

The development of a new Change Process Research approach to psychotherapy

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Thesis submitted in fulfilment of the requirements for the
degree Doctor of Philosophy in Psychology at the
North-West University

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Graduation: May 2020

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SOLEMN DECLARATION

I, Rümendo Kok, declare herewith that the thesis entitled ‘The development of a new Change Process Research approach to psychotherapy’, which I herewith submit to the North-West University, Potchefstroom Campus, in compliance with the requirements set for the PhD in Psychology degree, is my own work, has been language edited and has not already been submitted to any other university.

I understand and accept that the copies that are submitted for examination are the property of the University.

Signature of student:

A handwritten signature in black ink, appearing to be 'R. Kok', with a stylized flourish above the letters.

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PREFACE

This thesis is submitted in accordance with rule A.8, and specifically in article format as described in rule A.8.2.b of the North-West University.

This thesis comprises of four manuscripts.

The referencing style and editorial approach of this thesis is in line with the prescriptions of the Publication Manual (6th edition) of the American Psychological Association (APA). All four manuscripts have been styled according to these guidelines.

For the purpose of this thesis, the page numbering is consecutive as a whole.

Note to examiners:

- The length of manuscripts is deemed appropriate for examination purposes, seeing that relevant information is provided in order to better contextualise the broader study and research topic.
- Even though the intended journal for publication, the Journal of Psychology, does not have a page limit, the authors aim to reduce the length of each manuscript for publication purposes pending the feedback and comments received from the examiners.
- Also, with the aim of publication, the in-text referencing within the manuscripts will be amended, for example: instead of referring back to certain chapters or manuscripts, the authors will refer to published articles emanating from this PhD study.

ACKNOWLEDGEMENTS

- Praise to my Heavenly Father!
- To my wife, Tanya, thank you for your continuous support, comfort and encouragement. With you by my side, I can tackle any obstacle.
- To my three lovely children, Adilé, Lia-Tüné and Rüardt – this is for you!
- To my parents, Almero and Illasha Kok, as well as Belinda and Floris Fourie – thank you for your example and support.
- To Prof. Karel Botha, my promoter, thank you for your willingness and commitment to go on this journey with me. Your guidance is highly appreciated.
- Prof. Pieter Kruger, my co-promoter, thank you for believing in this study from the get-go. I would also like to thank you, in particular, for the no-questions-asked support that you provided (on different levels). I really appreciate your input, time and commitment towards this study.
- Prof. Werner de Klerk, my co-promoter, thank you for adding quality to this study through your expertise. I really appreciate your contribution towards this study.
- Prof. Karel Botha, Prof. Pieter Kruger and Prof. Werner de Klerk – we really made a mean research team!
- To Daleen Groenewald and Language Matters, thank you for the language editing and translation.
- To Petra Gainsford, thank you for the technical editing.
- To the NWU staff development fund, thank you for the financial support.
- Thank you to the scientist-practitioners, those in practice and/or research, who agreed to take part in this study as key informants (or experts). Your feedback was valuable.
- A special word of thanks to the psychotherapy clients who agreed to take part in this study. Without you, this would not have been possible.

SUMMARY

The development of a new change process research approach to psychotherapy

Keywords: case studies, change process research, intervention research design, psychotherapy, scientist-practitioner, systematic review

This study aimed to explore change process research (CPR) in psychotherapy and to develop and evaluate a new CPR approach to psychotherapy. An intervention research design was used as the overarching methodology. To achieve the study aim, the researchers initially conducted a systematic review of CPR in the context of psychotherapy to identify critical themes emerging from high-quality and relevant scientific literature. Eight themes were identified and grouped into two clusters, namely research- and practice-related themes, respectively. The research-related themes were: 1) research methodologies in CPR, 2) outcome measures, 3) process measures, and 4) existing CPR approaches, while the practice-related themes were: 1) therapeutic relationship, 2) therapeutic techniques, 3) change concepts, and 4) psychological understanding of the client.

These critical themes formed the baseline from which the pilot version of a new CPR approach to psychotherapy was developed, known as the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP). A design and development methodology was used to develop the SP-CPP. The pilot version of the SP-CPP was critically evaluated by 13 key informants (or experts) who met strict inclusion criteria, after which an amended version of the SP-CPP was developed.

Finally, the practical application of the amended version of the SP-CPP was illustrated through a multiple case study design with four clients who presented with anxiety-related difficulties. Two of the clients received cognitive behavioural therapy as evidence-

based treatment, while the other two received schema therapy. The write-up of the cases was presented according to the framework provided by the SP-CPP with the clients, psychotherapist, individual supervisor and a reflective team as important role players.

The SP-CPP was found to be a useful framework for conceptualising change process for clients from a cognitive behaviour and schema therapy perspective. In addition, it was possible to use the SP-CPP to reflect on the differences in outcomes across the four presented cases. Reasons for differences in outcomes could best be explained by the key change construct and therapy variable sections. In this regard, the client's readiness to change, cognitive-emotive developmental level (and/or conceptualisation) and the quality of the therapeutic alliance appeared to be the most significant empirical indicators. The study revealed, moreover, that mechanism of change and the client's response to the use of therapeutic techniques can also play an important part in explaining differences in outcome.

Based on the study's findings, increased collaboration between psychotherapy researchers and practitioners is recommended for empirical studies of CPR in psychotherapy. Such increased collaboration will not only reduce the scientist-practitioner gap but also add to the evidence-based nature of change process in psychotherapy. It is also recommended that the SP-CPP be applied practically with different clients with different presenting problems and who receive treatment from different therapeutic approaches. In addition, the application value of the SP-CPP for couples', family and group psychotherapy should also be explored.

Finally, it is recommended that the SP-CPP be used as an evidence-based framework by psychotherapists with different levels of training, experience and theoretical orientations. The SP-CPP can also be used during supervision of psychotherapists in training. Psychotherapists in practice can use the SP-CPP to further enhance the effectiveness of their clinical practices and to 'troubleshoot' or 'problem-solve' difficult cases. In this regard, the development of continuous professional development courses on the use of the SP-CPP is

strongly recommended. Psychotherapy researchers can use the SP-CPP as a single framework that combines process and outcome research to conceptualise and study CPR in the context of psychotherapy by integrating quantitative and qualitative data from multiple perspectives.

OPSOMMING

Die ontwikkeling van 'n nuwe benadering tot veranderingsprosesnavorsing vir psigoterapie

Sleutelwoorde: gevallestudies, intervensienavorsingsontwerp, veranderingsprosesnavorsing, psigoterapie, stelselmatige literatuur-oorsig, wetenskaplike praktisyn

Hierdie studie het ten doel gehad om veranderingsprosesnavorsing (VPN) in psigoterapie te ondersoek en om 'n nuwe VPN-benadering tot psigoterapie te ontwikkel en te evalueer. 'n Intervensienavorsingsontwerp is as oorkoepelende metodologie gebruik. Om die studie se doelwit te bereik, het die navorsers aanvanklik 'n stelselmatige literatuur-oorsig van VPN binne die konteks van psigoterapie uitgevoer om kritiese temas wat uit hoë-gehalte wetenskaplike literatuur voortspruit, te identifiseer. Agt temas is geïdentifiseer en in twee groepe geplaas, onderskeidelik: navorsings- en praktykverwante temas. Die navorsingsverwante temas is 1) navorsingsmetodologieë in VPN, 2) uitkomsmaatstawwe, 3) prosesmaatstawwe, en 4) bestaande VPN-benaderings, terwyl die praktykverwante temas 1) terapeutiese verhouding, 2) terapeutiese tegnieke, 3) konsepte van verandering, en 4) sielkundige begrip van die kliënt, is.

Hierdie kritiese temas het die basis van die loodsprogram wat vir 'n nuwe VPN-benadering tot psigoterapie ontwikkel is, gevorm en staan bekend as die wetenskaplike-praktisynbenadering tot veranderingsprosesse in psigoterapie (WP-VPN). 'n Ontwerp- en ontwikkelingsmetodologie is gebruik om die WP-VPN te ontwikkel. Die loodswaardering vir die WP-VPN is krities geëvalueer deur 13 sleutel informante (of kundiges) wat voldoen aan streng insluitingskriteria, waarna daar 'n gewysigde waardering van die WP-VPN ontwikkel is. Laastens is die praktiese toepassing van die gewysigde waardering van die WP-VPN geïllustreer by wyse van 'n meervoudige gevallestudie-ontwerp met vier kliënte wat met

angs-verwante probleme presenteer. Twee van die kliënte het kognitiewe gedragsterapie as bewysgebaseerde behandeling ontvang, terwyl die ander twee skematerapie ontvang het. Die opskryf van die gevalle het geskied volgens die raamwerk wat deur die WP-VPN voorsien is, waar die kliënte, psigoterapeut, individuele supervisor en refleksiespan as belangrike rolspelers opgetree het.

Die WP-VPN het 'n nuttige raamwerk voorsien vir die konseptualisering van veranderingsprosesse vir kliënte vanuit 'n kognitiewe gedrags- en skema terapeutiese perspektief. Daarbenewens was dit moontlik gewees om die WP-VPN te gebruik om te besin oor die verskille in uitkomst by elk van die vier voorgestelde gevalle. Redes vir die verskille in uitkomst kan die beste verklaar word in die konsepte van verandering en die terapie-veranderlike gedeeltes. In hierdie opsig blyk die kliënt se gereedheid om te verander, kognitiewe en emosionele ontwikkelingsvlak (en/of konseptualisering) en die gehalte van die terapeutiese alliansie die belangrikste empiriese aanwysers te wees. Die studie het verder onthul dat 'n meganisme van verandering en die kliënt se reaksie tot die gebruik van terapeutiese tegnieke ook 'n belangrike rol te speel kan hê in die uiteensetting van verskille in uitkomst.

Op grond van die studie se bevindinge, word 'n groter mate van samewerking tussen psigoterapie-navorsers en -praktisyns aanbeveel vir empiriese studies van VPN in psigoterapie. Sodanige verbeterde samewerking sal nie net die gaping tussen wetenskaplikes en praktisyns verminder nie, maar sal ook bydra tot die bewysgebaseerde aard van die veranderingsprosesse in psigoterapie. Daar word ook aanbeveel dat die WP-VPN prakties toegepas word by verskillende kliënte wat met verskillende probleme presenteer en wat behandeling vanuit verskillende terapeutiese benaderings ontvang. Daarby moet die toepassingswaarde van die WP-VPN vir huwelik-, gesin- en groeppsigo-terapie ook ondersoek word.

Laastens word daar aanbeveel dat die WP-VPN as 'n bewysgebaseerde raamwerk gebruik word deur psigoterapeute met verskillende vlakke van opleiding, ervaring en teoretiese oriëntasies. Die WP-VPN kan gebruik word tydens die supervisie van psigoterapeute in opleiding. Psigoterapeute in praktyk kan die WP-VPN gebruik om die doeltreffendheid van hul kliniese praktyke verder te verbeter en om moeilike gevalle 'op te los' of 'foutsporing' toe te pas. In hierdie verband word die ontwikkeling van deurlopende professionele ontwikkelingskursusse oor die gebruik van die WP-VPN sterk aanbeveel. Psigoterapie-navorsers kan die WP-VPN gebruik as 'n enkele raamwerk wat proses- en uitkomstnavorsing saamvoeg om VPN in die konteks van psigoterapie te konseptualiseer en te bestudeer deur kwantitatiewe en kwalitatiewe data vanuit verskeie perspektiewe sinvol te integreer.

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CHAPTER 1

INTRODUCTION, PROBLEM STATEMENT AND AIMS

Introduction

There is increased emphasis on the importance of evidence-based practice (EBP) in the field of psychology (Stiles, Hill, & Elliott, 2015). In addition, there is pressure on psychotherapists as they are expected to provide the best possible service to their clients at the lowest possible cost (Brown, 2015). To realise these expectations, psychotherapists are required to consult available research evidence which enables them to provide the most effective psychotherapy in the shortest space of time (Bledsoe, Lukens, Onken, Bellamy, & Cardillo-Geller, 2008). The foregoing is not unique to psychology but applies to all health professionals working in the field of mental health practice.

EBP is also regarded as an ethical imperative and requires a high level of professional competency from practitioners (Brown, 2015). The American Psychological Association (APA, 2006) defines EBP as the use of the best available research in combination with the clinician's experience while considering the client's background, environment and uniqueness. Psychotherapists who strive to enhance clinical effectiveness by practicing in line with guiding research evidence are known as scientist-practitioners (Chwalisz, 2003). Scientist-practitioners regularly consult literature on the efficacy of specific therapeutic approaches with the aim to enhance the effectiveness of psychotherapy by facilitating psychotherapeutic change processes (Katsikis, 2014). Goldfried (2013) as well as Haaga and Stiles (2000) describe psychotherapeutic change as positive subjective change due to psychotherapeutic intervention.

Goldfried (2003), Elliott (2010), Norcross and Lambert (2014) and Brown (2015), amongst others, highlight that the current need in psychotherapy research is to conceptualise and understand the change processes involved in psychotherapy sessions better. In order to

understand these change processes better, it is necessary to consider the role of and interaction between the therapeutic relationship and therapeutic techniques in the context of psychotherapy sessions (Brown, 2015). In addition, to understand change processes better, increased collaboration between psychotherapy researchers and practitioners is required in order to bridge the research-practice gap. The proficient psychotherapist needs to determine what works, for whom, under which circumstances (Miller, Zweben, & Johnson, 2005). This is also known as treatment matching and forms the essence of EBP within which the integration of idiographic and nomothetic information takes place.

With this being said, Elliott (2010) describes change process research (CPR) as the identification, description, explanation and prediction of the effects of processes that elicit therapeutic change over the course of psychotherapy. CPR in psychotherapy allows researchers and practitioners to become scientist-practitioners who are able to integrate therapeutic relationship factors with therapeutic technique factors in an attempt to ensure that effective psychotherapy is practiced for the benefit of clients (Kolden, 1996). As CPR is a broad construct, it encompasses both outcome- and process-research findings, with the main focus being to determine those aspects in psychotherapy that explain how change occurs.

Problem Statement

It is clear that current (and future) psychotherapy practice needs to be evidence-based. It appears that the definition of evidence-based practice is expanding to include both therapeutic techniques as well as the therapeutic relationship. To enable the integration of therapeutic technique aspects and therapeutic relationship aspects, certain models or approaches are suggested. These approaches are collectively referred to as CPR in psychotherapy. The utilisation of CPR approaches in psychotherapy shows potential to not only narrow the researcher-practitioner gap, but it will also most likely improve the overall efficacy of psychotherapy in general. This will enable psychologists, as scientist-practitioners

in practice and/or research, to gain a better understanding of what to do in psychotherapy and how to do it. This study is necessary because very little research is being conducted on existing CPR approaches, which limits the evidence-based nature thereof. Furthermore, the existing CPR approaches lack in terms of comprehensiveness and practical utility.

Aims

The aim of this study was to explore change process research in psychotherapy and to develop and evaluate a new CPR approach to psychotherapy. The specific objectives were to:

1. conduct a systematic review to identify critical themes and issues emerging from literature on CPR;
2. develop a new CPR approach based on the findings from the abovementioned systematic review;
3. gather and synthesise experienced psychotherapists' and psychotherapy researchers' critical evaluations of the newly developed CPR approach;
4. refine and/or modify the newly developed CPR approach based on the findings from the critical evaluation of experienced psychotherapists' and psychotherapy researchers'; and to
5. explore a qualified psychotherapist's experience of employing the newly developed CPR approach within multiple case studies.

Contribution of the Study

The current study will generate knowledge which will add value to psychotherapists' and psychotherapy researchers' understanding of change process in psychotherapy. The researcher will provide a synthesis of the available CPR literature by way of a systematic review which can be consulted by psychotherapists and/or psychotherapy researchers. Furthermore, the researcher will develop a new CPR approach which can be used by psychotherapists and/or psychotherapy researchers both in practice and in research. In

addition, the researcher will present multiple case studies where the new CPR approach has been utilised to provide an example of how theory and practice can be integrated and to stimulate further research and practical use of the new CPR approach. The researcher aims to publish at least four articles from this PhD study in accredited peer-reviewed journals and, once published, this information will be available to interested readers locally and internationally.

Overview of the Methodology

This study will be presented in four related but independent manuscripts. Manuscript one (Chapter 2) will address the first study objective, while manuscript two (Chapter 3) will address the second, third and fourth study objectives with manuscripts three (Chapter 4) and four (Chapter 5) addressing the fifth study objective. Each manuscript will present a different phase in the research process.

In order to conduct this study on CPR, an intervention research design was followed as the overarching research design (De Vos, Strydom, Fouché, & Delport, 2011; Rothman & Thomas, 1994). The focus of intervention research is to consider, develop and evaluate ways that will improve the wellbeing, life and health of individuals (Comer, Meier, & Galinsky, 2004; Melnyk & Morrison-Beedy, 2012). De Vos et al. (2011) as well as Rothman and Thomas (1994) distinguish between three kinds of intervention research, namely knowledge development, knowledge utilisation, and design and development research. Knowledge development refers to empirical research to extend knowledge of human behaviour and to relate such knowledge to human service interventions (De Vos et al., 2011). Knowledge utilisation refers to the means by which the findings from intervention knowledge development research may be linked to and utilised in practical application. Rothman and Thomas (1994) also refer to knowledge utilisation as research on the process of helping. Design and development research refers to the production of interventions in the form of a

programme, treatment method, policy or service system. Current research clearly appeals to knowledge utilisation as a type of intervention research following a design and development methodology (Rothman & Thomas, 1994).

De Vos et al. (2011) specify six phases during this type of intervention research, which are summarised in Figure 1.1 below. Figure 1.1 also presents the practical application of these six phases in the context of the current study.

The researchers obtained ethical approval from the Health Research Ethics Committee (HREC) of the North-West University (NWU) prior to conducting the study. The ethics number is NWU-00363-16-A1 (see Annexure A1).

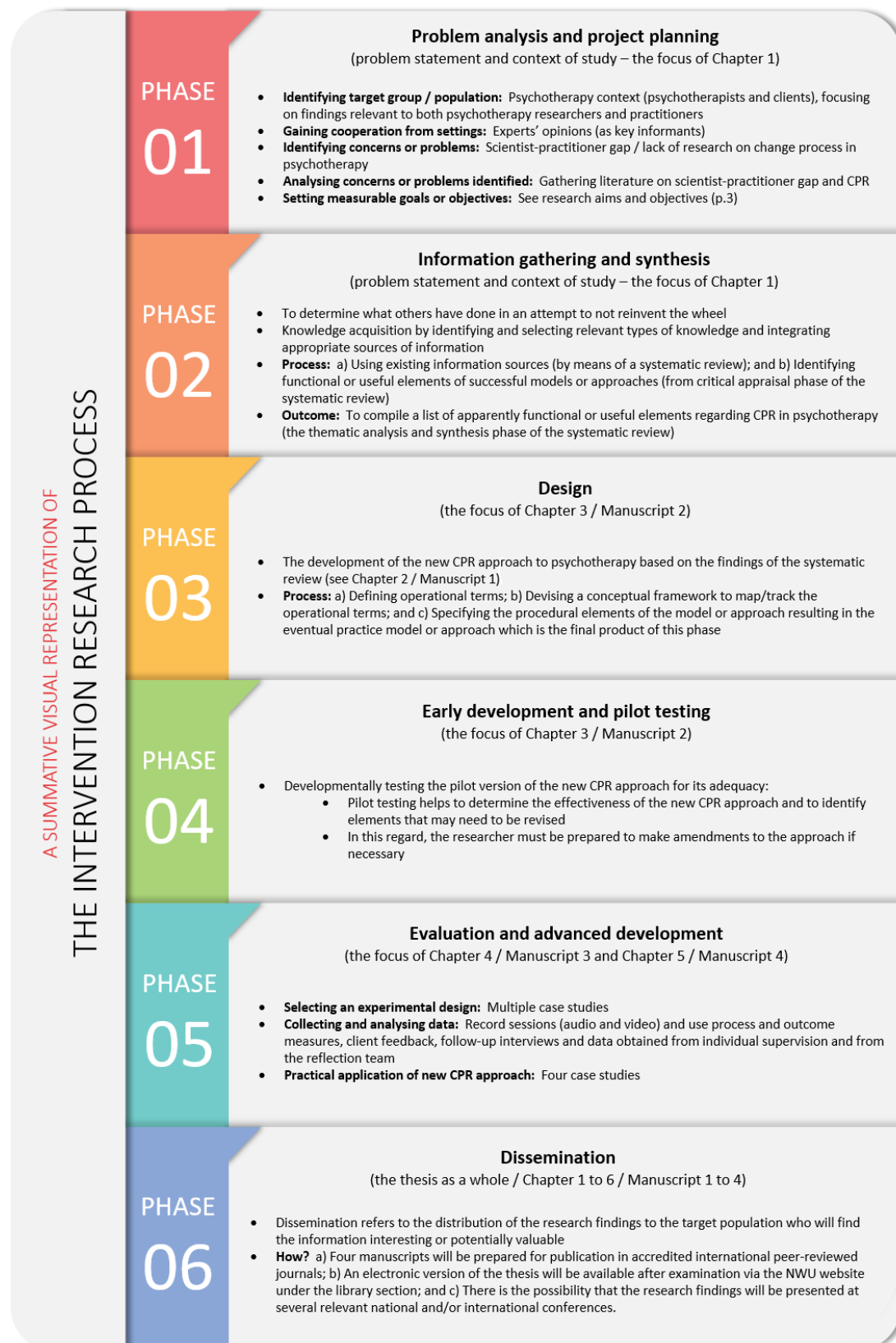


Figure 1.1 A summative visual representation of the intervention research process

(De Vos et al., 2011)

For the purpose of quick reference and ease of reading, see Table 1.1 for a structural overview of the layout of this thesis demonstrating how the chapters relate to the manuscripts and how the six phases of the intervention research design methodology were implemented.

Table 1.1

Structural overview of the layout of the thesis

Chapters	Chapter 1	Chapter 2	Chapter 3	Chapter 4	Chapter 5	Chapter 6
Manuscript		1	2	3	4	
Intervention Research Design Phases	Phase 1	Phase 2	Phase 3 + Phase 4	Phase 5		
	Phase 6					

Outline of the Manuscript

Chapter 1 provides a brief literature overview to contextualise the research topic and to orientate the reader to the study as a whole. The problem statement, aim and objectives are presented, and the potential contribution of the study is reflected on. Importantly, Chapter 1 provides an overview of the overarching research methodology used for the study as a whole, namely intervention research design with a prominent design and development methodology focus. Visual illustrations in the form of a figure and a table highlight the application of the research design in the different phases across the study as a whole.

Chapter 2, also referred to as manuscript 1, provides a systematic review that identifies critical themes and issues emerging from high-quality and relevant scientific literature regarding CPR in psychotherapy. The findings of this systematic review formed the baseline informing the remainder of the study. In this way, this chapter addresses research aim one.

In Chapter 3, presented as manuscript 2, a new CPR approach to psychotherapy is developed based on the findings of the systematic review and conducted within the design and development methodology of the overarching intervention research design. The development of the new CPR approach to psychotherapy addresses the second research aim.

A pilot version of the new CPR approach to psychotherapy was developed and critically evaluated by key informants, thus addressing research objective three. From the critical evaluation, certain changes were made and an amended version is presented, thus addressing research objective four.

Chapter 4, also referred to as manuscript 3, presents the practical application of the new CPR approach to psychotherapy with two clients presenting with anxiety-related difficulties who received treatment from a cognitive behavioural therapy approach. This chapter addresses research objective five.

Chapter 5, presented as manuscript 4, focuses on the practical application of the new CPR approach to psychotherapy with two clients also presenting with anxiety-related difficulties but who received treatment from a schema therapy approach. This chapter also addresses research objective five.

Chapter 6 provides a brief summary of the aim, method and most prominent findings and recommendations for each of the four manuscripts presented in this study. This chapter also highlights certain limitations and provides an integrated conclusion as synthesis. Finally, the contribution of the study is highlighted in this chapter and recommendations are made for future research and clinical practice, concluding with the researcher's critical reflection.

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CHAPTER 2

MANUSCRIPT 1

Change Process Research in Psychotherapy: A Systematic Review

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Abstract

The aim of this study was to explore what current scientific literature reports regarding change process research (CPR) in psychotherapy. To realise this aim, a systematic review was conducted in order to identify critical themes and issues emerging from literature on CPR. From the data analysis, two groups of themes emerged, namely research-related and practice-related themes. The research-related themes highlighted that quantitative and qualitative research methods should be integrated when studying CPR and that both process and outcome measures should be used within CPR studies. The practice-related themes identified therapeutic relationship and therapeutic techniques as important factors when studying CPR and found that certain change constructs, for example the mechanisms of change, should receive more attention within the formulation of the psychological understanding of clients. There is a need to bridge the gap between psychotherapy researchers and practitioners, and CPR provides a framework in which the identified research-related and practice-related themes can be integrated within a scientist-practitioner approach.

Keywords: change process research, psychotherapy, scientist-practitioner,
systematic review

Introduction

According to Norcross and Lambert (2011, p.4), a ‘culture war’ is arising in psychotherapy research between empirical evidence supporting the therapeutic relationship and empirical evidence supporting the specific psychotherapeutic approach as the most important indicators of treatment success. In this regard, the American Psychological Association (APA, 2006) defines evidence-based practice in psychology as the integration of the best available research with clinical expertise in the context of client characteristics, culture and preferences. By keeping to this definition, it is clear that empirically supported relationships have a rightful place alongside empirically supported treatments (Goldfried, 2013; Goldfried & Davila, 2005; Muran & Barber, 2010; Norcross, 2002; Wampold, 2001). Consequently, the therapeutic relationship is not considered ‘instead of’, or ‘better than’, treatment methods but ‘alongside’. This complementary position presents an alternative to the ‘versus’ position and resolves the culture war to a certain extent. Seemingly, rapprochement between the science and practice communities is indicated (Knobloch-Fedders, Elkin, & Kiesler, 2015). This emphasises the question: Do treatments cure disorders or do relationships heal people? Decades of psychotherapy research (see Boswell, 2015; Elliott, 2010; Goldfried, 2013; Greenberg, 1999; Wampold, 2001) indicates that the client, the psychotherapist, their relationship, the treatment method and the context all contribute to treatment success (or failure). Seeing that treatment methods are relational acts, a deep synergy between the content of treatment methods and the therapeutic relationship needs to be achieved. In other words, in psychotherapy, a distinction can be made between the “how” and the “what” of psychotherapy (Norcross & Lambert, 2011). The “how” refers to the interpersonal behaviour of relating (*how* psychotherapist and client behave towards each other). The “what” refers to the techniques or intervention strategies being utilised (*what* is done by the psychotherapist). In research and theory, the “how” and the “what” are often treated as separate categories. In

reality, of course, what one does and how it is done are mostly complementary and inseparable. In other words, the value of a treatment method is inextricably bound to the relational context in which it is applied (Norcross & Lambert, 2011).

In contrast, Neenan and Dryden (2011) regard the psychotherapeutic relationship as neither necessary nor sufficient to bring about therapeutic change, specifically in the context of rational emotive behaviour therapy (REBT). This was initially proposed by Ellis (1959), the founder of REBT, two years after Rogers (1957) published an influential paper on the importance of certain “core conditions” of the therapeutic relationship in therapeutic change. Ellis responded with a publication stating that the “core conditions” of the therapeutic relationship are important and often desirable but not necessary and sufficient for change to occur. Some REBT therapists regard the development of a good therapeutic relationship as laying the foundation for the ‘real therapy’ to take place, namely the application of REBT techniques. REBT therapists do not neglect the therapeutic relationship, but they do not regard it as the most essential aspect for therapeutic change. Dryden and Branch (2008) state that if REBT therapists are neglecting the therapeutic relationship, their clients do not seem to think so. Clearly, equivocal theories and approaches exist, but in the interest of best practice, it will be important to explore the relationship between process and content in psychotherapy in more detail.

Norcross and Wampold (2011a) argue that the therapeutic relationship can account for why clients improve (or fail to improve) at least as much as the particular treatment method. This is also supported by Castonguay and Beutler (2006), Muran and Barber (2010), Norcross (2002) and Wampold (2001), all clearly highlighting that the therapeutic relationship is just as important as the therapeutic techniques in determining treatment response. Goldfried and Davila (2005) as well as Goldfried (2013) emphasise that both the therapeutic relationship and the treatment approach play a significant role in treatment

outcome. Thus, it is clear that a strong case can be made for the therapeutic relationship (or therapeutic alliance) and the treatment method (or therapeutic techniques) being equally important determinants in treatment efficacy. Furthermore, in the context of psychotherapist training, Castonguay, Boswell, Constantino, Goldfried and Hill (2010) found that psychotherapists need more training on enhancing therapeutic relationships with clients in order to improve treatment response.

By adapting or tailoring the therapeutic relationship to specific client characteristics (in addition to diagnosis), the effectiveness of treatment is enhanced (Norcross & Wampold, 2011a). The identical psychosocial treatment for all clients is now recognised as inappropriate and, in selected cases, perhaps even unethical, because different types of clients require different treatments and relationships (Castonguay et al., 2010; Goldfried, 2013; Muran & Barber, 2010; Norcross, 2002; Stewart & Chambless, 2007; Wampold, 2001). Research now enables us, in terms of the philosophy of science, to balance particularity and generality (Norcross & Wampold, 2011b).

This balance is made possible through outcome research and process research. Outcome research may be understood as one side of an attempt to balance this culture war by delineating which treatment approach may be deemed more efficacious in working with a certain disorder (Kazdin, 2008). It is focused on determining the efficacy of a general treatment approach in managing the symptoms of a disorder, as compared to another general treatment approach (Lindgren, Folkesson, & Almqvist, 2010). According to Harris, Kelley and Shepard (2015), studies concerned with outcome research are usually based on a quantitative methodology and expansive in scope (in terms of the population and sample sizes). Randomised clinical trials (RCTs) are typical outcome research as they aim to determine the evidence supporting the claimed efficacy of a treatment approach (Barlow, 2010). The results of these studies inform empirically supported treatments (ESTs) by

providing evidence for the general efficacy of a treatment model or approach (Kazdin, 2008). In short, ESTs are developed and promoted as manualised treatments based on outcome research, resulting in the philosophy of an evidence-based practice (EBP) being formed and prescribed as an institutional guideline and a means to ensure the efficacy of psychotherapeutic practice (Katsikis, 2014). At best, though, EBP is restricted to the general impact a certain psychotherapy approach may have on a sample representative of a general population (such as a certain psychiatric disorder). Outcome research therefore seems to be mainly concerned with the nomothetic function of a psychotherapeutic treatment approach (Barlow, 2010; Harris et al., 2015).

Process research, on the other hand, is concerned with particular elements involved in a specific therapeutic session and how those factors relate to the effectiveness of that particular process (Stiles, Hill, & Elliott, 2015). The research design that informs process research usually consists of mixed-method and qualitative approaches (Elliott, 2010). Process research may be understood to inform a different part of the EBP movement, namely the focus on the characteristics and preferences of both the client and the psychotherapist, and how these aspects interact during a given session (Goldfried, 2013; Katsikis, 2014). Process research aims to understand a variety of unique and idiosyncratic aspects of a therapeutic process and to determine the impact these aspects may have on the client's subjective experience of change (Harris et al., 2015). Through an inductive approach, a psychotherapist starts to build an idiographic theory specifically applicable to the client and the therapeutic process (Elliott, 2010). This is understood as the theory building phase of process research. Elliott further explains that based on the evidence gathered, the effectiveness of the interactions during the process may be evaluated and adapted accordingly – leading to a theory testing phase. Through this deductive approach, a corpus of evidence may be compiled based on the

practice experience of a psychotherapist. This forms part of what is known as practice-based evidence (PBE) (Elliott, 2010; Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014).

In general, process refers to a specific action taken at a specific time. The overall aim of any process is to bring about change. Therefore, process and change are frequently used as synonyms in literature and research (Doyle, 2011). In the context of psychotherapy, process refers to the nature of the relationship between interacting individuals (Yalom, 2005). During individual psychotherapy, these interacting individuals are the client and the psychotherapist (Knobloch-Fedders et al., 2015). In order to obtain a full understanding of process, it is necessary to take into consideration a large number of factors (Castonguay et al., 2010; Goldfried, 2013; Goldfried & Davila, 2005; Muran & Barber, 2010; Norcross, 2002; Stewart & Chambless, 2007; Wampold, 2001). These factors include, amongst others, the internal psychological worlds of the interacting individuals, the interpersonal interaction patterns and the clinical environment (Yalom, 2005). Process is also concerned with what the words, style of the speaker and the nature of the conversation say about the interpersonal relationship between the interacting individuals (Doyle, 2011). Process is usually contrasted with content, which refers to the explicit words spoken, the substantive issues and the arguments put forth (Yalom, 2005).

CPR was introduced more than 20 years ago and refers to research focusing on identifying, describing, explaining and predicting the effects of the process that bring about therapeutic change (Elliott, 2010). CPR provides a necessary complement to RCTs and other forms of efficacy research. The focus of CPR is on the study of the process by which change occurs in psychotherapy.

Against this background, it is necessary to also consider available research on change process research (CPR) in psychotherapy, as it provides the canvas against which the therapeutic relationship and treatment is ‘created’ and aims to integrate both outcome and

process research. In addition, to map out the terrain of psychotherapeutic change, we need to study both psychotherapist and clients (Castonguay et al., 2010; Goldfried & Davila, 2005; Greenberg, 1999; Muran & Barber, 2010; Norcross, 2002; Stewart & Chambless, 2007; Wampold, 2001), more specifically, to explicate clinicians' cognitive maps of change processes and to understand clients' internal experiences of change processes. Taxonomy of different problematic states of mind that occur in psychotherapy and that are amenable to specific types of therapeutic attention would be generated. In addition to this taxonomy, a list of therapeutic compounds (interventions and interactions) that best apply to each state to produce change, as well as the change process they induce, would be specified (Greenberg, 1999).

From the available literature, there is a lack of specificity and follow-up publications regarding CPR which limits the practical utility of the existing conceptual-theoretical CPR approaches presented in current scientific literature. To emphasise this point, to date, no systematic review studies on CPR are available. In addition, no studies could be found attempting to synthesise the information currently available on CPR. Against this background, the following research question is formulated: *What does current scientific literature report regarding change process research (CPR) in psychotherapy and how can this information be used in the context of psychotherapy practice and research?* To address this question, the researchers aim to conduct a systematic review on change process research in the context of psychotherapy in order to provide a comprehensive synthesis of the findings.

Method

The Evidence for Policy and Practice (EPPI) Centre Methods for Conducting Systematic Reviews (EPPI, 2010) guidelines were used to guide the systematic review process to ensure the level of rigor required to ensure trustworthiness and a high level of

academic quality. Figure 2.1 provides a summative visual representation of the research process that was followed in this study to conduct the systematic review.

Ethical Considerations

The researchers obtained ethical approval from the Health Research Ethics Committee (HREC) of the North-West University (NWU) prior to conducting the systematic review. The ethics number is NWU-00363-16-A1 and proof of ethical approval is attached as Annexure A1. The authors discussed potential authorship dilemmas and the contributing authors are listed in descending order, in terms of their contribution, as recommended by Wager and Wiffen (2011). Appropriate citations and referencing are provided throughout to ensure the originality of this manuscript and to acknowledge and respect the intellectual property of the original authors. As an additional preventative measure, Turnitin was used to check for plagiarism (Wager & Wiffin, 2011). Finally, the researchers clearly documented the various processes involved in the systematic review and the first author kept a personal reflection journal as a means of bracketing and tracking thoughts.

Scope Review

A scope review was conducted as a preliminary assessment of the nature, potential size and scope of available literature (Grant & Booth, 2009; Petticrew & Roberts, 2006). The scope review specifically explored the viability of a systematic review on CPR in psychotherapy. Furthermore, the U.S. National Library of Medicine (2016) – Medical Subject Headings (MeSH) was consulted to determine additional possibilities in terms of keywords. The initial scope review produced 643 peer-reviewed journal articles that could be relevant to this study. This is viewed as sufficient for the purpose of a systematic review (Petticrew & Roberts, 2006). The scope review revealed that no studies on CPR were found before 1966, and that the major contributors to the field of CPR published in English.

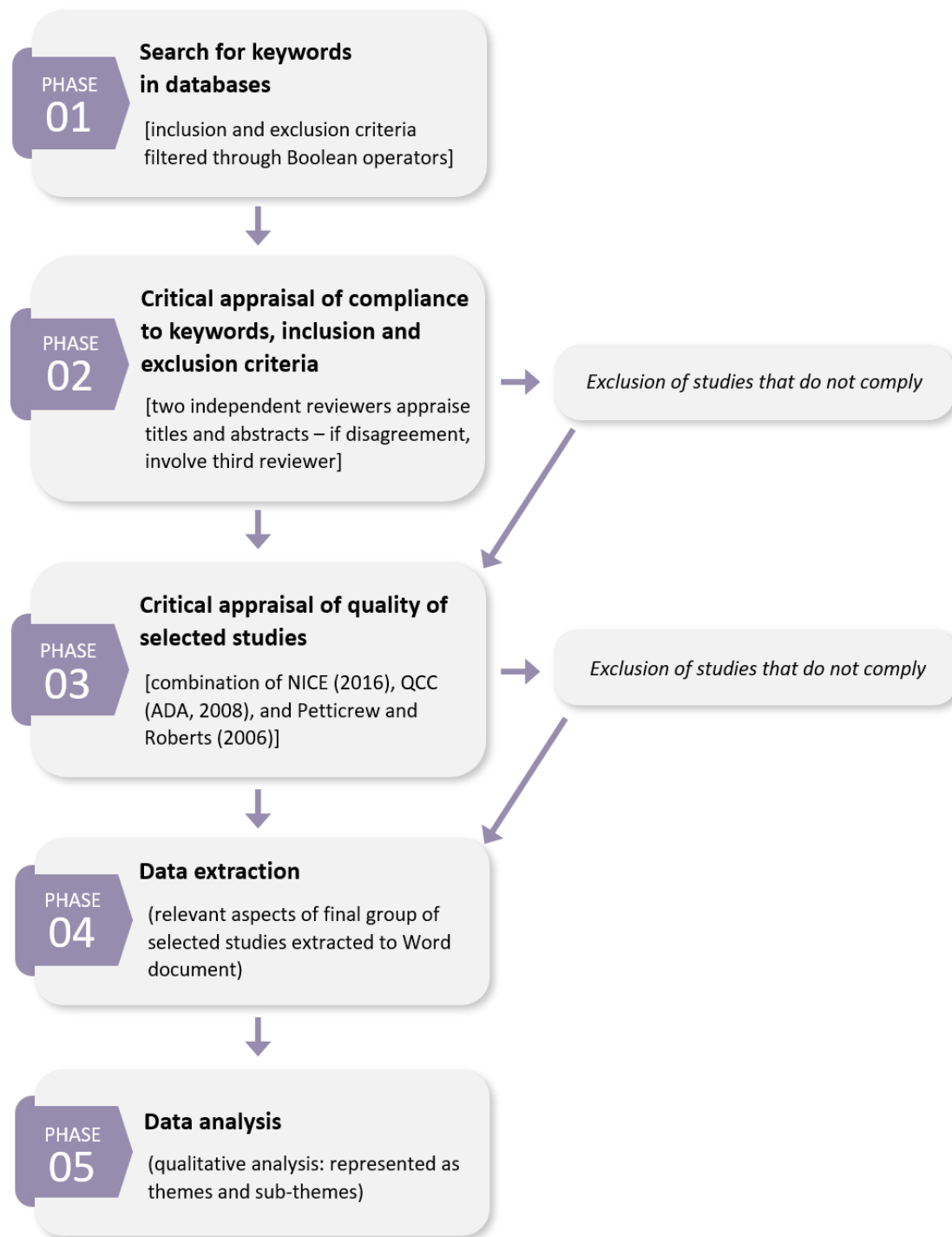


Figure 2.1 A summative visual representation of the systematic review process

Inclusion and Exclusion Criteria

The following inclusion criteria were used for the purpose of the systematic review: full-text journal articles, peer-reviewed articles, chapters in books, and studies that have been published between 1 January 1966 and 23 November 2016 (the date of the electronic search). A time span of more than 50 years is deemed acceptable as the scope review found no CPR publications prior to 1966.

The following exclusion criteria were used for the purpose of the systematic review: duplicate reports of the same study; conference proceedings; non-research reports, letters and commentaries; and studies published prior to 1966.

Search Strategy

Following on the scope review, a rigorous literature search was conducted of all relevant electronic databases in consultation with an experienced librarian at the NWU by using Onesearch, a search engine that has access to all the main international databases such as PsycInfo, PsycArticles, Science Direct and Academic Search Premier. A Boolean search was done by using operators such as AND, OR and NOT to combine the inclusion criteria with the following keywords: “change process research” OR “common factors approach” OR “evidence-based practice” AND psychotherap*.

Although the search yielded 325 articles, it was decided to include a second phase in the search strategy as certain prominent articles that featured in the literature review building up to this study did not feature in the first phase of the search strategy. The second phase of the search strategy was conducted on Google Scholar by using the same keywords (all in the field of *titles*) and Boolean operators as mentioned above. This phase yielded an additional 69 relevant articles and included those articles featured in the literature review that did not feature in the first search phase. Thus, the search strategy yielded a total number of 394 articles.

Screening

During the screening phase, the first and second reviewer aimed to determine the relevance of the 394 articles by screening the articles for relevance based on their titles and abstracts. To determine the relevance, the research question was used as the main guideline, in order words: “Would the information provided in the title and abstract of this article help the research team to answer the research question?” Of the 394 articles, 123 were excluded of which 66 were excluded because they were duplicates and 57 because they were book reviews. Of the remaining 271 articles, 200 were excluded due to irrelevance. Finally, 71 articles were deemed relevant to progress to the critical appraisal phase of the systematic review process. See Figure 2.2 for a visual illustration of this process.

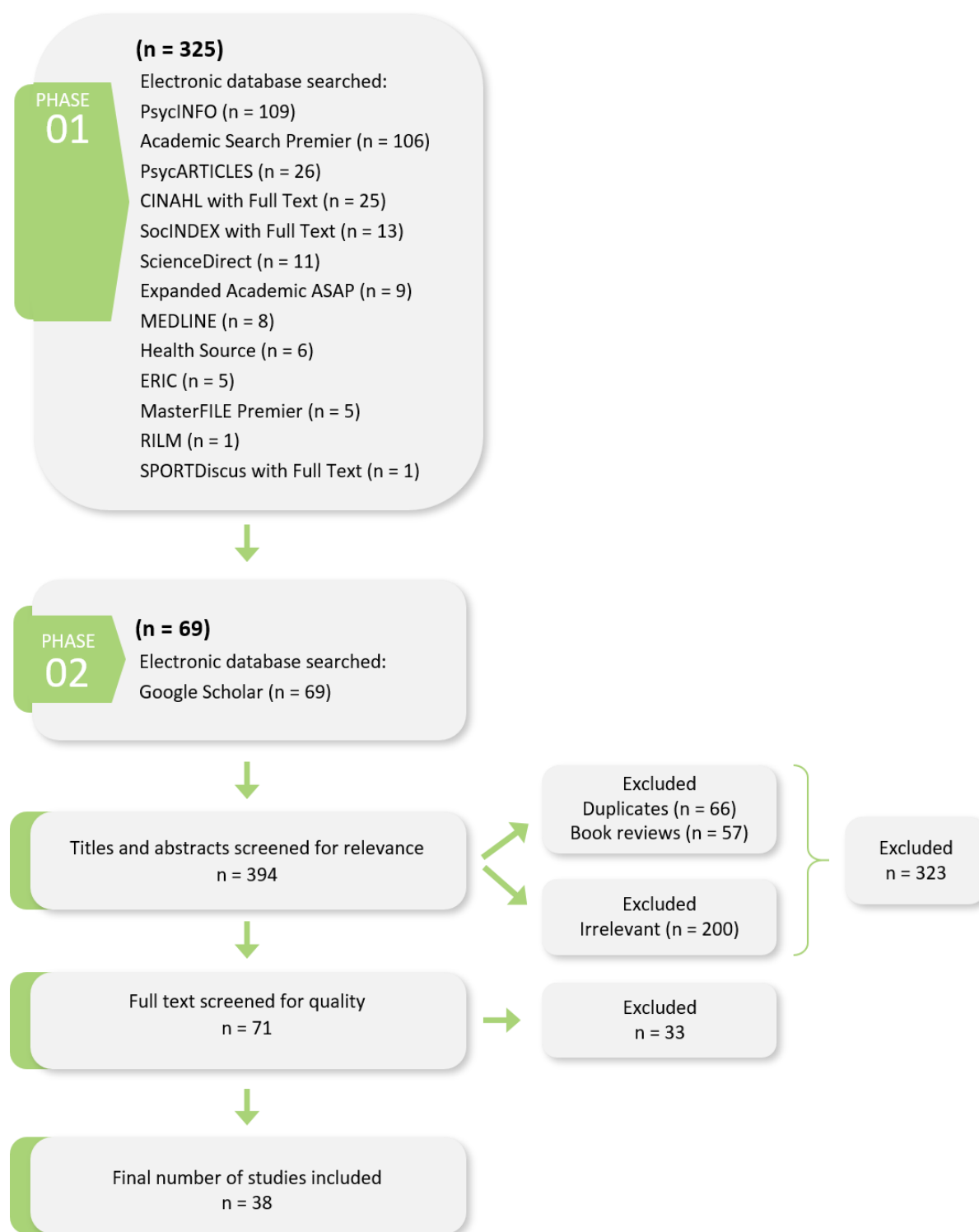


Figure 2.2 Search flow chart

Critical Appraisal

The critical appraisal aimed to determine the scientific quality of the articles. This was done according to the critical appraisal tool developed through a combination of the criteria and guidelines of The National Institute for Health and Care Excellence (NICE) (2012) and The Quality Criteria Checklists (QCC) (ADA, 2008), as well as the guidelines proposed by Petticrew and Roberts (2006). The specific tool utilised during this phase was developed by the research team and reviewed by an independent reviewer. This reviewer is an experienced researcher with expertise in systematic reviews. This critical appraisal tool is included as an appendix (see Addendum A) so as to further ensure (and enhance) the transparency, trustworthiness and reliability of this systematic review study.

The first and second reviewer conducted the critical appraisal process independently. After appraising the 71 articles according to the critical appraisal tool developed, the two reviewers met to discuss their appraisals to determine the level of agreement. Of the 71 articles, the two reviewers reached immediate consensus on 65 articles, while only six articles warranted further discussions. Consensus regarding these six articles was, however, reached without the need to consult a third reviewer. Of the 71 articles, 33 articles were excluded based on lack of relevance and/or poor scientific quality. Therefore, 38 articles were deemed relevant and met the quality criteria to be included in the full review.

