her a WhatsApp message, like "Hi, how are you?" "Fine, and you?" "Fine," and that's it....Yes, knowing she's there, that I can contact her through WhatsApp and that I can write to her, like, for example, when I'm really down I check my WhatsApp and I see her there, she's online. Fine, I say, okay but I don't send her anything. (patient, case B)

On the other hand, the posttherapy permanence of the bond is reflected in the recalling of the encounter and the memory of the relationship with the therapist:

[My son] always tells me, "Hey mom, aren't we gonna see uncle [therapist's name] again? Aren't we gonna see uncle [therapist's name] anymore?" "No," I tell him, "because he's already discharged you. "Oh, so I don't have to go." (mother, case A)

4 | DISCUSSION

The present study is intended to contribute to a deeper and broader understanding of the therapeutic relationship, taking into account the subjective perspective of patients and therapists, beyond the definitions established upon the basis of theoretical insights and traditional alliance measures. The narrations of participants with different characteristics and at different points of their life cycle made it possible to identify two domains of experience that, in a dynamic manner, constitute the therapeutic relationship throughout the therapy.

The first dimension is organized around the definition of a helping relationship in which the roles of each participant are established asymmetrically. Upon the basis of this organization, there emerges an affective dimension characterized by the symmetry of the patient–therapist relational experience.

These emergent aspects support the notions advanced by some authors who note that the therapeutic relationship is neither static nor uniform throughout the therapeutic process; instead, it is a phenomenon that—like any other intimate relationship—is characterized by an increasing level of complexity and richness; therefore, said dynamism must be considered when studying both the alliance and the therapeutic relationship (Bachelor & Salamé, 2000; Gelso, 2014; Horvath, 2006; Safran & Muran, 2006). This view extends what traditional alliance measures (self-report questionnaires) tend to assess, which includes the participants' level of agreement regarding tasks and goals, the generation of a trust-based bond, and the ability to work together, all of which are characteristic and necessary elements in the initial "commitment-centered" phase of most therapies.

We consider that the technical dimension and its asymmetric roles, derived from the initial organization of the helping relationship described in this study, has some points in common with the elements of the alliance assessed by traditional research measures, which are the necessary ingredients to lay the groundwork for therapeutic work. In this regard, the asymmetry phenomenon observed in this study is relevant because, as pointed out by Krause et al. (2011), the alliance is an emergent quality of the collaborative and productive work that occurs within an asymmetric relationship, in which participants' contributions to the alliance are not equivalent but complementary, and in which the therapist can be said to be "structurally" in charge of the therapy.

Similarly, the results obtained highlight the organizational role as articulator played by the therapist due to this relational asymmetry. The therapist is described as proactive, an asymmetry that patients experience as necessary because it allows them to lean on a figure who is in control and knows what he or she is doing. This element is complemented by the therapist's commitment to the patient, which is mostly manifested through his or her flexible attitude toward the nature and process of the work. The most genuine and spontaneous aspects of the relationship emerge in this context as well. This is consistent with Krause et al. (2011): For the patient, the therapeutic relationship is one in which he or she is mainly a recipient under no obligation to reciprocate emotionally. In addition, our qualitative analyses confirm what

previous quantitative studies have demonstrated regarding common factors, that the therapist's contribution is one of the most important factors in the establishment of the alliance and the attainment of therapeutic outcomes (Wampold, 2015).

According to Horvath (2006), as the relationship gains complexity, the initial alliance building processes progressively become part of the therapeutic routine, while new processes emerge in parallel. In the present study, the symmetric dimension of patient–therapist affective exchange was identified as one such emergent process. In this regard, it can be stated that the bidirectional affective dimension exists only because of the asymmetry in terms of technical expertise and roles that the format of the helping relationship determines, which protects the therapeutic setting of the relationship, and inasmuch as a modicum of relational trust is achieved. In this regard, it appears that the trust factor and its progressive construction are what allow relational intimacy to increase. This is a comprehensive process that starts with the first contact and then leads to the strengthening and consolidation of trust within the affective dimension, as the evolution of the therapeutic process indicates.

In our attempt to identify what the therapy participants understand by *therapeutic relationship* based on their subjective experience, we consider that we have contributed to describing said experience, which encompasses elements that extend beyond the traditional notion of therapeutic alliance. We can suggest that what we have described as the asymmetrical *technical and role-related dimension* reveals, from the participants' perspective, what we conceptually understand by therapeutic alliance, or at least certain core elements such as the establishment of initial trust and an agreed-upon operational setting. On the other hand, we could also suggest that what we have described as the *affective dimension*—the aspect that the participants most strongly highlighted—resembles what Gelso (2014) describes as the “real relationship” given that it includes elements such as genuine emotional contact and a realistic perception of the other; in addition, as the therapy progresses, the real relationship becomes deeper and more prominent in later stages.

This differentiation between an asymmetrical and a symmetrical dimension of the therapeutic relationship has clinical implications because it helps to distinguish relevant aspects of the alliance—which could be examined to lay the groundwork for therapeutic work and establish the relational structure that it requires—from relational elements associated with greater affective intimacy and the depth of therapeutic work, which can strengthen change processes in the patient. At the end of the therapeutic process, the participants regard these elements as essential for achieving positive results and therapeutic change, which is in line with other studies that have highlighted the influence of the therapeutic relationship on change in psychotherapy (Gelso, 2014; Norcross, 2011).

Even though the results reported were obtained from only three clinical cases, an aspect that limits the applicability of the conclusions reached, they reveal certain common aspects in how the therapeutic relationship is experienced by patients and therapists, regardless of differences in terms of diagnosis, reasons for seeking help, age, sex, clinical experience, and treatment duration. Subjective experiences are marked by individual traits and particular characteristics that were not addressed by this study; however, they should be taken into account in future research. The results obtained by this study may have certainly been influenced by certain participant characteristics, such as a particular availability and positive disposition toward the study, being particularly connected with their emotional experiences and the fact that their therapies had been successful. Therefore, it is important to contrast and expand these results using larger samples that include diverse populations (children, adolescents, various diagnoses) and incorporate unsuccessful therapies or dropout cases. This methodology would be a preliminary contribution to a line of research, which, despite its limited presence in the literature, can extend our understanding of the therapeutic relationship by enriching its definition based on the experiences of its participants.

NOTE

¹ The present study is part of a larger research project (Fondecyt 1141179), where other analyses have been carried out with samples that include the cases presented here. Specifically Cases B and C have been included in studies focusing on other specific topics (experience of therapy and change). For more information on these investigations see Abarzúa, Silva, Navarro, & Krause (2016), Duarte, Fischersworing, Martínez, & Tomicic (2017), and Krause, Abarzúa, Silva, Navarro, & Altimir (2016).

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