Data Extraction

During the data extraction process, the principal researcher (first author) followed the following approach: The full text of the 38 articles meeting the inclusion criteria was read and re-read several times. The researcher highlighted the text, deemed to be appropriate to answer the review question, in yellow in the pdf versions of the articles. All the highlighted sections were copied into a single Word document. This Word document was then regarded as the final data set from which themes were determined during the data analysis process. A

summative overview (condensed version) of the data extraction table is provided in Addendum B.

Data Analysis

The data analysis was inductive, allowing the themes to flow from the data rather than utilising preconceived categories. The guidelines for thematic analysis of Clarke and Braun (2013) were followed during the data analysis. They propose a process consisting of six steps when using thematic analysis, namely: 1) familiarising self with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) producing a report. These steps were followed by the principal researcher (first author) in order to conduct the thematic analysis, and co-coding and quality-checking of all six steps were done by the third author.

From the initial list of themes generated, it became clear that there was a natural divide between research- and practice-related themes. Although it is not desirable to distinguish research from practice within the scientist-practitioner approach, this distinction will be made here to enable a logical flow of arguments and to ensure clarity in terms of presentation of the themes and sub-themes obtained from the data analysis of the final set of articles.

Results

The final group of selected studies were all published between 1983 and 2016. A large number of studies were published between 2010 and 2016 ($n=17$; 44.74%), while a small minority were published between 1980 and 1989 ($n=3$; 7.90%). The remaining 18 studies are spread evenly between 1990 and 2000 ($n=9$; 23.68%) and between 2000 and 2009 ($n=9$; 23.68%). Of the 38 publications, 37 (97.37%) were articles while only one (2.63%) was a chapter in a book. The majority of the studies were theoretical in nature ($n=33$; 86.84%), while only five studies (13.16%) were empirical by nature. Of the 38 publications, 35 were conducted within a qualitative research design ($n=35$; 92.11%), with only two studies

(5.26%) conducted from a quantitative research design and only one study (2.63%) conducted from a mixed-method research design.

The 37 articles were published in 23 different journals, the highest number in the *Journal of Consulting and Clinical Psychology* (n=7; 18.92%), followed by *Psychotherapy Research* (n=4; 10.81%). Regarding the remainder of the journals, only one or two publications per journal are reported in the final group of studies.

The following section provides a qualitative narrative synthesis of the best available themes and sub-themes pertaining to CPR in the context of psychotherapy.

Themes

In total, eight themes were identified. These were grouped into two clusters, namely research related (four themes) and practice related (four themes). These themes will now be discussed separately.

Research-related themes and sub-themes. This group of themes refers to prominent research-related aspects identified from the final group of studies included in this systematic review that are relevant to understanding CPR in the context of psychotherapy. To clarify, this does not refer to the research methodologies used in the included studies, but rather to critical discussions on research methodologies that ought to be used when researching CPR. Seeing that CPR encompasses both outcome research and process research, findings pertaining to both are included in this section, as it is important for psychotherapy researchers to be aware of these aspects when conducting CPR.

In terms of research-related themes and sub-themes, four themes emerged, namely: 1) research methodologies in CPR; 2) outcome measures; 3) process measures; and 4) existing change process research approaches. These themes and their sub-themes will be discussed next.

Theme one: Research methodologies in CPR. Research methodologies in CPR as a theme refers to different research methodologies that are relevant or appropriate to use when studying CPR in the context of psychotherapy. Seeing that the majority of the publications included in the final group of studies were theoretical in nature, ideas regarding different conceptual frameworks were presented with the aim to stimulate future research.

Unfortunately, these conceptual frameworks were not used by the researchers who developed them, or even by other researchers in subsequent studies. This might also explain the limited number of empirical studies included in the final group of publications.

In terms of research methodology, the data extraction yielded the following sub-themes: quantitative research, qualitative research, mixed-method research, reviews and theory-building and theory-testing research.

Quantitative research. Historically, quantitative studies with randomised selection have been primarily used to assess the value and strength of evidence in psychotherapy research (Lindgren et al., 2010). According to the same authors, in the context of psychotherapy research, quantitative methods are used in outcome research to evaluate the outcome of psychotherapy. The focus of outcome research is to predict outcomes and to identify which type of psychotherapy is most effective, mainly through the use of RCTs (Barlow, 2010; Stiles et al., 2015). RCTs are an important source of evidence providing information about the efficacy of various interventions and allowing psychotherapy researchers to generate a list of ESTs as part of EBP (Barlow, 2010; Goldfried, 2013). Even though RCTs were historically viewed as the methodological gold standard for identifying ESTs, they are no longer viewed as the sole gold standard (Barlow, 2010; Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014; Shoham et al., 2014) due to methodological pluralism and more sophisticated qualitative and mixed-methods approaches (particularly evident in case study research) (Stiles et al., 2015). A limitation of RCTs is that they fail to predict outcome at the idiographic level of the

individual case, seeing that they are based solely on the nomothetic level (Lilienfeld et al., 2014). Kazdin (2008) recommends that the future of psychotherapy research should include more sophisticated quantitative process-outcome research of causal mediators and mechanisms in psychotherapy (Elliott, 2010). In line with this recommendation, there is significant growth in more sophisticated quantitative methods, amongst others, structural equation modelling, generalisability theory, multi-level modelling and item-response theory for data analysis involving very large samples (Kolden, 1996; Stiles et al., 2015). A problem with quantitative research is that of researcher allegiance effect (Stiles et al., 2015). This refers to studies conducted by psychotherapists and/or researchers with an allegiance towards a specific approach demonstrating an increased likelihood to find and report evidence that supports their preferred approach or finds their preferred approach to be more effective than alternative or control treatments (Stiles et al., 2015).

Qualitative research. The field of psychotherapy research has increasingly begun to welcome qualitative methods in the shift towards methodological pluralism (Llewelyn & Hardy, 2001; Stiles et al., 2015; Watson & McMullen, 2016). Qualitative methods enable researchers to gather information not accessible through quantitative methods, for example, the experience of psychotherapists and clients going through a treatment process and the thematic ways in which their lives have been influenced by the treatment process (Watson & McMullen, 2016). In the context of psychotherapy research, qualitative methods are used in process research to study change in psychotherapy (Greenberg, 1986). Furthermore, qualitative methods allow researchers to investigate infrequently occurring phenomena that are unique, complex and contextually dependent or aspects that are observable by external judges (like reflections of inner experiences) (Stiles et al., 2015). Qualitative methods in the context of psychotherapy research thus aim to empirically highlight the *how* or *what* (process) and *why* (outcome) aspects of psychotherapy (Watson & McMullen, 2016).

Examples of qualitative methods include qualitative meta-analyses, systematic reviews and systematic case study research (Stiles et al., 2015; Watson & McMullen, 2016). Examples of systematic case study research include pragmatic case studies (Fishman, 1999), consensual qualitative research case studies (Hill, 2012), theory-building case studies (Stiles, 2009) and hermeneutic single-case efficacy designs (Elliott et al., 2009; Stiles et al., 2015). Qualitative methods can both test and generate conceptual models and specific hypothesis (Kazdin, 2008). Therefore, qualitative methods are useful for theory building and theory testing, attempting to bridge the gap between research and practice (Elliott, 2010; Knobloch-Fedders et al., 2015; Stiles et al., 2015; Watson & McMullen, 2016). Through the use of qualitative methods, the researcher is brought much closer to the context of clinical practice and the scientific study of the individual in the context of psychotherapy research (Kazdin, 2008). Thus, it can be concluded that there is a need for more qualitative and process research on the unique experiences of psychotherapy participants (Paley & Lawton, 2001).

Mixed-method research. In the shift towards methodological pluralism over the last 25 years, it seems likely that the future of psychotherapy research will include both quantitative and qualitative research methods, as well as mixed-method research, in order to be most effective (Elliott, 2010; Stiles et al., 2015). Through the use of mixed-methods research, both researchers and/or psychotherapists can develop theories which they can test empirically through quantitative and qualitative approaches (Elliott, 2010; Kazdin, 2008; Margison, Barkham, Evans, McGrath, Clark, Audin, & Connell, 2000; Stiles et al., 2015). Events paradigm researchers, for example, argue for the combination of quantitative and qualitative methods for the identification and analysis of change episodes during psychotherapy research (Elliott, 1983; Llewelyn & Hardy, 2001).

Reviews. From the literature, meta-analyses and systematic reviews are frequently used in psychotherapy research (Barlow, 2010; Brown, 2015; Lindgren et al., 2010; Wampold &

Bhati, 2004). Meta-analyses can be used during RCTs to demonstrate that one treatment is superior to another or an alternative, aided by the calculation of effect sizes (to determine practical significance) (Brown, 2015). Meta-analyses, in the context of psychotherapy research, are viewed as a critical analytic tool that can be used to synthesise data within the EBP approach (Wampold & Bhati, 2004). Furthermore, meta-analyses are used to compare results in effectiveness studies or outcome studies through statistical analysis (Brown, 2015; Kazdin, 2008). A problem with meta-analyses is the limited range of clients engaged in psychotherapy due to the strict pre-determined criteria required to enable analysis, which results in very few studies involving psychotherapy in applied settings (instead, laboratory settings are represented) (Brown, 2015; Kazdin, 2008). Currently, in the field of psychotherapy research, there are reviews of reviews resulting in meta-meta-analysis, which is a meta-analysis of other meta-analyses (Lambert & Ogles, 2004; Luborsky et al., 2002). Rønnestad (2006) reports that meta-analyses found that as little as 1% of the outcome of psychotherapy can be explained by the treatment approach (Lindgren et al., 2010). A systematic review, on the other hand, refers to the extensive review of literature by means of qualitative synthesis (Orlinsky, Grawe, & Parks, 1994).

Theory-building and theory-testing research. During theory-building research, data is gathered and then used to develop theory (or theories) to account for the data (Elliott, 2010). Theory-building research is defined as a descriptive, naturalistic, non-comparative approach to psychotherapy research (Elliott, 2010; Stiles et al., 2015). During theory building, explanatory theories are developed through the logical operations of deduction, induction and abduction (Stiles et al., 2015). This occurs within a cyclic approach whereby an inductive inquiry approach feeds deductive research, which in turn guides further induction in a perpetual circle of mutual enrichment (Shoham-Salomon, 1990; Stiles et al., 2015). Induction refers to a method used to compare new observations with theoretical expectations used to

either strengthen or weaken the support and confidence in the theory (Shoham-Salomon, 1990; Stiles et al., 2015). During deduction, parts of theories are logically linked to hypothesis and observations (Shoham-Salomon, 1990; Stiles et al., 2015). Finally, abduction refers to the process during which theories are modified to accommodate new observations that diverged from expectations, while still maintaining the internal consistency of the theory (Stiles et al., 2015). Thus, when one part of a theory changes, it may require other parts of the theory be adjusted too. Thus, the aim of theory-building research is to increase a theory's generality, accuracy and practicality (Stiles et al., 2015).

The theories built in the discovery phase of descriptive psychotherapy research can be tested in validation comparative theory-testing psychotherapy research (Elliott, 2010; Greenberg, 2007; Watson & McCullen, 2016). Theory-testing research refers to a deductive approach to psychotherapy research (Elliott, 2010; Shoham-Salomon, 1990). Experimental manipulation is particularly useful for the confirmatory purposes of theory-testing research (Elliott, 2010; Shoham-Salomon, 1990).

Theme two: Outcome research. The focus of outcome research is to predict outcomes and to identify which type of psychotherapy is most effective, mainly through the use of RCTs (Brown, 2015; Kazdin, 2008). Traditionally, outcome research has been treated as a black box where only input and output are looked at, thus ignoring everything in the middle (i.e. the process) (Elliott, 2010). Cook and Campbell (1979) refer to this as the causal micro-mediating process. Outcomes may be specific to a particular type of problem (i.e. depression, anxiety or eating disorders) or may refer to a more general domain such as wellbeing, health, symptoms and general functioning (Elliott, 2010; Greenberg, 1986). Greenberg (1986) distinguishes between three types of outcomes, namely: 1) immediate outcomes (change within the session); 2) intermediate outcome (extra-session change); and 3) ultimate outcome (final change at the end of treatment and/or at follow-up). To provide a more complete picture

of the change process, outcomes should be measured on all three types of outcomes and be related to one another. The use of appropriate outcome measures should be routine practice in psychotherapy and should be interpreted against relevant normative data in order to indicate or highlight reliable and clinically significant change (Margison et al., 2000). However, many psychotherapy studies report statistical issues with the use of only some outcome measures (Kazdin, 2008). In addition, changes on rating scales are difficult to translate into changes in everyday life (Kazdin, 2009).

Theme three: Process research. Process research refers to the identification and conceptualisation of reliable markers or contributors that could either help or hinder the psychotherapy change processes (Castonguay et al., 2010; Elliott, 1983). Thus, information stemming from process research has the potential to enable psychotherapy researchers to generate an initial taxonomy of significant helpful and hindering change events in psychotherapy (i.e. insight or alliance ruptures) (Elliott, 1983).

Given that process research aims to determine what works and what does not work in psychotherapy (Constantino & Bernecker, 2014; Castonguay et al., 2010; Elliott, 2010), Elliott (1983) holds that process research should focus on the identification and conceptualisation of key, critical, decisive or significant helpful or hindering events in psychotherapy, a view that is supported by Hill (1990) and Reiter (2010). As one of two approaches to process research, the events approach focuses on the change process within specific types of events within psychotherapy (Elliott, 2010; Hill, 1990).

As an alternative to following the events approach, researchers involved in process research can also consider researching the helpful factors that aided the therapeutic process.

Researching helpful factors simply involves that subjects are asked what they found helpful, useful or important in describing how they changed over the course of psychotherapy and what they mostly ascribe these changes to (Elliott, 2010). A promising new development

in this approach is asking clients what they found helpful outside of psychotherapy, also known as extra-therapeutic change (Mackrill, 2008). Helpful-factors research produces rich qualitative accounts of change processes in psychotherapy that create a much closer-to-the-ground picture of the helpful factors in psychotherapy, thereby lending considerably more texture to the actual therapeutic change (Elliott, 2010).

Process research aims to explore patterns of change, events, tasks, change episodes or change processes in psychotherapy (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Knobloch-Fedders et al., 2015; Llewelyn & Hardy, 2001; Shoham-Salomon, 1990). The dichotomy between process and outcome can be transcended by focusing directly on change events occurring within sessions (Greenberg, 1986; Knobloch-Fedders et al., 2015).

To assist in this regard, there are certain process measures that can be administered at various stages in the therapeutic process (Davis & Reid, 1988; Elliott, 1983; Knobloch-Fedders et al., 2015; Watson & McMullen, 2016). These process measures are not only used to describe what happens in psychotherapy sessions but also to understand how change comes about (Knobloch-Fedders et al., 2015; Stiles et al., 2015). A truly comprehensive approach to process research must include not only the psychotherapists' intention with conducting an intervention, the intervention itself and the clients' response, but also the clients' processing of the intervention (referred to as the "absorption problem") (Hill, Nutt, & Jackson, 1994; Knobloch-Fedders et al., 2015).

This calls for the application of a battery of process measures, which should be psychometrically well-developed instruments that are trans-theoretical, applied across contexts and specifically tailored to the events being studied (Knobloch-Fedders et al., 2015). Said authors also hold that this battery should enable multiple perspectives, namely client, psychotherapist and observers. Other important process information is the context of the event, the stage of treatment, the clients' present state and the therapeutic alliance (Knobloch-

Fedders et al., 2015; Woolley, Butler, & Wampler, 2000). To this end, a number of process measures describing the type, quality and quantity of change in psychotherapy have been developed through the intensive observation and description of video and audiotapes and transcribed psychotherapy sessions by studying clients' and psychotherapists' overt behaviour within sessions over the course of treatment (Davis & Reid, 1988; Elliott, 1983; Knobloch-Fedders et al., 2015; Stiles et al., 2015; Watson & McMullen, 2016).

Theme four: Existing CPR approaches. From the review, it became apparent that there are only a few existing CPR approaches. These include the following: assimilation of problematic experiences sequences, abbreviated as APES (Stiles et al., 1990); case study approaches; conversational analysis; comprehensive process analysis; context-responsive psychotherapy integration, abbreviated as CRPI (Constantino, Boswell, Bernecker, & Castonguay, 2013) and the list of good moments in therapy (Mahrer, White, Howard, Gagnon, & MacPhee, 1992).

Assimilation of problematic experiences sequences. This approach to change process research holds that the changing relation of a problematic experience to the self is characterised by eight stages: 0) warded off/dissociated; 1) unwanted thoughts/active avoidance; 2) vague awareness/emergence; 3) problem statement/clarification; 4) understanding/insight; 5) application/working through; 6) resourcefulness/problem solution; and 7) integration/mastery (Llewelyn & Hardy, 2001; Stiles et al., 2015; Watson & McMullen, 2016). This sequence provides a developmental stage perspective of therapeutic progress across treatment (Stiles et al., 2015), enabling trained evaluators, psychotherapy researchers and psychotherapists to track how a particular issue changes over the course of psychotherapy (Elliott, 2010) and to track a client's progress through the eight stages where different types of events are helpful at different stages to progress towards assimilation (Elliott, 2010; Llewelyn & Hardy, 2001; Stiles et al., 2015). The APES was developed from

theory-building case study research and provides a pan-theoretical theory of change processes that describes how problematic experiences can be integrated into the client's sense of self (Watson & McMullen, 2016).

Case study approaches. From the literature, it is apparent that a variety of new systematic case study research approaches are being followed, many with mixed methods. Included amongst these are pragmatic case studies (Fishman, 1999), consensual qualitative research case studies (Hill, 2012), theory-building case studies (Stiles, 2009) and hermeneutic single-case efficacy designs (Elliott et al., 2009). Seemingly, since the paradigms of a new approach to the change process have been reset and cannot be fully realised by exclusive use of nomothetic experimental designs, several authors (Davis & Reid, 1988; Elliott, 1983; Knobloch-Fedders et al., 2015; Stiles et al., 2015; Marmar, 1990; Woolley et al., 2000) are of the opinion that a higher frequency of single-case or small-N studies are required (as opposed to large N studies). A case study approach allows researchers to examine how a technique is used in the context of the whole case and replication across cases to allow researchers to draw conclusions about general effects (Stiles et al., 2015).

Conversation analysis. Conversation analysis is the study of “talk-in-action” (Elliott, 2010; Stiles et al., 2015). It is a well-developed, systematic, qualitative analysis method which enables the collection of examples of a particular type of therapeutic process to produce careful, contextually grounded descriptions of how clients and psychotherapists successfully accomplish a particular therapeutic task (e.g. interpretation, chair work or imagery) (Elliott, 2010; Stiles et al., 2015).

Comprehensive process analysis. Comprehensive process analysis is a mixed-method approach, developed by Elliott (1989), which is based on a combination of conversation analysis, case study methods and sequential analysis (Elliott, 1983, 2010; Knobloch-Fedders et al., 2015; Llewelyn & Hardy, 2001; Stiles et al., 2015; Watson & McMullen, 2016).

Different strategies are used from different approaches to unpack the complex contextual and process factors that bring about particular significant helpful therapy events (Stiles et al., 2015). Comprehensive process analysis is an inductive approach to studying important moments of therapeutic change (also known as significant events) and to explain the unfolding effect and context from which they developed (Elliott, 2010). It lends itself for use in single-case (or small-N) studies as an alternative to qualitative interviews and attempts to stay close to practice (Davis & Reid, 1988; Elliott, 1983; Stiles et al., 2015). Through comprehensive process analysis, models of client and psychotherapist behaviour and experiences can be developed and refined (Elliott, 2010). It is a hermeneutic narrative method that looks at specific events in psychotherapy and explores how they are accomplished successfully (Llewelyn & Hardy, 2001). It explores the process, consequences and context of the event (Llewelyn & Hardy, 2001; Rhodes, 2011).

Context-responsive psychotherapy integration (CRPI). CRPI is an attempt to integrate the common-factors approach and EST paradigm of empirical inquiry (Constantino & Bernecker, 2014). In the CRPI framework, common factors are redefined as common clinical situations that a psychotherapist needs to be responsive to when encountered during psychotherapy sessions. The idea is to propose an if-then-structure for psychotherapists' to respond to clients' personal characteristics as they manifest in psychotherapy sessions and is based on context-relevant, principle-driven and evidence-based therapeutic strategies. On a practical level, this implies that psychotherapy can start from any therapeutic approach and move into and out of specific strategies based on readily available empirically derived markers indicating when it is necessary to make a shift. Within the CRPI framework, psychotherapists can incorporate evidence on responsiveness elements, while simultaneously maintaining an orientation that aligns with their own belief about change.

CRPI responsiveness elements include: 1) low expectations for change (addressed using expectancy persuasion strategies; see Constantino et al., 2013); 2) alliance ruptures (addressed using rupture-repair strategies; see Hilsenroth, Cromer, & Ackerman, 2012); 3) change ambivalence (addressed using motivational interviewing principles; see Westra, 2012); 4) self-strivings (addressed using social psychology principles; see Constantino & Westra, 2012); and 5) an alarm signal indicating that the client is “off-track” based on routine outcome measures (assessed with clinical support tools; see Lambert & Ogles, 2004). CRPI is based on the principles of deriving empirical markers of regularly occurring themes in psychotherapy sessions and developing evidence-informed ways of responding to these themes (Constantino & Bernecker, 2014). Within this if-then-structure, psychotherapists are encouraged to practice with moment-to-moment purpose and to adjust their practice in specific ways to be more responsive to clients’ needs.

List of good moments in therapy. Mahrer et al. (1992) compiled a list of good moments in therapy (Castonguay et al., 2010; Davis & Reid, 1988; Hill, 1990). This refers to moments when clients manifest therapeutic progress and include, for example, expression of insight; expression of new ways of being and behaving; exploration of feelings; expression of strong feelings towards the psychotherapist; and emergence of previously warded off material (Davis & Reid, 1988; Hill, 1990). These are examples of identifiable manifestations of client change or progress (Davis & Reid, 1988). The aim is to conduct an in-depth analysis of good moments and the therapist-client interaction that precedes and follows the identified moment. It is most useful when good moments are identified by clients, psychotherapists and third-party judges / observers during post-session reflections.

This section concludes with a summary of the four main CPR approaches as postulated in a pivotal conceptual-theoretical article by Elliott (2010), namely: the quantitative process-

outcome design; the qualitative helpful-factors design; the micro-analytic sequential process design; and the significant events approach.

The quantitative process-outcome design. The quantitative process-outcome design to CPR refers to empirical research in psychotherapy making connections between in-session processes and post-therapy outcomes (Elliott, 2010; Watson & McMullen, 2016). This is done by sampling key processes from different psychotherapy sessions and using these key processes to predict post-therapy outcomes (Elliott, 2010). Process and outcomes can be measured on various dimensions reflecting clients', psychotherapists' and observers' perspectives (Hill et al., 1994). Both relational variables (such as therapeutic alliance; see Martin, Garske, & Davis, 2000) and technique variables (such as transference interpretation; see Orlinsky, Rønnestad, & Willutzki, 2004) have been the focus of process-outcome research (Elliott, 2010). A limitation is that process-outcome research treats the change process as a black box (Cook & Campbell, 1979). Furthermore, process-outcome research has measurement issues and poor internal validity. In addition, it produces mixed results as there are huge differences between clients, and these complexities strongly affect outcome. On the positive side, it is intuitively appealing and widely used and accepted (Elliott, 2010). However, process-outcome research fails to adequately account for therapist responsiveness (Stiles, Honos-Webb, & Surko, 1998). The outcome-process research design is most suitable and useful to test well-developed empirical theories to determine what works and what does not work in psychotherapy (Elliott, 2010).

The qualitative helpful-factors design. The qualitative helpful-factors design is an approach to CPR that refers simply to asking clients what they found helpful (or unhelpful) in psychotherapy. This can be done by means of interviewing clients after sessions in the course of and at the end of the psychotherapy process (Elliott, 2010). In this regard, the Change Interview (Elliott, Slatick, & Urmr, 2001), an interview lasting between 30 and 90 minutes

with between four and eight open-ended questions, can be used (Elliott, 2010). During these interviews, clients are asked to reflect on what they found helpful, important or useful in psychotherapy sessions or over the course of psychotherapy and to describe how they changed as a result of the psychotherapy process. Furthermore, they also reflect on their understanding of these changes (Elliott, 2010). A new development that shows a lot of promise is to ask clients what they found helpful in their extra-therapy life (Mackrill, 2008). Another method is to use post-session questionnaires, such as the form titled Helpful Aspects of Therapy (HAT) (Llewelyn, 1988), that ask clients to indicate what they found helpful or important in psychotherapy sessions and to describe what made it helpful (Elliott, 2010).

Through the helpful-factors approach, a much closer-to-the-ground picture of helpful factors in psychotherapy is formed, enabling psychotherapy researchers and psychotherapists to understand actual therapeutic change in more detail. According to Elliott (2010), this approach provides a rich qualitative account of change processes in psychotherapy. A limitation of this approach is that individuals' judgments about the causes of events are often wrong (known by cognitive scientists as an attributional error). Furthermore, clients sometimes confuse psychotherapy changes with extra-therapy change and they also have different verbal expressiveness abilities and levels. Strengths of the approach are that it is consistent with the 'ask-the-client' movement in mental health, and it is relatively easy to conduct this appealing type of research. Elliott (2010) cautions that helpful factors should be accepted as but one source of evidence for EBP and recommends that it should not be used in isolation.

The micro-analytic sequential process design. The micro-analytic sequential process design is an approach to CPR focusing on the turn-by-turn in-session interaction between clients and psychotherapists (Elliott, 2010). Accordingly, a limited number of categories or rating scales are used to code client and psychotherapist responses, and this type of coding is

usually low-level quantitative by nature. The aim is to identify specific client processes activated by specific psychotherapist responses under certain conditions. This enables sequential process researchers to establish relationships among process variables themselves. According to Elliott (2010), the effect of a specific type of psychotherapist intervention (such as therapist interpretation) can thus be explored in relation to the client process (such as insight). The result of these relationships can then result in common therapeutic sequence models being constructed. These models can be tested, implying that micro-analytic sequential process approaches are both theory building and theory testing by nature. One aspect that could limit this approach is that a potentially huge gap between specific within-session causal processes and psychotherapy outcomes might occur. Furthermore, this gap creates room for reverse causation (client-to-therapist) and for third-party variable causation. Consequently, this type of research is difficult and time consuming to conduct and, for that reason, has lost track over the past 20 years as a recommended approach to CPR. Adhering to a micro-analytic sequential process design does, however, have some strengths in as far as it has the potential to test theories about fundamental psychotherapy processes given that this approach has the potential to identify and demonstrate causal inferences. Seemingly, though, a need exists for more qualitative micro-analytic research, for example conversation analysis.

The significant events approach. The significant events approach refers to a complex mixed genre type of CPR that combines qualitative and quantitative data collection methods within a framework that is mainly interpretive and theory building (Elliott, 2010). Examples of these approaches include task analysis (Greenberg, 2007; Rice & Greenberg, 1984), comprehensive process analysis (Elliott et al., 1994) and assimilation analysis (Stiles et al., 1990). All of these approaches focus on important moments in psychotherapy, also known as significant events that encompasses helpful and hindering events (Elliott, 2010). Helpful events refer to, amongst others, insight (Elliott, 1984; Elliott et al., 1994), empowerment

(Timulak & Elliott, 2003), resolution of therapeutic tasks (Greenberg, 1986) and transition points (for example the assimilation model postulated by Stiles et al., 1990). Hindering events include, amongst others, difficult moments (Davis et al., 1987), alliance ruptures (Safran, Crocker, McMain, & Murray, 1990), and misunderstandings (Rhodes, Hill, Thompson, & Elliott, 1994).

In the significant events approach, a combination of two or more methods are used to identify significant psychotherapy events, such as questionnaires (see HAT Form; Llewelyn, 1988), interviews (see Change Interview; Elliott et al., 2001) and observational methods (see Brief Structured Recall; Elliott & Shapiro, 1988; Greenberg, 2007). Sequential process measures are then used to track multiple parallel qualitative aspects of client and psychotherapist processes (Elliott, 2010).

The significant events approach is a flexible approach to use when studying different therapeutic approaches and types of events. In particular, this approach is useful for theory building and adapting theories (Elliott, Slatick, & Urman, 2000; Elliott, 2010). Whereas within-session processes are tied to post-session outcomes as well as to post-therapy outcomes (Elliott, 2010), significant events studies tie the process to the outcome in a more descriptive, non-comparative manner.

Despite the fact that this approach to CPR is technically demanding and time consuming, Elliott (2010) found that it has a natural appeal for psychotherapists since it closely resembles practice and integrates existing quantitative and qualitative CPR approaches. This integration is based on highlighting the strengths and minimising the impact of the weaknesses of the first three conceptual-theoretical CPR approaches discussed above as postulated by the same author.

To summarise, within CPR, the integration of qualitative and quantitative research methodologies is recommended. In addition, the use of both process and outcome measures

within the same CPR study is encouraged. Clearly, a need exists to publish more case studies to compliment RCTs. Although some existing CPR approaches are reported in literature, they generally lack empirical testing and validation in subsequent follow-up studies and, therefore, lack specificity which limits the practical application and/or usefulness thereof for psychotherapy researchers and practitioners alike.

Practice-related themes and sub-themes. This group of themes, as opposed to the research-related themes, refers to those aspects identified from the final group of publications that, although necessary for understanding CPR in the context of psychotherapy mainly have a bearing on the practice of psychotherapy. These include aspects that practitioners need to be aware of in order to conduct psychotherapy within a framework where increased awareness of change processes would be possible. By understanding these practice-related themes and sub-themes, a practitioner would better be able to conceptualise change processes in the context of psychotherapy better.

Before presenting the four practice-related themes, it is deemed necessary to create a context for the discussion by briefly touching on the importance of evidence-based aspects in psychotherapy as well as the role of common factors in psychotherapy. Taking into account that ESTs and EBP are consolidated under one umbrella (Wampold & Bhati, 2004), it was clear from the literature review that psychotherapy practice should be evidence based. ESTs refer to interventions or techniques that have produced therapeutic change in controlled trials (Constantino & Berncker, 2014), while EBP acknowledges the role that therapeutic techniques, the therapeutic relationship and common factors play in the change process (Goldfried, 2013). A new development, incorporated under the evidence-based umbrella, is PBE.

PBE refers to research on therapeutic practice informed by careful clinical observations of psychotherapy sessions (Elliott, 1983; 2010; Lilienfeld et al., 2014). Rhodes (2011) holds

that through the integration of EBP with PBE, an attempt can be made to not only narrow the researcher-clinician gap but also to encourage the development of more scientist-practitioners in psychotherapy. Following the same line of reasoning, but looking at the flip side of the coin, Castonguay et al. (2010) postulates that a list of potentially harmful treatments (PHTs) can also be generated, supplementing the *what to do* in psychotherapy with the *what not to do* in psychotherapy with some clients under some circumstances. In this regard, both Castonguay et al. (2010) and Lilienfeld et al. (2014) acknowledge that PHTs are a crucial albeit neglected aspect within the evidence-based approach, going as far as to state that scientist-practitioners ought to be mindful of and receive training in the PHTs.

Finally, in creating the context for the practice-related themes, the role of common factors should also receive attention. Meta-analyses found no significant differences between therapeutic approaches, which underscores the role common factors fulfil in psychotherapy (Brown, 2015). Common factors include the therapeutic relationship, hope and expectation of change (Harris et al., 2015) and provide trans-theoretical understandings of the active ingredients in any psychotherapeutic process that, regardless of approach, lead to positive outcomes in psychotherapy (Reiter, 2010).

In terms of practice-related themes and sub-themes, four themes emerged, namely: 1) therapeutic relationship; 2) therapeutic techniques; 3) change concepts; and 4) psychological understanding of the client. These themes and their sub-themes will be discussed next.

Theme one: Therapeutic relationship. The therapeutic relationship refers to the client-therapist relationship and related aspects in the context of psychotherapy and, as such, involves collaborative communication and consensus regarding therapeutic goals and the therapeutic approach or treatment plan that ought to provide a safe space or facilitate an environment in which the process of psychotherapy can take place. From an analysis of the ultimate group of publications used in this systematic review, two sub-themes seemingly

characterise the therapeutic relationship, namely therapeutic alliance and alliance ruptures. A discussion of these two sub-themes follows.

Therapeutic alliance. Therapeutic alliance is regarded as a common factor accounting for approximately 30% of the variance in psychotherapy outcome studies (Lindgren et al., 2010; Reiter, 2010). It has consistently been reported that the stronger the therapeutic alliance, the more effective the psychotherapy (Brown, 2015; Horvath & Bedi, 2002; Norcross, 2002; Orlinsky et al., 2004). In fact, Henry, Strupp, Schacht and Gaston (1994) pointed out that the best predictor of outcome is initial therapeutic alliance.

Therapeutic alliance is also referred to as the helping alliance (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983) or, in more general terms, the therapeutic relationship (Garfield, 1980; 1989; 1990). Goldfried (2013), Martin et al. (2000) and Woolley et al. (2000) are all of the opinion that therapeutic alliance has a bearing on the empathy, warmth and acceptance that are evident between the client and psychotherapist and that this alliance is regarded as a relational process variable in psychotherapy.

As cited in Margison et al. (2000), Bordin noted as early as 1979 that there are three essential components to a therapeutic alliance, namely the therapeutic bond, agreement about the task and agreement about goals. The therapeutic bond between psychotherapist and client usually comes to mind when the therapeutic relationship is considered. According to Kolden (1996), this bond refers to the mutual liking between psychotherapist and client: The feeling that there is good communication and a mutual willingness to work together clinically. Therapeutic bond is the special kind of relationship that supposedly develops in psychotherapy, consisting of three interpersonal micro-processes, namely collaborative role enactment, empathic resonance and mutual affirmation.

Collaborative role enactment is the degree to which client and psychotherapist jointly share in the purpose of psychotherapy, while empathic resonance is the extent to which the

client and psychotherapist understand one another in a manner that is thoughtful, alert and attentive (or mindful) (Kolden, 1996). Mutual affirmation, as the third interpersonal micro-process, refers to the mutual respect and emotional attachment evident between client and psychotherapist which manifests through warmth, friendliness and acceptance.

Lindgren et al. (2010) summarised therapeutic alliance rather succinctly as the trust, the confidence and the cooperative climate that develop between the psychotherapist and the client. Here it ought to be noted that as early as 1996, Kolden postulated that therapeutic alliance ought to be regarded as a universal change process construct that is trans-theoretical and common across theoretical models of psychotherapy, formulated at a macroscopic meta-theoretical level of conceptualisation.

Evidently, therapeutic alliance plays an important role in the change process in psychotherapy, especially given that Knobloch-Fedders et al. (2015), Llewelyn and Hardy (2001) and Watson and McMullen (2016) unequivocally state that alliance ruptures contribute to therapeutic failures. One of several well-established and empirically validated measures to assess therapeutic alliance is the California Psychotherapy Alliance Scales (referred to as CALPAS; Gaston, 1991). Given that clients' perceptions of collaboration will have an influence on the therapeutic alliance, it is recommended to clarify, from the onset of psychotherapy, what the roles and responsibilities of the client and psychotherapist are to avoid possible misconceptions (Watson & McMullen, 2016). Timulak and Lietaer (2001) found that the therapeutic alliance is strengthened when psychotherapists are transparent and communicates openly and directly about the goals and tasks in psychotherapy (Watson & McMullen, 2016).

Barlow (2010) found that to share a case conceptualisation with a client helps to maintain the therapeutic alliance. Meta-communication and the psychotherapists' ability to be

responsive and aware of the client's agency also have an influence on the strength of the therapeutic alliance (Llewelyn & Hardy, 2001; Winston, McCullough, & Laikin, 1993).

A good therapeutic relationship increases the likelihood of the client engaging in therapeutic techniques, and the successful implementation of therapeutic techniques enhances the therapeutic relationship and, ultimately, the outcome of psychotherapy (Castonguay et al., 2010; Goldfried, 2013; Harris et al., 2015).

Alliance ruptures. While acknowledging that the therapeutic alliance is an important change-process factor, it is also important to understand that ruptures in the alliance contribute to therapeutic failures (Castonguay et al., 2010). Early warnings of disruption of the therapeutic alliance can *flag* the case for additional supervisory discussion (Margison et al., 2000). In addition, the recognition of threats to the therapeutic alliance can point the psychotherapist in the direction of evidence-based methods to repair the therapeutic alliance. Safran et al. (1990) and Safran and Muran (1996; 2000) highlight that research on the therapeutic alliance also provide valuable information on how to identify alliance ruptures and how to intervene effectively in repairing those ruptures (Pachankis & Goldfried, 2007). Through the use of sequential analysis, Safran and Muran (1996) proposed a sophisticated model to illustrate the process that the resolution of alliance ruptures can follow, namely: 1) client withdrawal; 2) avoidance of confrontation; 3) partial expression of avoided negative material; 4) exploration of feelings; and 5) direct expression or assertion (Llewelyn & Hardy, 2001; Watson & McMullen, 2016). It is important to note that the significance of the rupture depends on its timing and whether a positive therapeutic alliance already exists (Llewelyn & Hardy, 2001). Safran et al. (1990) also identified certain common themes, namely: hostility or indirect communication of negative sentiments, overt expressions of negative sentiments, disagreement about the goals and tasks in psychotherapy, avoidance manoeuvres, non-responsiveness to interventions, and poor compliance (Watson & McMullen, 2016). The most

skilful psychotherapists are those that can notice an alliance rupture, use evidence-based techniques to address it and can determine when the alliance rupture is repaired before moving on to something else in the psychotherapy process (Constantino et al., 2013; Constantino & Bernecker, 2014). Hilsenroth et al. (2012) suggest rupture-repair strategies that can be used to repair alliance ruptures. By repairing the alliance ruptures, the therapeutic outcome is also improved (Castonguay et al., 2010). Safran and Muran (1996) also developed a number of therapeutic alliance repair principles, namely: 1) maintaining a balance between activity and receptivity; 2) being aware of specific types of alliance ruptures that are likely to emerge in particular forms of psychotherapy; and 3) carefully preparing clients for termination (Castonguay et al., 2010). Safran, Muran and Eubanks-Carter (2011) mention that the study of therapeutic ruptures also provides important process indicators for outcomes (Llewelyn & Hardy, 2001).

Rhodes et al. (1994) studied how misunderstanding events leads to ruptures in the therapeutic alliance (Llewelyn & Hardy, 2001). Misunderstanding events are resolved when clients feel that the issue was processed sufficiently and that they can continue to work in psychotherapy (Watson & McMullen, 2016). In resolved cases, clients tended to have good relationships with psychotherapists and were willing to disclose negative feelings about the misunderstanding. In cases where misunderstanding events were unresolved, clients felt that the alliance rupture continued to hinder their communication with the psychotherapist. In unresolved cases, clients tended to have poor relationships with their psychotherapist, and the psychotherapist was either unaware or unwilling to accept clients' assertion of negative reactions. These clients also often quit psychotherapy or terminate prematurely (Llewelyn & Hardy, 2001). According to Rhodes et al. (1994), misunderstanding events leads to alliance ruptures when psychotherapists failed to meet their clients' expectations.

Theme two: Therapeutic techniques. Therapeutic techniques refer to how a psychotherapist conducts psychotherapy and what a psychotherapist does and says. Therapeutic techniques include verbal and nonverbal communication between psychotherapist and client in the context of a therapeutic relationship. The therapeutic techniques are embedded in the therapeutic relationship and they are, therefore, interconnected. Therapeutic techniques refer to best practice from various psychotherapeutic approaches. Furthermore, it appears that there are certain common therapeutic techniques across therapeutic approaches, while others are specific to particular approaches (Brown, 2015). Castonguay et al. (2010) highlight that the rigid or preservative use of techniques in particular contexts is detrimental to clients as it can interfere with their change processes.

From the literature review, different therapeutic techniques were identified which can be grouped in three categories, namely behavioural, cognitive and emotive techniques.

In terms of common behavioural techniques, the psychotherapists' ability to maintain a balance between following and leading was identified (Henry, 1996; Smith & Grawe, 2003). In addition, psychotherapist need to accept where clients are at before they can lead them to what might be more beneficial for them (Goldfried, 2013). In addition, some clients can be readily led, while others might require more patience from the psychotherapist. Another example of behavioural techniques is motivational interviewing which refers to a focus on the clients' readiness for change and shows promise in addressing clients' resistance and ambivalence more effectively (Brown, 2015; Castonguay et al., 2010; Constantino & Bernecker, 2014). The clients' readiness to change is influenced by another common behavioural therapeutic technique namely the level of directness of the psychotherapist, which can vary between a more teaching, confronting, facilitating or supporting role (Brown, 2015; Castonguay et al., 2010). Another common behavioural technique is the principle of exposure as can be found in, for example, paradoxical intentions, systematic desensitisation,

emotion-focused therapy and interpersonal psychotherapy (Brown, 2015; Castonguay et al., 2010). Specific behavioural techniques include, for example, behavioural activation and behavioural exposure from a CBT perspective and classical and operant conditioning from a behavioural therapy perspective.

In terms of cognitive techniques, addressing cognitive distortions and meaning making were identified to be common across approaches. Addressing cognitive distortions refers to a cognitive change, brought about by insight and awareness, during which a critical belief or schema change leads to change in psychotherapy (Kazdin, 2008; Llewelyn & Hardy, 2001). Meaning making refers to clients being led to create new meanings rather than becoming overwhelmed by existing meanings (Brown, 2015). To enable meaning making, psychotherapists need to be able to contribute to a meaningful health-promoting context for their clients. When clients can contextualise their problem through the co-creation of new meaning within language, the problems tend to become more understandable and manageable, which promotes their psychological wellbeing (Madill & Barkham, 1997). It is important to note that cultural meanings and considerations play an important role in meaning making processes (Kazdin, 2008; Madill & Barkham, 1997). Different processes have different meanings in different contexts; therefore, a context-sensitive approach to meaning making is indicated (Greenberg, 1986; Paley & Lawton, 2001). More specific cognitive techniques, all from the CBT perspective, are cognitive awareness, thought restructuring and cognitive disengagement.

Then, in terms of emotive techniques, the facilitation of corrective experiences was identified to be common across approaches (Goldfried, 2013). Emotional expressiveness is another example of a common emotive technique and refers to the psychotherapists' ability to validate emotions and to facilitate the expression of emotions in psychotherapy sessions (Castonguay et al., 2010). More specific emotive techniques from an emotion-focused

therapy perspective, for example, include: empty chair in gestalt therapy, guided imagery in schema therapy and role playing in REBT.

Finally, there is also a lot of evidence for the emotive-cognitive nature of change, also referred to as the underlying cognitive-affective schema or the distinct cognitive-affective positions within the self (Watson & McMullen, 2016). Another important aspect is that of timing, seeing that the timing of, for example, interpretations, may result in differences in terms of client reactions to the interpretations (Castonguay et al., 2010; Davis & Reid, 1988; Elliott, 1983; Greenberg, 1986; Hill, 1990; Knobloch-Fedders et al., 2015; Llewelyn & Hardy, 2001; Pachankis & Goldfried, 2007; Winston et al., 1993).

Theme three: Change concepts. A change concept is a general approach to change that has been found to be useful in conceptualising how change occurs and leads to improvement. Change concepts are not synonymous with themes, but rather with theories. Although there are many kinds of changes that can lead to improvement, specific changes are best understood by studying specific change concepts. Thus, for the purpose of this study, change concepts aim to provide theories on change in the context of psychotherapy (answering the *how* and the *why* of client change).

The following change concepts were identified from the data extraction phase, namely: mediators of change, moderators of change, mechanisms of change, principles of change, and extra-therapy change. These sub-themes will be discussed next.

Mediators of change. A mediator of change refers to a causal or an explanatory factor that enhances or even fully accounts for client outcome in psychotherapy (Heatherington, Friedlander, & Greenberg, 2005; Rhodes, 2011). Mediators are change processes set in motion by treatments (Heatherington et al., 2005). A mediator of change can also be defined as a third variable accounting for the relationship between an initial independent variable and an outcome, in which the treatment itself can be the independent variable and the mediator of

change can be the specific component of the treatment hypothesised to be its critical component (Heatherington et al., 2005; Rhodes, 2011). In addition, mediators of change can also be viewed as treatment outcomes and as critical stepping stones for the final post-treatment result (Rhodes, 2011). The challenge is that some mediators of change are also moderators of change and that there are some mediators of mediators and moderators of mediators (Kazdin, 2008).

Moderators of change. Moderators of change refer to a set of variables related to an outcome, but not invariably related to outcome in any individual case (Heatherington et al., 2005). It is those characteristics that influence the intervention-outcome relation and include characteristics of the client, the psychotherapist and the therapeutic context. Moderators of change can be identified from research findings or from clinical experience. Examples of moderators of change related to client characteristics are gender and socio-economic status. These client characteristics can result in psychotherapy being more effective for some clients with a particular set of characteristics as compared to others. What is currently lacking in research regarding moderators of change is the study of a given moderator of change among different techniques, client samples and in different contexts. Without this information, it is difficult to determine if a moderator of change predicts different clients' responsiveness to a particular treatment or to multiple treatments. Moderators of change are only correlates of outcome. The ideal in terms of moderators of change is to improve outcome by determining the variables accounting for why psychotherapy works well for some clients and in some contexts and not as well or not at all for others (Kazdin, 2008). Moderators of change aim to delineate these different outcomes. In the context of psychotherapy research, a moderator of change is a factor interacting with the treatment approach affecting the degree or direction of client change. Moderators of change can thus alter the strength or direction of treatment outcome. Other examples of moderators of change are treatment adherence, treatment fidelity

(quality of the psychotherapists' interventions) and positive engagement in treatment. A moderator of change is the characteristic that influences the extent of the relationship between independent variables and outcome and is, therefore, inherently related to mediators of change (Heatherington et al., 2005; Kazdin, 2008; Rhodes, 2011).

Mechanisms of change. Mechanisms of change refer to processes that explain why psychotherapy works and how it produces change (Kazdin, 2008). Therapeutic change can be optimised by understanding critical factors of treatment and the processes through which they operate better. This will not only help clinical work, but also improve client care. The study of mechanisms of change might even indicate that multiple interventions activate similar mechanisms of change which could enhance the effectiveness of treatments in clinical application (Kazdin, 2008). A promising development is the study of evidence-based mechanisms of change, which might be more useful than ESTs. Examples of mechanisms of change are therapeutic alliance, transference and changes in cognition (Castonguay et al., 2010; Kazdin, 2008).

Principle of change. Goldfried (2013) and Pachankis and Goldfried (2007) refers to mechanisms of change as principles of change, while others refer to it as the active ingredients of change. The common principles of change include: 1) the facilitation of expectations that psychotherapy can be helpful; 2) the establishment of an optimal therapeutic alliance; 3) facilitation of the clients' awareness of factors within themselves, others and their environment that contribute to their problems; 4) the facilitation of corrective experiences; and 5) the encouragement of continued reality testing (Beutler, 2014). These principles of change are universal and can thus be adopted in any given theoretical orientation, regardless of theoretical origin (Castonguay et al., 2010; Goldfried, 2013; Knobloch-Fedders et al., 2015). Principles of change can be derived from empirical literature on technical factors, relationship variables and participant characteristics (Beutler, 2014; Castonguay & Beutler,

2006). Thus, principles of change are the specific ingredients necessary for client change at the level of the client, psychotherapist, relationship and intervention (Pachankis & Goldfried, 2007).

Extra-therapy change. There is a need for a better understanding of how extra-therapy events combine with in-session events to produce change, especially seeing that 40% of outcome variance is attributed to extra-therapeutic change variables unique to the client and the clients' circumstances (Paley & Lawton, 2001; Reiter, 2010). A strategy to minimise extra-therapy influences as a source of improvement in psychotherapy is the repeated use of the same measurements across the course of treatment (Greenberg, 1986). Another approach is to ask clients what they found helpful in their extra-therapy life in an attempt to gain a better understanding of what kind of in-therapy performances and outcomes lead to what types of extra-therapy changes (Elliott, 2010; Greenberg, 1986). A better understanding of extra-therapy change will also increase the understanding of mechanisms of client change in psychotherapy in general (Greenberg, 1986).

Theme four: Psychological understanding of the client. This theme refers to the manner in which psychotherapists formulate their psychological understanding of clients. It is trans-theoretical by nature, seeing that psychotherapists can formulate from any given theoretical perspective, keeping in mind that the formulation should be evidence-based and relevant to the clients' presenting problem.

In terms of the psychological understanding of the client, the following sub-themes were identified: nomothetic approach, idiographic approach, general theories, personal theories, and specific theories.

Nomothetic approach. When the nomothetic approach is applied to psychotherapy research, it refers to determining the average response of a group of clients to a specific target problem or diagnosis, usually when a comparison is made between an identified EST and a

good alternative (Barlow, 2010; Harris et al., 2015). This approach requires large sample (also known as large N) group-based experimental design studies in the context of RCTs and is frequently subjected to meta-analyses to enable the calculation of effect sizes (in order to determine practical significance) (Barlow, 2010). A problem with the nomothetic approach to psychotherapy research is that researchers are trying to answer idiographic questions with nomothetic approaches (Knobloch-Fedders et al., 2015; Lilienfeld et al., 2014). Thus, by looking at what works for a group of clients, we still do not know what will work for the uniqueness of the individual client sitting in front of the psychotherapist in a particular psychotherapy session (Kazdin, 2008; Paley & Lawton, 2001).

Idiographic approach. Since psychotherapists are faced with the unique needs of one individual at a time in psychotherapy, the idiographic approach shows promise (Harris et al., 2015). However, it is important to take cognisance of the fact that idiographic information should not be used in isolation but in combination with nomothetic information (Lilienfeld et al., 2014). Knowing what works in general can be applied more effectively to a client if it can be tailored to the unique needs and understanding of the specific client in psychotherapy (Harris et al., 2015). To gather idiographic information, it is important to view clients holistically, namely by conducting a multi-dimensional survey that looks at cognitions, emotions, behaviour and interpersonal relationships. Gathering information regarding these different domains has increased clinical significance once the interactions between them are conceptualised. Following this conceptualisation, it becomes possible for client and psychotherapist to decide collaboratively on one or two focal dimensions to focus on in the treatment and the firing order in which they will be addressed. The firing order refers to the treatment priority, namely what will be addressed first, second, third and so on. Within the context of integrative treatment planning, it is important to understand that the focus of treatment can shift over the course of psychotherapy as new themes emerge (Watson &

McMullen, 2016,). The case conceptualisation is the culmination of the multi-dimensional view of the client and informs diagnosis, treatment approach and prognosis (Harris et al., 2015). The main aim is to match the client's problems (idiographic information) with the nomothetic ESTs in order to offer a treatment approach that would be deemed as effective (Lilienfeld et al., 2014). This requires a high level of clinical judgement and integrative skills from the psychotherapist.

General theories. A general theory refers to an official theory or a familiar theory explaining normal and abnormal processes at a macro-level (Katsikis, 2014). It is an approach with a very large scope which offers a general view on how and why clients change. By generating empirical evidence and support for a general theory of change, practitioners are provided with a more reliable framework as guide for decision making, especially in terms of different forms of psychotherapy and general therapeutic techniques (or strategies) within that psychotherapy. A general theory is influenced by general psychological knowledge from different official or familiar psychotherapeutic theories and methods (Smith & Grawe, 2003). A theory of change refers to an approach to identify the active ingredients of change in psychotherapy (knowing *when* and *how* to offer an intervention) (Llewelyn & Hardy, 2001). General theories may include, amongst others: 1) theory of aetiology; 2) theory of problems; 3) theory of psychopathology; 4) theory of change (mechanisms of change); and 5) theory of treatments (Barlow, 2010; Katsikis, 2014; Watson & McMullen, 2016).

Personal theories. Practitioners gain experience from clinical practice in terms of different forms of psychotherapies within different contexts and with different clients (Kazdin, 2008; Watson & McMullen, 2016). This clinical experience can also be enhanced further through discussions with colleagues (if applicable) regarding clinical practice and/or specific cases (Kazdin, 2008; Lindgren et al., 2010). The sum of the practitioners' clinical experience is then combined with the personal experiences of the practitioner and interacts

with general theories to transform into personal theories (Lindgren et al., 2010). Personal theories are thus unique and tailored to fit the psychotherapist as person (Wampold & Bhati, 2004). In conclusion, personal theories are forms of general theories that successfully change through life-long learning, clinical practice and experience (Kazdin, 2008; Lindgren et al., 2010). Personal theories, a relatively new area in psychotherapy research, do not only open up new opportunities for a better understanding of psychotherapy but also show promise in providing a framework for understanding common factors as contextual conditions for effective psychotherapy (Lindgren et al., 2010).

Specific theories. The different forms of psychotherapy are based on their own specific theories of change (Lindgren et al., 2010; Llewelyn & Hardy, 2001). From these specific theories of change, specific therapeutic techniques or interventions are considered to create a link between the therapeutic interventions and psychotherapy outcome (Barlow, 2010; Garfield, 1990; Henry, 1996; Llewelyn & Hardy, 2001). These specific theories are hypothesised to develop at a micro-level and thus become a micro-theory of change strongly influenced by clinical observations and experience (Castonguay et al., 2010; Elliott, 1983; Hill, 1990; Knobloch-Fedders et al., 2015; Lilienfeld et al., 2014; Rhodes, 2011; Stiles et al., 2015). Specific theories can result in specific therapeutic techniques which should be used at specific times in psychotherapy, for example when to reflect, when to interpret or when to provide direct guidance (or psycho-education). (Knobloch-Fedders et al., 2015; Rhodes, 2011). Specific theories would help to answer the question: What intervention has what type of impact at what particular client moment in psychotherapy? (Knobloch-Fedders et al., 2015; Llewelyn & Hardy, 2001).

In summary, regarding the practice-related themes, it is clear that psychotherapy practice should be evidence based and consider the role of common factors. Evidence based should be broadened to include ESTs, EBP and PBE. Common factors should not only be

considered at the level of therapeutic techniques but also at the level of the therapeutic relationship. In terms of the therapeutic relationship, certain factors were identified to increase the quality of the therapeutic alliance, while the importance of repairing alliance ruptures has also been discussed. Next, in terms of therapeutic techniques, it was clear that there are certain common cognitive, behavioural and emotive techniques, but these techniques become more specific when implemented from different treatment approaches. Change concepts were identified as a very important theme, but one that lacks operational clarity and consensus, particularly regarding the differentiation between mechanisms and principles of change. The practice-related themes culminate in the psychological understanding of the client, in other words case conceptualisation based on an integration of nomothetic information at the level of general theories with idiographic information on the level of specific and personal theories.

Conclusion

To conclude, this systematic review yielded important findings regarding CPR in psychotherapy which were divided into two groups, namely research- and practice-related themes. In an attempt to synthesise these findings and highlight the implications thereof, the most pertinent research- and practice-related findings were highlighted followed by an integration thereof, as one would expect within a scientist-practitioner model.

The research-related themes emphasised that even though there is a need for more mixed-method systematic psychotherapy case studies, the field is currently just entering into this specific type of research methodology. Within these systematic case studies, it is necessary to use relevant process and outcome measures and report on any changes noticed during the process of psychotherapy. Even though some CPR approaches exist, a logical, coherent, integrative framework for conceptualising the change process in the context of psychotherapy is lacking. Gonçalves et al. (2011) support this finding by emphasising that

psychotherapy can be effective in producing significant changes in individuals' lives, and these changes need to be anticipated, reflected, stimulated and discussed during the process of psychotherapy. Even though many clients recognise that psychotherapy has a major impact on altering their lives in significant ways, there is no clear framework explaining this change and there is a clear need for more research in order to provide such a framework for better understanding such change processes (Binder, Holgersen, & Nielsen, 2009).

In terms of practice-related themes, it is clear that the therapeutic relationship and therapeutic techniques play an important role in conceptualising change and that the therapeutic techniques are embedded in the therapeutic relationship, making them inseparable. This finding is supported by Timulak (2010), highlighting that psychotherapists usually focus more on cognitive aspects of change in psychotherapy, while clients focus more on the interpersonal aspects between client and psychotherapist, as well as the accompanying emotional aspects during significant moments. In addition, Hill (2005) found that psychotherapeutic techniques are not helpful in the absence of a well-established therapeutic relationship with a participative client. Norcross and Wampold (2011a) found, from a meta-analysis, that the therapeutic relationship is just as important as the treatment methods that are used. Furthermore, it was found that psychotherapy practice should be evidence based and that the definition of evidence based should be expanded to not only include ESTs and EBP, but also PBE (in the form of publishing more case studies). Kazdin (2008) and Rubin and Bellamy (2012) highlight that research-generated principles and guidelines should be used in combination with psychotherapists' experience, competence and expertise to guide the therapeutic approach and to enhance treatment efficiency and the quality of psychotherapy. The same authors emphasise that the vital role that the client plays during the therapeutic process should not be neglected. A need for establishing more practice research networks was identified, stemming from which a database of case studies can be developed

(Margison et al., 2000). Edwards (2019) refers to such a database as a series of psychotherapy case study trials.

The practice-related theme with the lowest degree of clarity in current scientific literature, within the context of the process of change in psychotherapy, was the conceptualisation of different change constructs. From the systematic review, the difference was unclear between mediators and moderators of change. Frequent reference is made to the importance of mechanisms of change, principles of change and active ingredients in the process of change, yet operational definitions and clear descriptions thereof are lacking. Hoffman and Barlow (2014) echo the same sentiment, stating that there are specific elements in therapeutic approaches and their associated mechanisms of change which we are only now beginning to learn about.

Finally, when psychotherapists formulate their psychological understanding of clients, they need to integrate nomothetic information from general theories with idiographic information from specific and personal theories in order to create a specific framework within which client change can be conceptualised. This finding is in line with EBP that proposes that proficient psychotherapy is more about what works, for whom, under which circumstances than it is about focusing on a specific therapeutic approach (APA, 2006; Miller, Zweben, & Johnson, 2005).

To synthesise, when the findings from research- and practice-related themes are integrated, it is clearly implicated that increased collaboration is required between psychotherapy researchers and practitioners to not only address the scientist-practitioner gap but also to advance the field of CPR. Chwalisz (2003) supports this finding by describing scientist-practitioners as those who strive to integrate the best available research with their clinical expertise as well as the context of each specific client and who also strive for effectiveness throughout the process of practicing based on guiding research evidence. More

case study publications are required, from both researchers and practitioners, conducted from mixed-method approaches in which data is collected from multiple sources and reported on. The sources should include, but are not limited to, process and outcome measures administered at multiple times throughout the therapeutic process. This finding is in line with Pfeifer and Strunk (2015) who state that CPR aims to uncover the manner in which proficient psychotherapy brings forth change within clients and how to use this data to the advantage of other clients. When conducting CPR, the role of supervision and the involvement of third-party observers (or judges) are important, as this enhances the trustworthiness of the findings by increasing the level of objectivity and, consequently, decreases bias (Edwards, 2019). There is a need, amongst practitioners and researchers, to not only develop an integrative CPR framework but to also use this framework in subsequent studies and/or publications.

Recommendations and Suggestions for Future Research and Clinical Practice

It is recommended that CPR be conducted within mixed-method research methodologies. Within CPR frameworks, the findings from RCTs should be complimented with more systematic case study publications. Future research on CPR approaches should highlight different stages of change within change processes and should be able to track how a particular issue changes over the course of psychotherapy for different clients, within a trans-theoretical and trans-diagnostic framework. It is recommended that practitioners should be mindful when formulating their psychological understanding of clients to integrate nomothetic (general) and idiographic (specific) information.

It is also recommended that researchers and practitioners should expand their view of evidence based to include PBE and PHT evidence. There is a need for future research to identify and conceptualise specific empirical markers contributing towards helpful and hindering psychotherapy change processes. When psychotherapists conceptualise and reflect on the therapeutic relationship, they should be aware of possible alliance ruptures and be

mindful of evidence-based ways of repairing such ruptures. It is indicated that practice-research networks should be established as structures within which increased collaboration between researchers and practitioners can be made possible, based on the scientist-practitioner model.

It is recommended that future scientific literature regarding change constructs attempt to provide more clarity on different change constructs in an attempt to create a better distinction between mediators of change, moderators of change, mechanisms of change, principles of change and active ingredients in the process of change. There is also a need to conceptually distinguish common factors from CPR, as the difference between these two constructs were not clear from the findings of the current systematic review. Finally, it is recommended that CPR frameworks be used in an attempt to not only integrate the best aspects from process and outcome research and quantitative and qualitative research approaches but also to address (decrease/narrow) the scientist-practitioner gap.

Limitations

Onesearch was used as search engine during the search strategy, which might limit the findings since this engine only allows access to the databases the NWU subscribes to. Although this covers most of the important international databases, some relevant studies might have been excluded from the search. In an attempt to address this limitation, a second phase was implemented as part of the search strategy which was conducted through Google Scholar.

The lack of empirical studies on CPR could be regarded as a limitation, but in the context of a systematic review, it is acceptable to also include conceptual and/or theoretical articles (which would not be the case with a meta-analysis study). Furthermore, the fact that the majority of the final group of publications were conceptual and/or theoretical in nature,

with only a few empirical studies, is also indicative of the current state of affairs regarding the scientific literature available on CPR.

Another limitation is that there were only two reviewers (and coders in as far as the data-analysis phase is concerned) who had to ensure the quality of the systematic review process. Even though a third reviewer/coder was on hand if agreement could not be reached between the two reviewers/coders, the need to involve the third reviewer/coder in the current systematic review did not arise. The involvement of more reviewers/coders could possibly increase the trustworthiness of the findings. It is also a limitation that no African studies and, by inference, no South African studies were found on this topic.

Finally, no systematic reviews were found on CPR in the context of psychotherapy. Consequently, the findings stemming from this systematic review study can be used as a baseline summary to provide a frame of reference for future related studies.

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Addendum A: Critical Appraisal Tool**CRITICAL APPRAISAL TOOL**

Article Number: _____

Critical appraisal done by		
Description	Response options	Comments
Aims of the research - Clearly stated - Appropriate	☐ clearly described ☐ unclear ☐ not reported ☐ not applicable ☐ appropriate ☐ unclear ☐ not appropriate ☐ not applicable	
Study design Methodology	☐ appropriate ☐ unclear ☐ not appropriate ☐ not applicable	
Recruitment and data collection - Recruitment / sampling strategy / literature review (for theoretical articles) - Data-collection methods / literature review (for theoretical articles)	☐ appropriate ☐ unclear ☐ not appropriate ☐ not applicable ☐ adequate ☐ not adequate ☐ not reported ☐ not applicable	
Data analysis	☐ rigorous ☐ not rigorous ☐ not applicable	

Findings / interpretation • Validity and reliability / trustworthiness • Relevance	○ valid / trustworthy ○ unclear ○ potential bias ○ not applicable ○ relevant ○ unclear ○ limited relevance	
Ethical considerations	○ adequate ○ unclear / not adequate ○ not applicable	
Implications of the study	○ clearly reported / adequate ○ unclear / not adequate ○ not reported	

OVERALL ASSESSMENT OF THE STUDY

How well was the study conducted? ○ ++ (All or most of the criteria have been fulfilled – where they have not been fulfilled, the conclusions of the study or review are very unlikely to alter) ○ + (Some of the criteria have been fulfilled – those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions) ○ - (Few or no criteria fulfilled – the conclusions of the study are likely or very likely to alter)	Are the results of the study directly applicable to the target group? ○ YES ○ NO

FINAL DECISION

- **IN**
- **OUT**
- **MAYBE**

Addendum B: Summative Data Extraction from Articles Included in the Study

No	Reference	Methodology and aim	Core findings
1	Goldfried, M. R. (2013). What should we expect from psychotherapy? <i>Clinical Psychology Review</i> , 33, 862-869.	Methodology Theoretical article/literature review/qualitative research Aim To address the very general question of what we should expect from psychotherapy	• Differences between ESTs and EBP • Ways to close the gap between treatment and practice • There are times when psychotherapy makes clients worse.
2	Brown, J. (2015). Specific techniques vs. common factors? Psychotherapy integration and its role in ethical practice. <i>American Journal of Psychotherapy</i> , 69(3), 301-316.	Methodology Theoretical article/literature review/qualitative research Aim To explore major issues related to the evidence-based literature with regard to specific techniques and common factors	• Increasing evidence that supports common factors provides validity for the psychotherapy integration movement.
3	Katsikis, D. (2014). Evidence-based research: The importance for the present and future of evidence-based practice. <i>Journal of Evidence-Based Psychotherapies</i> , 14(2), 259-270.	Methodology Theoretical article/literature review/qualitative research Aim To offer further support to the concepts of evidence-based research and EBP	• Treatment packages could be tested across different types of theories given that practice should be accompanied by a general theory of concepts, a classificatory schema of problems, a theory of problems and a theory of change.
4	Harris, J. E., Kelley, L. J., & Shepard, L. M. (2015). Multitheoretical psychotherapy for depression: Integrating strategies from evidence-based practices. <i>Journal of Psychotherapy Integration</i> , 25(4), 353-367.	Methodology Theoretical article/literature review/qualitative research Aim To propose multi-theoretical psychotherapy for depression as an EBP in psychology	• Multi-theoretical psychotherapy for depression describes 12 clinical hypothesis and 45 key strategies to help psychotherapists make treatment decisions based on individual client characteristics.
5	Lindgren, O., Folkesson, P., & Almqvist, K. (2010). On the importance of the therapist in psychotherapy: A summary of current research. <i>International Forum of Psychoanalysis</i> , 19, 224-229.	Methodology Theoretical article/literature review/qualitative research Aim To highlight the importance of the psychotherapist in psychotherapy	• There is a plea for a comprehensive psychotherapist-related 'g-factor' of psychotherapy. • There is a decisive lack of scientific knowledge about the interaction between the psychotherapist, the client and the therapeutic relationship.

No	Reference	Methodology and aim	Core findings
6	Stiles, W. B., Hill, C. E., & Elliott, R. (2015). Looking both ways. <i>Psychotherapy Research</i> , 25(3), 282-293.	Methodology Theoretical article/literature review/qualitative research Aim A retrospective look at the past 25 years' publications in psychotherapy research, followed by looking at what the next 25 years may have in store	• The controversial persistence of the Dodo verdict • The connection between process and outcome • The move towards methodological pluralism • The politicisation of the field around EBP and treatment guidelines
7	Beutler, L. E. (2014). Welcome to the party, but... <i>Psychotherapy</i> , 51(4), 496-499.	Methodology Commentary/theoretical article/literature review/qualitative research Aim To highlight that integration rather than amalgamation captures the complexity of psychotherapy better	• Common factors should be considered within the research definition of psychotherapy. • There are important characteristics of the participants that are not captured in either the client's diagnosis or the intervention that the psychotherapist uses that affect outcome. • Common factors should not be equated to nonspecific factors as this would exclude a list of moderating variables in psychotherapy that produce specific and differential effects. • ESTs should not be equated to EBP.
8	Constantino, M. J., & Bernecker, S. L. (2014). Bridging the common factors and empirically supported treatment camps: Comment on Laska, Gurman, and Wampold. <i>Psychotherapy</i> , 51(4), 505-509.	Methodology Commentary/theoretical article/literature review/qualitative research Aim To offer potential future research directions that can help elevate the scientific credibility of the common factors model and allow common factors and ESTs researchers to unite in uncovering clinical change mechanisms	• If researchers want their work to be taken seriously and incorporated into practice, it is not enough to say that the presence of a supportive psychotherapist or hopeful expectations of change is associated with symptom improvement; it is necessary to say why and to develop evidence for those change mechanisms. • The study of change mechanisms would benefit and advance the goals of both common factors and EST approaches.
9	Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. I., & Latzman, R. D. (2014). Why ineffective psychotherapies appear to work: A taxonomy of causes of spurious therapeutic effectiveness. <i>Perspectives</i>	Methodology Theoretical article/literature review/qualitative research Aim To address the error in human reasoning, namely that practitioners assume that they can rely on	• Twenty-six causes of spurious therapeutic effectiveness (CSTEs) are described across three overarching categories: 1) perception of client change in its actual absence; 2) misinterpretation of actual client change stemming from extra-therapeutic

No	Reference	Methodology and aim	Core findings
	on <i>Psychological Science</i> , 9(4), 355-387.	informal clinical observations to infer whether treatments are effective	factors; and 3) misinterpretation of actual client change stemming from non-specific treatment factors. Addressing the CSTE's may narrow the science-practice gap and foster a need for methodological safeguards afforded by EBP.
10	Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. <i>American Psychologist</i> , 65(1), 34-49.	Methodology Theoretical article/literature review/qualitative research Aim To delineate training implications regarding harmful effects associated with psychotherapy	Additional guidelines for the prevention and repair of harmful impacts can be derived from psychotherapy research on process variables (e.g. techniques and relationships) and participant variables (e.g. client and psychotherapist).
11	Barlow, D. H. (2010). The case of Hope: "Evidence-based practice" (EBT) in action. <i>Pragmatic Case Studies in Psychotherapy</i> , 3(4), 50-62.	Methodology Commentary/single-case study/mixed-methods research Aim Provides commentary on a single-case study publication illustrating how Paul Clement, an experienced psychotherapist, integrates EBP into the realities of clinical practice	- Shortcomings are currently endemic in the profession of psychology related to the choice of psychological intervention, the understanding of the role of non-specific factors and the use of assessments within psychotherapy. - A distinction between psychological treatments and psychotherapy is proposed. - There is an increased need for guidelines on how to integrate EBP into the realities of clinical practice.
12	Reiter, M. D. (2010). Hope and expectancy in solution-focused brief therapy. <i>Journal of Family Psychotherapy</i> , 21, 132-148.	Methodology Theoretical article/literature review/qualitative research Aim To explore how the therapeutic factor 'hope and expectancy' plays a role in solution-focused brief therapy (SFBT)	- It is commonly accepted that hope and expectancy factors account for roughly 15% of outcome in psychotherapy. - SFBT is designed to incorporate common factors to help clients develop solutions that increase their expectancy of change and their hope for a positive outcome.
13	Wampold, B. E., & Bhati, K. S. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. <i>Professional Psychology: Research and Practice</i> , 35(6), 563-570.	Methodology Theoretical article/literature review/qualitative research Aim To provide a historical examination of EBP movements	EBP and EST movements are potent forces that affect the practice of psychotherapy and have the potential to mandate the types of treatments psychotherapists conduct.

No	Reference	Methodology and aim	Core findings
14	Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. <i>American Psychologist</i> , 63(3), 146-159.	Methodology Theoretical article/literature review/qualitative research Aim To highlight issues in the research-practice debates as a backdrop for rapprochement	• Evidence-based movements tend to ignore aspects of psychotherapy that have been shown to be related to outcome, such as variation among psychotherapists, the relationship and other common factors. • Both research and practice contribute to our knowledge base and provide information that can be used more readily to improve client care and, in the process, reduce the perceived and real gap between research and practice. • Regarding research, more work is needed on the mechanisms of change – not correlated to change alone, but rather to explanations of how psychotherapy works. • Researchers can do more to identify moderators of treatments and how they make a difference. • Regarding practice, it is recommended to monitor treatments with systematic assessments.
15	Winston, A., McCullough, L., & Laikin, M. (1993). Clinical and research implications of patient-therapist interaction in brief psychotherapy. <i>American Journal of Psychotherapy</i> , 47(4), 527-539.	Methodology Multiple case studies/secondary data analysis/qualitative research Aim To illustrate transference interpretations and client response as examples of change episodes through five clinical case vignettes	• A better understanding of mechanisms of change can be obtained by measuring the quality of process interactions and the context in which change episodes occur. • Transference interpretations followed by affect are associated with a positive outcome, while interpretations and clarifications followed by client defensive behaviours correlate with poor outcome. • An affective response to a transference interpretation should serve as an empirical marker to the clinician that he/she is on the right track. • Repeated defensive behaviours by the client should alert the psychotherapist to consider a change in approach.

No	Reference	Methodology and aim	Core findings
16	Margison, F. R., Barkham, M., Evans, C., McGrath, G., Clark, J. M., Audin, K., & Connell, J. (2000). Measurement and psychotherapy: Evidence-based practice and practice-based evidence. <i>British Journal of Psychiatry</i> , 177, 123-130.	Methodology Theoretical article/literature review/qualitative research Aim To review the developments in measurement relevant to psychotherapy	• Highly defensive clients generally have a lower level of object relations, less psychological flexibility and diminished access to feelings. • Modern methods of measurement can support EBP for psychological treatments. • Modern methods of measurement support PBE, a complementary paradigm to improve clinical effectiveness in routine practice via the infrastructure of practice research networks.
17	Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. <i>Psychotherapy Research</i> , 20(2), 123-135.	Methodology Theoretical article/literature review/qualitative research Aim The author describes and evaluates four types of CPRs	• CPR should allow for multiple complementary strategies for identifying key causal change processes in psychotherapy as well as multiple lines of evidence for testing these change processes. • What is most needed is systematic methodological pluralism, requiring all lines of evidence to provide a more solid foundation for the EBP of psychotherapy. • Different reviewers of CPR approaches will undoubtedly evaluate them differently: Qualitative researchers can be expected to favour helpful factors and significant event designs, while quantitative researchers would be most likely to prefer process-outcome and sequential process designs.
18	Paley, G., & Lawton, D. (2001). Evidence-based practice: Accounting for the importance of the therapeutic relationship in UK National Health Service therapy provision. <i>Counselling and Psychotherapy Research</i> , 1(1), 12-17.	Methodology Theoretical article/literature review/qualitative research Aim To argue that different models of psychotherapy result in broadly similar outcomes and that the therapeutic relationship is the most important factor in relation to outcome	• It is suggested that both the implementation of EBP and the development of PBE need to account fully for the primacy of the therapeutic relationship. • When a client feels accepted and understood, therapeutic change will follow. • There is a need for more qualitative and process research that taps into the unique experiences of psychotherapy participants. • More sophisticated research methodologies are required to determine how to combine both

No	Reference	Methodology and aim	Core findings
			empirically supported treatments and empirically supported relationships.
			• We have to accept that we currently do not know exactly how psychotherapy works. • The challenge to researchers, trainees and practitioners is to embrace diversity as different manifestations leading to the primacy of the therapeutic relationship.
19	Madill, A., & Barkham, M. (1997). Discourse analysis of a theme in one successful case of brief psychodynamic-interpersonal psychotherapy. <i>Journal of Counseling Psychology</i> , 44(2), 232-244.	Methodology Case study/literature review/qualitative research Aim To introduce discourse analysis as a fruitful approach to psychotherapy CPR (with supporting case extracts)	• Socio-cultural considerations are argued to be an essential element in understanding the client's particular dilemma. • The discursive analysis, therefore, offers an understanding of therapeutic process based on a view of language use and cultural meanings, rather than viewing mechanisms of change as hidden within the client's head.
20	Kolden, G. G. (1996). Change in early sessions of dynamic therapy: Universal processes and the generic model of psychotherapy. <i>Journal of Consulting and Clinical Psychology</i> , 64(3), 489-496.	Methodology Case studies/quantitative research Aim To highlight the usefulness of the generic model of psychotherapy in the evaluation of change processes in the context of dynamic therapy	• Change in early sessions of dynamic therapy is fostered by the contributions of technical (e.g. operations), intrapersonal (e.g. openness-involvement) and interpersonal (e.g. bond) factors. • Supportive techniques should be used in early sessions before the use of interpretive techniques. • Early use of interpretive techniques in dynamic therapy leads to regression, resistance, premature termination and generally poorer outcome. • Clients seem to respond more productively early in dynamic therapy to experiential interventions that facilitate self-reflection, here-and-now exploration and discovery.
21	Henry, W. P. (1996). Structural analysis of social behavior as a common metric for programmatic psychopathology and psychotherapy research. <i>Journal of</i>	Methodology Theoretical article/literature review/qualitative Research	• SASB fosters cumulative, theory-driven research by permitting problem-treatment-outcome congruence. • A generic interpersonal model of psychotherapy is proposed that theoretically links all these elements.

No	Reference	Methodology and aim	Core findings
	<i>Consulting and Clinical Psychology</i> , 64(6), 1263-1275.	Aim Describes the use of the structural analysis of social behaviour (SASB) applied to programmatic psychodynamic-interpersonal psychotherapy research	SASB can also be seen as a more theory-neutral, descriptive language of interpersonal behaviours for the exploration of common factors and change processes that encompass other traditions.
22	Heatherington, L., Friedlander, M. L., & Greenberg, L. S. (2005). Change process research in couple and family therapy: Methodological challenges and opportunities. <i>Journal of Family Psychology</i> , 19(1), 18-27.	Methodology Theoretical article/literature review/qualitative research Aim A discussion of five critical needs regarding change process mechanisms in the field of couple and family therapy	- There is more theory-based research on change mechanisms, more work on systems-level alliance measurement and more attention to cognition and emotion as well as to behavioural interaction in couple and family therapy. - Psychotherapists have more tools available to study change processes, but they fail to use them consistently or wisely. - There is reason to be optimistic about the trajectory and potential for clinically rich, theoretically driven CPR.
23	Greenberg, L. S. (1986). Change process research. <i>Journal of Consulting and Clinical Psychology</i> , 54(1), 4-9.	Methodology Theoretical article/literature review/qualitative research Aim To emphasise that research on change processes is needed to help explain how psychotherapy produces change	- To explain processes of change, it will be important to measure three types of outcomes, namely: 1) immediate; 2) intermediate; and 3) final. - These three outcomes should be measured on three levels of process, namely: 1) speech acts; 2) episode; and 3) relationship. - The assumption that all processes have the same meaning needs to be dropped and context-sensitive process research needs to be developed. - It is recommended that speech acts need to be viewed in the context of the types of episodes in which they occur, and episodes need to be viewed in the context of the type of relationship in which they occur. - The use of a battery of process instruments is recommended in order to measure process patterns in context and to relate these to outcomes.

No	Reference	Methodology and aim	Core findings
24	Knobloch-Fedders, L. M., Elkin, I., & Kiesler, D. J. (2015). Looking back, looking forward: A historical reflection on psychotherapy process research. <i>Psychotherapy Research</i> , 25(4), 383-395.	Methodology Theoretical article/literature review/qualitative research Aim To review the current state of the field of psychotherapy process research in order to address methodological and conceptual issues and to provide recommendations to advance scholarship in this field	• There is a need for a more differentiated conceptualisation of the therapeutic alliance. • More research is needed on the initial investigation of key events in the change process. • The change process paradigm emphasises that the dichotomy between process and outcome must be transcended by focusing directly on change events occurring within sessions. • Precise, theoretically meaningful units of the change process should be examined. • To find the effective ingredients of psychotherapy, discovery-oriented studies of significant in-session change events are required. • The therapeutic change process should be conceptualised as a system of bidirectional influence and reciprocal transactions. • A valid understanding of psychotherapy requires measurements collected from multiple perspectives, including client, psychotherapist and external observers. • A taxonomy of temporal scoring units which describes the multiple durations in which significant therapeutic events occur is needed. • Researchers should use measures that assess trans-theoretical commonalities of the psychotherapy process, in addition to measures that address theoretically specific process components. • Psychotherapy change process must be described in ways accessible to both researchers and clinicians.

No	Reference	Methodology and aim	Core findings
			• New statistical methods are needed to study the complex and recurring patterns of the therapeutic process.
25	Pachankis, J. E., & Goldfried, M. R. (2007). On the next generation of process research. <i>Clinical Psychology Review</i> , 27, 760-768.	Methodology Review article/theoretical article/literature review/qualitative research Aim To briefly review state-of-the-art psychotherapy research	• The increasing prevalence of RCTs has contributed to the continuing gap between clinicians and researchers. • Process research methodologies and statistical approaches have become increasingly more sophisticated and should be considered alongside RCTs as the ‘gold standard’ against which psychotherapy research is judged. • Methodologies should allow for greater clinician-researcher collaboration. • A combination of designs can come closer than the RCT design to capture clinical realities and to ultimately advance better therapeutic interventions.
26	Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. <i>Psychotherapy Research</i> , 21(5), 497-509.	Methodology Conceptual theoretical article/literature review/qualitative research Aim To develop a coding system and method for assessing innovative moments in psychotherapy	• An innovative moments coding system (IMCS) is presented as a method for the assessment of innovative moments in psychotherapy. • The theoretical background and coding procedure of the IMCS are discussed. • Innovative moments are regarded as novel to the client’s problematic self-narrative as verbalised during the course of psychotherapy. • It is suggested that common factors or common principles shared by all psychotherapies seem to be the main processes through which change occurs.
27	Smith, E. C., & Grawe, K. (2003). What makes psychotherapy sessions productive? A new approach to bridging the gap between process research and practice. <i>Clinical</i>	Methodology Empirical study/statistical analysis/quantitative research Aim To suggest a new strategy for bridging the gap between psychotherapy process research and	• A general theory of change provides practitioners with a general view of how and why clients change, offering practitioners a reliable framework guiding decision making during treatment selection.

No	Reference	Methodology and aim	Core findings
	<i>Psychology and Psychotherapy</i> , 10, 275-285.	practice	• Mini-theories are required to assist practitioners with session-to-session and moment-to-moment decisions that they have to make constantly. • These mini-theories, smaller in scope, should provide guidelines on how to deal most effectively with commonly arising situations in psychotherapy.
28	Garfield, S. L. (1990). Issues and methods in psychotherapy process research. <i>Journal of Consulting and Clinical Psychology</i> , 58(3), 273-280.	Methodology Theoretical article/literature review/qualitative research Aim To provide a discussion on problems and issues in process research in psychotherapy	• It is more desirable to evaluate both process and outcome in the same study and not to study them in separate studies. • Due to the complexity of the combined study of process and outcome, researchers often separate these two concepts in their studies. • CPR is an attempt to understand process in the context of clinically meaningful units. • The idea is to study psychotherapy process or significant events that produce change during the course of psychotherapy and not to separate outcome and process.
29	Hill, C. E., Nutt, E. A., & Jackson, S. (1994). Trends in psychotherapy process research: Samples, measures, researchers, and classic publications. <i>Journal of Counselling Psychology</i> , 41(3), 364-377.	Methodology Theoretical article/review study/qualitative research (including low-level quantitative elements) Aim To explore trends in psychotherapy process research by examining publications in two psychotherapy process journals over a period of 15 years	• Most attempts at process research did not last long as researchers developed measures in one study that they abandoned in subsequent studies with no other researchers using the newly developed measures thereafter. • Process research is defined as studies examining within-session interactions in face-to-face treatment between psychotherapists and clients. • Outcome research is defined as studies examining the global effects of treatment or changes occurring as a result of treatment. • Process-outcome research is defined as studies examining at least one aspect of both process and outcome as defined above.

No	Reference	Methodology and aim	Core findings
30	Marmar, C. R. (1990). Psychotherapy process research: Progress, dilemmas, and future directions. <i>Journal of Consulting and Clinical Psychology</i> , 58(3), 265-272.	Methodology Conceptual theoretical article/literature review/qualitative research Aim To provide a review of the paradigm shift in psychotherapy process research towards sequentially patterned, significant change episodes	• It is recommended that a centralised archive of significant change events be developed to study psychotherapy process. • Change processes can be studied on four levels organised hierarchically from small, discrete units to longer-term patterns, namely content, speech acts, episodes and relationships. • Configurational analysis organises change process on three levels, namely states, role relationships and information processing. • The tendency to view process and outcome as separate domains has been replaced by studies focusing on the process-outcome relations and a redefinition of outcome-process.
31	Llewelyn, S., & Hardy, G. (2001). Process research in understanding and applying psychological therapies. <i>British Journal of Clinical Psychology</i> , 40, 1-21.	Methodology Review study/literature review/qualitative research Aim To demonstrate reasons why process research has to be undertaken in order to enhance therapeutic effectiveness	• Process research in psychotherapy can be divided into three broad types, namely exploratory studies, hypothesis testing and theory development. • Descriptive studies in process research have provided a more in-depth understanding of the process of psychotherapy, but have failed to reliably indicate the process-outcome link. • Comparative studies in process research have been scarce. • There is a need for more studies linking models of change tracking therapist responsiveness.
32	Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. <i>Journal of Consulting and Clinical Psychology</i> , 58(3), 288-294.	Methodology Review study/literature review/qualitative research Aim To discuss recent trends in literature on exploratory in-session process research	• It is still unclear how process is linked to distal outcomes. • There is a need for methods determining the influence of specific therapeutic techniques or events on session or treatment outcomes. • More research is needed specifying the interaction between therapeutic techniques and therapeutic

No	Reference	Methodology and aim	Core findings
			relationship variables and on how they influence treatment outcome. • More research is also required explaining how extra-therapeutic events interact with in-session events to produce change. • The timing of therapeutic interventions as well as the readiness of clients to change needs to be studied in more detail.
33	Woolley, S. R., Butler, M. H., & Wampler, K. S. (2000). Unraveling change in therapy: Three different process research methodologies. <i>The American Journal of Family Therapy</i> , 28, 311-327.	Methodology Conceptual theoretical article/literature review/qualitative research Aim To present and evaluate three different process research methodologies	• Process research investigates interactional sequences between clients and psychotherapists. • The therapist-client interaction provides the context in which the content of psychotherapy is embedded and that assists in mediating outcomes. • Three different process research methodologies are grounded theory, change events analysis and experimental manipulation. • There is a need for more process research linking specific psychotherapist behaviours to micro- and macro client outcomes. • It is strongly recommended that different methodologies must be integrated to provide more robust findings.
34	Rhodes, P. (2011). Why clinical psychology needs process research: An examination of four methodologies. <i>Clinical Child Psychology and Psychiatry</i> , 17(4), 495-504.	Methodology Theoretical article/literature review/qualitative research Aim To advocate process research as a valid source of evidence in clinical psychology	• Process research focuses on <i>why</i> and <i>how</i> psychotherapy works across the course of treatment and within the details of interactions between psychotherapists and clients. • Process research is very much in line with the aims set forth within the scientist-practitioner model. • There is a need for increased collaboration and interaction between researchers and practitioners. • Researchers should look more to practitioners for research questions, and practitioners should consult

No	Reference	Methodology and aim	Core findings
35	Shoham-Salomon, V. (1990). Interrelating research processes of process research. <i>Journal of Consulting and Clinical Psychology</i> , 58(3), 295-303.	Methodology Conceptual theoretical article/literature review/qualitative research Aim To provide a conceptual framework for studying process variables that integrate theory-driven and discovery-oriented strategies in a cyclical manner from a systematic perspective	researchers on methodological considerations to support their own studies. The cyclic approach within the ecologically oriented research paradigm recommends that inductive inquiry feeds deductive research, which in turn guides induction in ongoing perpetual circle of mutual enrichment.
36	Elliott, R. (1983). Fitting process research to the practicing psychotherapist. <i>Psychotherapy: Theory, Research and Practice</i> , 20(1), 47-55.	Methodology Theoretical article/literature review/qualitative research Aim To make the prediction that new research approaches will close the gap significantly between psychotherapy process research and the practice of psychotherapy	- It is a more clinically relevant question to determine if a therapeutic intervention occurs in a clinically appropriate context than it is to determine if a therapeutic intervention occurs or not. To enable this, taxonomies of intervention contexts are required. - In order for psychotherapy process research to advance, it is necessary to determine key, critical, decisive or significantly helpful or harmful events in psychotherapy and to understand how these events relate to psychological change. - There is also a need for more systematic case studies.
37	Davis, I. P., & Reid, W. J. (1988, May). Event analysis in clinical practice and process research. <i>Social Casework: The Journal of Contemporary Social Work</i> , 298-306.	Methodology Review study/literature review/qualitative research Aim To review literature in an attempt to demonstrate how therapeutic events are used in clinical practice and process research	- All types of clinical events begin with a marker that indicates that the client is ready to work on a certain task. - The marker is followed by an intervention which activates a therapist-client interaction, which is followed by a certain reactive behaviour experienced by both client and psychotherapist as a natural ending to the sequence. - There is a need for practitioner-based event-analysis systems. - Event analysis has a dual focus as it attempts to capture what is simultaneously unique and common about an event.

No	Reference	Methodology and aim	Core findings
38	Watson, J. C., & McMullen, E. J. (2016). Change process research in psychotherapy. In K. Olson, R. A. Young, & I. Z. Schultz (Eds.), <i>Handbook of qualitative health research for evidence-based practice</i> (pp. 507-525). New York: Springer.	Methodology Chapter in a book/literature review/qualitative research Aim To review literature on CPR in psychotherapy	• It appears as if practitioners are more interested in the uniqueness of events, while researchers focus mostly on the commonalities of events across cases. • Qualitative research highlights aspects of the psychotherapeutic process not evident from clinical trials or from quantitative methods alone. • The philosophical frameworks of experiential and humanistic psychotherapies fit well with that of qualitative research methodologies emphasising clients' reflexivity, autonomy and capacity for growth.

CHAPTER 3

MANUSCRIPT 2

Developing a New Change Process Research Approach to Psychotherapy

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Abstract

The intention with this manuscript is to report the process of developing a new change process research (CPR) approach to psychotherapy. To realise this aim, an intervention research design was followed. Findings from a systematic review on CPR was critically analysed and synthesised in order to develop a pilot version of the new CPR approach to psychotherapy. This pilot version was then critically evaluated by psychotherapy researchers and practitioners who met strict inclusion criteria. Thematic analysis was conducted on the data obtained from their critical evaluations, and their feedback was used to further refine the approach. Based on the findings of this study, a new CPR approach to psychotherapy, known as the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP), was developed and will be presented here. In general, this approach aims to conceptualise change processes in the context of psychotherapy and is trans-theoretical and trans-diagnostic in nature. By following a stepwise intervention design process, it was possible to develop the SP-CPP which will be presented by means of two visual illustrations, namely a broad overview for practitioners and a more detailed overview for psychotherapy researchers. However, the authors recommend that, in order to narrow the researcher-practitioner gap, increased collaboration is required between psychotherapy researchers and practitioners. To this end, future research should explore the practical application of the SP-CPP with different clients presenting with a variety of problems and from different treatment approaches, making adjustments as and when required. This might result in specific change process approaches for specific presenting problems and for specific age groups or populations.

Keywords: change process research, development and design methodology,

intervention research design, psychotherapy, scientist-practitioner

Introduction

Psychotherapy research has focused extensively on ‘what works in general’ and ‘what works in particular’. Regarding ‘what works in general’, research generally refers to evidence-based therapy relationships. A meta-analysis (Norcross & Wampold, 2011a) yielded eleven statistically significant relevant aspects, namely alliance in individual psychotherapy; alliance in youth psychotherapy; alliance in family therapy; cohesion in group therapy; empathy; collecting client feedback; goal consensus and collaboration; positive regard; congruence/genuineness; repairing alliance ruptures; and managing countertransference. In as far as ‘what works in particular’ is concerned, research generally refers to effective methods of adapting treatment to the individual. In this regard, Norcross and Wampold (2011a) identified eight statistically significant relevant aspects, namely resistance/reactance; stages of change; preferences; culture; coping style; expectations; attachment style; and religion and spirituality. A comprehensive understanding of effective (and ineffective) psychotherapy should consider all of these determinants and their optimal combinations (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Goldfried, 2013; Goldfried & Davila, 2005; Muran & Barber, 2010; Norcross, 2002; Norcross & Wampold, 2011b; Stewart & Chambless, 2007; Wampold, 2001).

It is thus essential that practice and treatment guidelines should explicitly address psychotherapist behaviours and qualities that promote a facilitative therapy relationship along with the therapeutic techniques or approaches indicated for the identified problems that clients present with. In this regard, it is important to mention two leading authorities in evidence-based practices, namely the National Institute of Mental Health (NIMH, 2016) in the United States and the National Institute of Health and Clinical Excellence (NICE, 2016) in the United Kingdom. The main focus of these organisations is to provide guidelines based on the best available global research databases to indicate which particular types of

psychotherapy are empirically supported in the treatment of specific disorders. For example, these organisations indicate that specified psychotherapy procedures, such as interpersonal psychotherapy or cognitive behavioural therapy, are recommended in the treatment of depression or that dialectical behaviour therapy and schema therapy are recommended for the treatment of borderline personality disorder (NICE, 2016; NIMH, 2016; Stewart & Chambless, 2007).

Greenberg and Newman (1996) suggest that psychotherapists should be able to formulate conceptual models of client-change processes and the therapeutic interventions that set these change processes in motion. In order to formulate such models, it is necessary that researchers systematically attend to the process of psychotherapy in order to discover how therapeutic change takes place. This will aid in developing a basic science of psychotherapy.

Psychotherapists need to investigate the actual process of psychotherapy in order to discover certain common factors or specific mechanisms that account for change in different therapeutic approaches. In the past, it seems as if psychotherapists leaned too heavily on theories for answers as to what contributes to therapeutic change (Boswell, 2015; Greenberg, 1999; Knobloch-Fedders, Elkin, & Kiesler, 2015; Wampold, 2001). Given that science proceeds by observation, measurement, explanation and prediction, it is a serious limitation that observation is lacking in many psychotherapy research publications (Greenberg, 1999; Knobloch-Fedders et al., 2015). Consequently, an intensive and rigorous observation of how change takes place is essential to understand what psychotherapy really entails. By observing the process of change, new understandings of what actually occurs can arise, rather than relying on rote theoretical explanations stemming from a favourite, often too strongly held, theory.

This clearly indicates a gap between theory and practice in psychotherapy (known as the scientist-practitioner gap) and as a result of this discrepancy, psychotherapy may be

lacking in terms of effectiveness (Boswell, 2015; Gyani, Shafran, Myles, & Rose, 2014). Consequently, there is a need to develop a methodology that goes beyond experimental manipulation and testing of hypotheses and a move towards the intensive analysis of within-therapy variables. Rather than viewing psychotherapy as a black box, looking only at input and output variables, the complex performance patterns and interaction sequences that constitute psychotherapy need to be monitored and studied (Cook & Campbell, 1979; Elliott, 2010). In other words, psychotherapy ought not to be viewed from a direct linear cause-and-effect assumption, because it fails to adequately consider the complexities of psychotherapy (Heatherington, Friedlander, & Greenberg, 2005). The assumption that there is a relationship between an independent variable (treatment) and a dependent variable (outcome) is difficult to contemplate, unless the complex dynamics that occur between psychotherapist and client and how these dynamics influence both the treatment and the outcome of psychotherapy are taken into account (Elliott, 2010). The problem is that a number of psychotherapists practice each day without having a clear systematic or rigorous way of checking their implicit, or even explicit, assumptions that certain interventions help or work in particular ways at particular times. The implication is that practitioners are often left with questions regarding the effectiveness of psychotherapy, for example: *Did psychotherapy help? If it helped, how did it help? What actually happened in psychotherapy to make a difference? What exactly, in what I did, helped? What changed? Will the change last?*

If psychotherapy is a true investigative science, then researchers would ask and answer the abovementioned questions. Arguably, psychotherapy will never be a deterministic science in which a specific process or outcome can be predicted for a particular individual. It is, however, important to emphasise that even though the predictive validity of specific interventions for specific problems or disorders might be low, there is still predictive value in

using certain therapeutic techniques or approaches for certain presenting problems or disorders (NICE, 2016; NIMH, 2016).

It could also be that some or other order in the complexity of the psychotherapeutic process has hitherto not been observed or described. In order to observe and describe these complexities, psychotherapists (in practice and research) need to find patterns in the content (what is being done) and process (how it is done) of psychotherapy practice (Doyle, 2011; Yalom, 2005).

Change process research (CPR) was introduced more than 20 years ago and refers to research focusing on identifying, describing, explaining and predicting the effects of the process that brings about therapeutic change (Elliott, 2010). CPR provides a necessary complement to randomized clinical trials (RCTs) and other forms of efficacy research. Current research on CPR indicates four major approaches to identifying and evaluating psychotherapy change processes, namely: 1) the quantitative process-outcome design; 2) the qualitative helpful-factors design; 3) the micro-analytic sequential-process design; and 4) the significant events approach (Elliott, 2010).

Although CPR is of fundamental importance for advancing the science of psychotherapy, some approaches (e.g. sequential process) have been neglected, whereas some might be regarded as being overused (e.g. process-outcome design). Elliott (2010) holds that most researchers seem to restrict themselves to a single genre to the exclusion of the others and have rarely used more than one genre in a given study. According to him, though, the principle of multiple operations suggests that it is important to have a range of methods to apply to a particular measurement situation – each method with different particular strengths and weaknesses.

The first approach, quantitative process-outcome design, connects in-session processes with post-therapy outcomes by sampling key processes from one or more therapy sessions

and using those to predict post-therapy outcomes (Orlinsky, Rønnestad, & Willutzki, 2004). This is not only the most popular CPR but also the most common type of psychotherapy research. The qualitative helpful-factors design, the second approach, is based on the premise that the psychotherapist asks clients what they found helpful (and/or unhelpful) in psychotherapy. This model is based on grounded theory (Charmaz, 2014), interpretative phenomenological analysis (Smith, Flowers, & Larkin, 2009) and consensual qualitative research (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005). There are two options available to use in order to identify helpful and/or unhelpful factors in psychotherapy from the client's perspective, namely an interview (change interview; Elliott, Slatick, & Urman, 2000) and a post-session questionnaire known as the Helpful Aspects of Therapy (HAT; Llewelyn, 1988). Thirdly, micro-analytic sequential-process design refers to a micro-analysis of sequential dependencies among successive client and psychotherapist responses. In other words, it focuses on turn-to-turn in-session interactions between client and psychotherapist. It is a process in which the psychotherapist talks and the client talks, and their responses are analysed and scored. The analysis and scoring is low-level quantitative in nature, meaning that codes used for client and psychotherapist responses are assigned by means of a relatively small number of categories or rating scores (Sachse, 1992; Wiseman & Rice, 1989). It primarily involves establishing relationships among process variables themselves (Elliott, 2010). Lastly, the significant events approach combines multiple elements of the more basic approaches to provide more comprehensive strategies for understanding how change occurs in psychotherapy. In this mixed-method approach, qualitative and quantitative data collection is combined and it is generally done within an interpretive, theory-building framework (Elliott, 2010). The focus is on important moments in psychotherapy, which may include insight (Elliott, 1983; Elliott, Shapiro, Firth-Cozens, Stiles, Hardy, Llewelyn, & Margison, 1994), empowerment (Timulak & Elliott, 2003), resolution of therapeutic tasks (Greenberg,

1984) and other problematic moments (Davis, Elliott, Davis, Binns, Francis, Kelman, & Schröder, 1987). Examples of significant events approaches are task analysis (Greenberg, 2007; Pascual-Leone, Greenberg, & Pascual-Leone, 2009; Rice & Greenberg, 1984), comprehensive process analysis (Elliott et al., 1994) and assimilation analysis (Stiles, Elliott, Llewelyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990). In short, it simultaneously attempts to build and test theories (Elliott, 2010).

A critical discussion of the abovementioned four CPR approaches could only be found in one article, that of Elliott (2010), by the time this study was conducted. This is a serious limitation given the strong emphasis on evidence-based practice in psychotherapy. From the available literature, there is a vagueness regarding the significant events approach in particular, which limits the practical utility thereof. Furthermore, the researcher found other important CPR literature and concepts that are not included in the four existing CPR approaches. To address this limitation, the researcher aims to not only integrate the four existing CPR approaches but also to include other relevant CPR concepts from a systematic review of CPR (see Chapter 2) and to develop a new CPR approach to psychotherapy.

The potential contribution of this study is that a new CPR approach to psychotherapy will be developed, enabling psychotherapy researchers and practitioners to conceptualise change process in a scientific evidence-based framework. The implication thereof can be that the effectiveness of psychotherapy may be enhanced within a change process framework that has the potential to bridge and/or narrow the scientist-practitioner gap. Through the increased collaboration between psychotherapy researchers and practitioners, the possibility also exists for the integration of practice-based evidence complementary to evidence-based practice.

The main aim of this manuscript was to develop a new CPR approach to psychotherapy. The specific objectives to realise this aim was to 1) develop a pilot version of the new CPR approach to psychotherapy based on the findings from the systematic review (see Chapter 2);

2) to gather and synthesise experienced psychotherapists' and psychotherapy researchers' critical evaluations of the pilot version; and 3) to refine and/or modify the pilot version based on the findings of the critical evaluation done by experienced psychotherapists and psychotherapy researchers and to present an amended version of the new CPR approach to psychotherapy.

Methodology

In developing a new CPR approach, an intervention research design (De Vos, Strydom, Fouché, & Delport, 2011; Rothman & Thomas, 1994) was followed. Intervention research is a non-experimental approach that is flexible, capitalises on the availability of small samples and accommodates the dynamics of practice conditions (Melnik & Morrison-Beedy, 2012). It can be used where professionals want to integrate knowledge from theory and research with practice experience and wisdom to develop innovative and effective approaches that address the specific needs of particular populations (Comer, Meier, & Galinsky, 2004). This approach aims to be as close to the clinical realities as possible and explicitly values practitioners' insights as part of the attempt to address the practice application of research (Rothman & Thomas, 1994). The intervention research design was developed to provide an integrated perspective for understanding, developing and examining the feasibility (and effectiveness) of innovative human service approaches (Schilling, 1997). It typically encourages researchers and practitioners to work together to design and assess new approaches (Melnik & Morrison-Beedy, 2012). In intervention research, a six-phase process is followed (De Vos et al., 2011; Rothman & Thomas, 1994) to achieve methodological rigor and credible findings. See Figure 1.1 and Table 1.1 in Chapter 1 for a detailed explanation and illustration highlighting the implementation of the intervention research design methodology. It is important to keep in mind that these phases are not linear but often cyclical and iterative (Comer et al., 2004).

Phase one was addressed in Chapter 1. Phase two was addressed in Chapter 2, and the findings culminated in the systematic review of CPR in psychotherapy (see Chapter 2). The synthesis of the findings from Chapter 2 identified a gap in psychotherapy literature regarding CPR and a need to develop a new CPR approach to psychotherapy (the focus of the current chapter, Chapter 3). Phases three and four are addressed in this chapter: (i) Phase three consists of a critical analysis of the findings from Chapter 2 to compile a list of functional or useful elements relating to CPR in psychotherapy; (ii) phase four consists of the identification of key informants and/or experts to critically evaluate the pilot version of the new CPR approach to psychotherapy. In their critical analysis, they were requested, amongst others, to identify the strengths and weaknesses of the pilot version. During the critical evaluation of the pilot version, the key informants were asked to provide their biographic details, as well as to complete a semi-structured questionnaire (see Addendum A).

Phase five of the intervention research design highlights the importance of full-scale empirical testing of the new CPR approach to psychotherapy, but this falls outside the scope of the current chapter and will be presented in Chapters 4 and 5. In these two chapters, the newly developed CPR approach is applied during the psychotherapeutic process of four clients with presenting problems on the anxiety spectrum. Chapter 4 will present two clients treated from a CBT approach, while Chapter 5 will present two clients treated from a schema therapy approach. The dissemination of findings (phase six) is addressed through Chapters 1 to 6 and Manuscripts 1 to 4 of this PhD thesis.

Ethical Considerations

Ethical permission was obtained by the researchers from the Health Research Ethics Committee (HREC) of the North-West University (NWU). The ethics number is NWU-00363-16-A1 and is attached as Annexure A1. Also see the informed consent document completed by the key informants (or experts) attached as Annexure A2.

Sampling

No sample was used during the development of the pilot version of the new CPR approach to psychotherapy, as it was based on the findings from the systematic review presented in Chapter 2. For the identification of key informants, a nonprobability, purposive sample was used. Patton (2002) identified sixteen types of purposive samples and, for the purpose of this study, expert sampling was used. Expert sampling is a technique used when the study requires knowledge from individuals who have particular expertise that is usually required during the exploratory phase of qualitative research to highlight or identify potential new knowledge on an area of interest. According to Patton, expert purposive sampling is particularly useful where there is a lack of empirical evidence in an area and/or a high level of uncertainty.

Regarding the number of key informants (or experts) required, Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, and Grimshaw (2010) recommend the 10 + 3 criterion as a fairly effective guideline as it accounted for 97% of the codes in their study. Similarly, Guest, Bunce, and Johnson (2006) also found that the first 12 interviews elicited 97% of the important codes out of a total of 60 interviews. Therefore, for the purpose of this study, 13 key informants were used, following the 10 + 3 criterion as recommended by Francis et al. (2010) as guideline, which is also in line with the findings reported by Guest et al. (2006). The inclusion criteria for key informants were: 1) at least five years' practical experience post-registration as a psychologist (clinical/counselling/educational/research) with the relevant professional board to be considered as a senior psychologist; 2) completion of at least one additional accredited post-graduate course in recognised evidence-based therapies as reported by NICE (2016) and NIMH (2016); and 3) involvement in a group-based practice and/or academic affiliation with a training institution.

Table 3.1 provides a detailed summary of the biographic information of the key informants. From Table 3.1, it is clear that five are international key informants and eight South African key informants. From the 13 key informants, nine are registered as clinical psychologists, two as counselling psychologists, one as educational psychologist and one as research psychologist. Seven key informants are involved in both practice and research, while five indicated that they are only involved in practice and only one indicated involvement in research only. Years of experience range from nine to 37 years with a mean age of 17 years. Participants allocated an average mark of 75% for the pilot version of the CPR approach (75% for international and 76% for South African participants). This indicates a high degree of agreement in terms of the quality of the pilot version of the SP-CPP.

Table 3.1

Biographic details of key informants

*P	Registration Category	Years of Experience	Research, Practice or Both	International or South African	Mark allocated
1	Counselling Psychologist	13	Both	International	70%
2	Clinical Psychologist	18	Practice	International	80%
3	Clinical Psychologist	16	Practice	International	85%
4	Clinical Psychologist	12	Both	International	80%
5	Clinical Psychologist	10	Practice	International	60%
6	Educational Psychologist	26	Both	South African	75%
7	Clinical Psychologist	10	Both	South African	65%
8	Clinical Psychologist	17	Practice	South African	70%
9	Counselling Psychologist	37	Both	South African	76%
10	Research Psychologist	9	Research	South African	85%
11	Clinical Psychologist	15	Both	South African	70%

*P	Registration Category	Years of Experience	Research, Practice or Both	International or South African	Mark allocated
12	Clinical Psychologist	17	Both	South African	80%
13	Clinical Psychologist	18	Practice	South African	85%

*P = Participant (key informant or expert)

Process Followed in Developing the Pilot Version of the New CPR Approach to Psychotherapy

The findings from the systematic review were used to compile a list of functional or useful elements relating to CPR in psychotherapy (see Table 3.2). From this list, a pilot version of the new CPR approach to psychotherapy was developed.

Systematic review.

Firstly, the findings from the systematic review on CPR in psychotherapy (see Chapter 2) were used as baseline for the development of the pilot version of the new CPR approach to psychotherapy. The findings from the systematic review were critically analysed to identify key themes, strengths and limitations reported in the scientific literature on change process in the context of psychotherapy. From this data, a list of apparently functional or useful elements was compiled. The functional or useful elements were identified from the data extraction table reported in Chapter 2. These elements were considered functional or useful, since they were relevant and published in articles with a high scientific quality as assessed by a panel of reviewers. What made these elements functional or useful was not merely the frequency of the themes but also the significance thereof in relation to the research topic (namely, CPR in the context of psychotherapy). In the following paragraphs, the pilot version of the CPR approach to psychotherapy will be presented as developed exclusively from the findings of the aforementioned systematic review.

The pilot version of the new CPR approach to psychotherapy.

The pilot version of the new CPR approach to psychotherapy, namely the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP), will be presented by way of two figures. Figure 3.1 provides a broad overview of the main elements of the approach. Figure 3.2 presents a detailed overview regarding the pilot version of the SP-CPP.

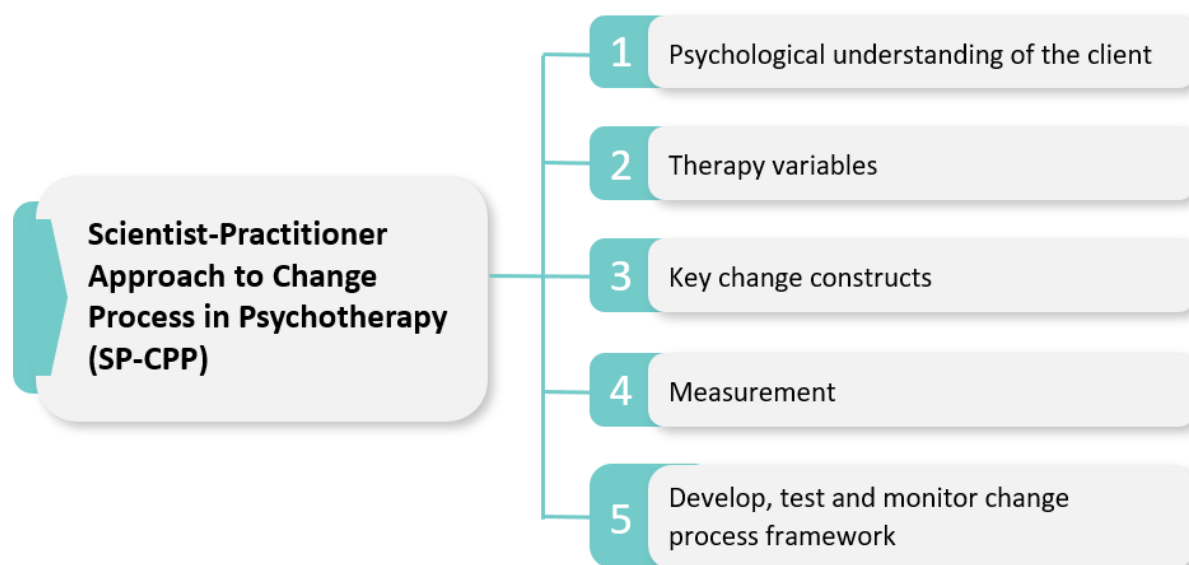


Figure 3.1 A broad overview of the pilot version of the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP)

The first element, psychological understanding of the client, refers to the psychotherapist's ability to formulate a case conceptualisation in which a matching of the idiographic and nomothetic information relevant to the client's case is reflected. The nomothetic information is reflected in the *general model* developed by the psychotherapist for the client, which is a conceptualisation based on a macro-level mainly from official theories on aetiology, psychopathology, psychotherapy and change. The general model is then elaborated on in more depth, when the psychotherapist conceptualises specific models for the particular client.

Specific models are on a micro-level and refer to the psychotherapist's ability to translate official theories into private theories which are also influenced by the

psychotherapist's practical experience, life experience and reflections or case discussions with other professionals. Within the context of conceptualising specific models for the client, the person-of-the-psychotherapist plays an important role and refers to the psychotherapist's personal view of people, pathology and psychotherapy. The integration of the general model and specific model then results in a *case conceptualisation* in which a matching of idiographic with nomothetic information is captured accurately.

Table 3.2

Themes and subthemes from the data extraction phase of the systematic review manuscript

	Theme 1	Theme 2	Theme 3	Theme 4
RESEARCH-RELATED THEMES AND SUBTHEMES	Research Methodology in CPR Quantitative research Qualitative research Mixed-methods research Reviews Theory-building and theory-testing research	Outcome Research	Process Research	Existing CPR Approaches Assimilation of problematic experiences sequences (APES) Case study approaches Conversation analysis Comprehensive process analysis Context-responsive psychotherapy integration (CRPI) List of good moments in therapy The quantitative process-outcome design The qualitative helpful-factors design The micro-analytic sequential-process design The significant events approach
	Theme 1	Theme 2	Theme 3	Theme 4
PRACTICE-RELATED THEMES AND SUBTHEMES	Therapeutic Relationship Therapeutic alliance Alliance ruptures	Therapeutic Techniques	Change Concepts Mediators of change Moderators of change Mechanisms of change Principles of change Extra-therapeutic change	Psychological Understanding of the Client Nomothetic approach Idiographic approach General theories Personal theories Specific theories

(see Chapter 2 for a detailed discussion)

The second element, therapy variables, encompasses relational and technique variables. *Relational variables* mainly refer to empirically supported relationships, while *technique variables* mainly refer to empirically supported treatments. Empirically supported relationships include aspects such as the therapeutic alliance, which refers to the Rogerian principles of empathy, warmth and acceptance. The therapeutic alliance refers to the therapeutic bond and the agreement between the client and psychotherapist about the therapeutic task and goals. As part of empirically supported relationships, it is also important to be mindful of alliance ruptures in the sense that the psychotherapist should be able to identify and repair alliance ruptures and/or misunderstanding events when they occur.

Technique variables encompass empirically supported treatments which refer to those therapeutic techniques that are common amongst different psychotherapies, regardless of theoretical orientation. Examples include maintaining a balance between following and leading (knowing when to contain and when to challenge a client), facilitating corrective experiences (especially corrective emotional experiences), addressing cognitive distortions, using motivational interviewing to increase the client's readiness for change and facilitating meaning-making processes as well as the level of directness of the psychotherapist (knowing when to take on a teaching, confronting, facilitating and supporting role), the importance of timing of techniques and/or interventions and the ability to identify focal dimensions and to determine their 'firing order'.

The third element, key change constructs, encompasses important change constructs required to enable the psychotherapist to have a better understanding of change in the context of psychotherapy. In this regard, it is important to determine the *stage of change (or readiness for change)* of the client, which refers to the psychotherapist being able to determine the client's motivation to change. It is important to consider the client's *cognitive-emotive development* in determining the client's readiness for change. This will also help with

tailoring the psychotherapy to the unique needs and preferences of the client, for example a more cognitive-concrete therapeutic stance versus a more emotive-experiential therapeutic stance. The most important change construct in this regard is that of the *mechanism of change*. This refers to the active ingredients of change or the principles of change and also encompasses the mediators and moderators of change. A conceptualisation of the mechanism of the change thus refers to the psychotherapist's understanding of the key dynamics or processes (also referred to as the nodal point) to focus on in order for change to occur.

The fourth element, measurement, refers to the use of outcome and process measures as part of change monitoring during the process of psychotherapy. *Outcome measures* are typically administered at the beginning and end of a psychotherapeutic process with a client, while *process measures* are administered at frequent intervals during the course of a psychotherapeutic process. Currently, numerous outcome and process measures with good psychometric properties in terms of validity and reliability are readily available for routine use in clinical practice.

The final element encompasses the psychotherapist's ability to develop, test and monitor the change process framework. This process starts with the psychotherapist's ability to *identify significant events* in the psychotherapeutic process with the client. These significant events are also referred to as key moments, decisive moments or change events. In this regard, it is important for the psychotherapist to be able to identify not only helpful factors that work in psychotherapy with a particular client but also to identify hindering and/or harmful factors that could be detrimental to the psychotherapeutic process and should rather be avoided. To further assist the psychotherapist, it is recommended to *identify empirical markers (or themes)* that ought to be the focus of psychotherapy. Upon identifying these empirical markers (or themes), the psychotherapists need to *respond to these in*

evidence-informed ways. Finally, the psychotherapist needs to *monitor the change process framework*.

When the client is responding well to the treatment approach and the psychotherapist can envision change occurring, the psychotherapist adheres to the change process framework as conceptualised and the psychotherapeutic process continues accordingly. This evaluation is based on the clinical judgment of the psychotherapist in combination with client feedback. However, if the clinical judgement of the psychotherapist and/or feedback obtained from the client indicates that the client is not responding well to the treatment approach and change is not envisioned, a different course of action is indicated. This is referred to as ‘case flagging’ and indicates instances where clients are ‘off track’ or when the psychotherapist requires additional supervision and/or other professional input to get ‘back on track’. ‘Case flagging’ also implies that the psychotherapist needs to *re-think* and *amend* the change process framework, which also necessitates a re-assessment and re-formulation of the entire SP-CPP (in particular the case conceptualisation).

Therapist responsiveness is of utmost importance *throughout the process* and refers to the psychotherapist’s ability to act with moment-to-moment awareness and moment-to-moment purpose during psychotherapy. Therapist responsiveness is fostered by the psychotherapist’s ability to practice in a manner that is context relevant, principle driven and tailored to the individual needs and preferences of clients. The literature recommends that psychotherapy should be viewed from different perspectives as a phenomenon that occurs from the time the appointment was made up and until follow-up several months later.

Therefore, the SP-CPP should be conceptualised from different perspectives and at different times. For this reason, it is important to include the perspectives of the client, psychotherapist and observers (if possible or applicable) at different stages throughout the therapeutic process, namely the pre-therapy, within-therapy and extra-therapy stage as well as

during follow-up after termination. Note, too, that this approach has trans-diagnostic and trans-theoretical applications.

Results

Feedback Obtained from Evaluation by Key Informants of the Pilot Version

In conjunction with the findings from the narrative synthesis of the systematic review in Chapter 2, the researcher also integrated the most prominent themes and issues identified from the thematic analysis of the semi-structured open-ended questionnaires completed by the key informants or experts (namely experienced psychotherapists and psychotherapy researchers who met the inclusion criteria) based on their evaluation of the pilot version of the CPR approach to psychotherapy.

Initially, the identified key informants who met the inclusion criteria received an invitation letter to participate in this study. Those who indicated their willingness or interest in participating in this study were then requested to complete an informed consent form (see Appendix A2). On receipt of the duly completed informed consent forms, the key informants were provided with the following: 1) a request for biographic information and a semi-structured, open-ended questionnaire (see Addendum A); 2) a graphic illustration depicting a broad overview of the SP-CPP (see Figure 3.1); 3) a graphic illustration depicting a detailed overview of the SP-CPP (see Figure 3.2); 4) a theoretical explanation of the pilot version of the SP-CPP (see pages 104-110); and 5) a practical application of the pilot version of the SP-CPP by way of a case vignette (see Addendum B). Only fully completed semi-structured, open-ended questionnaires received from the key informants were used during the data analysis phase.

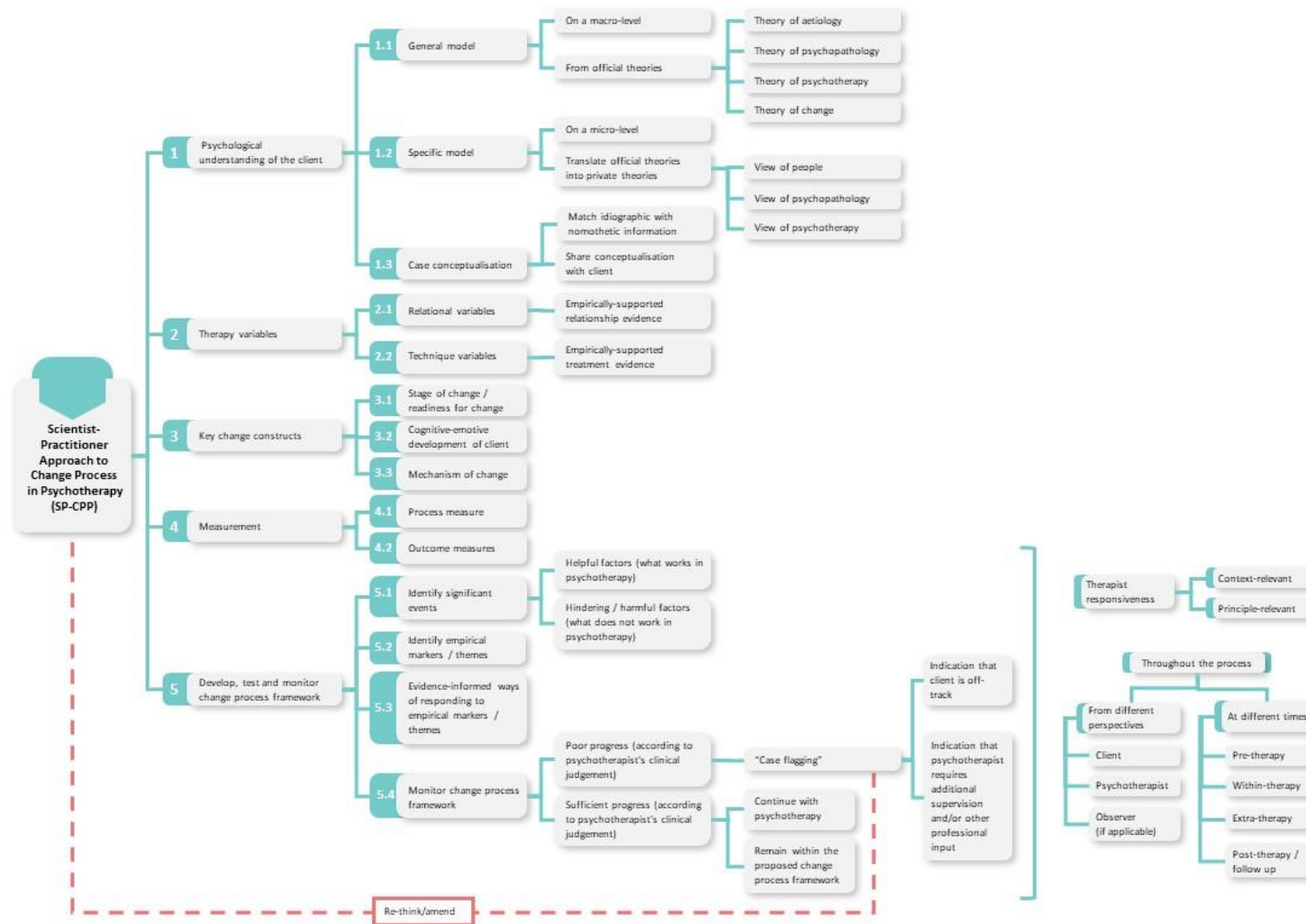


Figure 3.2 A detailed overview of the pilot version of the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP)

The key informants were requested to evaluate this pilot version. Based on their feedback, a thematic analysis was conducted according to the six phases as stipulated by Clarke and Braun (2013), namely: 1) familiarising self with the data by reading and re-reading the data and noting down initial codes; 2) generating initial codes by coding interesting features of the data in a systematic fashion across the entire data set; 3) searching for themes by collating codes into potential themes and gathering all data relevant to each potential theme; 4) reviewing themes by checking whether the theme works in relation to the coded extracts and to the entire data set in order to generate a thematic ‘map’ of the analysis; 5) defining and naming themes to refine the specifics at each theme and the overall story that the analysis tells; and 6) producing the report by selecting vivid, compelling extract examples to include in the final analysis in the manuscript.

From the thematic analysis process, two themes were identified each with subthemes. Theme one focused on the strengths and theme two focused on the perceived weaknesses and/or limitations of the pilot version of the newly developed CPR approach to psychotherapy.

Theme one: Perceived strengths of the approach. The first theme, consisting of four subthemes, refers to the perceived strengths of the pilot version of the SP-CPP. It is clear that the key informants perceived the approach to be a well-structured, systematic scientist-practitioner approach to CPR. They found the approach to be clear, logical and easy to understand. In addition, they perceived that this approach has the potential to encourage psychotherapists’ reflection and their ability to practice with moment-to-moment awareness.

Subtheme one: Good scientist-practitioner approach. The key informants indicated that the approach appears to be an informed model that draws on multiple sources of information. Based on their feedback, it has the potential to provide a sound scientific framework that is trans-theoretical and trans-diagnostic by nature and can be described as a multi-layered

approach with apparent good clinical face validity for practitioners. Furthermore, they also described it as a process-oriented approach which seems deeply grounded in theory that can enable a contextual, holistic understanding of the client in a framework that aims to integrate nomothetic and idiographic information in a meaningful way. According to them, the approach shows promise in as far as it will facilitate the psychotherapist's ability to use evidence-based approaches that might result in arriving at a solution much earlier, adding that the approach seems to provide a clear feedback loop in which pre- and post-feedback is emphasised. Overall, the respondents were of the opinion that this approach has the potential to be useful not only for novice and experienced psychotherapists in practice, but also for psychotherapy researchers.

P1 wrote, "[i]t seems like a well-articulated and informed approach that has good general face validity from a clinician's perspective" while P2 pointed out, "I think the Scientist-Practitioner model is the best practice approach".

P6 said: "The proposed approach is logical and scientifically based and it encapsulates the most prominent elements associated with the Scientist-Practitioner approach to clinical practice and psychotherapy. The integration of both nomothetic and idiographic information for creating a more holistic and contextual understanding of the client and the attention given to relational variables and a collaborative working alliance between psychotherapist and client are laudable and counters criticism directed against the somewhat clinical and impassive nature of the scientific approach to psychotherapy."

P9 pointed out that "[t]his approach can guide psychotherapists in their work with clients but it can also shape further research in the field. The approach can be used by psychotherapists from different theoretical orientations and also with clients with different 'problems'".

Finally, P11 commented, "[i]t offers both novice and experienced psychotherapists with what one could refer to as a checklist, or possibly rather a road map".

Subtheme two: Approach is clear, logical, self-explanatory and easy to understand.

The key informants perceived the approach to be a clear, logical, self-explanatory and well-formulated model. It is also described by the key informants as an approach that seems easy to understand.

P3 gave the following feedback: "... very clear structure, systematic, comprehensive, multi-layered, draws on different theoretical models, and provides a clear feedback loop for exploring potential obstacles to change." This is also highlighted by P9, stating: "I am excited about the approach. It is a comprehensive and complex approach but at the same time simplistic." Finally, P11 pointed out: "The approach has an intuitive logic to it, and lends itself to application by both novice and experienced psychotherapists."

Subtheme three: Approach is well-structured and systematic. The approach is perceived as a very systematic approach offering the potential to provide a general to specific focus in conceptualising psychotherapeutic change. It shows promise as being utilised as a detailed road map which could guide the psychotherapeutic process. Furthermore, it seems to be a very structured and useful way for working in a targeted manner. Finally, it provides a framework that seems comprehensive and thorough.

P4 mentioned: "It provides a well-structured general to specific focus." This is also supported by P11, stating: "It makes sense. The key elements follow each other logically and systematically, and are in general inclusive and comprehensive in terms of their representation of aspects that one would need to consider when doing therapy in a mindful manner." P12 wrote: "I think it is a systematic and clear presentation of the therapeutic process, taking various influences into consideration ... Well researched, integrative and practical." Finally, P13 reflected: "It seems to be a systematic approach to follow change process."

Subtheme four: Approach enables psychotherapists' reflection. According to the key informants, the approach shows potential to stimulate constant awareness of the psychotherapeutic process. Within this framework, reflective practice seems to be encouraged by emphasising the importance of practicing with moment-to-moment awareness and

moment-to-moment purpose. Furthermore, the approach is perceived as allowing sufficient flexibility to include psychotherapists' creativity.

In the words of P1, "I think the attempt to articulate such a process is a useful activity as it supports reflective practice and thinking/talking about change processes in psychotherapy in a trans-theoretical way". This is also supported by P4, stating: "It is a cognitively theoretically orientated practical reflective process."

Theme two: Perceived weaknesses of the approach. In terms of the second theme, the key informants highlighted certain perceived weaknesses and/or limitations of the pilot version of the SP-CPP. This theme is captured by way of two subthemes summarising the key informants' perception that the approach might create the risk of the client assuming a passive role during the psychotherapeutic process and that it might be perceived as being a strong top-down approach.

Subtheme one: Risk of client becoming a passive receiver of treatment. Some of the criticism on the approach is that it lacks emphasis on the client's voice in the approach which might result in a mechanistic way of working with clients. In this regard, the key informants perceived the approach as lacking in terms of the humanistic and collaborative nature of psychotherapy. Consequently, some key informants perceived the approach as over-emphasising the practitioner's role which can create the impression that the psychotherapist is in the expert position with the client being regarded as a passive receiver of a treatment. Finally, some key informants were of the opinion that strengths and human potential were not emphasised sufficiently within this approach.

P1 mentioned: "I wonder if it would be possible or desirable for the approach to incorporate a greater focus on the client's 'voice'..." P6 was of the opinion that "[o]ne of the potential risks of this approach is that the psychotherapist could be regarded as the omnipotent expert who dictates/manages the therapeutic process (treatment) and the client (patient) who becomes a passive receiver of the treatment". P11 also stated that "[t]he

client seems to remain relative silent as the ‘consumer’ or ‘receiver’ of psychotherapy, instead of playing an active role in the process”.

Subtheme two: Appears to be a strong top-down approach. The final subtheme centres around criticism that the approach appears to have a strong top-down emphasis with less emphasis on bottom-up approaches. In addition, some key informants had concerns regarding the ability of the approach to integrate theoretical models with different epistemological assumptions.

In the words of P1, “although I think the principle of seeking to be evidence-based/informed is very sound, my impression was that the approach seems at points to apply knowledge from the existing literature in a somewhat uncritical or even circular way ... There is also a broader danger of developing a top-down circular theory”. This sentiment is also echoed by P4, stating: “It could be perceived as being heavily ‘top-down’ approach focused.”

Some key informants also included interesting recommendations in their feedback. One key informant pointed out that it could be useful to extend the application of the approach to not only include individual psychotherapy but also couples and family therapy. Along a similar vein, application to group therapy should also be considered. Furthermore, in their feedback, key informants voiced the need for two separate visual illustrations of the SP-CPP to be presented, namely one with less detail providing a broad overview for practitioners and one with more detail for researchers.

Amended Version of the SP-CPP

The research team held several critical discussions based on the feedback received from the key informants’ evaluations of the pilot version of the SP-CPP. During these discussions, emphasis was placed on deciding which comments had sufficient merit to consider certain amendments to the pilot version of this approach. Seemingly, the key informants viewed the approach as one emphasising the expert position of the psychotherapist and lacking in terms

of the humanistic and collaborative nature of psychotherapy. In order to address this misconception, the therapeutic relationship has consequently been placed in the middle of the graphic illustration of the approach, thereby emphasising the centrality and importance thereof. In addition, given that the pilot version was also perceived to be a strong top-down approach, the elements were restructured in the form of a circle. The restructuring in the form of a circle enables the approach to be perceived as circular rather than linear (as some key informants initially perceived it to be). Furthermore, it also makes it easier to illustrate the interdependence between all the different components of the CPR approach and highlights that the therapeutic relationship forms the context in which therapeutic change occurs. Finally, to enable a more logical flow when conceptualising change process within this approach, it was decided to move from the psychological understanding of the client to change constructs before moving on to therapy variables and then to measurement which, ultimately, culminates in developing, testing and monitoring the change process framework. Even though altering the order of the key change constructs and therapy variables does not have an impact on the circular nature of the approach, it enables a better flow of arguments for those scientist-practitioners who prefer a more structured and linear approach, thereby making the approach even more accessible. See Figure 3.3 for the amended version of the SP-CPP.

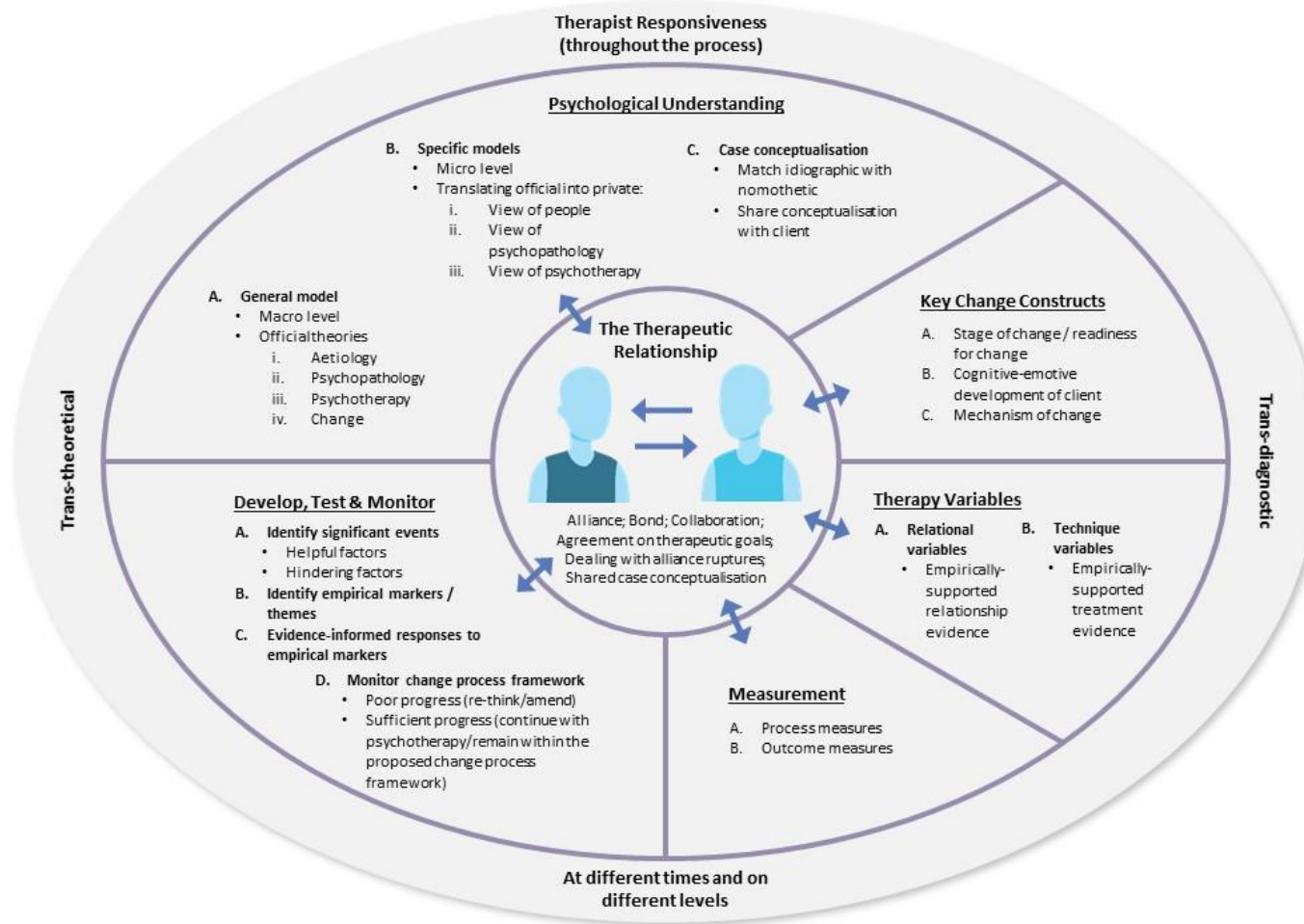


Figure 3.3 The amended version of the SP-CPP

Discussion

In this article, the need for a new CPR approach to psychotherapy has been highlighted and consequently developed. The need for such an approach is supported by Katsikis (2014) who pointed out that the modern-day psychotherapist needs to consult literature on the efficacy of a specific evidence-based therapeutic approach in terms of facilitating psychotherapeutic change. Goldfried (2013) also emphasises that the current focus of psychotherapy research should be on change processes involved in psychotherapy sessions and how these lead to psychotherapeutic change. McCarthy, Caputi and Grenyer (2017) found that significant change events in psychotherapy sessions correlate strongly with positive psychotherapy outcome and that a framework for studying these change events could provide the psychotherapist with a better understanding of the therapeutic process. In addition, Bledsoe, Lukens, Onken, Bellamy and Cardillo-Geller (2008) state that clinical realities require psychotherapists to provide the most effective evidence-based treatment in the shortest time possible.

A new CPR approach to psychotherapy is presented in this article, namely the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP). This approach is primarily based on findings stemming from a systematic review (see Chapter 2) and conducted from an intervention research design (De Vos et al., 2011). Within the intervention research design, the research team progressed through the six phases stipulated as part of the design and development methodology for intervention research (Rothman & Thomas, 1994).

A critical analysis and synthesis of the findings from the systematic review on CPR in psychotherapy were conducted in order to identify prominent themes and subthemes as identified from high-quality scientific literature relevant to the topic. These prominent themes and subthemes were organised in a meaningful way in a pilot version of the new approach to CPR. The pilot version was then critically evaluated by 13 key informants who met strict

inclusion criteria. After several critical discussions by the research team regarding the feedback obtained from the evaluations by the key informants, the pilot version was further refined and an amended version is presented.

It is important to highlight that the amended CPR approach to psychotherapy (namely the SP-CPP) provides a trans-theoretical and trans-diagnostic framework in which change processes can be conceptualised for different clients with different client characteristics. In addition, the approach encourages therapist responsiveness throughout the process. Stiles, Honos-Webb and Surko (1998) emphasise that therapist responsiveness directly influences the effectiveness of psychotherapy as the most consistent variable linked with outcome. They found that when psychotherapists were directed to increase or decrease specific therapeutic behaviours indiscriminately, it resulted in less responsiveness and, consequently, decreased effectiveness.

Greenberg (1986) builds on this by highlighting that the use of process and outcome measures assists psychotherapists to not merely describe what happens in psychotherapy sessions or to only predict outcome but, more importantly, to conceptually understand how change comes about as a result of psychotherapy. An argument can also be made for the selection of unique batteries of process and outcome measures with sound psychometric properties which are specifically tailored for the unique needs of the individual. Watson and McMullen (2016) emphasise that process and outcome measures can be used to link specific client and therapist processes that occur within-sessions with post-therapy outcomes. They continue by stating that these links can then be used to not only develop models identifying different types of changes but also to test them empirically.

The therapeutic relationship is situated in the centre of the visual representation of the amended approach (see Figure 3.3) as it forms the pathway through which the entire psychotherapeutic process is operationalised. This is supported by Hill et al. (2005); Miller,

Duncan and Hubble (2005); and Winston, McCullough, and Laikin (1993) who also emphasise that the therapeutic relationship is the central element of dynamic change in the context of psychotherapy.

The therapeutic relationships also form the basis of the clinical observations conducted by Rogers (1957) who hypothesised that most treatment failures were directly linked to the inability of psychotherapists to build meaningful therapeutic relationships. Smith and Grawe (2003) add to this by highlighting that the most important therapeutic skill is the ability to guide the therapeutic relationship in a direction that promotes healthy self-regulation. Even from a common factors approach, the therapeutic relationship is regarded as a central common factor explaining approximately 30% of psychotherapy outcomes (Lambert, 1992; Wampold, 2010). This finding is further supported by Kazdin (2008), emphasising that the therapeutic relationship is often regarded as a key mechanism of change in psychotherapy, and Henry (1996) who regards the therapeutic relationship as playing either a direct or mediating role in most change processes. The primacy of the therapeutic relationship above specific techniques or specific models in psychotherapy is further highlighted by Paley and Lawton (2001), specifically in the context of evidence-based practice and practice-based evidence of psychotherapy. Elliott (1983), Greenberg (1986) and Rice and Greenberg (1984) specify that the therapeutic relationship is a clinically meaningful unit providing the context in which the process of client change can be studied.

The graphic illustration of the therapeutic relationship depicts two individuals (see Figure 3.3), one representing the psychotherapist and one the client. It is clear from this depiction that there is two-way communication between client and psychotherapist and that the communication takes place within the context of collaboration where both the role of the psychotherapist and that of the client are regarded as important. The emphasis is also on the client's voice (and feedback) as can be seen through the agreement on therapeutic goals and

the importance of a shared conceptualisation. This is in line with the recommendations of Margison, Barkham, McGrath, Clark, Audin and Connell (2000), suggesting that psychotherapists should share their case conceptualisations with their clients in order to maintain and strengthen the therapeutic alliance. In addition, the shared case conceptualisation ensures that the agreed upon focus is still maintained throughout sessions. According to Watson and McMullen (2016), a shared case conceptualisation can also ensure that clients engage more productively in psychotherapy. Through a shared case conceptualisation, clients are encouraged to give feedback to improve the accuracy of the formulation (Margison et al., 2000).

Based on the in-depth process followed, as highlighted in Chapter 3, the research team identified several strengths which add to the uniqueness of the amended version of the approach. Seeing that the approach appears to be a broad or general approach to conceptualise change processes in the context of psychotherapy, since it was developed from the findings of a systematic review of CPR (see Chapter 2), the constructs and concepts highlighted seem to be universal and have potential cross-cultural application value. Pinsof (1989) and Yalom (2005) highlight the importance of a change process framework to demonstrate universality and reconstructivity. They define universality as the ability to capture common features of the psychotherapeutic process through language and measurements which are not tied to a particular theoretical model yet still capture certain unique elements in a given case. Universality can produce clinically relevant results with broad application value in different clinical settings (Woolley, Butler, & Wampler, 2000). In terms of cross-cultural application value, Comas-Díaz (2006) emphasises that culturally insensitive treatments may result in psychotherapists unintentionally selecting treatments reflecting the culture of the psychotherapist, rather than that of the client. Furthermore, it is important to be cognisant thereof that the same presenting problem can have different

culturally ordained meanings in different cultures. The implication is that psychotherapists need to carefully consider and be sensitive towards socio-cultural considerations in their attempts to understand their clients' specific presenting problems and/or dilemmas (Knobloch-Fedders et al., 2015; Rhodes, 2011).

From the abovementioned discussion, it is clear that the apparent universality and potential cross-cultural application value of the amended CPR approach to psychotherapy has specific advantages. Firstly, it can be used for clients of different ages and genders from different cultural and socio-economic groups with different client characteristics, for example sexual orientations and religious affiliations. Secondly, it can be used from different evidence-based treatment approaches, for example so-called top-down approaches such as CBT, bottom-up approaches such as psychodynamic psychotherapy or integrative forms of psychotherapy such as schema therapy (which is both top-down and bottom-up). This highlights the trans-diagnostic and trans-theoretical nature of the approach. This is in line with Castonguay et al. (2010) and Reiter (2010) who argued for a need for a trans-theoretical approach to conceptualise psychotherapeutic change in order to improve psychotherapy outcome. In addition, Kolden (1996) believes that there are certain universal change processes that are trans-theoretical and common across different theoretical models of psychotherapy. Various authors have also identified the need for a trans-diagnostic framework in psychotherapy (Beutler, 2014; Castonguay, 1993; Constantino & Bernecker, 2014; Knobloch-Fedders et al., 2015).

The approach is unique in the sense that from the systematic literature review on CPR (see Chapter 2), no other CPR framework was found, thus highlighting a gap in this regard and a need to develop such an approach. Through developing this approach, both psychotherapy researchers and practitioners are provided with a framework to conceptualise change process within the context of psychotherapy by integrating idiographic and

nomothetic information in a systematic and meaningful manner. Ridley (2005) emphasises that idiographic information refers to a consideration of the needs of one individual at a time, while nomothetic information looks at groups of clients. This is also supported by Barlow (2010); Harris, Kelley, and Shepard (2015); and Lilienfeld, Ritschel, Lynn, Cautin, and Latzman (2014) who pointed out that nomothetic information is mostly derived from RCTs, while idiographic information focuses on the level of the individual case, usually in the context of single-case or small N-studies where new change processes can be identified.

By addressing the gap between research and practice, the effectiveness of psychotherapy can be increased to the benefit of clients. Because the amended CPR approach to psychotherapy is based on the scientist-practitioner model, it is a process-orientated approach deeply grounded in evidence-based theory. This is in line with the recommendations made by Katsikis (2014) and Lilienfeld et al. (2014), namely that psychotherapy researchers and practitioners should assume the position of scientist-practitioners in order to realise the needs of evidence-based practice. This is further supported by Rhodes (2011) who refers to the link between a change process framework and the need for a scientist-practitioner model (Petersen, 2007) to provide a practical and realistic framework supporting both practitioners and researchers. This calls for increased collaboration between psychotherapy researchers and practitioners, implying that scientists should look more to practitioners for research questions and researchers should act as methodological consultants or research facilitators supporting practitioners to develop, conduct and disseminate more case study research reflecting the realities of clinical practice. To this end, Castonguya et al. (2010) recommend that it is desirable for psychotherapists' training to be scientist-practitioner based. Although the amended version strongly emphasises that psychotherapy practice and research should be evidence-based, it also emphasises that such evidence should be gathered from the psychotherapists' clinical experience too. This is supported by numerous authors who argue

that practice-based evidence and traditional evidence-based practice should be weighted equally, seeing that it focuses on the thoughtful clinical observations of real-life cases which inform actual clinical practice (Barkham, Hardy, & Mellor-Clark, 2010; Green & Latchford, 2012; Lilienfeld et al., 2014; Margison et al., 2000; Paley & Lawton, 2001; Stricker, 2003). Margison et al. (2000) and Paley and Lawton (2001) emphasise that through practice-based evidence, very large datasets can be generated within the context of established practice-based networks, which would allow for much better predictions to be made at the idiographic level of individual cases.

By highlighting the importance of therapist responsiveness and the role of peer supervision and case discussions, reflective practice is encouraged. Reflective practice is further encouraged by the clear feedback loop emphasised by this approach and by incorporating process and outcome measures during the psychotherapeutic process. A benefit of the amended version is that it can assist psychotherapists to practice with higher levels of moment-to-moment awareness and increased moment-to-moment purpose. This is supported by Constantino and Bernecker (2014); Kolden (1996); Laska, Gurman, & Wampold (2014); and Stiles, Hill, and Elliott (2015) who refer to the importance of reflective practice which encompasses moment-to-moment awareness and moment-to-moment purpose. In addition, numerous researchers pointed to the need to develop a framework that will facilitate the type of reflective practice as described above (Greenberg & Bolger, 2001; Heatherington et al., 2005; Llewelyn & Hardy, 2001; Macaulay, Toukmanian, & Gordon, 2007; Rennie, 1994; Rennie, 2001; Smith & Grawe, 2003; Watson & McMullen, 2016; Watson & Rennie, 1994).

Finally, the amended version clearly highlights the importance of the therapeutic relationship and the collaborative nature of psychotherapy, thereby moving away from the psychotherapist as expert position.

Conclusion

The main aim of this manuscript was to develop a new CPR approach to psychotherapy. An intervention research design was used with specific emphasis on the design and development methodology thereof. To realise the main aim, the researcher team used the findings from a systematic review conducted on CPR in psychotherapy (see Chapter 2) in order to develop the pilot version of such an approach (thus addressing objective one). In an attempt to ensure the rigor and scientific quality of the approach developed, the researcher team involved 13 key informants to critically evaluate the pilot version of the CPR approach to psychotherapy (thus addressing objective two). These key informants were experienced psychotherapy researchers and/or psychotherapists who met strict inclusion criteria. A thematic analysis was conducted on the feedback obtained from the critical evaluation by the key informants. The themes and subthemes identified during the thematic analysis were used to critically reflect on the need for refinement or modification of the pilot version of the approach. Consequently, certain amendments were made to the pilot version that are reflected in the amended version of the CPR approach to psychotherapy presented by means of Figure 3.3 (thus addressing objective three). The SP-CPP provides a trans-theoretical and trans-diagnostic framework in which change processes can be conceptualised for clients in psychotherapy. This framework has the potential to increase the effectiveness of psychotherapy in the context of evidence-based practice and practice-based evidence.

As per the recommendations stemming from the feedback received from the key informants, two different graphic representations of the SP-CPP are presented in this manuscript: A broad overview is depicted in Figure 3.1 and a more detailed overview in Figure 3.3. Given the context of private practice and the concomitant limited time for case conceptualisations, treatment planning and treatment implementation, it is recommended that the broad overview (see Figure 3.1) be used by psychotherapy practitioners as it is deemed

more appropriate since it highlights the five key constructs of the newly developed approach, namely: 1) psychological understanding of the client; 2) therapy variables; 3) key change constructs; 4) measurement; and 5) developing, testing and monitoring the change process framework. Psychotherapy researchers, though, may find the graphic depiction presented in Figure 3.3 more useful since it provides a more detailed overview of this approach to the change process.

The ideal, however, is to transcend beyond the psychotherapy practitioner and psychotherapy researcher divide and to narrow the gap by increasing collaboration between practitioners and researchers (Rhodes, 2011). As early as 2003, Chwalisz held that by narrowing this gap, both practitioners and researchers will essentially become scientist-practitioners in the context of psychotherapy. Therefore, working from the context of practice research networks (Margison et al., 2000) and in an attempt to bridge the practitioner-researcher gap, it is strongly recommended that more articles on case studies and volumes covering multiple case studies be published (Edwards, 2019).

Limitations

In as far as possible limitations of the SP-CPP are concerned, more emphasis could have been placed on the ability of the approach to integrate theoretical models with different epistemological assumptions. Another possible limitation is that the approach was mainly developed with individual psychotherapy in mind and that the research team has not, as yet, sufficiently considered the application of the approach for couple, family and group therapy. Furthermore, key informants were not initially consulted in the course of developing the pilot version of the approach and were only approached to render a critical evaluation afterwards with a view to refining and/or amending the pilot version. This limitation despite, the fact that they were not part of the initial development process also ensured increased objectivity in key informants' evaluation of the pilot version of the approach. With regards to the inclusion of

key informants, it should also be noted that despite the research team's attempts to involve more psychotherapy researchers in the critical evaluation process, only one research psychologist agreed to act as a key informant or expert in the current study. Still on the subject of critical evaluation, another limitation might be that only one case vignette was offered to the key informants for the purpose of critical evaluation, since this limited the practical demonstration of this approach in conjunction with therapeutic approaches besides CBT. This could also explain why some key informants perceived the approach to be top-down focused, too structured or less applicable to bottom-up and/or psychodynamic approaches.

Nevertheless, despite the fact that a couple of limitations might have been pointed out, the research processes that were followed were thorough and in-depth, involving discussions and critical reflections by different professionals in different phases of the research.

Implications and Suggestions for Future Research and for Clinical Practice

It is recommended that future research apply the SP-CPP to clients with varying presenting problems and diagnosis across a broad spectrum (implying that clients should vary in terms of age, gender and cultural group as well as in terms of the characteristics typically associated with a specific client problem and/or diagnosis). Furthermore, it is also recommended that this approach be applied within the context of varying evidence-based treatment approaches. The application value of the approach should also be explored in group, couples and family therapy. Findings stemming from studies such as these will not only help to develop the SP-CPP even further but will also contribute towards refining the approach and to adjust it in accordance with the needs of specific clients presenting with specific problems who require specific treatments.

In due course, the research team envisages that specific CPR approaches will be developed for children (from a specific cultural group) with separation anxiety disorder, or

for adults (from a specific cultural group) with major depressive disorder, to cite but two examples. Specific change process conceptualisations such as these will then assist researchers and practitioners to focus on specific mechanisms of change to increase the effectiveness of psychotherapy and to, ultimately, decrease the duration of the psychotherapy process (thereby meeting the requirement of evidence-based practice, namely to deliver the best possible service to clients in the shortest space of time needed).

The research team also suggests that future research should focus on providing additional conceptual frameworks that also aim to integrate idiographic and nomothetic information in a systematic and meaningful manner. If a variety of CPR frameworks are at their disposal, psychotherapy researchers and practitioners may gain a better understanding of what works for whom and under which circumstances. Nevertheless, the research team concurs that it is of utmost importance to adhere to the ethical principles of beneficence and non-maleficence and that psychotherapists (be they scientists or practitioners) should always act in the best interest of their clients.

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Addendum A

Semi-Structured Open-Ended Questionnaire for Key Informants

Biographical Information

Name and Surname: _____

Position: _____

Professional Registration Category: _____

Number of years' post-registration experience: _____

Work Experience (circle where applicable): Research Practice Other

If other, please specify: _____

Questions for Key Informants

(Semi-structured, open-ended questionnaires)

1. Kindly provide your overall impression of the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP).

2. What do you view as strengths of the SP-CPP?

3. What do you view as weaknesses of the SP-CPP?

4. If you had to score the newly developed SP-CPP out of a hundred, how would you rate it?

_____ / 100

5. Do you have any ideas/suggestions that will assist in improving the proposed SP-CPP?

6. Any additional information you would like to mention?

Thank you for your time and valuable feedback.

Addendum B

Practical Application by way of a Case Vignette

Case Vignette

Michelle is a 35-year-old married female who for the past six months has had increasing anxiety and panic attacks. Although the anxiety and panic attacks were initially not associated with any particular situation, they are now associated with her work as a human resources manager for a large company. When she goes to work, she often (sometimes more than once a week) has sudden attacks of nausea, perspiring, a feeling of unreality, and trembling. These symptoms become quite intense within a few minutes and last about half-an-hour. Michelle fears these episodes, which are so uncomfortable that she occasionally prevents them by staying home rather than going to work. Michelle denies any discomfort at work, saying that she enjoys her position, handles it well and feels very comfortable as a member of the management team. She is not affected in ordinary social situations or while dealing with people in other contexts. She has never had other psychiatric symptoms, enjoys a normal family life and is in good health. She takes no medications, has a low caffeine intake and denies drug or alcohol abuse.

Practical Application

Gaining a psychological understanding of the client. In terms of conceptualising the *general model* for Michelle's presenting problem on a nomothetic level, the psychotherapist should consult current evidence-based literature regarding the aetiology, diagnosis and treatment of panic disorders. Evidence-based literature indicates that panic disorders are most likely caused by a combination of a genetic predisposition in reaction to environmental factors (which can include major life transitions in particular). Furthermore, cognitive behavioural therapy (CBT) is indicated as an evidence-based treatment approach for panic disorder, and the duration for effective psychotherapy in this framework is between seven and 14 sessions in total with weekly sessions recommended (according to the NICE-guidelines). Self-help interventions, particularly in the form of bibliotherapy, are also recommended (running parallel with the weekly individual psychotherapy).

As a next step, the psychotherapist needs to conceptualise Michelle on a micro-level in order to formulate an idiographic understanding of her through *specific models* which are based on official theories that are translated into private theories, informed by the psychotherapist's professional and personal life experience. In this case, for example, it might be that the psychotherapist

developed a private theory that anxiety is caused by a perceived loss of control experienced by clients. Thus, perceived loss of control, in particular, can become an important part of the conceptualisation of the mechanism maintaining the panic disorder. Specific models can also include conceptualisations of Michelle's experience at work, family relationships and other interpersonal relationships. A specific model will also be formulated for Michelle's thought processes, which might focus on cognitive distortions such as catastrophic misinterpretations.

The *case conceptualisation* then takes shape by integrating the idiographic and nomothetic formulations in a meaningful manner. On a practical level, this implies that the psychotherapist summarises his/her psychological understanding of Michelle in no more than a couple of paragraphs, for example:

Michelle, a 35-year-old female in a management position at a large company suddenly started experiencing increased anxiety and panic attacks with the first onset six months ago. She only experiences these symptoms at work. Given the duration and nature of her presenting problem, a diagnosis of panic disorder has been made. The panic disorder is caused and maintained by her catastrophic misinterpretation of her physiological cues: She experiences a perceived lack of control which is most evident at work and will need to be explored in more detail.

Reflecting on therapy variables. The psychotherapist is required to reflect on two sets of variables, namely relational and technique variables. Firstly, regarding *relational variables*, the psychotherapist reflects on the quality of the therapeutic alliance between himself/herself and Michelle. Furthermore, the psychotherapist continuously reflects on the levels of empathy, warmth and acceptance between them. At the same time, the psychotherapist also identifies possible alliance ruptures / misunderstanding events and evidence-informed ways of responding to these ruptures in an attempt to repair / resolve them. An example of this might be when the psychotherapist communicates (verbally and/or nonverbally) a sense of disappointment in Michelle's progress, creating the impression or expectation that she should have progressed better in the therapeutic process. The psychotherapist might perceive tension in the therapeutic alliance which can manifest through a change in communication and/or collaboration between Michelle and him/herself. Once the alliance rupture has been identified, the psychotherapist can use therapeutic

meta-communication to start a collaborative inquiry into the rupture events so as to enable a process of emphatic non-defensive communication about the communication process with resolution as goal.

Then, in terms of *technique variables*, the psychotherapist reflects on certain therapeutic techniques common to most psychotherapies but also considers the specific techniques that need to be applied to Michelle's case, based on the models indicated above. The treatment techniques will be informed and determined by the evidence-based treatment model for panic disorders, namely CBT. During this process, it is also important for the psychotherapist to determine the most suitable therapeutic stance and role when interacting with Michelle. For example, when the focus is more on psycho-education regarding the physiology and function of Michelle's panic attacks, the psychotherapist will adopt a more teaching role, while a more confronting role will be adopted when addressing Michelle's cognitive distortions and operational beliefs by, for instance, making use of Socratic questioning. The aim would be to change the meaning of the symptom in her life by redefining the function thereof in her life (and/or addressing the cognitive distortions maintaining the dysfunctional beliefs). This can be accomplished by means of a range of cognitive techniques (for example, thought restructuring) or behavioural techniques (for example, exposure exercises).

Exploring and conceptualising key change constructs. Whilst reflecting on the relational and technique variables, certain *key change constructs* need to be explored and conceptualised. In so doing, Michelle's *stage of change (or readiness for change)* will be matched with her *cognitive-emotive development* in order to determine the most suitable therapeutic approach to obtain the desired changes. If Michelle is in the pre-contemplation phase (see Prochaska & Norcross, 2018),¹ motivational interviewing techniques can be used to increase her motivation to change. If she is in

¹ Prochaska, J. O., & Norcross, J. C. (2018). *Systems of psychotherapy: A transtheoretical analysis* (9th ed.). New York, NY: Oxford University Press.

the action phase, behavioural exposure exercises or pattern breaking can be used. If Michelle responds well to concrete problem-solving tasks, a more cognitive-focused therapy would be indicated during which CBT techniques, such as addressing cognitive distortions, would be the focus. Michelle then finds herself in the concrete operational or formal operational stage (according to Piaget's cognitive development). However, if Michelle responds well to abstract processes and the psychotherapist deems her to function on a sensorimotor or preoperational stage of cognitive development, emotion-focused therapy would be indicated during which certain gestalt techniques might be utilised, such as working through unfinished business. This will, however, necessitate the need to revisit the diagnosis and/or explore comorbidities since emotion-focused therapy is not indicated as the first- or second-line of treatment for panic disorders (according to the NICE-guidelines)². The psychotherapist might then consider exploring Michelle's personality functioning by, for example, using a schema therapy approach so as to arrive at a schema mode conceptualisation for Michelle.

Once the most suitable therapeutic stance and treatment modality have been determined, the psychotherapist engages with one of the most important aspects of the change process framework, namely determining the *mechanism of change*. The mechanism of change refers to the core dynamic that needs to be focused on in order for Michelle to understand the reason why she is experiencing the symptoms that she has. As much as this explains the psychotherapist's understanding of pathology, it looks more specifically at the specific reasons why Michelle is experiencing the symptoms and why they are triggered and maintained. The mechanism of change should be featured as the primary focal point of the case conceptualisation and should, therefore, also underpin the planning of the intervention strategies. In this regard, note that according to literature,

² National Institute of Health and Clinical Excellence (NICE). (2016). *Getting help and support for common mental health problems: Understanding NICE guidance*. London: NICE.

evidence-based mechanisms of change for panic disorders centre around catastrophic misinterpretation of physiological cues.

Measuring outcomes and processes. The next step would be to determine appropriate outcome and process measures that are not only clinically relevant but also report good psychometric properties in terms of reliability and validity. In addition, the psychotherapist needs to be mindful of how often these measures will be administered and how the information obtained will be used.

To begin with, in terms of *process measures*, literature recommends that, in the case of panic disorder, the psychotherapist can consider administering the Panic Disorder Severity Scale (PDSS; Houck, Spiegel, Shear, & Rucci, 2002)³ or the Panic Disorder Self-report (PDSR; Newman, Holmes, Zuellig, Kachin, & Behar, 2006)⁴. In addition, the Panic Attack Questionnaire (PAQ; Norton, Harrison, Hauch, & Rhodes, 1985)⁵ is also recommended as a process measure in the case of panic disorder. The PAQ measures panic attacks rather than anxiety in general. It is also recommended that a process measure be included that focuses on the therapeutic alliance. In this regard, the Working Alliance Inventory (WAI; Hatcher & Gillaspay, 2006)⁶ is recommended since this inventory includes a number of specific questionnaires that must be completed by both the psychotherapist and the client. This will enable the psychotherapist and Michelle to also measure and reflect on the therapeutic alliance as an important process variable during treatment. Based on the

³ Houck, P. R., Spiegel, D. A., Shear, M. K., & Rucci, P. (2002). Reliability of the self-report version of the Panic Disorder Severity Scale. *Depression and Anxiety*, 15(4), 183–185.

⁴ Newman, M. G., Holmes, M., Zuellig, A. R., Kachin, K. E., & Behar, E. (2006). The reliability and validity of the Panic Disorder Self-Report: A new diagnostic screening measure of panic disorder. *Psychological Assessment*, 18(1), 49–61.

⁵ Norton, G. R., Harrison, B., Hauch, J., & Rhodes, L. (1985). Characteristics of people with infrequent panic attacks. *Journal of Abnormal Psychology*, 94(2), 216–221.

⁶ Hatcher, R. L., & Gillaspay, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, 16(1), 12–25.

psychotherapist's clinical judgement, these process measures can be administered at frequent intervals throughout the therapeutic process, for example after every third session.

Then, in terms of *outcome measures*, literature recommends that in cases where panic is a prominent symptom, outcome measures can be used to determine the pre- and post-measures of the overall anxiety of the client. In the case of Michelle, the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988)⁷ would be an appropriate outcome measure to use. It is recommended that outcome measures be administered during the first session and upon termination. This will enable the psychotherapist (and Michelle) to get an accurate picture of what her overall anxiety looked like at the onset of treatment and upon termination. By comparing these two static points, the psychotherapist can determine whether psychotherapy made a difference for Michelle, particularly regarding her overall level of anxiety.

Developing, testing and monitor. By collating all of the abovementioned information, the psychotherapist now develops a change process framework. To accomplish this, the psychotherapist needs to *identify significant events and empirical markers (or themes)* indicating if and when change occurs in the context of psychotherapy. In the case of Michelle, a significant event can, for example, be finding herself in a situation at work where she is exposed to a previous trigger situation but does not experience a panic attack. The empirical markers can take the form of thought processes, behavioural changes or even themes discussed during psychotherapy sessions. An empirical marker in Michelle's case can be her anxiety levels at work or her thought processes regarding her physiological cues. Once the significant events and empirical markers have been identified, the psychotherapist needs to make use of *evidence-informed ways of responding to the empirical*

⁷ Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of Consulting and Clinical Psychology*, 56(6), 893-897.

markers (or themes). Given Michelle's case, this would refer to the psychotherapist assuming the therapeutic stance as indicated by CBT and using the appropriate CBT techniques as and when required. Here the assumption, of course, is that the psychotherapist will be able to identify when it is indicated to use certain cognitive techniques (such as Socratic questioning or thought restructuring) and when using certain behavioural techniques (such as exposure exercises) would be appropriate.

Encapsulated in *therapist responsiveness* is the psychotherapist's ability to take cognisance of evidence-informed means to respond to Michelle's empirical markers, not only in terms of aspects identified as helpful but also in terms of hindering or harmful aspects. This method of practicing with moment-to-moment awareness and moment-to-moment purpose needs to happen *throughout the process* and should, therefore, not only manifest within sessions but also during pre-therapy, extra-therapy and post-therapy (or follow-up) sessions. Pre-therapy change refers to the change that might have occurred between the time that Michelle made her first appointment and when she arrived for the first session, and literature indicates that the psychotherapist should explore this. Extra-therapy change refers to change between sessions or outside of psychotherapy and also includes the influence of other external variables not related to the psychotherapy context. Post-therapy change refers to follow-up sessions and/or interviews and can happen at different intervals, for example at three, six, nine or even twelve months after termination. The idea with the follow-up sessions and/or interviews would be to monitor Michelle's anxiety levels (and panic attacks in particular) over the course of time following the termination of psychotherapy.

When Michelle responds well to the treatment and the psychotherapist's change process framework, the psychotherapeutic process continues and the proposed change process framework is adhered to. When Michelle does not respond well, 'case flagging' is indicated, implying that the psychotherapist should determine if Michelle is off-track and/or seek additional supervision or other professional input to address these concerns. Should 'case flagging' occur, the psychotherapist

needs to *re-think* the entire Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP) and *adjust or amend* where necessary (particularly in terms of the case conceptualisation).

CHAPTER 4

MANUSCRIPT 3

**The Scientist-Practitioner Approach to Change Process in Psychotherapy applied to
cognitive behavioural therapy: Two case studies**

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Abstract

This manuscript focuses on the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP) as applied to two cognitive behavioural therapy (CBT) case studies. First and foremost, the authors must highlight that the SP-CPP is not a therapeutic approach in itself, but rather a framework that can be used by psychotherapists to conceptualise change processes from start to finish in the course of psychotherapy as applied from varying theoretical orientations. Moving from these premises, this manuscript aims to illustrate the findings of two case studies where the SP-CPP framework was applied to two case studies that involved cognitive behavioural therapy. A multimethod case study research design was followed to investigate and analyse the outcome of the two studies presented here in accordance with the SP-CPP framework. From their findings, the authors concluded that the difference in outcome between the two cases can be ascribed to differences in terms of the clients' motivation to change and their cognitive-emotive conceptualisations. Furthermore, the quality of the therapeutic alliance, session attendance and commitment to therapeutic work between sessions seemingly also contributed significantly to the difference in outcome. Based on the findings of this study, all indications are that SP-CPP can be used as a change process framework to conceptualise clients receiving treatment from a CBT approach. It is recommended that future research should explore the application value of the SP-CPP from different therapeutic approaches with diverse clients presenting with varying problems.

Keywords: case study, cognitive-behavioural therapy (CBT), change-process research, psychotherapy, scientist-practitioner

Introduction

In this chapter, the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP) developed in Chapter 3 will be discussed as applied to two cases with a view to exploring the application of this framework from a cognitive behavioural therapy (CBT) approach (Clark & Beck, 2010; Beck, 2011). In both cases, the clients presented with anxiety-related symptoms and received CBT as evidence-based intervention. The first case is that of Cindy, a 20-year-old female, and the second case is that of Mark, a 28-year-old male. Both clients were consulted by the same psychotherapist. The SP-CPP (see Figure 3.4) was used throughout the psychotherapy process – in a dynamic manner – to conceptualise the clients, to inform the treatment process, to monitor therapeutic progress and to make changes and/or amendments as and when required. Before discussing the practical application, though, a brief descriptive overview of the SP-CPP is warranted.

Given that the SP-CPP is a circular approach, centring around the collaborative therapeutic relationship, five main themes are highlighted, namely: 1) psychological understanding of the client; 2) key change constructs; 3) therapy variables; 4) measurement; and 5) develop, test and monitor (see Chapter 3 for a detailed discussion in this regard).

Firstly, the *psychological understanding of the client* refers to when the psychotherapist formulates a case conceptualisation of the client by integrating nomothetic information based on official theories on a macro level and idiographic information based on specific models on a micro level. In this regard, it is important that the psychotherapist should share the conceptualisation with the client since the formulation of such a conceptualisation is a collaborative venture. Secondly, in terms of the *key change constructs*, the SP-CPP encourages the psychotherapist to determine the client's readiness for change (or stage of change), as well as the client's cognitive-emotive development from any developmental theory deemed relevant. Also, as part of the key change constructs, the psychotherapist

conceptualises the mechanism of change which refers to the nodal point that would have the biggest therapeutic impact in terms of psychotherapeutic change potential in the shortest space of time. Thirdly, in terms of *therapy variables*, a distinction can be made between relational and technique variables. The relational variables refer to empirically supported evidence of aspects in the therapeutic relationship that increase the effectiveness of psychotherapeutic interventions, while technique variables refer to empirically supported treatment evidence. Fourthly, in terms of *measurement*, the SP-CPP recommends that psychotherapists incorporate both process and outcome measures within any psychotherapeutic process. While process measures can be administered at various intervals during psychotherapy to monitor specific aspects identified as relevant, outcome measures are typically used to compare scores obtained at the beginning and end of psychotherapy. Finally, the fifth theme emphasises the need for psychotherapists to *develop, test and monitor* the change process framework. In order to develop a change process framework, the psychotherapist is encouraged to identify significant events, both helpful and hindering, that are usually derived from the client's narrative and case conceptualisation. From these significant helpful and/or hindering events, the psychotherapist can then identify the most prominent empirical markers (or themes) that are usually evident from the mechanism of change identified as part of the key change constructs. In order to test the accuracy of the change process framework, the psychotherapist ought to research evidence-informed therapeutic responses to these empirical markers. If, according to the psychotherapist's change process formulation and clinical judgment, the client responds well to the individualised change process framework, there is sufficient progress and the psychotherapist should continue with the treatment as planned. However, if according to the psychotherapist's change process formulation and clinical judgment, the client is not responding well to the

individualised change process framework signifying poor progress, the psychotherapist should revise, amend or adjust the conceptualisation.

In the SP-CPP, the centrality of *the therapeutic relationship*, encompassing both the therapeutic alliance and bond, is emphasised given the core position assigned to it in this approach. The therapeutic relationship also refers to collaboration, the agreement on therapeutic goals, dealing with alliance rupture and arriving at a shared case conceptualisation. Another important aspect, also applicable to the entire change process framework, is *therapist responsiveness*. This refers to the psychotherapist's ability to practice with moment-to-moment awareness and moment-to-moment purpose throughout the psychotherapeutic process. As a final comment, note that the proposed approach to change process in psychotherapy is *trans-theoretical* and *trans-diagnostic* and can be applied at *different times* and on *different levels* throughout the psychotherapeutic process.

The SP-CPP was not initially developed as a reflective framework to be used after a psychotherapy process has been completed, even though one can argue that it can also be used for this purpose. Rather, the purpose is for practitioners and researchers alike to use this change process framework throughout the process of psychotherapy as a reflective instrument (or tool) guiding evidence-based clinical practice in the best interest of clients. Therefore, it is important that the proposed change process framework should highlight a dynamic process in which modifications or adjustments ought to be made on a continuous basis as new information surfaces.

Having provided a brief descriptive overview of the SP-CPP, the manuscript presented in this chapter will now explore the application of this framework specifically from a CBT approach as illustrated by two case studies following a multi-method case study research design.

Methodology

In order to achieve the aim of this study, the SP-CPP was applied as framework to two CBT cases. CBT was chosen as evidence-based treatment approach in both cases, based on the clients' cognitive-developmental formulation and case conceptualisation (Clark & Beck, 2010; Beck, 2011). This approach was determined after deliberation between the psychotherapist, the individual supervisor and input from a reflective team. Within the broader SP-CPP framework, a CBT approach was used to ensure the effective management of the change processes of both clients. The psychotherapeutic process was monitored continuously by means of individual supervision and reflective team meetings throughout the psychotherapy process. Data collection consisted of video recordings of psychotherapy sessions, the psychotherapist's clinical notes, process and outcome measures and client feedback obtained during psychotherapy sessions as well as from follow-up interviews with the clients. Data analysis consisted mainly of critical reflection by the researchers in their respective roles and the integration of the reflections within the SP-CPP framework.

Case studies are particularly helpful in understanding the internal dynamics of change processes (Powell et al., 2013). When applying this to the context of psychotherapy, it enables the researcher to investigate how change occurs in real life and in the natural context of psychotherapy. Including multiple case studies enables the researcher to capitalise on the individual variations and unique characteristics of individual psychotherapy clients (Nonthaleerak & Hendry, 2008; Stake, 2013). Within a case study design, each individual psychotherapy client is conceptualised as a 'case'. By relying on multiple units of analysis, the researcher gains a more in-depth understanding of change processes in psychotherapy and how contextual factors may influence these processes (Stake, 2013; Yin, 2009). A number of studies have been conducted that emphasised the importance of using case study (and other mixed-methods observational) designs in order to develop a more nuanced, theoretically

informed understanding of change processes (Nonthaleerak & Hendry, 2008; Palinkas et al., 2011).

Inherent to the process of theory building from case studies is the overlap of data analysis with data collection. Several authors argue for the simultaneous collection, coding and analysis of data (Glaser & Strauss, 1967; Stake, 2013; Yin, 2009). This overlap is maintained and accomplished through field notes and involving a research team. Frequent team meetings, where investigators share their perspectives and emergent ideas, are also reported as useful methods for ensuring an overlap between data collection and analysis (Eisenhardt, 1989). This process also provides a sense of flexibility in generating possible new emerging themes, which could provide new theoretical insight or better empirical grounding for emergent theory (Harrison, Birks, Franklin, & Mills, 2017). In order to become intimately familiar with each case as a standalone entity, the analysing of data starts on the level of each single case. According to Eisenhardt (1989), within-case analysis usually involves a detailed case study write-up for each individual case. This process, according to Crowe, Cresswell, Robertson, Huby, Avery, and Sheikh (2011), allows the unique patterns of each case to emerge before investigators attempt to compare and/or generalise patterns across cases. This also provides the researchers with a rich familiarity with each individual case, which streamlines the cross-case comparison level of analysis. The cross-case level of analysis is to afford the research team an opportunity to look at the data in several divergent ways (Harrison et al., 2017). This further increases the empirical grounding and strength of the emergent theory by corroborating evidence throughout the multiple cases, in the event that a pattern from one case is supported and corroborated by evidence from another case. Conflicting evidence provides the opportunity for deeper reflection on the possible meaning behind the conflict, or reflection on the possibility of bias or external influence (Aaboén, Dubois, & Lind, 2012).

In the paragraphs to follow, the roles of the respective role players involved in the research process highlighted in this manuscript will be clarified and their involvement explained briefly.

Role Clarification

The gatekeeper or mediator.

An independent person acted as gatekeeper or mediator and was responsible for initially contacting both clients and obtaining informed consent from them. The gatekeeper was also responsible for making the initial or first appointment with both clients.

The psychotherapist.

The first author was the psychotherapist for both clients. He is a 36-year-old white male who is registered as a clinical psychologist and has nine years' post-registration experience. He is currently involved in a group-based practice within a tertiary education environment where he is mainly responsible for providing psychotherapy to clients, but he also has academic responsibilities. He is responsible for lecturing at post-graduate level (master's degree students in clinical and counselling psychology), as well as for supervising the practical work of clinical and counselling psychologists at master's degree and internship level. In addition, he is also responsible for research supervision of master's degree students in clinical and counselling psychology.

Individual supervision.

The second author was responsible for providing individual supervision for the two CBT cases seen by the psychotherapist. He is an associate professor with 15 years' post-registration experience as a clinical psychologist with the Health Professions Council of South Africa and the Health and Care Professions Council (in the United Kingdom). In addition, he has received formal training in CBT at both the Ellis Institute in New York City (chartered by New York State University) and the Beck Institute for Cognitive Behaviour

Therapy in Philadelphia, Pennsylvania. There was a total of 20 individual supervision sessions of two hours each throughout the psychotherapeutic process of both clients. During the individual supervision, the first and second authors viewed video recordings of both cases together and had critical discussions regarding the diagnosis, case conceptualisations, mechanisms of change, treatment plans and prognosis (to name but a few). The second author was also responsible for conducting the follow-up interviews with both clients to gather their experience of, amongst others, the psychotherapeutic process, therapeutic relationship and use of therapeutic techniques.

Reflective team.

All the authors were part of the reflective team, along with one independent member. The third author is a full professor also registered as a clinical psychologist with more than 20 years' post-registration experience and is mainly involved in research aspects related to psychology. The fourth author is a registered research psychologist with a PhD in psychology and ten years' post-registration experience, mainly in research-related aspects in the field of psychology. The independent member of the reflective team is an associate professor and registered clinical psychologist with ten years' post-registration experience. During reflective team discussions, the reflective team watched the recorded sessions and critically discussed the cases. The main focus was to ensure that the psychotherapist adhered to the SP-CPP. There were a total of 15 reflective team discussions of two hours each throughout the research process. The reflective team also watched the follow-up interviews of both clients in order to identify the most prominent themes (as will be presented later in this manuscript).

Ethical Considerations

Ethical permission for this study was obtained through the Health Research Ethics Committee (HREC) of the North-West University (NWU). The ethics number is NWU-00363-16-A1 and proof is attached (see Annexure A1). The most important ethical

considerations, for the purpose of case study research in psychotherapy, are highlighted in Annexure A3, and include: informed consent; ethical issues in case selection; the possible risks or likelihood of benefits and measures implemented to mediate and/or minimise potential risk factors; ethical use of audio and video recordings; confidentiality and privacy and issues pertaining to objectivity when reporting on cases for publication purposes. As an additional ethical consideration, even though it was not required, the first author scheduled individual post-therapy appointments with the two clients during which their case write-up's were read and discussed. In addition, they were provided the opportunity to ask questions or make amendments to their case write-up's if and where required. Both clients also gave separate written-consent or permission for their case studies to be used for examination and/or publication purposes following the in-depth discussion thereof.

The Two Cases

Case one is the case of Cindy, a 20-year-old female who received 12 sessions of CBT for a presenting problem relating to anxiety. Case two is the case of Mark, a 28-year-old male who received 22 sessions of CBT also for a presenting problem on the anxiety spectrum. Both clients filled out application forms for psychological consultation at the group-based practice where the psychotherapist is employed.

The SP-CPP, as presented in Chapter 3 (and briefly described above), was used as the structure for the write-up of these two cases. Within these two cases, certain aspects were similar across both cases, while there were also aspects that were unique to each case. Those aspects that were common across both cases will be presented first, followed by the unique aspects in each case (according to the SP-CPP framework depicted in Figure 3.4).

Common Aspects Across Both Cases

Psychological Understanding of the Client

General model on a macro level.

The general CBT conceptualisation model (Beck, 2011) provides for recognising certain triggers or activating events which individuals will encounter in life. These triggers can activate a set of behavioural, emotional and physiological consequences. This relationship is, however, not causal. The activating events will not necessarily directly lead to the consequences but are mediated by the individual's cognitive/belief system. In order to understand the aetiology of the beliefs which regulate the psychological consequences, it is important to identify the key factors which shaped and formed the core belief system in the formative years (predisposing factors). An individual will develop certain views and beliefs about himself or herself as he or she progresses chronologically through life. Although many of these beliefs can be healthy and helpful, often, due to various environmental and other factors, some of these beliefs about the self might not be functional, helpful or healthy. Based on life experiences, especially in the formative years, the individual will, furthermore, develop core beliefs about other people and a perception of the world in general. In order to survive physically and mentally in this world, and to protect one's self-worth, an individual develops certain unwritten rules for living, as well as assumptions about what the consequences will be if one does not live up to the self-created internal rules. These procedural or intermediate beliefs will have a significant impact on the way in which cognitions will manifest in the conscious mind. Usually, this will present in the form of an internal narrative about the relevant trigger or activating event, which will mediate the impact of the activating event and – most of the time – will significantly contribute to the specific emotional, physical and behavioural consequences which the individual is experiencing in the moment.

The general CBT model suggests that psychopathology stems from unhelpful or dysfunctional cognitions about a particular activating event, also known as negative automatic thoughts. These cognitions are influenced by the intermediate beliefs which, in turn, are significantly influenced by the content of the core beliefs. Therefore, the aim of psychotherapy is to create cognitive awareness by identifying these unhelpful cognitions and, through a process of thought restructuring and/or thought disengagement, attempt to change the dysfunctional rules and assumptions in order to, eventually, develop healthier and more functional core beliefs (Beck, 2011).

Key Change Constructs

Cognitive-emotive development of client.

Even though any other developmental theory can be used, it was decided that Piaget's theory of cognitive development (Piaget, 1965) was the best fit in the cases of both Cindy and Mark. Although they are clearly chronologically past Piaget's developmental stages (Piaget, 1964), there are very particular residual developmental tendencies which adults generally display later in life, especially when they find themselves in challenging moments (Piaget, 1968). Within Piaget's theory, both clients found themselves in the concrete to formal operational phase (Piaget, 1972). This implies that they have the ability to reason on an abstract level and to perform more complex cognitive operations, although there might still be a tendency for linear thinking under certain emotionally charged or high pressure situations. This cognitive-emotive developmental understanding of Cindy and Mark helped the psychotherapist to decide on the best set of intervention techniques or strategies to use to ensure that psychotherapy is delivered on a level where it makes the most significant difference for or has the most significant impact on them.

Therapy Variables

Relational variables.

Important elements in developing and maintaining a good therapeutic relationship, from a CBT perspective, include demonstrating good counselling skills and an accurate understanding of the client; sharing one's conceptualisation and treatment plan with the client; making decisions collaboratively; ensuring open feedback between client and psychotherapist; and assisting clients to become their own therapists (e.g. helping clients to solve their own problems and alleviate their distress). For these elements to come to fruition, it is important to establish rapport with the client and to build trust over time. According to Beck (2011), besides empathy, the ability to clarify expectations assists the psychotherapist to develop a positive therapeutic alliance.

Technique variables.

From a CBT perspective, emphasis is placed on the importance of collaborative empiricism. This implies a joint venture between psychotherapist and client to examine the client's automatic thoughts and beliefs, to test their validity and/or utility, and to develop more adaptive responses (Beck, 2011). The therapeutic techniques used in the cases of Cindy and Mark can be distinguished in terms of those focusing on their *content of thinking* (what they think about) and those focusing on their *process of thinking* (how they think about it).

Content of thinking. Firstly, to explore their content of thinking, cognitive awareness was increased through the use of psychoeducation regarding CBT and anxiety. This was followed by thought restructuring through guided discovery of negative automatic thoughts, intermediate beliefs and core beliefs. Techniques used for thought restructuring included Socratic dialogue and the downward-arrow techniques in conjunction with belief monitoring and thought record sheets to identifying potential unhelpful thinking patterns.

Process of thinking. Regarding their process of thinking, thought disengagement techniques were used to focus on the thought appraisal process. This was done by looking at styles and patterns of thinking and potential cognitive biases, in conjunction with the 'Big I, little i' activity. In addition, mindfulness techniques were also used for the purpose of thought disengagement.

Behavioural experiments and homework were also used to challenge their content and process of thinking. In addition, emphasis was also placed on the protective and resilience factors in their lives.

Measurement

The Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) and Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) were used in the cases of Cindy and Mark. The DASS-21 was used as an outcome measure to assess their levels of depression, anxiety and stress during the first and last sessions of psychotherapy. In addition, the DASS-21 also doubled up as a process measure and was administered at different intervals throughout the psychotherapeutic process to monitor their levels of depression, anxiety and stress. Finally, the BAI was used as a process measure purely with the aim to assess their levels of anxiety at different intervals throughout psychotherapy and hence the effectiveness of the intervention techniques. The BAI assesses the frequency and intensity of anxiety symptoms over the most recent month, while the DASS-21 focuses on the most recent week. The DASS-21 and BAI were administered at different intervals according to the clinical judgment of the psychotherapist and as per discussions with and recommendations by the individual supervisor as well as feedback obtained from the reflective team.

Develop, Test and Monitor the Change Process Framework

Evidence-informed responses to empirical markers.

The empirical markers identified in the cases of Cindy and Mark were addressed by using evidence-based models within the CBT framework (Beck, 2011; Clark & Beck, 2010).

Monitor change process framework.

Cindy and Mark gave consent for all psychotherapy sessions to be recorded (audio and video) and for the psychotherapist to use their cases for research purposes, which included discussions with an individual supervisor as well as with a reflective team. The psychotherapist made use of his clinical judgement in and between sessions to determine progress. In addition, the psychotherapist also had regular individual supervision sessions regarding both cases, as well as regular reflective team meetings (as discussed earlier).

Unique Aspects in Each Case

Case One: The Case of Cindy

Background information.

Cindy is a 20-year-old female student studying towards a degree in the field of Humanities. Her main referral reason was struggling to cope with multiple anxiety attacks over the past several months. She described the anxiety attacks as *inner claustrophobia* and reported between three to five anxiety attacks per day over a period of six months. She mentioned having to make multiple adjustments to her life during her formative years, since her family relocated frequently and she, consequently, lived in different countries and cultures as a child. She is the youngest of three siblings and has an older brother (29 years old) and an older sister (25 years old). She was home-schooled by her mother. A very significant event in her life happened when she was 18 years old, and her mother unexpectedly passed away from a stroke, due to an undiagnosed medical condition. This happened right before her final school exams. Her panic attacks started a few months after

her mother's death when Cindy was 19 years old. Cindy is hardworking and performs well academically. She comes across as confident and straightforward. Others readily perceive her to be opinionated and atypical as is evident from her attire, appearance and thought processes. She holds high expectations of herself and others, and frequently experiences high levels of self-doubt.

Psychological understanding of the client.

General model on a macro level. According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), Cindy best meets the criteria for "other specified anxiety disorder". Although she presented with panic attacks, she did not meet the criteria for "panic disorder". She also displayed symptoms of "social anxiety", "posttraumatic stress" (in relation to her mother passing away unexpectedly) as well as some "generalised anxiety disorder" symptoms, but none of these met the full criteria for a diagnosis in any of the aforementioned categories.

When working with most anxiety disorders, CBT is generally indicated as an evidence-based treatment approach of choice (NICE, 2019; NIMH, 2019), as it is geared towards identifying the mechanisms of anxiety, as well as changing the cognitions involved in triggering and maintaining various forms of anxiety. The main aim of psychotherapy was, in this case, to assist Cindy with understanding the origin of her anxiety but, more importantly, to learn to control it.

Specific model on a micro level. Within the CBT framework, Clark and Beck (2010) have suggested a specific, adjusted meta-cognitive model to understand anxiety better and to allow for a focused intervention approach to relieve symptoms and create long-lasting positive results. Anxiety is defined as *a feeling of worry, nervousness, or unease about something with an uncertain outcome* and often appears to be a metaphorical *false alarm to a perceived threat*. It means that unlike fear, which is the reaction an individual will develop in

the presence of a real and actual threat, anxiety usually happens in the absence of a physical threat and is a result of cognitive factors. Clark and Beck (2010) postulate that anxiety is the result of various cognitive distortions and unhelpful thinking processes, more specifically the tendency to a) overestimate the risk of something bad happening in any given situation, but also to b) underestimate one's ability to deal with it. This is commonly known as the 'risk: resource ratio' in anxiety. The way these cognitions manifest in the conscious mind, either in the form of negative intrusive thoughts or deliberate thinking, have a profound impact on the level of anxiety which a person is experiencing. The aim of psychotherapy will, therefore, be to identify and modify the unhelpful cognitions which affect Cindy's anxiety responses.

As a slight variation on the original ABC model (Beck, 2011), this metacognitive model (see Figure 4.1) makes provision for recurring cognitions in anxiety disorders; however, it also suggests that the secondary appraisal of the immediate fear response (i.e. restructuring the automatic cognitions) can have a very positive outcome on mediating and dealing with anxiety (Clark & Beck, 2010).

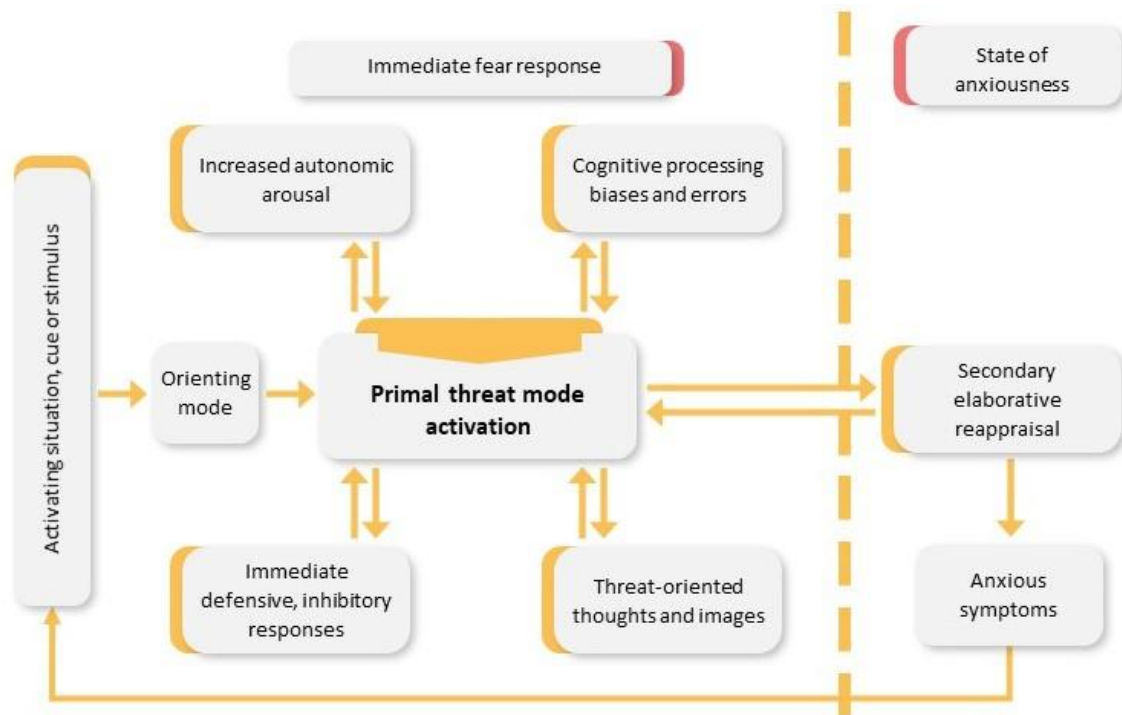


Figure 4.1. Metacognitive model of anxiety

This specific model suggests that the activating event trigger the *primal threat mode* by simultaneously a) triggering the autonomic nervous system, creating increased autonomic arousal, while b) activating cognitive processing biases (thought distortions) thereby c) allowing recurring anxiety cognitions to be processed with specific threat-oriented thoughts and images, which will then d) trigger the fight/flight/freeze response. Although the *immediate fear response* can happen in an instant, the *secondary elaborate reappraisal* of the situation ('risk: resource ratio' appraisal) will have the biggest mediating effect on how long the primal threat mode will last. Unlike the primal threat mode, which happens primarily in the limbic system, the secondary reappraisal happens predominantly in the prefrontal cortex of the brain and refers to the cognitions which one has direct access to. As discussed above, in the general model, these cognitions or thoughts can be restructured and changed in ways which can influence, mediate and control the anxiety response.

Within this specific CBT model for dealing with anxiety, and in collaboration with Cindy so as to ensure that her primary needs were taken into consideration throughout the process, the following therapeutic goals were formulated as the outcome goals for Cindy's psychotherapy: 1) to better understand her anxiety (by using the specific anxiety model); 2) to decrease the anxiety symptoms (by targeting the relevant cognitive processes); 3) to better understand the link between her depression and her anxiety (by looking at the cognitive and behavioural interactions); and 4) to develop the necessary skills and techniques to deal with the depression and anxiety in the longer term (through a combination of thought restructuring as well as thought disengagement processes).

Case conceptualisation.

Distal past (predisposing factors). Cindy described a history of constant changes and instability growing up as a child, moving around frequently between different towns and different countries. She consequently had to make multiple adjustments in terms of settling in, making friends and finding her social identity. Being exposed to different cultures and religions at a young age also had an impact on the formation of her social identity, as well as her ability to forge long-lasting relationships. Such events will not necessarily influence one in a negative way, but the key learning experiences extracted from these experiences can have a significant impact on the formation of core beliefs about the self, others and the world. It appears that the interpersonal instability and lack of lasting relationship had an influence on Cindy's core beliefs created in the early years of her life. The lack of lasting, meaningful social relationships created a sense of not belonging and not fitting in anywhere. She always had to try to break into established friendship groups, which was very difficult to accomplish at times. This potentially made her question her own adequacy and likeability and, inevitably, created self-doubt and insecurity. This poor ability to relate to others also created a sense of wariness and caution when interacting with others, which in the longer term fuelled the

feelings of not belonging. These predisposing events in her early life changed her general world view to one of expecting instability and uncertainty, often triggering her insecurity and self-doubt. It created beliefs around the world being an unpredictable place where one does not have anyone else to depend on, and you have to fend for yourself. The only stable factor in her life, and her primary source of support, was her mother. The fact that her mother home-schooled her during her school career further reinforced her beliefs about the fact that no-one else will probably support her and other relationships will probably not last anyway. These are just a few predisposing factors (influencing her core beliefs) which partially explain Cindy's vulnerability and reactions to later life events and the anxiety she experienced.

In order to ensure self-preservation (emotionally and physically), individuals create a set of rules for living (also known as intermediate beliefs), consisting of assumptions and attitudes, which prevent the activation of negative core beliefs. Cindy developed a set of unwritten, subtle internal rules and assumptions, for self-protection, to keep her from feeling like an outcast, and to deal with her uncertainty and the instability of the world. As a way of finding her niche and making herself feel worthwhile, some of these global intermediate beliefs included rules such as "I should be able to help myself", "I should excel in all aspects of life" and "I should not disappoint myself". These rules were deployed as protective factors, helping her to keep her self-doubt and insecurity at bay.

She also had strong beliefs that "I must be prepared for everything", clearly not trusting external sources to help her with any difficult situations. She frequently mentioned assumptions such as "If I make a mistake, then I will have to fix it myself" and "If I don't live up to my expectations, I will disappoint myself", reflecting on her self-doubt and feelings of insecurity. With reference to other people, she said that "I don't want to become like my brother and sister... they have a lot of problems and are dependent on others", stating it in a way that insinuates she regards being dependent on others as dangerous or not sustainable.

Clearly, in her mind, these rules and assumptions served the purpose of not falling victim to this uncertain and unstable world by taking sole responsibility, not necessarily trusting others or expecting help from external sources. There are clear indications that she is trying to protect herself from what she believes to be wrong with the world, and also to compensate for the self-doubt, insecurity and feelings of not belonging which she was experiencing.

Proximal past (precipitating factors). With Cindy's mother being her primary support and probably the only stable factor in her life, the negative core beliefs were kept at bay for most of the time. Cindy did not need to confront or deal with these unhelpful core beliefs, since the security, friendship and stability that the relationship with her mother offered her at the time led to emotional stability. When her mother suddenly (and unexpectedly) passed away, everything she held at a core belief level was negatively activated and confirmed. Not only was her primary source of support removed, but this loss reinforced the notion that everything in life is unstable and unpredictable: Suddenly, she had to deal with all of this by herself, with no external support. Shortly after her mother passed away, the first high levels of anxiety and panic attacks started. This trigger event (her mother passing away) clearly activated her range of negative core beliefs, which had a profound impact on her general cognitions in most situations. This made her feel exposed, unsafe and without support in a world where things are unpredictable and uncertain. It is, therefore, not surprising that the associated cognitions triggered a range of anxiety symptoms since they activated all of the aspects in the metacognitive model as explained above.

Here and now (perpetuating factors). After the initial high levels of anxiety and the first panic attack, Cindy's fear was not about having more panic attacks, but the problem appeared to be around the intolerance of uncertainty. She wanted to control the instability and uncertainty in life and to avoid the feelings of insecurity and self-doubt. As a result, she mainly tried to control her performance behaviours by devoting most of her time and energy

towards achieving academic excellence. This compensatory strategy clearly gave her a situational sense of self-worth and control over life, but the negative consequence was that she spent most of her time studying and not investing enough in building relationships. In a way, she was further isolating herself, perpetuating the problem. The lack of external support and long-lasting meaningful relationships, in turn, reinforced her beliefs about not belonging. This activated her self-doubt and feelings of insecurity which, in turn, made her revert to the compensatory behaviour of working harder and performing better. This, clearly, created a negative feedback loop which perpetuated her negative intermediate and core beliefs.

Focusing on Cindy's positive attributes (or protective factors), it ought to be noted that she has high levels of psychological mindedness, objectivity and adaptability. She is intelligent, hardworking and displayed good levels of social intelligence to form meaningful, stable interpersonal relationships (even though she did not devote sufficient time and energy to establish such relationships). She demonstrated very good self-insight and awareness and was clearly motivated for psychotherapy.

Functional analysis.

For the purposes of providing a functional analysis, a particular activating event from the case of Cindy will be used to illustrate the case conceptualisation. To this end and by highlighting the *immediate fear response*, Figure 4.2 illustrates an example of how the aforementioned global intermediate and core beliefs affected Cindy situationally. Figure 4.3 presents the *secondary elaborative reappraisal* as applicable to Cindy's case with the intention to explain why her *state of anxiousness* is being maintained.

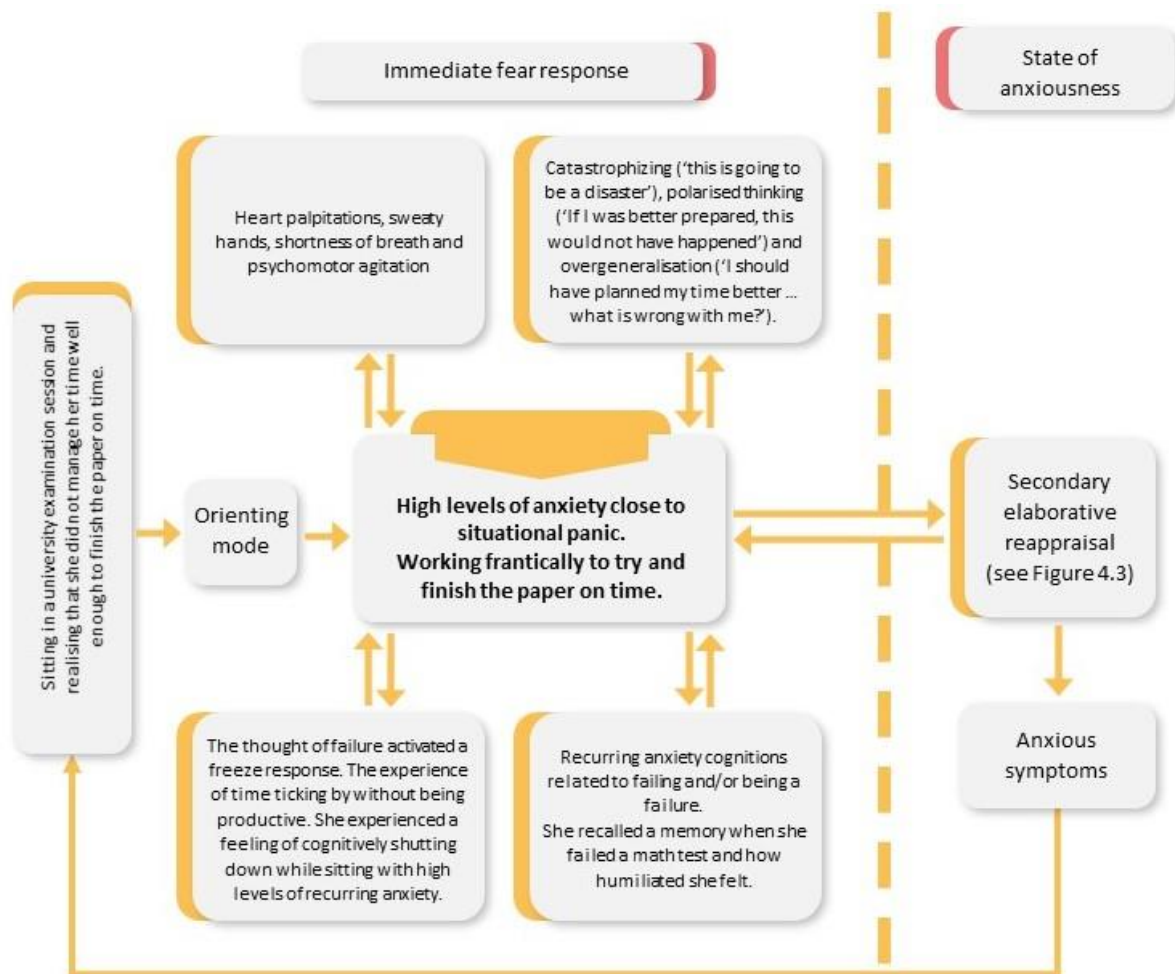


Figure 4.2. Practical application of the metacognitive model of anxiety to the case of Cindy



Figure 4.3 Practical application of the secondary elaborative reappraisal to the case of Cindy

Key change constructs.

Stage of change (or readiness for change). In terms of Prochaska's transtheoretical model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 2014), Cindy was in the *preparation phase* at the start of psychotherapy and quickly progressed to the *action phase*. She realised that she needed to

change and demonstrated a willingness to do so. She was motivated to attend sessions and to work on identified areas within and between sessions (Prochaska, Redding, & Evers, 2015).

Cognitive-emotive development of client. Cindy is in the *formal operational phase* in terms of Piaget's theory of cognitive development (Piaget, 1972) and, therefore, CBT is indicated as evidence-based treatment of choice (NICE, 2019; NIMH, 2019).

Mechanism of change. The specific CBT anxiety model (Clark & Beck, 2010) suggests that the activation of the primal threat mode is the initial reason why an individual will experience anxiety, but this can be mediated and changed by the secondary elaborate reappraisal of the activating event. Therefore, if the key mechanism for triggering anxiety is the activation of cognitive processing biases and recurring (or persistent) cognitions with specific threat-oriented thoughts and images, the key *mechanism of change* would be to a) create awareness of the impact of the aforementioned cognitive processes; and b) to reappraising and change these dysfunctional and unhelpful cognitive processes. The aim of psychotherapy is, therefore, to instigate change by helping Cindy to gain the necessary awareness of the triggers of anxiety and to find ways to change the *content* and *process* of her cognitions (Beck, 2011).

Therapy variables.

Relational variables. From the outset, the psychotherapist defined the therapeutic relationship as an equal relationship. Rapport was established with ease and the client cooperated from the first session. The psychotherapist encouraged Cindy to be honest and open in the therapeutic relationship and to say when any therapeutic technique or therapeutic intervention was helpful (or hindering). Cindy was also encouraged to ask questions whenever any uncertainty and/or ambivalence arose. At the outset, expectations were discussed from Cindy's and the psychotherapist's perspectives. Therapeutic goals were formulated collaboratively and mutually agreed upon. The psychotherapist often reflected on

the quality of the therapeutic relationship. The therapeutic alliance was of a high quality, and this was also evident from the follow-up with an independent person post therapy (see *monitor change process framework* section for themes identified from the follow-up interview).

Technique variables. Three sets of CBT techniques were used to focus on Cindy's content and process of thinking, namely: 1). cognitive awareness; 2). thought restructuring; and 3). cognitive disengagement (as already discussed in the *common aspects across both cases* section).

Measurement.

Process and outcome measures. The DASS-21 (Lovibond & Lovibond, 1995) was used as both a process and outcome measure during the therapeutic process with Cindy and was administered on four occasions during the process. The BAI (Beck et al., 1988) was used as a process measure and administered three times during the process. See Table 4.1 for a summative overview of the findings which clearly indicate that the scores in both measures decreased significantly during the psychotherapeutic process.

Depression, as measured on the DASS-21, decreased from an initial score of 14 (extremely severe) to a score of 0 (normal). Anxiety, as measured on the DASS-21, also decreased significantly from an initial score of 18 (extremely severe) to a score of 2 (normal). There was also a significant decrease in the anxiety scores as measured by the BAI with an initial score of 40 (high / potentially concerning levels of anxiety) to a score of 4 (low levels of anxiety). Finally, in terms of stress, the DASS-21 also highlights a significant decrease from an initial score of 15 (severe) to a score of 0 (normal). The client also indicated that she did not experience any anxiety attacks since psychotherapy started up and until termination (session 12).

Table 4.1

DASS-21 and BAI for Cindy

	Session	Score / Interpretation
*DASS-21	Pre-therapy (with application form)	Depression = 14 (extremely severe) Anxiety = 18 (extremely severe) Stress = 15 (severe)
	Session 1	Depression = 13 (severe) Anxiety = 15 (extremely severe) Stress = 12 (moderate)
	Session 10	Depression = 1 (normal) Anxiety = 0 (normal) Stress = 4 (normal)
	Session 11	Depression = 0 (normal) Anxiety = 2 (normal) Stress = 0 (normal)
**BAI	Session 6	40 (potentially concerning levels of anxiety)
	Session 10	7 (low levels of anxiety)
	Session 11	4 (low levels of anxiety)

*DASS-21 (Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995)

**BAI (Beck Anxiety Inventory; Beck et al., 1988)

Develop, test and monitor the change process framework.

Identify significant events (helpful and/or hindering factors). Cindy experienced the psychotherapist's approach and use of techniques as helpful. She did not mention any hindering factors. She also mentioned that she felt comfortable enough to mention any hindering factors during sessions with the psychotherapist, should these have occurred. In terms of Cindy's session attendance, she attended 100% of the scheduled sessions, which is regarded as a helpful factor and directly relates to her readiness for change. See Table 4.2 for a summative overview of the scheduled sessions and relevant themes discussed.

Table 4.2

Overview of Cindy's scheduled sessions

Session	Date	Description / Themes discussed
Application form	2018/06/13	DASS-21 (1)
1	2018/08/06	DASS-21 (2); Clinical interview
2	2018/08/15	T-shirt (self-esteem)
3	2018/08/23	Family dynamics and loss of mother
4	2018/08/28	Cognitive behaviour therapy: Psychoeducation
5	2018/09/11	Exploring examples of recent anxiety attacks
6	2018/09/25	BAI (1); Exploring recent anxiety levels
7	2018/10/09	Cognitive behaviour therapy: Homework sheets
8	2018/10/15	Mindfulness: Psychoeducation
9	2018/10/24	Explore and challenge procedural beliefs
10	2018/11/08	DASS-21 (3); BAI (2); Reflection on changes
11	2019/01/28	DASS-21 (4); BAI (3); Preparation for termination
12	2019/02/12	Termination session
Follow-up	2019/04/02	Interview with individual supervisor

Identify empirical markers (or themes). On an intrapersonal level, Cindy's levels of anxiety can be regarded as an important empirical marker (addressing her first and second therapeutic goals). In addition, she also reported experiencing self-doubt, insecurity and uncertainty. Consequently, she felt as though she was not good enough, a failure or even incompetent at times. Thus, another clear empirical marker is Cindy's level of depression that manifested through the way Cindy spoke about and presented herself in psychotherapy (addressing her third therapeutic goal). In this regard, her self-doubt, insecurity and uncertainty serve as indicators.

When considering Cindy's coping, an empirical marker was her ability to distribute her time and energy more equally between the performance- and relationship-related aspects of her life (addressing her third and fourth therapeutic goals). This will be evident when, for example, Cindy no longer channels her insecurity and self-doubt into her academic performance at the expense of her interpersonal relationships.

On an interpersonal level, Cindy reported that she struggled to develop and maintain meaningful interpersonal relationships. This was a consequence of Cindy perceiving others to be inconsistent and unpredictable and the world as unstable and possibly dangerous. As a result, she felt as though she did not belong and did not fit in. Since she reported a need to increase her interpersonal effectiveness, a clear empirical marker was Cindy's ability to develop and maintain new meaningful, stable relationships (also addressing her third and fourth therapeutic goals).

Evidence-informed responses to empirical markers (or themes). All of the empirical markers or themes were adequately addressed using an evidence-based model (namely the metacognitive model) from a CBT framework (Beck, 2011; Clark & Beck, 2010).

Monitor change process framework. Regarding the identified empirical markers (or themes), a distinction can be made between interpersonal and intrapersonal empirical markers. Firstly, and directly relating to her presenting problem, Cindy's level of anxiety was regarded as the most important empirical marker. In terms of anxiety, she reported a consistent decline in her levels of anxiety over time throughout the course of psychotherapy (see Table 4.1). From Table 4.1, it is clear that her presenting problem was addressed, highlighting a significant change in terms of anxiety as an empirical marker (addressing the first and second therapeutic goals). Another intrapersonal empirical marker was Cindy's level of self-doubt, insecurity and uncertainty. As psychotherapy progressed, she started talking more about herself from a positive or 'good enough' perspective and also started highlighting her strengths, abilities and talents. This represents a clear change regarding this intrapersonal empirical marker (addressing the third and fourth therapeutic goals). Next, Cindy's coping was also regarded as an empirical marker, specifically regarding her tendency to channel most of her time and energy into academic performance at the expense of meaningful interpersonal relationships. This empirical marker, in effect, contains both an intrapersonal

and interpersonal component. During the course of psychotherapy, there was a marked change in coping with Cindy investing more time and energy into interpersonal relationships and being able to achieve and maintain a healthier balance between the performance- and relationship-related aspects in her life (also addressing her third and fourth therapeutic goals). Of interest here is that her academic performance remained at the same very high level, even though she invested less time in it. This also clearly indicates that there is a significant change in terms of coping as one of her empirical markers.

An interpersonal empirical marker was Cindy's need to develop and maintain new meaningful, stable relationships. It became evident towards the end of the therapeutic process that Cindy started talking more about the importance of new friends she has made and the positive feedback they gave her as part of her social support network. This represents an important change regarding this interpersonal empirical marker (also addressing the third and fourth therapeutic goals).

From the abovementioned, it is evident that the case conceptualisation informed the empirical markers and that the empirical markers were dealt with in an evidence-informed manner. The accuracy of the case conceptualisation and the effectiveness of handling the empirical markers are clearly highlighted by the changes observed and described from Cindy's and the psychotherapist's perspective regarding all of the identified empirical markers (or themes). This serves as confirmation that the formulation of Cindy's change process framework could be regarded as accurate and that the psychotherapist could, consequently, adhere to this framework.

During the psychotherapy sessions, Cindy and the psychotherapist continuously and frequently reflected on her progress. She mentioned the possibility of termination at the end of session 10, as she believed that her therapeutic goals have been achieved, but was unsure if the change would last. This notion was discussed further in session 11, which occurred 12

weeks later when she was ready to start the process of termination. Session 12, which occurred another two weeks later, served as termination session and confirmation that the change did, in fact, occur and appears to last. Based on the process measures, Cindy was doing even better in session 12 than in session 11. These changes are also confirmed and highlighted by the process and outcome measures used (see Table 4.1) as well as the themes reported during the follow-up interview.

In the follow-up interview, conducted by the individual supervisor seven weeks after termination, Cindy confirmed that she was still improving and maintaining (and even building on) the changes resulting from psychotherapy. Stemming from the follow-up interview, the reflective team identified the following prominent themes with regards to her general experience of the therapeutic process: 1) positive and refreshing; 2) respectful; 3) practical, interactive, collaborative and productive; 4) helpful in changing mind-set by providing a new perspective that is a better fit with reality; and 5) flexible in as far as the process was adapted or tailored according to her personality and needs. The following within-therapy themes were also identified: 1) good open communication; 2) good client-therapist interaction and relationship; 3) professional therapeutic relationship without being too clinical; 4) psychotherapist perceived as hands-on and the therapeutic relationship as mutually respectful and reciprocal 5) good use of techniques (appreciated the use of visual representations or illustrations in particular); 6) psychoeducation helpful to gain an understanding of and to follow the process with ease; 7) therapeutic approach made it possible to take ownership of psychological processes (to quote Cindy, “to become my own therapist”); and 8) therapeutic confrontation facilitated personal introspective processes. Finally, in terms of extra-therapeutic factors, only one theme was identified, namely the role of external sources that provided positive feedback and formed a support system. Note, too,

that on concluding the follow-up interview, Cindy remarked that she would strongly recommend psychotherapy to others.

Case Two: The Case of Mark

Background information.

Mark is a 28-year-old male student currently busy with a PhD in the field of natural sciences. He presented with a neurological sleeping disorder and chronic pain due to a cracked vertebrae and herniated discs. According to Mark, this was confirmed by a medical specialist, but he could not provide supporting evidence to the psychotherapist. In addition, he also presented with high levels of anxiety and depression. He has been in psychotherapy with numerous psychotherapists in the past and has also consulted with several medical specialists, including neurologists and psychiatrists. He was previously diagnosed with obsessive compulsive personality disorder, obsessive compulsive disorder, major depressive disorder, generalised anxiety disorder and panic disorder, to name but a few. He reports hoarding as a problem and also mentioned an excessive need for control and symmetry. He frequently experiences anxiety attacks which had its first onset in July 2016. He comes across as someone who is highly self-critical and who does not respond well to change. When speaking about himself, he mainly refers to himself as a 'scientist'. He enjoys listening to music and playing guitar, as well as playing computer games, fishing and hunting. He is currently on medication and occasionally abuses substances (mainly alcohol, cannabis, LSD and occasionally heroin). He indicates a preference for psychedelics when it comes to abusing substances. At the start of psychotherapy, he mentioned that he has not been in a romantic relationship for more than seven years and that he had a lack of meaningful relationships in general.

Psychological understanding of the client.

General model on a macro level. According to the DSM-5 (American Psychiatric Association, 2013), Mark best meets the criteria for ‘other specified anxiety disorder’. Although he presented with panic attacks, he did not meet the criteria for panic disorder. He also displayed symptoms of social anxiety, obsessive-compulsive disorder as well as some generalised anxiety disorder symptoms but failed to meet the full criteria for a diagnosis in any of the aforementioned categories.

When working with most anxiety disorders, CBT is generally indicated as an evidence-based treatment approach of choice (NICE, 2019; NIMH, 2019), as it is geared towards identifying the mechanisms of anxiety, as well as changing the cognitions involved in triggering and maintaining various forms of anxiety. Given Mark’s presentation and background information, the main aim of psychotherapy would be to assist him in understanding the origin of his anxiety but, more importantly, to teach him how to control it more effectively.

Specific model on a micro level. Anxiety is a complex cognitive, affective, physiological and behavioural response pattern that is activated when an event is subjectively interpreted as being a highly uncertain, uncontrollable or unpredictable threat. Thus, anxiety is a subjective response pattern triggered when fear is activated. Clark and Beck (2010) point out that anxiety is the tendency to overestimate the threat and to underestimate one’s resources to deal with the threat. This, as was also highlighted in the case of Cindy, is referred to as the *risk: resource ratio* in anxiety. It is helpful to view anxiety as an emotion ranging on a continuum with concern and stress on the one side (known as the healthy side of anxiety) and over-concern, distress, anxiety and panic (known as the unhealthy side of anxiety) on the other. Within this continuum, it is useful to distinguish between functional or healthy anxiety and dysfunctional or unhealthy anxiety. By developing the skill to identify this boundary,

anxiety is normalised and consequently becomes less distressing and disruptive in day-to-day living. As a result, individuals realise that the elimination of all anxiety is not possible or even desirable. Hence, CBT aims to reduce anxiety levels to within the healthy range of human functioning.

On a neurological level, when anxiety is triggered, prefrontal cortex based executive functions (for example rational thinking, deductive reasoning, analytical thinking, planning and problem solving) are inhibited and the limbic system (amygdala) responds to the affective significance of physical or mental stimuli. The prefrontal cortex is the part of the brain responsible for conscious, cognitive processes, while the amygdala in the limbic system is often referred to as the emotional brain that provides emotional processing of stimuli. The prefrontal cortex provides input to the limbic system, which in turn will activate, causing activity in the prefrontal cortex to situationally disengage, as the chemical and electrical activity in the limbic system generates significant activity in this region, which can activate the fight-or-flight response. The fight-or-flight response is a natural survival mechanism when used appropriately but, seeing that anxiety is *a false alarm to a perceived threat*, this response is mostly activated in the absence of an actual threat (and thus unnecessary). Within the cognitive model of anxiety, the intervention focuses on inhibiting anxiety by engaging the prefrontal cortex in the process of reasoning and meaning-making when it comes to emotional experiences. Furthermore, seeing that cognitions play an important role in producing anxiety, increased executive functioning can inhibit anxiety so as to remain within the healthy boundaries that are necessary for daily human functioning.

The aim of psychotherapy will, therefore, be to identify and modify the unhelpful cognitions which are affecting Mark's anxiety response. See Figure 4.4 for a visual illustration of the cognitive model for anxiety (Clark & Beck, 2010).

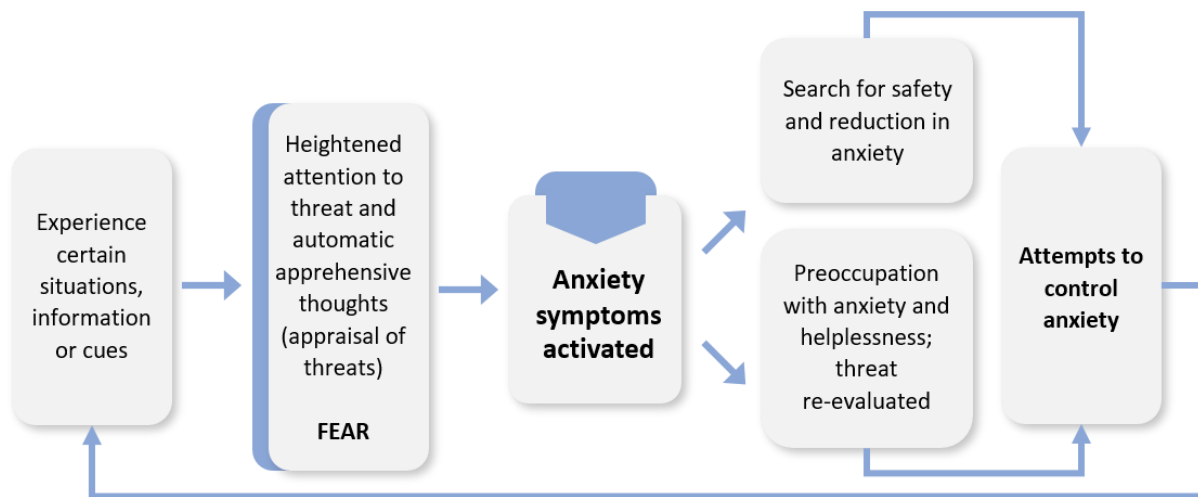


Figure 4.4. Cognitive model of anxiety

Within this specific CBT model for dealing with anxiety, the following therapeutic goals were formulated as *superordinate therapeutic goals* for Mark: 1) to increase his cognitive awareness; 2) to increase his understanding of his anxiety and depression symptoms; and 3) to increase his self-worth. In order to achieve these superordinate goals, the following *subordinate therapeutic goals* were formulated in collaboration with Mark with the aim to promote his best interest: 1) to decrease his anxiety symptoms (by targeting the relevant cognitive processes); 2) to decrease his depressive symptoms (by looking at the cognitive and behavioural interactions); and 3) to increase his levels of self-acceptance (through cognitive disengagement techniques).

Case conceptualisation.

Distal past (predisposing factors). Mark describes that his parents divorced when he was very young. Both parents remarried, and he has a half-brother on his father's side who is 18 years younger than him and two half-sisters on his stepfather's side who are both younger than him. He describes a poor relationship with his stepmother and half-brother, but good relationships with his father, mother, stepfather and two half-sisters. He was bullied in primary school and felt different compared to his peers. When talking about his primary school years, he describes himself as shy and an introvert. He mentions that everyone viewed

him as an outsider. Consequently, he did not have meaningful relationships with peers and found himself constantly reasoning about emotional matters. According to him, he then realised that “my brain works differently than those around me”. He mentions that he found it difficult to relate to his peer group in primary school due to his “superior intellect”. This resulted in him frequently feeling misunderstood by others.

The events mentioned above had a significant impact on the development of Mark’s core beliefs as they occurred during crucial formative years in primary school. He did not only perceive these events as negative but extracted key learning experiences from them that led to him to develop core beliefs about himself, others and the world. Regarding himself, he developed the belief that he is *shy, different from his peers* and that he *does not fit in anywhere*. Furthermore, he was bullied and labelled in primary school and consequently perceived others to be cruel. He also developed scepticism about relationships stating that *relationships will not last* and *it is not worth investing in relationships*. In his process of ascribing meaning to other individuals’ treatment of him, he did not question or doubt his own abilities and/or self-worth but rather compensated by viewing himself as superior compared to others (often referring to his “superior intellect”, for example). Based on his early interactions with significant others, he developed the belief that *life is more about performance than it is about relationships*. As a result, he started measuring himself against his performance (mainly academic or intellectual at that time). He then started viewing the world as “being comprised of a set of tasks that needs to be completed”. In line with this reasoning, he frequently refers to himself as being “a supercomputer” that “needs to be able to complete these tasks perfectly”. These were some of the main predisposing factors which partially explains Mark’s presenting problem and particularly the anxiety he experienced.

For survival, both psychologically and physically, Mark developed a set of rules, assumptions and attitudes (also referred to as intermediate or procedural beliefs) that aims to

prevent the activation of his negative core beliefs. Regarding the self, he developed the rules that “I must excel in academics”, “I must be exceptional” and “I must be perfect” to keep him from feeling defective and like a social misfit. When it comes to other individuals, he developed the rule that “I am not allowed to be the norm” as justification for not investing emotionally in others and perpetuated this notion with the assumption that “being the norm means that I have failed”. The function of these intermediate beliefs is to protect his self-worth from being challenged or questioned. In attempting to protect his self-worth by excelling on an academic performance level, he compensated for feeling like a social misfit. This can be viewed as a behavioural consequence that did not only develop but was also maintained over time and became a behavioural pattern (or a safety behaviour that developed into a compensatory strategy).

Proximal past (precipitating factors). Mark describes himself as a rebel in his high school years who found his self-worth and meaning through music and, in particular, playing the guitar. In line with the belief system that he developed, he also had to excel at playing this instrument. The difference was that he received significantly more acknowledgement and recognition for his ability to play the guitar than he did for his sustained high academic performance. In mastering this skill, he did not allow his academic performance to decline and maintained grades above 80% throughout his entire school career. As a result of his exceptional academic performance, he was offered full bursaries by several universities and felt as though he was in demand. Mark’s experience of high school was vastly different and more positive than that of primary school.

This pattern persisted in his university studies where he performed well academically, although he did not obtain his undergraduate and Honours degrees with distinction (he still maintained above-average academic grades). During his university studies, he played in several bands, abused alcohol and started experimenting with different types of substances.

Even though he pursued a party lifestyle characterised by frequently hanging out at live music venues where he abused alcohol and drugs, he still maintained good academic performance. He started developing two sets of beliefs, which he describes as beliefs about himself as a scientist and beliefs about himself as a person living in the world with others. As a scientist, he believed that “I must constantly be able to accurately quantify all measurable variables” and developed a rule stating that “I need to receive a Nobel Prize for me to be good enough”. As a person living in the world, he believed that “I have a need to socialise, but I lack the social skills to do so” and “interpersonal relationships are easier for other people and much more difficult for me, because I have a superior brain and reason cognitively about emotional processes”. With reference to beliefs about the world, he stated that “life has infinite possibilities...”, continuing by stating that “...I can’t control all of these variables”.

A significant event occurred four years ago when Mark collapsed in the laboratory while in the second year of his master’s degree in the field of natural sciences. He attributes this event to working exceptionally long hours resulting in a serious lack of sleep. One can argue that he was in denial about his limitations as a human being and rather equated himself to a computer (or some sort of robot, for that matter). After the collapse in the laboratory, he started experiencing chronic pain, chronic fatigue and a resultant loss of identity. According to Mark, he sustained nerve damage due to, what he refers to as “disrupted sleep architecture”. Mark describes this as a precipitating event to his neurological sleeping disorder. Accompanying the physical symptoms (which he regards as the primary problem), he experienced an array of psychological symptoms (which he describes as secondary problems). During this time, he was treated by several medical professionals and specialists and took one year’s sick leave, during which time he could not continue working on his studies.

The abovementioned significant event was a direct threat to Mark's beliefs about himself, others and the world. As a result, he started experiencing increased levels of anxiety culminating in panic attacks.

Here and now (perpetuating factors). Mark recently obtained his master's degree with distinction and is currently enrolled for a PhD. He still reports difficulty sleeping, as well as a range of physical symptoms and psychological problems. The physical symptoms include chronic pain (especially in his back) and chronic fatigue. The psychological problems include, but are not limited to, mood and anxiety symptoms, obsessive-compulsive tendencies (such as hoarding and a need for symmetry), substance abuse and some dysfunctional personality traits. He complains excessively about the abovementioned physical and psychological symptoms which he experiences intensely on a regular basis. Seeing that there is a combination of physical and psychological problems, the possibility should be explored that some of these physical symptoms might be psychosomatic by nature and can possibly exacerbate his high levels of anxiety (particularly seeing that Mark could not provide the psychotherapist with evidence thereof).

He has very high levels of anxiety that are observable in sessions. His anxiety occasionally still escalates to the point of a panic attack. In addition, he reports a lack of meaningful relationships with significant others, across different contexts. Seeing that Mark mostly focuses his energy and attention on performance-related aspects, he neglects several significant relationships. This has become a compensatory strategy used by him to experience a temporary sense of self-worth and control over himself, others and life. The consequence is that he does not invest enough time and energy in developing and maintaining meaningful interpersonal relationships. Mark is left with a feeling of still being a social misfit that is misunderstood by others and different compared to them. Even though he verbalises a need for meaningful interpersonal relationships, he believes that he does not have adequate

interpersonal skills to develop and maintain such relationships. This realisation activates a negative feedback loop, as the more he realises that he does not fit in socially, the harder he works academically (thus perpetuating his negative intermediate and core beliefs).

In addition, and focusing on his positive attributes (or protective factors), Mark is intelligent and hardworking. He expresses a need to develop and maintain meaningful interpersonal relationships and to achieve a balance between performance- and relationship-related aspects.

Functional Analysis

The following example, as presented in Figure 4.5, will illustrate how Mark's unhelpful thinking processes (negative intermediate and core beliefs) affect him situationally.

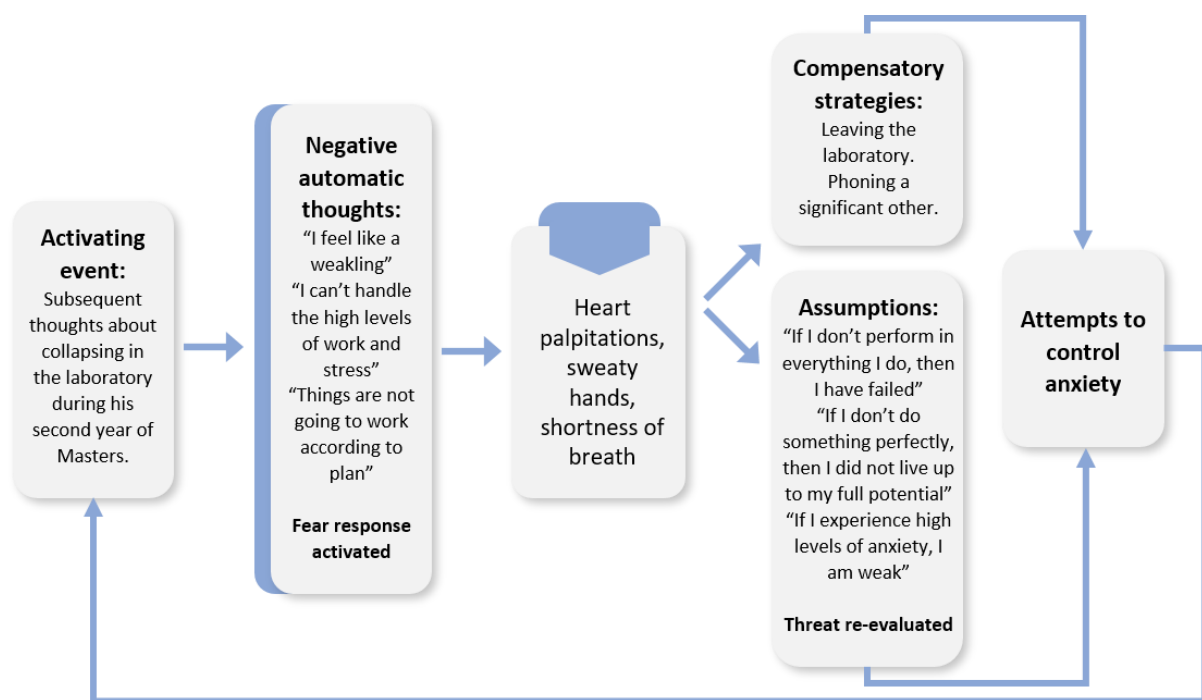


Figure 4.5. Practical application of the cognitive model of anxiety to the case of Mark

Key change constructs.

Stage of change (or readiness for change). In terms of Prochaska's transtheoretical model (Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska & Norcross, 2014), Mark appears to be in the *contemplation phase*. He realises that he needs to change but

does not yet demonstrate a willingness to change (Krebs, Norcross, Nicholson, & Prochaska, 2019). His attendance of sessions was poor, and he did not complete homework between sessions. He also did not appear committed to work on the therapeutic goals and on prominent themes identified in or between sessions. His history of previous long-term processes with other psychotherapists is also relevant and impacts negatively on his prognosis (Prochaska et al., 2015).

Cognitive-emotive development of client. In terms of Piaget's theory of cognitive development (Piaget, 1964), Mark is in the *concrete operational phase* (Piaget, 1972); therefore, CBT is indicated as the evidence-based treatment approach which should be able to work effectively with him (NICE, 2019; NIMH, 2019).

Mechanism of change. The key mechanism triggering Mark's anxiety is the activation of cognitive processing biases; therefore, the key *mechanism of change* would be a) creating awareness of the impact of the aforementioned cognitive processes; and b) reappraising and changing these dysfunctional and unhelpful cognitive processes. The ultimate aim of Mark's psychotherapy is, therefore, to critically check, challenge and change his cognitive sub-systems. This is accomplished by, firstly, creating the necessary cognitive awareness of his anxiety triggers and, secondly, by finding ways of changing the content of cognitions through cognitive restructuring and, finally, to apply cognitive disengagement techniques.

Therapy variables.

Relational variables. From the outset, the psychotherapist defined the therapeutic relationship as an equal relationship. Rapport was difficult to establish, and the client cooperated fairly from the first session. The psychotherapist encouraged Mark to be honest and open in the therapeutic relationship and to say when any technique or therapeutic intervention was helpful (or hindering). Mark was also encouraged to ask questions whenever any uncertainty and/or ambivalence arose. At the outset, expectations were discussed from

both Mark's and the psychotherapist's perspectives. Therapeutic goals were formulated collaboratively and mutually agreed upon. The psychotherapist often reflected on the quality of the therapeutic relationship during the process. Given Mark's lack of interpersonal skills and his social awkwardness, it is not surprising that the quality of the therapeutic alliance can be described as 'average' at best. Some of the abovementioned themes were evident from a follow-up interview post therapy (see *monitor change process framework* section for themes identified from the follow-up interview).

Technique variables. In order to address the content and process of Mark's thinking, three sets of techniques were used, namely: 1) cognitive awareness; 2) thought restructuring; and 3) cognitive disengagement.

Measurement.

Process and outcome measures. The DASS-21 (Lovibond & Lovibond, 1995) was used as both a process and outcome measure during the therapeutic process with Mark. The DASS-21 was administered four times during the process. The BAI (Beck et al., 1988) was used as a process measure and also administered on four occasions during the process. From Table 4.3, the scores on both measures decreased during the process of psychotherapy.

Depression, as measured on the DASS-21, decreased significantly from an initial score of 11 (extremely severe) to a lowest score of 3 (normal). Anxiety, as measured on the DASS-21, remained at extremely severe levels throughout the therapeutic process. There was also a decrease in the anxiety scores as measured by the BAI with an initial score of 40 (potentially concerning levels of anxiety) to a score of 25 (moderate levels of anxiety). Finally, in terms of stress, the DASS-21 also highlights a decrease from an initial score of 16 (severe) to a lowest score of 8 (mild).

Table 4.3

DASS-21 and BAI for Mark

	Session	Score / Interpretation
*DASS-21	Session 1	Depression = 11 (severe) Anxiety = 15 (extremely severe) Stress = 16 (severe)
	Session 13	Depression = 7 (moderate) Anxiety = 11 (extremely severe) Stress = 8 (mild)
	Session 33	Depression = 3 (normal) Anxiety = 10 (extremely severe) Stress = 8 (mild)
	Follow-up	Depression = 4 (normal) Anxiety = 13 (extremely severe) Stress = 10 (moderate)
**BAI	Session 5	40 (potentially concerning levels of anxiety)
	Session 13	34 (moderate levels of anxiety)
	Session 33	32 (moderate levels of anxiety)
	Follow-up	25 (moderate levels of anxiety)

*DASS-21 (Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995)

**BAI (Beck Anxiety Inventory; Beck et al., 1988)

Develop, test and monitor the change process framework.

Identify significant events (helpful and/or hindering factors). Mark experienced the psychotherapist's approach and use of techniques as helpful. He did not mention any hindering factors. He made a recommendation, during the follow-up interview, that he would have appreciated receiving additional reading material on topics relevant to his presentation and mechanisms of change in order to have an even better understanding thereof. Mark attended 63% of his scheduled sessions, which can be regarded as a hindering factor, and which can be directly linked to his readiness to change. Table 4.4 provides a summative overview of his scheduled sessions and the relevant themes discussed.

Table 4.4

Overview of Mark's scheduled sessions

Session	Date	Description / Themes discussed
1	2018/08/08	DASS-21 (1); Clinical Interview
2	2018/08/14	MMSE; Clinical Interview (continue)
3	2018/09/21	Psychoeducation: Cognitive behaviour therapy and anxiety

4	2018/09/26	Cognitive behaviour therapy: Homework sheets;
5	2018/10/03	BAI (1); Identify mind traps
6	2018/10/11	Explore motivation to change Explore self-worth statements
7	2018/10/19	Metaphor (athletics field): passive observer vs. active participant
8	2018/10/22	New romantic relationship Family dynamics
9	2018/10/30	Identity: student vs. young adult Where do I fit in? Who am I?
10	2018/11/08	Trauma: robbed at knife point Containment and trauma debriefing
11	2018/11/15	Did Not Attend (1)
12	2018/12/07	Explore identity further
13	2018/12/11	DASS-21 (2); BAI (2); Explore identity further
14	2019/01/16	Coping with uncertainty
15	2019/01/25	Explore coping styles
16	2019/01/30	Difference between his self-concept and personality. Reflection on his interpersonal impact
17	2019/02/07	Did Not Attend (2)
18	2019/02/11	Key learning events analysis Developmental timeline
19	2019/02/19	Did Not Attend (3)
20	2019/03/04	Continue with key learning events analysis Developmental timeline
21	2019/03/12	Did Not Attend (4)
22	2019/04/01	Explore key learning events from primary school years and the associated beliefs
23	2019/04/05	Did Not Attend (5)
24	2019/05/10	Explore key learning events from high school years and the associated beliefs
25	2019/05/14	Did Not Attend (6)
26	2019/06/06	Cognitive disengagement
27	2019/06/13	Did Not Attend (7)
28	2019/06/20	Did Not Attend (8)
29	2019/06/27	Did Not Attend (9)
30	2019/07/25	Balance between performance- and relationship-related aspects
31	2019/08/02	Did Not Attend (10)
32	2019/08/06	Did Not Attend (11)
33	2019/08/19	DASS-21 (3); BAI (3); New romantic relationship
34	2019/08/26	Did Not Attend (12)
35	2019/09/09	Did Not Attend (13)
Follow-up	2019/10/08	DASS-21 (4); BAI (4); Interview with individual supervisor

Identify empirical markers (or themes). On an intrapersonal level, Mark's levels of anxiety are regarded as an important empirical marker (addressing the first subordinate

therapeutic goal). In terms of anxiety, as an empirical marker, it is important to pay attention to the triggers for his anxiety as well as the context and nature thereof. It appears that there is a strong social component to his anxiety, but then also a strong performance component. In terms of the social component to his anxiety, he believes that he is a very shy introvert and that he is different from others. In terms of the performance component to his anxiety, he believes that he should be able to maintain a very high level of performance, no matter what. The desired level of performance that he aims to maintain is at the level of perfection. The abovementioned provides the context in which the nature and extent of Mark's anxiety is conceptualised as an empirical marker (addressing the first and second therapeutic goals). Mark's level of depression is regarded as another important intrapersonal empirical marker (addressing his second subordinate therapeutic goal). Also, Mark's possible psychosomatic symptoms is another empirical marker. In this regard, the psychotherapist is mindful of the frequency and intensity of the possible psychosomatic complaints reported by Mark.

On an interpersonal level, Mark has a need for more meaningful interpersonal relationships and that he believes that he does not have the social skills required to form and maintain such meaningful relationships (to address his third subordinate therapeutic goal). An empirical marker would be the quality of Mark's interpersonal relationships in different contexts, namely relationships with his family members and friends, professional relationships at university and intimate relationships. In this regard, Mark verbalised a strong need for a romantic relationship. When Mark succeeds in forming and maintaining such meaningful interpersonal relationships, it will also address his feeling of being different and not fitting in anywhere.

Next, an empirical marker that succeeds in integrating both the intrapersonal and interpersonal level is the ability to achieve and maintain a balance between the performance-

related and relationship-related aspects of Mark's self-worth and functioning (to also address his third subordinate therapeutic goal).

Evidence-informed responses to empirical markers (or themes). All of the empirical markers or themes were adequately addressed using an evidence-based model (namely the cognitive model of anxiety) from a CBT framework (Beck, 2011; Clark & Beck, 2010).

Monitor change process framework. Regarding the identified empirical markers (or themes), a distinction was made between interpersonal and intrapersonal empirical markers. Mark's levels of anxiety, levels of depression and possible psychosomatic symptoms were regarded as three important intrapersonal empirical markers. Although his anxiety levels remained relatively constant throughout the psychotherapeutic process (see Table 4.3), Mark experienced significantly fewer anxiety attacks since the beginning of psychotherapy (referring to the first subordinate therapeutic goal). Regarding his levels of depression, there was clearly a significant decrease from severe to normal levels of depression (see Table 4.3). This indicates that Mark made good progress in achieving his second subordinate therapeutic goal. His psychosomatic symptoms, though, fluctuated significantly throughout the psychotherapeutic process.

Next, in terms of interpersonal empirical markers (or themes), Mark managed to establish two romantic relationships during the psychotherapeutic process, of which the first did not last long, but he currently finds himself in another romantic relationship. He finds the current romantic relationship meaningful and believes that it holds potential for sustainability. Mark should be commended for being brave enough to take the social risks in pursuing these relationships, as he initiated them on both occasions. In terms of the other relational contexts, Mark's relationships with family members remain more or less the same, and he also did not manage to form any new friendships in the course of psychotherapy. His professional

interpersonal relationships appear to be satisfactory and can be described as functional and/or adequate.

Finally, when combining the intrapersonal and interpersonal empirical markers, Mark developed a strong need to be able to balance the performance-related and relationship-related aspects of his functioning better. Mark realised that he does not only want to be known as an important scientist in his field, but that he also wants someone with whom he can share his life. This realisation prompted him to put himself in situations where he could meet a potential partner. He also developed the need to have a family one day. Upon realising that the scientist is only a part of him (namely the performance-related aspects) and not all of him, it created room to explore and to develop the need to also include more relationship-related aspects. In terms of all the empirical markers discussed, Mark demonstrated the most improvement with the latter, which relates directly to his third subordinate therapeutic goal. From the abovementioned, it is clear that the case conceptualisation informed the empirical markers (or themes) and that the empirical markers were dealt with in an evidence-informed manner.

Mark attended 22 of his 35 scheduled psychotherapy sessions (see Table 4.4). His poor session attendance (63% of sessions attended), noncompliance with homework and lack of commitment to work on therapeutic goals were hindering factors that interfered with his change process. As a result, the psychotherapist, individual supervisor and reflective team members frequently reflected critically regarding Mark's lack of progress and questioned the accuracy of the case conceptualisation. It is also important to highlight that his continuous use of substances throughout the psychotherapy process, was another hindering extra-therapeutic factor that hampered his outcome. It is important to mention that in terms of Prochaska's transtheoretical model (Prochaska & DiClemente, 1983; Prochaska & Norcross, 2014), Mark failed to progress beyond the *contemplation phase*, despite the attempts by the

psychotherapist to assist him in transitioning (Krebs et al., 2019). The abovementioned factors explain, to a very large extent, why Mark did not manage to achieve all of his therapeutic goals during this psychotherapeutic process.

From a follow-up interview, the following themes were identified by the reflective team relating to how Mark experienced the therapeutic process: He found the therapeutic process to be 1) positive; 2) a means to facilitate self-improvement and 3) a marked improvement compared to previous exposures to psychotherapy. In addition, according to the reflective team, Mark reported a significant decrease in anxiety symptoms (theme 4), resulting in a significant improvement in many other areas apart from anxiety (theme 5), which might explain why Mark regarded the therapeutic process as being top-level (theme 6) (*experienced the full power of the psychotherapeutic process for the first time*). Next, in terms of the therapeutic relationship, the following themes were highlighted in Mark's case: 1) good client-therapist fit; 2) high levels of empathy displayed by psychotherapist; 3) therapeutic relationship of an acceptable quality maintained throughout; 4) working method tailored by psychotherapist to fit the client's needs (proper understanding of the client's internal working models); and 5) high level of compatibility between client and psychotherapist. When reflecting on the therapeutic techniques, the following themes were prominent in the follow-up interview with Mark: 1) used appropriately; 2) followed a logical order and applied in a manner that made sense; 3) applied meaningfully and coherently; 4) followed a good layout and planned methodologically; 5) use of analogies or metaphors to illustrate internal and external dynamics highly valued; 6) enabled Mark to create a new perspective (*by looking at the same thing, but in a different way*); 7) facilitated introspection and metacognition; 8) found the use of psychoeducation helpful and/or valuable; and 9) increased awareness and/or insight into internal and external dynamics. When talking about the role of extra-therapeutic factors, Mark highlighted two aspects, namely: 1) mainly experienced negative extra-

therapeutic factors, but these did not result in setbacks or relapses; and 2) new romantic relationship was the only positive extra-therapeutic factor. Mark mentioned that although he was made to realise and face certain uncomfortable truths about himself in this psychotherapeutic process, he experienced this as positive and therapeutic (as it did not result in an increase in depression and/or anxiety, but rather in a much better understanding of his internal working models). As a recommendation that will further improve the psychotherapeutic process, Mark recommended that he would have appreciated even more reading material offered to him regarding constructs related to his internal and external dynamics. Finally, as also mentioned during the follow-up interview with Cindy, Mark will strongly recommend psychotherapy to others based on his positive experience thereof.

Reflection

When comparing the cases of Cindy and Mark, there are important implications for research and clinical practice. Both clients were treated by the same psychotherapist, from a CBT perspective, under the supervision of the same individual supervisor and with input from the same reflective team. In addition, both clients were conceptualised according to the SP-CPP (developed in Chapter 3 – see Figure 3.4).

It was clear that the case of Cindy can be regarded as a good-outcome case, as all the therapeutic goals were achieved and psychotherapy was terminated after 12 sessions. Changes were highlighted by Cindy's outcome and process measure scores and also evident from the themes identified from the follow-up interview. The case of Mark, however, was a fair-outcome case seeing that not all the therapeutic goals were achieved and psychotherapy was not yet terminated after 22 attended sessions. Although the outcome and process measures indicate that Mark's case might be regarded as a poor outcome one, the same sentiment was not echoed by Mark during his follow-up interview, where he mentioned that

he found the therapeutic process very helpful. Therefore, by considering all the available sources of information, Marks' case is regarded as a fair outcome one.

Possible reasons for the difference between the good-outcome case of Cindy and the fair-outcome case of Mark could be hypothesised from the SP-CPP. In this regard, the most significant sections are the *key change constructs* and the *therapy variables*, in particular relational variables. Regarding the key change constructs, Cindy moved from the *preparation* into the *action phase* according to Prochaska's transtheoretical model (Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska & Norcross, 2014), which partly explains the good progress she made. In addition, she was in the *formal operational phase* of cognitive development according to Piaget (1964; 1972), which indicates that her insight was not limited to cognitive insight within psychotherapy sessions, but she also applied this insight practically outside and between psychotherapy sessions. Mark, on the other hand, remained in the *contemplation phase* (Prochaska & Norcross, 2014), which partly explains the lack of progress he made. This lack of progress can also be explained by the *concrete operational phase* in which he finds himself according to Piaget's theory of cognitive development (Piaget, 1964; 1972). This is evident from the difference between the cognitive insight Mark displays within psychotherapy sessions and his lack of practical application outside psychotherapy sessions. Mark appears to understand the concepts cognitively (referring to *cognitive insight*) but lacks the internalisation and practical application thereof (referred to as *psychological or true insight*). This becomes a linear style of thinking where cognitive insight and understanding does not necessarily translate into subsequent behaviour change (Beck, 2011; Clark & Beck, 2010).

In addition, Cindy had a 100% session attendance and worked on therapeutic goals in between sessions by doing the homework given to her, which also explains why she made good progress. With Mark only attending 63% of his sessions, and not being committed to

work on therapeutic goals in between sessions and not doing his homework, it is not surprising that he did not make sufficient progress in terms of all his therapeutic goals. In addition, his persistent substance abuse throughout the therapeutic process was another hindering factor that had a negative influence on the outcome of psychotherapy.

Also, in terms of the therapy variables, specifically the relational variables, the psychotherapist had a significantly better therapeutic alliance with Cindy than with Mark. It was easy to establish rapport with Cindy, and she demonstrated a high level of trust in the psychotherapist's level of professional competency. Seeing that Mark struggles with interpersonal relationships in general, the therapeutic relationship was no exception. Mark's interpersonal impact of social awkwardness and discomfort was also evident during the psychotherapeutic process and consequently resulted in a therapeutic alliance of an average quality. In addition, seeing that Mark views himself as superior to others, he also did not display as much trust in the psychotherapist's level of professional competency as Cindy did.

Through the use of these two case studies of clients presenting with anxiety who were both treated from a CBT perspective by the same psychotherapist, the value of the SP-CPP is illustrated when distinguishing between good- and fair-outcome cases. The SP-CPP makes provision to evaluate and assess all the possible variables which could be part of the change process and have an impact on the therapeutic outcome of a particular case.

Finally, the importance of therapist responsiveness throughout the process cannot be emphasised enough. The psychotherapist should aim to practice with moment-to-moment awareness and moment-to-moment purpose. This was highly appreciated by Cindy, and the same sentiment was also echoed by Mark.

Recommendations for Research and Clinical Practice

It is strongly recommended that psychotherapy researchers collaborate with practitioners and apply the SP-CPP during the psychotherapeutic process with different

clients with different presenting problems. In doing so, specific models can be developed for specific client populations treated from specific treatment approaches, for example CBT for children with anxiety-related difficulties or schema therapy for adults with relationship-related difficulties. It is also recommended to adapt the current approach for application in couples and family therapy, as well as group psychotherapy. By applying the abovementioned approach to diverse client populations, the need for possible modifications or adjustments can be identified and the approach can be refined to fit the needs of different client populations better. In this way, the practice-based evidence for the approach will culminate in a series of case studies which can become an important source informing the evidence-based nature and usefulness of the SP-CPP.

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CHAPTER 5

MANUSCRIPT 4

**The Scientist-Practitioner Approach to Change Process in Psychotherapy applied to
schema therapy: Two case studies**

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Abstract

This manuscript aims to illustrate that the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP) as an evidence-based treatment approach can contribute to a greater awareness of important change process elements and afford psychotherapists the opportunity to reflect on these elements from start to finish throughout the psychotherapeutic process. To this end, the findings of two schema therapy case studies following the SP-CPP will be reported and discussed, with recommendations as to how the SP-CPP can be improved. For the purposes of this investigation, a multiple case study research design was followed. This involved following a mixed-method approach to gather data from two clients, a psychotherapist, an individual supervisor and a reflective team as role players. Both cases are presented according to the structure provided by the SP-CPP. As evident from the results, the case of Helen can be regarded as a good outcome case, while the case of Gloria can be regarded as a poor outcome case. Differences found between the outcome of the two cases can mainly be explained through the key change constructs and therapy variables within the SP-CPP. In terms of the key change constructs there were differences between the readiness to change, cognitive-emotive developmental conceptualisations and mechanisms of change of the two cases. In terms of the therapy variables there were differences in terms of their responses to the therapeutic techniques used and also in the quality of the therapeutic alliance. Applying the SP-CPP framework, with schema therapy as evidence-based treatment approach, contributed to a better awareness of important change process elements in both cases and provided the psychotherapist with the opportunity to reflect upon these elements throughout the psychotherapeutic processes from start to finish. From the findings, specific recommendations are also suggested for psychotherapy research and clinical practice in order to further refine the SP-CPP.

Keywords: case study, change process research, psychotherapy, schema therapy, scientist-practitioner

Introduction

In the chapter to follow, two cases will be presented of clients who presented with anxiety-related symptoms and received schema therapy as evidence-based treatment. The first case is that of Helen and the second case is that of Gloria, both 21-year-old females. Both clients were seen by the same psychotherapist and conceptualised according to the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP) developed by the research team (see Figure 3.4).

In the interest of following the argument, note that the manuscript submitted here follows a specific structure: To begin with, a summative theoretical overview of the SP-CPP will be presented, followed by the practical application of the two case studies within this framework. In the case write-up, a discussion of those aspects common across both cases will be presented followed by an in-depth discussion of the unique aspects in each case. To conclude this manuscript, a critical reflection of the findings across both cases will be offered, followed by recommendations for psychotherapy research and clinical practice with a view to further improving on the SP-CPP.

In order to provide a summative theoretical overview of the SP-CPP, it is deemed relevant to emphasise the five main elements thereof, namely: 1) psychological understanding of the client; 2) key change constructs; 3) therapy variables; 4) measurement; and 5) develop, test and monitor the change process framework. These five main elements are circular in nature and focused around the collaborative therapeutic relationship as the central element. The SP-CPP emanated from the findings of a systematic review on change process in psychotherapy (conducted by the same research team – see Chapter 2) and can be used as an evidence-based change process framework to conceptualise clients. It is useful for conceptualising cases, highlighting change mechanisms, informing treatment processes and monitoring therapeutic progress (or lack thereof) on a continuous dynamic basis throughout

the psychotherapeutic process. The SP-CPP can be applied at different times and from different perspectives (or on different levels) throughout the psychotherapy process in a manner where therapist responsiveness is strongly emphasised.

Firstly, the *psychological understanding of the client* refers to the integration of nomothetic information with idiographic information in a manner which enables a case conceptualisation that results in a meaningful combination of official theories (on a macro level) with specific models (on a micro level). The role of client feedback is important in this regard, seeing that the sharing of the case conceptualisation enables clients to refine or amend the formulation to not only increase the accuracy thereof but to also increase the collaborative nature of psychotherapy (i.e. therapeutic alliance).

Secondly, in terms of the *key change constructs*, significant emphasis needs to be placed on the psychotherapist's cognitive-emotive developmental conceptualisation of the client (which can be based on any relevant developmental theories). In addition, the psychotherapist needs to determine the client's stage of change in order to determine the most suitable therapeutic approach and subsequent therapeutic techniques to be used to increase the client's readiness for change. The next variable, forming a crucial part of the key change constructs, is the mechanism of change. This refers to the specific point of focus in the psychotherapist's formulation (and in the psychotherapy process) that would result in the most significant therapeutic impact due to the highest potential for psychotherapeutic change.

Thirdly, in terms of *therapy variables*, the psychotherapist should critically reflect on the evidence-based relational variables as they play out in the context of psychotherapy and on the evidence-based techniques used to increase the effectiveness of the evidence-based treatment approach used in specific cases.

Fourth, in terms of *measurement*, the psychotherapist should purposefully select a combination of evidence-based process and outcome measures to monitor the client's

progress (or lack thereof) during the entire psychotherapy process. It is recommended that the psychotherapist administers process measures at different intervals throughout the psychotherapy process to monitor specific empirical markers (or themes) identified as most significant within the case conceptualisation and mechanism of change. Outcome measures, on the other hand, are typically administered during the first and last sessions (and/or during follow-ups) and used to determine change as a result of the psychotherapeutic process as a whole.

Finally, the last element refers to where the psychotherapist *develops, tests and monitors* the change process framework as formulated according to the SP-CPP. As part of developing a change process formulation for a particular client, it is recommended that the psychotherapist identifies helpful and hindering significant events based on the case information obtained from the client. The identification of such helpful and hindering significant events enables the psychotherapist to determine the most prominent empirical markers (or themes) which would also feature as the essence of the mechanism of change (which forms part of key change constructs). To increase the potential effectiveness of the psychotherapeutic intervention, the psychotherapist is encouraged to conduct research regarding evidence-informed therapeutic responses to those prominent empirical markers (or themes) identified for the specific client. To determine the accuracy of the change process formulation, the psychotherapist needs to determine the client's progress (or lack thereof) throughout the entire psychotherapy process. For this purpose, the psychotherapist's clinical judgment is used in combination with the process measures and feedback obtained from the client. In addition, input from individual supervision and/or reflective team discussions (as a form of peer supervision or a platform facilitating case discussions) can also be utilised. If, according to the abovementioned, the client demonstrates progress, then the psychotherapist adheres to the change process framework as formulated and treatment continues as planned.

If, however, the client demonstrates a lack of progress (or even no progress and/or deterioration), then the psychotherapist needs to revise, amend or adjust the change process conceptualisation.

As can be seen in Figure 3.4, the *therapeutic relationship is central* within the SP-CPP, as emphasised by its position as mediating agent within the change process as a whole. Variables such as collaboration, consensus regarding the therapeutic goals, evidence-informed responses to possible alliance ruptures and the importance of a shared case conceptualisation are all highlighted within the context of the therapeutic relationship. In addition, therapist responsiveness is also emphasised as an important element applicable throughout the psychotherapy process from start to finish, and it is defined as the ability of psychotherapists to practice with moment-to-moment awareness and moment-to-moment purpose. Finally, the SP-CPP is developed as a *trans-theoretical* and *trans-diagnostic* framework to conceptualise change processes of clients and should thus be applied at *different times* and from *different perspectives* (or on *different levels*).

It is deemed necessary to highlight that the SP-CPP was developed not only to be used as a dynamic instrument to conceptualise change processes of clients throughout the entire psychotherapy process (similar to *process measures*) but also at the beginning and end points of psychotherapy (similar to *outcome measures*). Seeing that change process research refers to the integration of process and outcome research in the context of a single study, this framework combines the strengths of both methodologies within a single coherent change process framework. Thus, it is recommended that the SP-CPP be used as a dynamic reflective instrument or framework throughout the process of psychotherapy and that changes or amendments be made continuously as new information comes to the fore.

Methodology

The aim of this study is realised through the practical application of two schema therapy cases within the SP-CPP as change process framework. Based on the presenting problem, the case conceptualisations and the psychotherapist's cognitive-emotive developmental conceptualisation of the clients, schema therapy was indicated as evidence-based treatment approach of choice in both cases (Edwards, 2019; NICE, 2019; NIMH, 2019). In addition, the choice of treatment approach was also confirmed during individual supervision and reflective team discussions. The SP-CPP was used as dynamic reflective framework continuously throughout the psychotherapeutic processes of both clients in an attempt to conceptualise their change processes. In doing so, the research team aimed to increase the effective management of both cases by ensuring the evidence-based nature thereof. In terms of data collection, both quantitative and qualitative data was collected. The recordings of psychotherapy sessions and the psychotherapist's clinical notes constituted the qualitative data. In addition, client feedback was obtained qualitatively throughout the process and a follow-up interview was also conducted. Different process and outcome measures were administered as quantitative data to be used in conjunction with the qualitative data. Data analysis happened in the context of individual supervision and reflective team discussions where critical reflections and themes were integrated within the SP-CPP framework. Thematic analysis was used to determine the most prominent themes from the follow-up interviews according to the criteria of Clarke and Braun (2013) – see Chapter 3.

Case study research design allows a researcher to focus on understanding the dynamics present within a single setting (Crowe, Cresswell, Robertson, Huby, Avery, & Sheikh, 2011). The design can involve either single or multiple cases and numerous levels of analysis. According to Yin (2009), a case study design is the preferred strategy in the following scenarios: when questions of *how* or *why* are posed; when the researcher has little

experimental control over the research events; and when the research focus is on a contemporary phenomenon which takes place in some real-life context.

The evidence under analysis may be qualitative, quantitative or both (Crowe et al., 2011). This implies that a case study design typically consists of a combination of data collection methods, such as archives, interviews, questionnaires and observations. By combining multiple data collection methods, the researcher aims to comprehensively explore the emergent theory, as it plays out within each of the cases investigated. Through using different methods of data collection, across both qualitative and quantitative evidence, the researcher is able to triangulate the emerging constructs and hypotheses. The quantitative evidence may indicate possible salient relationships, while the qualitative evidence is useful for understanding the rationale or theory which underpins the relationships revealed in the quantitative data (Eisenhardt, 1989). The use of multiple investigators or a research team is also an important aspect in case study research, and especially in theory-building research (Yin, 2009). The role a team of investigators play in minimising personal bias and ensuring trustworthiness is crucial in the process of theory development, particularly in the context of case study research. The use of multiple investigators thus further increases the creative potential of this study (Eisenhardt, 1989). The convergence of observations from multiple investigators also further enhances confidence in the findings of this study. Eisenhardt (1989) further explains that the convergent perceptions of the investigators add to the empirical grounding of the hypotheses, while the conflicting perceptions serve to keep the exploration from premature closure and from over-elaboration of constructs and/or hypotheses. By allowing the cases to be viewed from different perspectives, confidence in the findings is further strengthened.

The level of cross-case analysis increases the likelihood of an accurate and reliable theory, which has a close fit with the empirical data. Ragin (2000) argues that ‘small N’

research may be seen as a compromise in which multiple comparative case studies are carried out with a focus on explaining potential causal paths that produce particular outcomes for each case. The focus on in-case analysis leads the researcher to identify and analyse patterns in certain processes within each case, which can then be used to explain possible differences between cases by contrasting them with one another (Aaboen, Dubois, & Lind, 2012). These authors further explain that the use of multiple case studies may, therefore, contribute to a better understanding of the relational links between phenomena and contexts. The aforementioned provides insight into the researcher's choice of a multiple case study research design, as the researcher aims to treat each individual case as analogous to an experiment and the series of cases as multiple experiments (Yin, 1984). The abovementioned methodology therefore increases the empirical validity of the SP-CPP.

In the paragraphs to follow, the roles of the respective role players involved in the research process highlighted in this manuscript will be clarified and their involvement explained briefly.

Role Clarification

The gatekeeper or mediator.

The initial contact with potential participants was made by an independent person who acted as gatekeeper or mediator for the purpose of recruitment. This independent person was also responsible for obtaining informed consent from the participants and for setting up the initial appointment (or first session) with both clients.

The psychotherapist.

A 36-year-old registered clinical psychologist was responsible for delivering the psychotherapy to both clients. He is a white male with eight years' post-registration experience (and the first author of this manuscript). He finds himself in a tertiary environment where he is mainly responsible for delivering psychotherapy to clients in a

group-based practice, but he also has academic responsibility. In terms of his academic responsibilities, he is responsible for the following: 1) lecturing at post-graduate level (master's degree students in clinical and counselling psychology); 2) supervision of practical work of clinical and counselling psychologists at master's degree and internship level; and 3) research supervision of master's degree students in clinical and counselling psychology. In addition, he obtained a diploma in schema therapy after meeting the requirements specified by the International Society of Schema Therapy (ISST) which included 25 hours of didactic training and 15 hours of experiential training.

Individual supervision.

An associate professor (the second author) with 15 years' post-registration experience acted as individual supervisor in both schema therapy cases. He is a registered clinical psychologist with the Health Professions Council of South Africa (HPCSA) and with the Health and Care Professions Council in the United Kingdom. In total, there were 20 individual supervision sessions of approximately two hours each. During individual supervision, the psychotherapist and individual supervisor observed recordings of the psychotherapy sessions and had critical discussions on aspects such as case conceptualisations, diagnoses, treatment planning, key change constructs and prognosis (to name but a few). In addition, the second author also conducted the follow-up interview with both clients during which their experience of the psychotherapeutic process, therapeutic relationship and therapeutic techniques, amongst others, was gathered.

Reflective team.

This team consisted of five members, namely all four authors and one independent member. The third author is a registered clinical psychologist with more than 20 years' post-registration experience and works mainly in a research capacity as a full professor in psychology. The fourth author has a PhD in psychology and is a registered research

psychologist with more than ten years' post-registration experience and works mainly in research-related aspects in the field of psychology. Finally, the independent member of the reflective team is a registered clinical psychologist with ten years' post-registration experience. He is an associate professor and works in both research- and practice-related aspects of psychology.

The reflective team met for 15 discussion sessions of approximately two hours each during which they observed the recorded psychotherapy sessions and engaged in critical discussions and reflections to ensure that the psychotherapist conceptualised the two clients according to the SP-CPP. The reflective team also identified prominent themes from observing the follow-up interviews of both clients, which will be presented later.

Ethical Considerations

Ethical permission for this study was obtained through the Health Research Ethics Committee (HREC) of the North-West University (NWU). The ethics certificate is attached in Annexure A1 (Ethics number: NWU-00363-16-A1). As part of the ethics application, various ethical issues were dealt with referring to the current manuscript. A summative overview thereof is presented in the informed consent document that the psychotherapy clients had to complete (see Annexure A3). Firstly, clients had to give informed consent before psychotherapy could commence and they were reminded that participation in the study was voluntary. They were informed that their anonymity will be ensured and that confidentiality will be extended to the individual supervisor and the reflective team. Risks and benefits were weighted and preventative measures were implemented to minimise or mediate potential risks. Other ethical considerations included the ethical use of recordings (audio and video) and objectivity when reporting on cases for publication purposes. Even though it was not required, and as an added ethical measure, the psychotherapist scheduled individual feedback sessions with both clients' post-therapy during which their case write-up

was read and discussed. During the feedback session, they were encouraged to ask any questions that they might have regarding their case write-up and these questions were addressed by the psychotherapist. The clients were also offered the opportunity to make any relevant amendments to their case write-up, if they deemed it necessary. To conclude the in-depth feedback session, both clients gave written consent or permission for their case studies to be used for examination and/or publication purposes.

The Two Cases

Case one is the case of Helen, a 21-year-old female who received 32 sessions of schema therapy for a presenting problem on the anxiety spectrum. Case two is the case of Gloria, also a 21-year-old female who received 25 sessions of schema therapy also for a presenting problem on the anxiety spectrum. Helen and Gloria filled out application forms indicating a need for psychotherapy sessions at the group-based practice where the psychotherapist is employed.

The SP-CPP, as presented in Chapter 3 (and briefly described above), was used as the structure for the write-up of these two cases. Within these two cases, there were certain aspects that were similar across both cases, as well as aspects that were unique to each case. Those similar aspects that are common across both cases will be presented first, followed by the unique aspects in each case.

Common Aspects Across Both Cases

Psychological understanding of the client.

General model on a macro level. From a schema therapy perspective, the aetiology of psychopathology has its origin in unmet needs while growing up (mainly during early childhood). Every child has a need to feel safe and secure and to have a loving and reliable bond with their primary caregivers (Edwards, 2016). In addition, every child has a need to be supported over the course of growing up, moving from helplessness and dependence to a

sense of competence and autonomy (Young, Klosko, & Weishaar, 2003). Furthermore, every child has a need to be allowed the appropriate expression of emotions and to learn to manage and control their emotional and behavioural reactions flexibly (Farrell, Reiss, & Shaw, 2014). Finally, in terms of needs, a child needs to express him- or herself in a spontaneous, playful and creative way (Jacob, Van Genderen, & Seebauer, 2015). When any one or more of the abovementioned six basic childhood needs are unmet in any one or more of the following developmental pathways, early maladaptive schemas (EMSs) form. These four developmental pathways include: 1) toxic frustration of needs; 2) traumatisation; 3) overindulgence and overprotectiveness; and 4) internalisation of or identification with significant others (Edwards, 2016). Toxic frustration of needs refers to when a child's basic needs for a stable, loving relationship and consistent care are unmet (Rafaeli, Bernstein, & Young, 2011). Traumatisation refers to occasions where a child is harmed, victimised or exposed to traumatic events (Lobbestael, Van Vreeswijk, & Arntz, 2007). Overindulgence and overprotectiveness refer to parents or primary caretakers who prevent children from developing autonomy or appropriate self-control (Young et al., 2003). Finally, internalisation of or identification with a significant other refers to children who take on the thoughts, feelings, experiences and behaviours of their parents or primary caretakers in an attempt to be noticed by their parents and to have their needs met (Edwards, 2016). When any one or more of the abovementioned four developmental pathways are present, individuals can develop any one or more of the following 18 EMSs, namely: 1) emotional deprivation; 2) abandonment; 3) mistrust; 4) social isolation (or alienation); 5) defectiveness (or shame); 6) failure; 7) incompetence (or dependence); 8) vulnerability to harm or illness; 9) enmeshment; 10) subjugation; 11) self-sacrifice; 12) emotional inhibition; 13) unrelenting standards; 14) entitlement (or superiority); 15) insufficient self-control (or self-discipline); 16) admiration (or recognition-seeking); 17) pessimism; and 18) self-punitiveness (Young et al., 2003).

These schemas lie dormant and are mostly automatic and outside conscious control.

Whenever these schemas are activated, it is referred to as schema triggering (Farrell et al., 2014).

Schema triggering strongly shapes our patterns of perception, interpretations, feelings and behaviour (Arntz & Jacob, 2012). There are three characteristic response patterns when schema triggering occurs, namely: 1) freeze; 2) flight; and 3) fight (Riso, Du Toit, Stein, & Young, 2007). Whenever a freeze response occurs, it is referred to as *schema surrendering*, while a flight response is referred to as *schema avoidance* and a fight response as *schema overcompensation* (Van Vreeswijk, Broersen, & Schurink, 2014). Schema triggering consequently also activates different schema modes (Edwards, 2016). Even though schema triggering activates EMSs from the past, it also activates specific schema modes in the here-and-now. These schema modes refer to the healthy adult mode, damaged child modes, maladaptive coping modes and/or dysfunctional parent modes (Young et al., 2003).

The healthy adult mode refers to the capacity to integrate information, to solve problems and to make informed decisions (Farrell et al., 2014). It creates meaning, takes responsibility for choices and behaviour and remains committed (Rafaeli et al., 2011). The healthy adult mode mainly refers to an individual's cognitive system in the here-and-now.

The damaged child mode refers to the experience of a child whose needs were unmet (Edwards, 2016). When an individual has these childhood schemas, he or she is in vulnerable child modes. There are different vulnerable child modes that can be activated, namely the abandoned, lonely, dependent, angry, enraged, impulsive and undisciplined child mode (Young et al., 2003).

Maladaptive coping modes, on the other hand, refer to the way in which an individual cope with the emotional distress in the damaged child modes (Lobbestael et al., 2007). There are three classes of maladaptive coping modes, namely: 1) surrender modes (*freeze-*

response); 2) avoidant modes (*flight-response*); and 3) overcompensation modes (*fight-response*). Surrender coping refers to the belief that an individual has that the EMSs are accurate and the feelings associated with them are inevitable. Examples of these surrender modes are the compliant surrenderer and the poor-me/victim modes (Edwards, 2016).

Avoidance coping modes refer to individuals cutting off from the emotional pain associated with the underlying EMSs. Examples of avoidance modes include the avoidant protector, the detached protector, the angry protector and the detached self-soother (Young et al., 2003).

Then, overcompensation coping modes refer to when individuals behave in a way in contrast to how they are when an EMS is triggered. Examples of overcompensation modes are the self-aggrandiser and the perfectionistic overcontroller (Farrell et al., 2014).

Finally, dysfunctional parent modes refer to when individuals behave like dysfunctional parents towards themselves (Farrell et al., 2014). Dysfunctional parent modes can develop in one of two ways, firstly by setting unrealistically high expectations for achievement or self-control for themselves (known as the *demanding parent*) and, secondly, by being very critical and belittling towards themselves (known as the *punitive parent*). When both a demanding and a punitive parent are present, it is referred to as a *guilt-inducing parent* (Edwards, 2016). These dysfunctional parent modes are, in contrast to all the other modes, external by origin but internalised (through introjections) by individuals based on their experiences with parents or any significant adult figure(s) (Jacob et al., 2015).

Psychopathology, from a schema therapy perspective, is when individuals experience schema triggering which activates EMSs to which they respond in ways where they switch between several different maladaptive or dysfunctional schema modes (also referred to as *mode shifting* or *mode cycling*) in ways that are confusing for themselves and others (Farrell et al., 2014).

There are four super-ordinate goals in psychotherapy from a schema therapy perspective, namely: 1) healing the damaged child mode; 2) reducing the power of maladaptive coping and dysfunctional parent modes; 3) strengthening the healthy adult mode; and 4) working with relationships (Young et al., 2003). The focus of psychotherapy is thus to identify self-defeating mode cycles and to find ways to interrupt them and to change them into healthier, more mature and more authentic ways of relating (Edwards, 2016). These new ways of relating should be experienced as being more supportive and satisfying by nature than individuals are accustomed to.

Van Vreeswijk, Broersen and Nadort (2012) point out that before being referred to as early maladaptive schemas (EMSs), they were named relational schemas. Thus, given that these schemas developed in the context of a meaningful relationship, they should also be challenged and changed in the context of another meaningful relationship (Edwards, 2016). That meaningful relationship can be between the healthy adult mode of the client and the damaged child mode of the client *or* between the healthy adult mode of the psychotherapist and the damaged child mode of the client. The first option is preferred, if possible, as it does not create dependency on the psychotherapist and, consequently, empowers the client.

Quite simply, what needs to happen in psychotherapy is that a platform must be created where dialogue between the healthy adult mode and damaged child mode is facilitated (Bamber, 2004). This platform can only be created if maladaptive coping and/or dysfunctional parent modes are identified, challenged and changed (Farrell et al., 2014).

Conceptually, the maladaptive coping and dysfunctional parent modes act as a barrier hindering dialogue between the healthy adult and damaged child modes (Young et al., 2003). When this barrier is addressed and no longer hinders the dialogue, the healthy adult mode becomes a *good enough parent* (Louis & Louis, 2015; Winnicott, 1953; 1967) who should satisfy the unmet needs of the damaged child through a process known as *limited re-*

parenting (Van Vreeswijk et al., 2014). When limited re-parenting happens, and the unmet needs of the damaged child are met by the healthy adult mode, a *corrective emotional experience* occurs which, in effect, rescripts/re-authors the narrative of the client (Jacob et al., 2015). Techniques used to achieve the goals of schema therapy includes guided imagery, chair work, psychodrama and somatic experiencing (Rafaeli et al., 2011).

To summarise, schema therapy is an integrative framework in which bottom-up and top-down techniques are used to bring about change (Edwards, 2014). Top-down techniques refer to different techniques used to strengthen the healthy adult mode, for example CBT-techniques, narrative therapy and behavioural interventions (Young et al., 2003). Bottom-up techniques refer to different techniques used to heal the damaged child mode, for example gestalt, attachment therapy, psychodynamic therapy and object relations therapy (Riso et al., 2007). These two sets of techniques do not occur sequentially or in phases but simultaneously or parallel to one another.

Key change constructs.

Cognitive-emotive development of client. Even though any developmental theory can be used in order to provide a developmental conceptualisation of both clients, Erikson's theory of psychosocial development (Erikson, 1982) was deemed most appropriate given the clients' clinical presentation and case conceptualisations. According to Erikson, there are eight psychosocial stages of development individuals progress through during their lifetimes. These stages are as follows: 1) trust vs. mistrust; 2) autonomy vs. shame and doubt; 3) initiative vs. guilt; 4) industry vs. inferiority; 5) identity formation vs. role confusion; 6) intimacy vs. isolation; 7) generativity vs. stagnation; and 8) integrity vs. despair. At each stage, the individual must cope with a crisis in either an adaptive or a maladaptive way. Irrespective of whether the conflict in a particular stage is successfully resolved or not, the individual is pushed by both biological maturation and social demands into the next stage.

With the resolution of the crisis in each developmental stage, the individual develops certain basic virtues such as hope, will, purpose, competence, fidelity, love, care and wisdom (Erikson, 1968).

Mechanism of change. There are seven general steps in schema mode work, namely to: 1) identify and label the clients' modes; 2) explore the origin and (when relevant) adaptive value of their modes during their childhood and/or adolescence; 3) link their maladaptive modes to their current problems and symptoms; 4) demonstrate the advantages of modifying or giving up one of their modes if it is interfering with access to the other modes; 5) access their vulnerable child modes through guided imagery; 6) conduct dialogues among their modes (initially the psychotherapist models the healthy adult mode and later the clients play these modes); and 7) help the clients to generalise mode work to real-life situations outside psychotherapy sessions (Young et al., 2003).

The abovementioned seven steps can be used as a summative integration for a schema therapy case conceptualisation and treatment planning in both cases presented in this manuscript.

Therapy variables.

Relational variables. As already mentioned, seeing that EMSs (previously known as relational schemas) develop in the context of a relationship, they should be reconfigured in the context of another meaningful relationship, namely the therapeutic relationship (Van Vreeswijk et al., 2012). In the context of schema therapy, the psychotherapist must relate to the client in the way a *good enough parent* would, in other words be consistent, empathic and genuine (Louis & Louis, 2015; Winnicott, 1953; 1967). Thus, the psychotherapist relates to the client in ways that can undo the schema perpetuation processes. The psychotherapist does so through *limited re-parenting* where the psychotherapist acts as a committed and caring parent (Farrell et al., 2014). Being a *good enough parent* also implies not ignoring problems

(Louis & Louis, 2015). The psychotherapist identifies the schema-driven patterns that play out between client and psychotherapist in psychotherapy and provides the client with honest feedback in this regard. This feedback is given through the use of *empathic confrontation* by the psychotherapist (Rafaeli et al., 2011). Through empathic confrontation, the psychotherapist confronts the client's schema-driven behaviours in the form of maladaptive coping patterns and self-defeating beliefs and empathises with the emotions related to the damaged child modes when schema triggering occurs (Edwards, 2016). The psychotherapist uses self-disclosures as it can be very helpful for the client in normalising the client's experiences and modelling appropriate thought processes, coping, emotions and behaviour to the client. In this regard, though, Young et al. (2003) caution that self-disclosures, in the context of schema therapy, should aim to meet the needs of the client and not those of the psychotherapist.

Technique variables. In terms of technique variables, a distinction can be made between the top-down techniques used to strengthen the healthy adult mode and the bottom-up techniques used to heal the damaged child modes (Edwards, 2014).

Top-down techniques. In order to strengthen the healthy adult modes of both clients, three sets of cognitive top-down techniques were used, namely: 1) cognitive awareness; 2) thought restructuring; and 3) cognitive disengagement. In terms of cognitive awareness, the psychotherapist made use of psychoeducation explaining CBT, schema therapy and anxiety. Then, in terms of thought restructuring, the psychotherapist made use of Socratic dialogue and the downward-arrow technique in order to identify, evaluate and modify the clients' negative automatic thoughts, procedural beliefs (namely rules, assumptions and attitudes) and core beliefs regarding self, others and the world. As part of strengthening their healthy adult modes, the psychotherapist made use of mindfulness techniques and the "Big I, little i"-technique to facilitate the cognitive disengagement processes.

The psychotherapist remained cognisant of the importance of asking questions when the emphasis of sessions was on strengthening the healthy adult modes in order to prevent *mode cycling* or *mode shifting* (Edwards, 2016).

Bottom-up techniques. As part of the healing of the damaged child modes, different emotion-focused bottom-up techniques were used. In order to identify the damaged child modes, *guided imagery* was used in combination with *psychodrama* and *chair work* (Van Vreeswijk et al., 2012). During the guided imagery, the psychotherapist recreated certain key memories from Helen's and Gloria's narratives (Padmanabhanunni & Edwards, 2014). Within the guided imagery, elements of psychodrama were incorporated to enable the psychotherapist and clients to play various roles. The aim with the guided imagery was to create situations where their needs were unmet and to offer them the opportunity to experience a *corrective emotional experience* through *limited re-parenting* within the context of the guided imagery (Young et al., 2003). Regarding the limited re-parenting, the psychotherapist had to initially assume the role of a *good enough parent* (Louis & Louis, 2015; Winnicott, 1953; 1967), as Helen and Gloria did not have enough confidence in their healthy adult modes to assume the role. According to Louis and Louis (2015), if the psychotherapist models good-enough parenting, clients could succeed in assuming the role of being a good enough parent towards themselves.

In addition, the psychotherapist made use of *chair work* when dealing with the various maladaptive schema modes (Van Vreeswijk et al., 2012). The chair work took the form of sculpting by placing chairs in a particular arrangement providing a visual representation of the clients' internal processes or dynamics. During chair work, the psychotherapist would, for example, use a chair representing an EMS (e.g. self-sacrifice), another chair representing the maladaptive coping mode associated with the EMS (e.g. detached protector), another chair representing the damaged child mode triggered by the EMS (e.g. angry child) as well as a

chair representing the client's healthy adult mode. The aim of the chair work was to enable the two clients to provide a voice for each of the chairs and, through the use of sculpting, to redefine the relationships between the different chairs. These redefinitions do not only provide the opportunity for a corrective emotional experience but also to re-author/rescript their narratives by offering a more accurate *reconfiguration* of their schema mode conceptualisations (Edwards, 2016).

When using bottom-up techniques to heal the damaged child modes, the psychotherapist focused on giving reflections and offering interpretations. The psychotherapist remained mindful not to ask too many questions when using bottom-up techniques, as the use of questions activates the healthy adult mode which can result in *mode cycling* or *mode shifting*. The risk of mode cycling or mode shifting is that it can cause or maintain the schema-driven pattern (i.e. maladaptive schema configuration).

Measurement.

In both cases, the psychotherapist used the Depression Anxiety Stress Scale (DASS-21; Lovibond & Lovibond, 1995) as an outcome and process measure, as well as the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988) purely as a process measure. Furthermore, seeing that schema therapy was used as evidence-based treatment approach, the Young Schema Questionnaire – Long Form Third Edition (YSQ-L3; Young, 2014) was used to determine the EMSs of both clients, while the Schema Mode Inventory, Version 1.1 (SMI; Young et al., 2008) was used to determine the different schema modes. Finally, the Young Parenting Inventory (YPI; Young, 1999) was also administered in both cases to gain a better understanding of the dysfunctional parent modes involved.

Develop, test and monitor the change process framework.

Evidence-informed responses to empirical markers. By conceptualising and treating Helen and Gloria from a schema therapy perspective, the psychotherapist ensured that

evidence-based approaches were used to focus on all the identified empirical markers (Edwards, 2019; NICE, 2019; NIMH, 2019; Young et al., 2003). When working with their damaged child modes, the psychotherapist made use of bottom-up techniques and did so mainly in line with the principles of emotion-focused therapy (Leahy, 2015). The psychotherapist also included techniques from gestalt therapy, psychodrama, psychodynamics, object relations and Jungian therapy. When working with their healthy adult modes, the psychotherapist made use of top-down techniques and did so mainly in line with the principles of CBT. The psychotherapist also included techniques from interpersonal psychotherapy and narrative therapy. When the focus of psychotherapy was on providing limited re-parenting (Farrell et al., 2014), the psychotherapist did so mainly in line with good-enough parenting principles (Louis & Louis, 2015; Winnicott, 1953; 1967).

Monitor change process framework. Helen and Gloria gave consent for all the psychotherapy sessions to be recorded (audio and video) and for the psychotherapist to use their cases for research purposes, which included discussions with the individual supervisor as well as with a reflective team. The psychotherapist made use of his clinical judgement in and between sessions, in conjunction with the findings from the process measures, client feedback obtained and discussions during individual supervision and reflective team meetings to determine the progress (or lack thereof) of the two clients.

Unique Aspects in Each Case

Case One: The Case of Helen

Background information.

Helen is a 21-year-old female student studying psychology. She presented with post-traumatic stress disorder and complained of frequent and intense anxiety attacks. She also reported a traumatic childhood. More recently, she reported a series of losses that she suffered within a short period of time. Within the span of eight months, she lost her uncle, maternal

grandmother, paternal grandfather and mother. Shortly after the death of her mother, she also experienced a break-up of her first romantic relationship which she experienced as yet another loss. She reportedly had her first anxiety attack three months prior to the start of psychotherapy. As a result of that initial anxiety attack, she was admitted to the psychiatric ward of a private hospital for three weeks. She is currently on medication for her anxiety.

She is the eldest of two siblings and has a younger sister aged 19. She reports a poor relationship with her mother, who passed away two years ago due to natural causes. She, furthermore, describes very high levels of conflict and domestic violence between her mother and father while growing up. Her mother abused alcohol regularly as well as prescription medication and would often threaten suicide. She highlighted that her mother had attempted suicide on at least six occasions. She describes her father as overtly aggressive and as someone who would mainly direct his anger towards her mother but also occasionally towards them as children. Helen assumed the position of a 'parentified child' being triangulated between mother and father and also acting as a buffer to protect her sister from the parental conflict. She also reports high levels of conflict between the maternal and paternal extended families. While growing up, she mentions that her father mainly used avoidance coping by throwing himself into his work, while her mother also mainly used avoidance coping but in the case of the latter, this took the form of alcohol abuse, self-medicating and excessive sleeping. In terms of the marital dyad, the more passive the mother became, the more aggressively the father acted. This dynamic became the dominant story at home, and she cites this as the main reason why role reversals occurred in the family, with Helen becoming the mother to her mother and also the mother to her sister.

Psychological understanding of the client.

General model on a macro level. According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013),

Helen best meets the criteria for “other specified anxiety disorder”. Although she presented with panic attacks, she did not meet the criteria for “panic disorder”. She also displayed symptoms of “social anxiety”, “posttraumatic stress” or “bereavement” (in relation to all the losses she experienced), as well as some “generalised anxiety disorder” symptoms but did not meet the full criteria for a full diagnosis in any of the aforementioned categories.

From Helen’s presenting problem (and the case conceptualisation that follows in the next section) as well as her cognitive-emotive level of development (see key change constructs section), it is clear that schema therapy is indicated as an evidence-based treatment approach in her case (Edwards, 2019; NICE, 2019; NIMH, 2019). Schema therapy is geared towards dealing with unresolved emotional trauma by facilitating a corrective emotional experience (Young et al., 2003). The main aim of psychotherapy would be to heal her damaged child modes and to strengthen her healthy adult mode, but this can only be done after a re-evaluation of her maladaptive coping modes and/or dysfunctional parent modes has occurred (Edwards, 2016).

Specific model on a micro level. All six of the needs mentioned above were unmet in Helen’s case (see Figure 5.1). This resulted in Helen viewing her parents as unavailable or unpredictable in meeting her needs. In addition, she also perceived her parents as inconsistent in as far as they attempted to meet her needs, especially her need for empathy, nurturance and protection. These unmet needs resulted in Helen developing the following EMSs, as identified in sessions and confirmed by the YSQ-L3 (Young, 2014): 1) self-sacrifice (81%); 2) unrelenting standards (80%); 3) abandonment (77%); and 4) emotional deprivation (76%).

These EMSs are triggered in the here-and-now and consequently activate different schema modes. All of these schema modes were identified in sessions and were also confirmed by the SMI (Young et al., 2008). In terms of her damaged child modes, these EMSs have a tendency to activate Helen’s vulnerable (lonely, abandoned, abused and

dependent) and angry child modes. Then, in terms of maladaptive coping modes, she mainly resorts to the detached protector and detached self-soother (both schema-avoidance coping modes). Finally, regarding the dysfunctional parent modes, Helen has prominent demanding parent and punitive parent modes, thus culminating in a guilt-inducing parent mode. See Figure 5.1 for a visual presentation of Helen's schema mode conceptualisation. This schema mode conceptualisation was shared with Helen and she was offered the opportunity to provide her feedback in order to refine or amend the conceptualisation. In sharing the conceptualisation, a significant degree of psycho-education regarding the schema therapy approach and constructs also took place.

The following superordinate goals inherent in schema therapy were prominent in the psychotherapist's mind: 1) strengthening Helen's healthy adult mode; 2) healing her damaged child modes; 3) re-evaluating the effectiveness of her maladaptive coping modes and dysfunctional parent modes; and 4) working with relationships.

In addition, from Helen's schema mode conceptualisation, the psychotherapist in collaboration with Helen formulated the following subordinate therapeutic goals: 1) to deal better with situations by not avoiding them (addressing the avoidance coping); 2) to no longer suppress emotions (also addressing the avoidance coping); and 3) to gain better control of her anxiety (addressing the presenting problem).

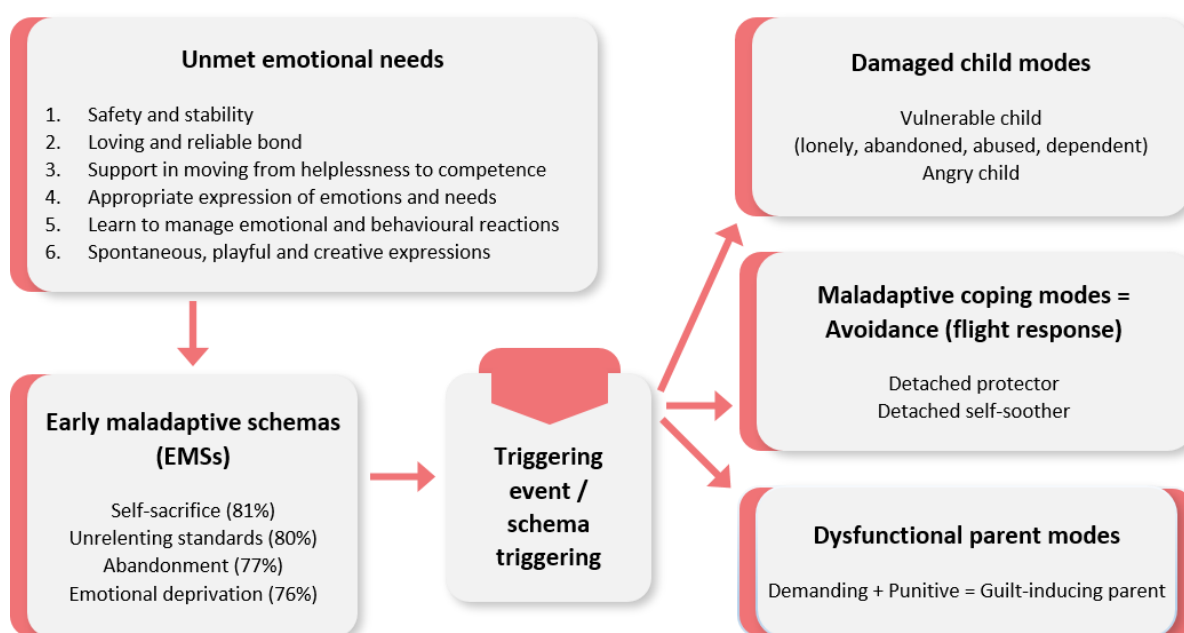


Figure 5.1 Helen's schema mode conceptualisation

Case conceptualisation.

Unmet needs. While growing up, Helen's need for safety and stability was unmet due to the high level of domestic violence that she was continuously exposed to. In addition, she perceived her mother as emotionally unavailable due to depression and the combination of avoidance coping mechanisms her mother used such as self-medication, alcohol abuse and excessive sleeping. Her mother's six attempts to commit suicide during Helen's crucial formative years, also played a significant role in her emotional needs being unmet. Furthermore, Helen's need for a secure, loving and reliable bond was also unmet due to her mother's emotional unavailability, as already discussed, and her father's unavailability due to excessive working, as his form of avoidance coping. Helen's need to be supported from helplessness or dependence to competence or autonomy was also unmet, due to her feelings of being overwhelmed and unsafe in a home environment where she did not receive consistent loving support. Helen could not learn to express her emotions and needs appropriately because, first of all, she did not experience a loving, supportive relationship with one of her parents allowing her the safety to do so and, secondly, the appropriate

expression of emotions and needs were not modelled to her (Louis & Louis, 2015). Due to the poor modelling of emotions and behaviour from both her parents, she could also not learn to manage and control her emotional and behavioural reactions flexibly (Leahy, 2015). In addition, because she perceived her parents as uninvolved and absent, she did not have a consistent point of reference (one that is safe and stable) to compare her own emotions and behaviour with. Finally, due to the family dynamics already discussed, Helen was, most likely, actively discouraged from expressing herself in a spontaneous, playful and creative manner. Her parents probably did not offer her sufficient opportunities to be a spontaneous, playful and creative child, as is evident from Helen being the one taking care of her mother and protecting her sister. It comes as no surprise that Helen was overwhelmed by these adult responsibilities that she had to assume at an age where she was not ready to do so.

Consequently, this resulted in Helen becoming a ‘parentified child’ in her family of origin.

Early maladaptive schemas (EMSs). The unmet needs identified above where perpetuated over many years, leading to the toxic frustration of Helen’s needs. In addition, Helen was exposed to trauma, not only in the form of witnessing the high levels of domestic violence at home but also by being exposed to her mother’s six suicide attempts without adult protection and/or support. As a consequence, Helen developed certain EMSs. The most prominent EMS, as identified in the psychotherapy sessions and confirmed by the YSQ-L3 (Young, 2014), will be discussed in the following paragraph.

Self-sacrifice was identified as Helen’s most prominent EMS. Self-sacrifice refers to Helen’s need to focus excessively on voluntarily meeting the needs of other people in everyday situations, at the expense of having her own needs met. Common reasons why she has this EMS might be because she has a desire to prevent pain to others and that she perceives this as a way to maintain the connection with other individuals whom she perceives as needy. She might also have developed an acute sensitivity to the pain of her mother and

her sister. Another possible reason is that Helen might use self-sacrifice in an attempt to avoid the guilt of feeling selfish. Regardless of her reasons, the consequence was that she experienced a sense of not having her needs met adequately and resenting those who she took care of (Young et al., 2003). In short, Helen had to take care of her mother and protect her sister from both the *not good enough parenting* she received from their parents as well as the high levels of conflict in the marital system (Louis & Louis, 2015). It is clear that she did so at the expense of having her own needs met.

Then, in terms of unrelenting standards, Helen developed the underlying belief that she must strive to meet very high internalised standards of behaviour and performance. This was identified as Helen's second most prominent EMS. A typical consequence of this EMS is a constant feeling of pressure and the development of a hypercritical stance towards self and others (Jacob et al., 2015) which, according to Van Vreeswijk et al., (2014), unavoidably results in a significant impairment of pleasure, relaxation, health, self-esteem, sense of accomplishment and satisfying relationships. Unrelenting standards can manifest in one of three ways: a) perfectionism; b) rigid rules; and c) preoccupation with time and efficiency (Edwards, 2016). In Helen's case, there are clear manifestations in all three of these areas.

Helen's third most prominent EMS, abandonment, refers to the perceived instability or unreliability of those primary caregivers who ought to be available for support and connection (Skeen, 2014). It is clear that Helen's mother had a significant impact in this regard as Helen perceived her mother as not being able to provide emotional support, connection, strength and practical protection. Helen perceived her mother to be emotionally unstable, unpredictable and unreliable. In addition, the continuous conflict between her parents and her father's overtly aggressive behaviour also contributed to Helen developing this EMS. The six suicide attempts by Helen's mother also strengthened the belief that her

mother was emotionally unstable, unavailable to provide protection and might die any time soon.

Finally, her fourth EMS, emotional deprivation, refers to the expectation that she has that her desire for a healthy degree of emotional support will not be met adequately by significant others. According to Edwards (2016), three major forms of emotional deprivation can be distinguished, namely: 1) deprivation of nurturance; 2) deprivation of empathy; and 3) deprivation of protection. From Helen's background information, as provided above, it is clear that she was deprived of all three of these forms.

Schema mode conceptualisation. When schema triggering occurs, past EMSs are activated in the here-and-now and can, according to Arntz and Jacob (2012), take the form of one of several schema modes. These schema modes, as identified in psychotherapy sessions and confirmed by the SMI (Young et al., 2008), will be discussed next.

Healthy adult mode. Helen reports a moderate to high healthy adult mode. This indicates that she can perform appropriate adult functions in a responsible manner (Kellogg & Young, 2006). She has the ability to glean and evaluate information and to make informed decisions (Farrell et al., 2014). Furthermore, she ought to be effective at problem-solving and she will most likely be able to do things in a balanced and rational way, demonstrating respect for her own needs as well as the needs of others (Edwards, 2016).

Child modes. Firstly, looking at the healthy child modes, Helen reports a moderate to high score for the *contented child* mode on the SMI (Young et al., 2008). This is an interesting finding given that all six of her basic needs were unmet and her life story has prominent themes of loss and trauma.

Then, in terms of the *damaged child* modes, Helen displays *vulnerable child* modes as well as the angry child mode. Regarding Helen's vulnerable child modes, she has a combination of lonely, abandoned, abused and dependent child modes. In terms of the

vulnerable child modes, Helen reports a moderate to high score on the SMI (Young et al., 2008). In Helen's case, the lonely child is the part of her that feels empty, sad, socially unacceptable, undeserving of love, unloved and/or unlovable. Her abandoned and abused child is the part of her that feels sad, frightened, defenceless, hopeless, needy, victimised, worthless and lost (Young et al., 2003). A subtype of the abandoned and abused child is the humiliated and inferior child modes, and these are also evident in Helen's case. Her dependent child is the part of her that feels overwhelmed by the adult responsibilities that she had to assume and the part of her that demonstrates strong regressive tendencies. The dependent child is also the part of her that lacks the development of autonomy and self-reliance (Jacob et al., 2015). The prevalence of these vulnerable child modes, to a large extent, explains Helen's fragile and childlike presentation during psychotherapy. Finally, in terms of child modes, Helen also demonstrates an *angry child* mode which is the part of her that feels intensely angry and frustrated due to her emotional needs not being adequately met by significant others (Kellogg & Young, 2006). Even though she reported a very high score on the angry child on the SMI (Young et al., 2008), she only reported an average to moderate score on the enraged child. This highlights her ability to regulate emotions (Dadomo, Grecucci, Giardini, Ugolini, Carmelita, & Panzeri, 2016; Leahy, 2015).

Maladaptive coping modes. In terms of Helen's maladaptive coping modes, she mainly utilises the *detached protector* and *detached self-soother* coping modes (Farrell et al., 2014). Both of these modes are *schema-avoidance* coping modes (Lobbestael et al., 2007). When Helen uses the *detached protector*, she withdraws psychologically from the pain of the EMS that was triggered by detaching emotionally. In this coping mode, she shuts off all emotions, disconnects from others, rejects help and functions in an almost robotic manner, while still appearing quite functional from other individuals' point of view (Edwards, 2016).

The other schema-avoidance coping mode, the *detached self-soother*, also refers to Helen shutting off emotions but in instances such as these, she engages in activities that soothe, stimulate or distract her attention from the EMS being triggered (Van Vreeswijk et al., 2012). Behaviours utilised when in this mode are often addictive or compulsive: An example in Helen's case would be workaholism (Lobbestael et al., 2007). She self-soothes by channelling most of her time and energy into her academic performance with the aim to excel academically. When in this mode, she believes that if only she could succeed in getting excellent grades, she would feel better about herself.

Dysfunctional parent modes. Finally, in terms of dysfunctional parent modes, Helen experiences both punitive and demanding parent modes (Young et al., 2008). The *punitive parent* mode refers to an internalised voice of her parents criticising and punishing her in a harsh, critical and unforgiving manner (Kellogg & Young, 2006). She consequently becomes angry with herself as she believes that she deserves the punishment. Then, in terms of the *demanding parent* mode, Helen has an internalised voice of her parents continually pushing and pressuring her to meet excessively high standards of performance (Rafaeli et al., 2011). Consequently, Helen developed certain rigid rules and standards and, as a result, developed a lot of 'shoulds', 'musts' and 'ought-tos'. Seeing that she reported both a punitive and a demanding parent mode, a *guilt-inducing parent* mode is also present (Jacob et al., 2015). This guilt-inducing parent mode maintains Helen's feelings of guilt by making her believe that she 'should' act or perform in a certain way and that she is 'bad' for not having done so (Young et al., 2003).

The YPI (Young, 1999) was used to determine the specific parenting styles that Helen was exposed to as a child by both of her parents. In terms of Helen's parents as a parenting unit, the most prominent parenting styles that she experienced were emotionally depriving and punitive, followed by a conditional or narcissistic parenting style and a controlling

parenting style. She also experienced that both her parents made use of a pessimistic or fearful parenting style. In terms of those parenting aspects unique to her mother, she experienced her mother to have utilised a belittling parenting style. Her father, on the other hand, was experienced as displaying emotionally inhibiting and perfectionistic parenting styles.

Key change constructs.

Stage of change (or readiness for change). According to Prochaska's transtheoretical model of change (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Norcross, 2018), Helen was in the *preparation stage* at the beginning of psychotherapy. Even though she acknowledged that there was a problem and she talked about the need to change, she did not yet demonstrate a behaviour change (Prochaska, Redding, & Evers, 2015) despite verbalising a commitment to change. It is important to note that preparation is viewed as a transition phase, rather than a stable stage (Krebs, Norcross, Nicholson, & Prochaska, 2019). Thus, in order to increase Helen's motivation to change and to assist her in progressing from the preparation stage into the action stage, the psychotherapist made use of psycho-education regarding CBT, schema therapy and anxiety with the aim to enable Helen to understand and accept what was required to make a change (Prochaska & Norcross, 2018). Furthermore, the psychotherapist assisted Helen to engage in a process of introspection about her decisions and provided reaffirmation regarding her needs and desire to change. The consequence was that Helen could progress from the preparation phase into the *action phase*.

Cognitive-emotive development of client. With the aid of Erikson's theory of psychosocial development (1982), the following developmental conceptualisation was formulated. From Helen's background information, it is clear that instability, inconsistency and unavailability of parental nurturance, understanding or empathy and support resulted in

Helen developing mistrust in others and the world. Consequently, she perceived the world to be an unsafe and unstable place. In terms of the second stage, it appears that Helen developed autonomy as she had to learn to fend for herself. Regarding the third stage, it appears that Helen developed initiative. Here it can be argued that the combination of autonomy and initiative contributed to her becoming a 'parentified child' at a young age. Regarding the fourth stage, Helen developed industry as she channelled her time and energy into her academic performance and into generally getting things done at home. She internalised the idea that if she wanted something done, she had to do it herself. This resulted in high levels of productivity in the different domains of her life. Next, in terms of the fifth stage, it appears that Helen could succeed in forming her identity as she presents with a solid sense of self and currently faces adulthood with confidence and certainty. Finally, the last stage applicable to Helen is intimacy vs. isolation. She currently finds herself in a meaningful romantic relationship and, prior to this relationship, there is a history of three other romantic relationships after completing school. It is clear that she has a desire to be independent and to function as an autonomous adult in mature and responsible ways. She also has a desire to commit herself to a shared identity with another individual in a manner where she does not have to surrender her own individuality in the process. In summary, it appears that Helen mastered the second to fifth stages of Erikson's theory successfully and is currently in the process of mastering the sixth stage as well (Erikson, 1975). Regarding the first stage, though, Helen appears to have not resolved the crisis. However, during that particular stage, the resolution of the crisis seems to have a greater bearing on her attachment and the parenting style she was subjected to than on her own psychological resources.

Helen's EMSs, as well as her childlike and immature presentation, can be linked strongly to her developing mistrust in the first stage of Erikson's theory of psychosocial development (Erikson, 1950). This developmental conceptualisation provides further support

and evidence why schema therapy was indicated as the preferred evidence-based treatment approach for Helen (Edwards, 2019; NICE, 2019; NIMH, 2019).

Mechanism of change. From a schema therapy perspective, EMSs are perpetuated through three primary mechanisms: 1) cognitive distortions; 2) self-defeating life patterns; and 3) schema coping styles (Young et al., 2003). These three primary mechanisms are further maintained by relational patterns (Van Vreeswijk et al., 2012). Thus, the mechanism of change can be punctuated on the level of EMS, damaged child modes, maladaptive coping modes and dysfunctional parent modes.

Early maladaptive schemas (EMSs). When the focus of psychotherapy was on working on the *self-sacrifice* schema that Helen presented with, the following is relevant in terms of the mechanism of change (see Figure 5.2):



Figure 5.2 Self-sacrifice schema

When the focus of psychotherapy was on working on the *unrelenting standards* schema, the following was relevant regarding her mechanism of change (see Figure 5.3):



Figure 5.3 Unrelenting standards schema

When the focus of psychotherapy was on working on the *abandonment* schema, the following is relevant in terms of the mechanism of change (see Figure 5.4):

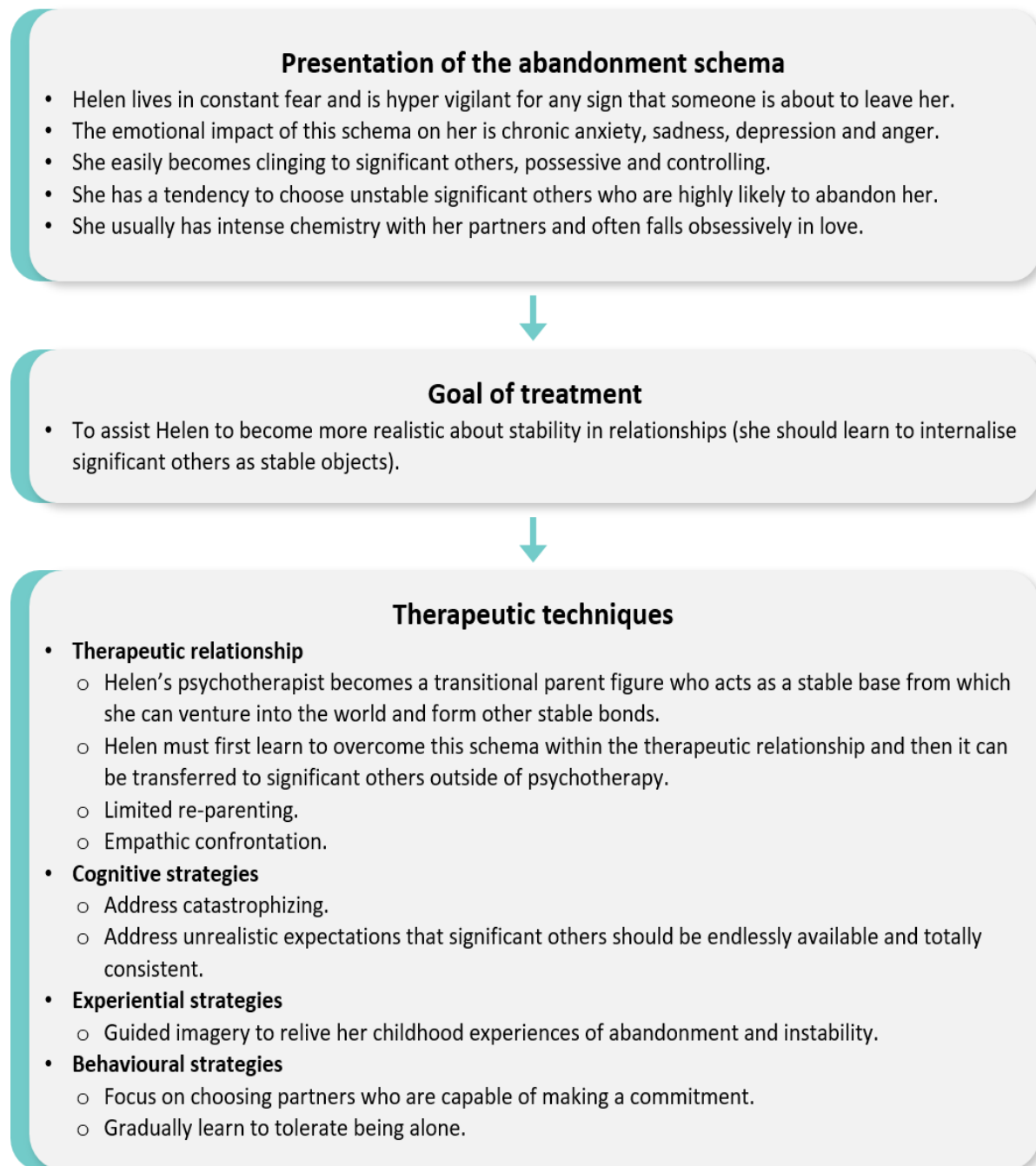


Figure 5.4 Abandonment schema

When the focus of psychotherapy was on working on the *emotional deprivation* schema that Helen presented with, the following is relevant in terms of the mechanism of change (see Figure 5.5):

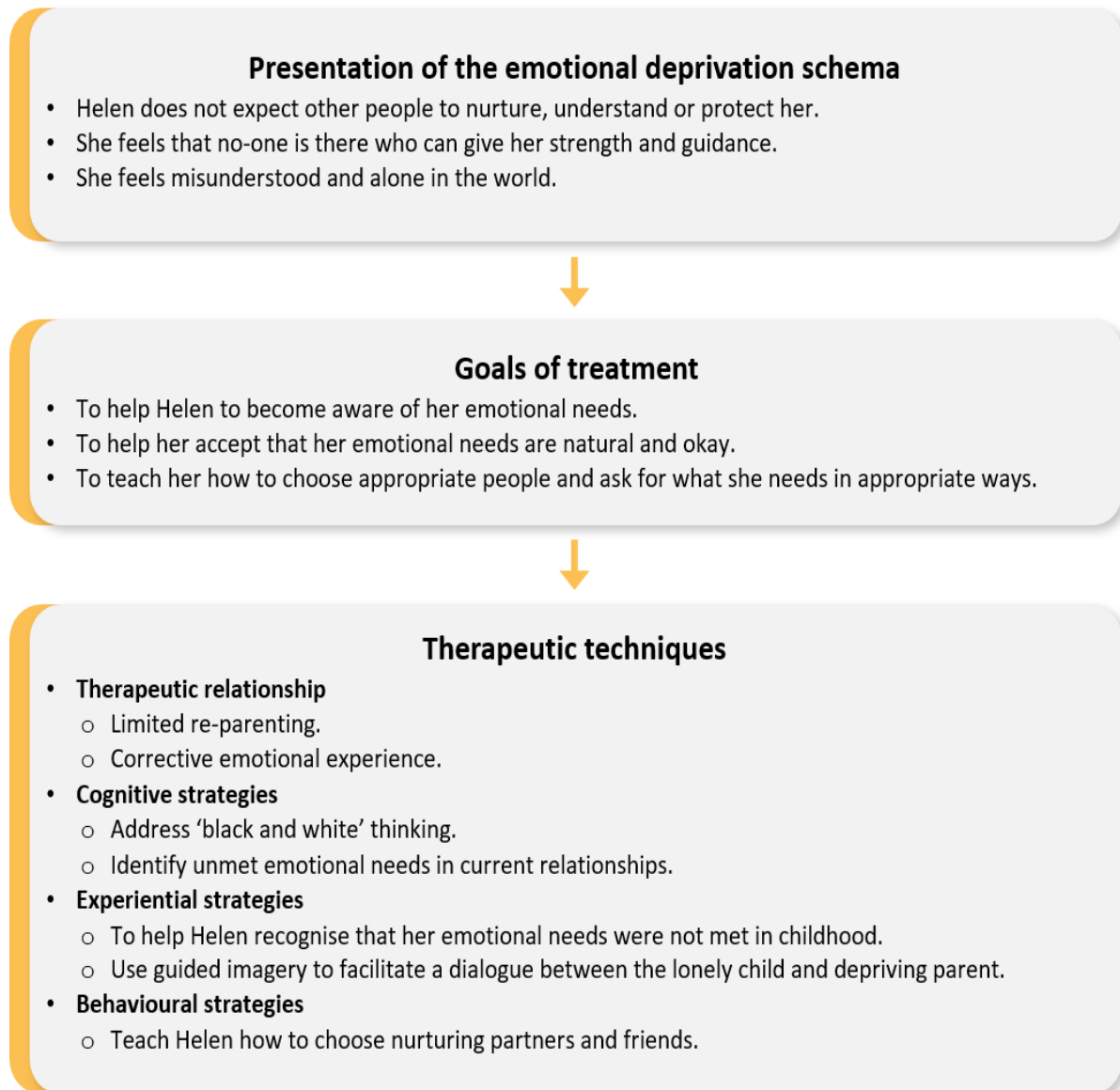


Figure 5.5 Emotional deprivation schema

Next, in terms of Helen's schema modes activated in the here-and-now, a distinction can be made between her damaged child modes, maladaptive coping modes and dysfunctional parent modes.

Damaged child modes. When Helen's EMS activates her child modes, her vulnerable child or angry child mode is mostly triggered. When in *vulnerable child* mode, Helen

experiences dysphoric or anxious affect, especially fear, sadness and helplessness. She also feels frightened and overwhelmed as the vulnerable child is strongly linked with her abandonment and emotional deprivation schemas (Young et al., 2003). When in *angry child* mode, Helen tends to vent her anger directly in response to perceived unmet core needs or unfair treatment related to her core schemas, mainly linked to her abandonment and emotional deprivation schemas (Kellogg & Young, 2006).

Maladaptive coping modes. In order to cope with the abovementioned child modes, Helen mainly uses *schema-avoidance* coping styles. The most prominent schema-avoidance modes that she uses are the detached protector and the detached self-soother. When Helen uses the *detach self-soother* mode, she withdraws psychologically, detaches from others and shuts off her emotions in order to protect herself from the pain associated with being vulnerable by engaging in activities that she finds self-soothing (Edwards, 2016). She uses this mode like protective armour or a protective wall, with the more vulnerable modes hiding inside (Young et al., 2003). When in *detached protector* mode, Helen feels numb or empty and she adopts a cynical or aloof stance to avoid investing emotionally in other people or activities (Farrell et al., 2014). When Helen was a young child, she developed the detached protector mode as an adaptive strategy to survive. In her early childhood, she was trapped in a traumatic environment that created too much suffering and it made sense for her to distance herself, to detach and not to feel. As an adult entering a less hostile or depriving world, it would have been adaptive to let go of the detached protector and become open to the world and her own emotions again (Bennett-Goleman, 2001; Dadomo et al., 2016). However, she became so accustomed to being in the detached protector mode that it became automatic and she no longer knows how to get out of it (“her refuge became her prison”).

Dysfunctional parent modes. When Helen is in a dysfunctional parent mode, she becomes her own parent and treats herself as her parents treated her when she was a child by

thinking, feeling and behaving as her parents did towards herself (Farrell et al., 2014). Consequently, she takes on the voice of her parents, but in her “self-talk” (Lobbestael et al., 2007), her *punitive parent* is the critical parent that angrily punishes or restricts her from expressing her needs and making mistakes (Jacob et al., 2015). The *demanding parent* on the other hand, is the parent mode that pressures her to meet unrealistically high parental expectations (Edwards, 2016). Consequently, Helen feels that the ‘right’ way to be is to be perfect and the ‘wrong’ way to be is fallible or spontaneous (Rafaeli et al., 2011). The combination of Helen’s punitive and demanding parent modes results in a *guilt-inducing parent* mode that sets high standards and punishes her when she fails to meet their expectations (Lobbestael et al., 2007). These parent modes are strongly associated with Helen’s unrelenting standard and self-sacrifice schemas (Young et al., 2003).

Therapy variables.

Relational variables. From a schema therapy perspective, the psychotherapist acted as a *good enough parent* towards Helen (Louis & Louis, 2015; Winnicott, 1953; 1967). Rapport was established with ease and Helen cooperated very well from the beginning of psychotherapy. Helen responded well to the psychotherapist’s use of questioning, reflections, interpretations and *emphatic confrontation*. The *therapeutic alliance* was of a high quality and Helen attended 86% of her scheduled sessions. A summative overview of the scheduled sessions and themes discussed are presented in Table 5.1.

Table 5.1

Overview of Helen’s scheduled sessions

Session	Date	Description / Themes discussed
1	2018/09/13	DASS-21 (1); Clinical interview
2	2018/09/17	Psychoeducation: Schema therapy Psychoeducation: Anxiety
3	2018/09/27	BAI (1); Therapeutic goals
4	2018/10/09	Schema Mode Inventory (SMI): Administer and feedback
5	2018/10/15	Young Schema Questionnaire: Feedback
6	2018/10/25	Schema triggering and further schema therapy psychoeducation

Session	Date	Description / Themes discussed
7	2018/10/31	Graphic family sculpting (GFS): Administer and interpretation
8	2018/11/06	DASS-21 (2); BAI (2); Explore interpersonal relationship difficulties Young Parenting Inventory (YPI): Feedback
9	2018/11/13	Interpersonal relationship dynamics Forgiveness
10	2018/11/22	New romantic relationship linked to early maladaptive schemas
11	2018/11/27	Beliefs about romantic relationships and men
12	2019/01/16	DASS-21 (3); BAI (3); Discussed three recent schema triggering examples
13	2019/01/31	Reflection on current relational difficulties
14	2019/02/11	Explored new romantic relationship dynamics
15	2019/02/18	Explored new romantic relationship dynamics
16	2019/02/25	Explored new romantic relationship dynamics
17	2019/03/01	Couples session: Schema therapy for couples
18	2019/03/08	Schema healing through meaningful relationships
19	2019/03/15	Focused on early maladaptive schema: Self-sacrifice and associated coping modes
20	2019/03/20	DASS-21 (4); BAI (4); Focused on early maladaptive schema: Unrelenting standards and associated coping modes
21	2019/04/05	DASS-21 (5); BAI (5); Focused on early maladaptive schema: Abandonment and associated coping modes
22	2019/05/13	Did not attend (1)
23	2019/05/17	Focused on early maladaptive schema: Abandonment and associated coping modes
24	2019/05/24	Focused on early maladaptive schema: Emotional deprivation and associated coping modes
25	2019/05/27	Emotion-focused therapy; Chair work; Guided imagery
26	2019/06/07	Did not attend (2)
27	2019/06/12	Emotion-focused therapy; Chair work; Guided imagery
28	2019/06/18	Emotion-focused therapy; Chair work; Guided imagery
29	2019/06/27	Did not attend (3)
30	2019/07/24	Relational difficulty with father
31	2019/07/30	Did not attend (4)
32	2019/08/02	DASS-21 (6); BAI (6); Relational difficulty with father
33	2019/08/07	Reflection on therapeutic process
34	2019/08/16	Did not attend (5)
35	2019/08/23	DASS-21 (7); BAI (7); Reflection on therapeutic process
36	2019/08/30	Review psychotherapy goals; Share case conceptualisation
37	2019/09/05	Forgiveness: Self and others
Follow-up	2019/10/08	DASS-21 (8); BAI (8); Interview with individual supervisor

Technique variables. In the psychotherapeutic process with Helen, various top-down techniques were used to strengthen her healthy adult mode, but the psychotherapist also used bottom-up techniques to heal her damaged child modes. According to the psychotherapist's

clinical judgment, in conjunction with the client's feedback and critical discussions during individual supervision and reflective team discussions, the chair work had the most significant impact in facilitating *corrective emotional experiences* in Helen's case. Helen frequently highlighted that she also appreciated the psychotherapist's use of drawings or visual illustrations of her internal dynamics and also the sharing of his psychological understanding with her.

Measurement.

Process and outcome measures. Table 5.2 provides a summative overview of the findings of the process and outcome measures used in Helen's case. In terms of Helen's depression, as measured by the DASS-21 (Lovibond & Lovibond, 1995), her level of depression was moderate at the beginning of psychotherapy and remained moderate until session 21, when it changed to mild. From session 32 until follow-up, her score on depression remained in the normal range.

Next, Helen's anxiety was measured by the DASS-21 (Lovibond & Lovibond, 1995) and BAI (Beck et al., 1988). On the DASS-21, her anxiety was initially extremely severe at the start of psychotherapy, but this changed to severe in session 12 and to moderate in session 21. Although she obtained severe scores on anxiety in session 35, her score was in the normal range when measured during the follow-up. This is supported by the findings of the BAI, which initially reported moderate levels of anxiety in session three and low levels of anxiety in session 20. There was a slight increase between the levels of anxiety reported between session 20 (low levels of anxiety) and session 21 (moderate levels of anxiety) and also between sessions 32 (low levels of anxiety) and session 35 (moderate levels of anxiety), but these differences were not meaningful. At follow-up, Helen's score on the BAI was in the range of low levels of anxiety, thus supporting the findings of the DASS-21 regarding her anxiety.

Table 5.2

DASS-21 and BAI for Helen

	Session	Score / Interpretation
*DASS-21	Session 1	Depression = 7 (moderate) Anxiety = 12 (extremely severe) Stress = 8 (mild)
	Session 8	Depression = 9 (moderate) Anxiety = 15 (extremely severe) Stress = 15 (severe)
	Session 12	Depression = 7 (moderate) Anxiety = 8 (severe) Stress = 8 (mild)
	Session 20	Depression = 8 (moderate) Anxiety = 8 (severe) Stress = 7 (normal)
	Session 21	Depression = 6 (mild) Anxiety = 7 (moderate) Stress = 7 (normal)
	Session 32	Depression = 4 (normal) Anxiety = 7 (moderate) Stress = 9 (mild)
	Session 35	Depression = 3 (normal) Anxiety = 8 (severe) Stress = 9 (mild)
	Follow-up	Depression = 3 (normal) Anxiety = 3 (normal) Stress = 5 (normal)
**BAI	Session 3	27 (moderate levels of anxiety)
	Session 8	30 (moderate levels of anxiety)
	Session 12	25 (moderate levels of anxiety)
	Session 20	19 (low levels of anxiety)
	Session 21	22 (moderate levels of anxiety)
	Session 32	19 (low levels of anxiety)
	Session 35	23 (moderate levels of anxiety)
	Follow-up	16 (low levels of anxiety)

*DASS-21 (Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995)

**BAI (Beck Anxiety Inventory; Beck et al., 1988)

Finally, regarding Helen's stress as measured by the DASS-21, mild scores were reported during the first session, which changed to severe scores in session eight and to mild scores in session 12. During sessions 20 and 21, she obtained normal scores on stress, while mild scores were reported for sessions 32 and 35. However, during follow-up, her score for stress as measured on the DASS-21 was in the normal range.

In addition, the YSQ-L3 (Young, 2014) was administered between session four and five with the SMI (Young et al., 2008) completed during session four. The psychotherapist administered the YSQ-L3 to determine Helen's most prominent EMSs (formed in the past) and the SMI to determine her most prominent schema modes (activated when schema triggering occurs in the here-and-now). Seeing that prominent dysfunctional parent modes were highlighted by the SMI, the YPI (Young, 1999) was also administered to gain a better understanding of Helen's dysfunctional parent modes by determining her perceptions regarding the specific parenting styles she was exposed to. Graphic family sculpting (GFS; Venter, 1993) was administered in session seven to gain a better understanding of Helen's family dynamics since this was highlighted as an important element based on her background information and featured prominently in her case conceptualisation.

Develop, test and monitor the change process framework.

Identify significant events (helpful and/or hindering factors). In terms of significant events, Helen reported that the therapeutic relationship was a helpful factor in achieving her therapeutic goals. She also mentioned that the use of therapeutic techniques was particularly helpful. In terms of therapeutic techniques, she found *psychoeducation* particularly helpful. In addition, she also found the *experiential techniques* particularly helpful, especially the use of guided imagery, chair work and psychodrama. Another helpful factor was to involve Helen's new boyfriend in psychotherapy. The psychotherapist had an individual session with her new boyfriend followed by a couples session, in order to involve him in her therapeutic process. This was deemed valuable as it provided the psychotherapist with first-hand information and clinical impressions regarding Helen's new boyfriend as well as enabled the psychotherapist to involve him as an extra-therapeutic factor.

When reflecting on hindering factors, the use of collateral information can be regarded as a hindering factor. There were three sessions where collateral information was received

from a family member mainly regarding concerns pertaining to Helen. These sessions did not assist the psychotherapist and Helen to work towards the therapeutic goals as specified, as they were mostly the family member's understanding of Helen's functioning prior to the start of psychotherapy and, therefore, punctuated from Helen's schema mode configuration prior to psychotherapeutic change occurring.

Identify empirical markers (or themes). Helen's *schema mode conceptualisation* is regarded as an empirical marker as it provides a *configuration* of what it looks like when Helen functions in a maladaptive, unhelpful and unhealthy way (Edwards, 2016). A change in this empirical marker was when a *reconfiguration* occurred in Helen's schema mode conceptualisation resulting in Helen functioning in more adaptive, helpful and healthy ways (Young et al., 2003). This was evident when a) Helen's EMSs were triggered less frequently and with a lower intensity and/or strength; b) Helen used more adaptive coping modes when schema triggering occurred; c) Helen's damaged child modes were healed and integrated through the limited re-parenting provided by her healthy adult mode; d) the strength of Helen's healthy adult mode increased; e) Helen's dysfunctional parent mode was addressed by no longer believing it to be her own voice but realising that it was the voice of her parents and that is was unhelpful (either by getting rid of the voice or by turning down the volume of the voice); and f) Helen succeeded in developing and maintaining long-term meaningful relationships in which needs are mutually met. These empirical markers focused on her therapeutic goals of addressing her avoidance coping and being able to express her emotions.

In addition, Helen's *levels of anxiety* were also regarded as an empirical marker. An indication of a change or shift in this empirical marker was when lower levels of anxiety were reported. In Helen's case, her levels of anxiety were determined by means of a) the psychotherapist's clinical judgment and/or impressions; b) Helen's self-reported levels of anxiety in sessions; c) the use of the BAI (Beck et al., 1988) and DASS-21 (Lovibond &

Lovibond, 1995) as measuring instruments throughout psychotherapy; d) critical discussions during individual supervision sessions; and e) critical discussions during reflective team meetings. This empirical marker addressed her therapeutic goal of controlling her anxiety better (which was also the presenting problem).

Emotional expression is regarded as another empirical marker. A change in this empirical marker was when Helen started expressing more vulnerable emotions (Bennett-Goleman, 2001; Leahy, 2015). In her case, this refers mostly to anger and sadness. During the guided imagery and chair work, Helen could express the anger and sadness mostly directed at her mother. To make it even more meaningful, Helen could do so from the chair of the vulnerable- and angry child modes. The opportunity to say the ‘unsaid’ or the ‘not yet said’ to her mother in the context of the guided imagery and through the use of chair work resulted in Helen experiencing a corrective emotional experience. As a consequence, Helen no longer had the need to suppress her emotions, as she could express her anger and sadness appropriately and focused towards her mother (the individual at whom the anger should have been directed from the outset). This empirical marker addressed her therapeutic goal of no longer suppressing emotions.

Finally, Helen’s interpersonal relationships can be viewed as another empirical marker. Regarding this empirical marker, Helen’s intimate (or close) relationships are of particular importance as, in the past, this used to be the context in which her schema mode activation was most dysfunctional, unhelpful and unhealthy. A change in this empirical marker was when Helen entered into a new romantic relationship and did not merely repeat the patterns from the past and did not react in ways confirming her ‘default’ schema mode configuration when it comes to intimate (or romantic) relationships. Seeing that psychotherapy, per definition, is also regarded as an intimate relationship, the psychotherapist used the therapeutic relationship as a platform to challenge and change Helen’s view of intimate (or

close) relationships (Skeen, 2014). The psychotherapist did so through frequent reflections regarding the nature and quality of the therapeutic relationship. In addition, the psychotherapist remained mindful of the different roles he needed to play during the psychotherapeutic process and did so in a manner aimed to meet Helen's needs in a predictable and consistent manner (while continuously practicing with moment-to-moment awareness and purpose regarding the important role of being a transitional good enough parent).

Evidence-informed responses to empirical markers. All of the empirical markers (or themes) identified in the cases of Helen were dealt with therapeutically from schema therapy as the evidence-based treatment approach of choice (Edwards, 2019; NICE, 2019; NIMH, 2019).

Monitor change process framework. Directly relating to her presenting problem, Helen's level of anxiety was regarded as the most important empirical marker. In terms of anxiety, Table 5.2 clearly highlights the significant change in her levels of anxiety over the course of psychotherapy, thus addressing her presenting problem.

From the abovementioned, it is clear that the case conceptualisation informed the empirical markers and that the empirical markers were dealt with in an evidence-informed manner. The accuracy of the case conceptualisation and the effectiveness of the handling of the empirical makers are clearly highlighted by the changes observed and described from Helen's and the psychotherapist's perspective regarding all of the identified empirical markers. This serves as confirmation that her SP-CPP formulation could be regarded as accurate and that the psychotherapist could, consequently, adhere to this framework.

During the psychotherapy sessions, Helen and the psychotherapist continuously and frequently reflected on her progress. Changes as a result of the psychotherapeutic process are

confirmed and highlighted by the process and outcome measures used (see Table 5.2) as well as the themes reported during the follow-up interview.

In the follow-up interview, conducted six weeks after session 32, Helen confirmed that she was still improving and maintaining (and even building upon) the changes resulting from psychotherapy. This was also confirmed by her scores on the DASS-21 and BAI (see Table 5.2). The reflective team identified the following themes from the follow-up interview in terms of Helen's experience of the psychotherapy process: 1) very positive ("life changing"); 2) learned a lot; 3) enabled her to gain a different perspective; and 4) experienced significant personal growth.

Next, in terms of Helen's experience of the therapeutic relationship, the following themes were identified as being prominent: 1) psychotherapist was approachable and displayed high levels of empathy; 2) she felt safe and comfortable; 3) she was appropriately challenged; and 4) she experienced trust in the context of the therapeutic relationship.

When reflecting on the therapeutic techniques used, the following themes were emphasised: 1) appropriate use of and purposeful choice of therapeutic techniques; 2) therapeutic techniques used were very helpful or impactful; 3) she appreciated the use of visual illustrations or drawings, chair work and use of images or metaphors; 4) she highlighted emotional experiencing as an important therapeutic technique; 5) the psychoeducation was very helpful; 6) she learned how to set appropriate boundaries; and 7) the use of the therapeutic techniques increased her insight and awareness regarding her internal and external dynamics.

Regarding the role of extra-therapeutic factors, she mentioned her new romantic relationship as a helpful factor and the collateral information volunteered by her family members as a hindering factor. Near the conclusion of the follow-up interview, Helen mentioned that she would strongly recommend psychotherapy to others.

Case Two: The Case of Gloria**Background Information.**

Gloria is a 21-year-old female student enrolled for a BA Honours degree. She presented with anxiety, stating that she has been admitted to casualties on several occasions after hours as a result of uncontrollable vomiting due to extremely high levels of anxiety. She continued by stating that she has “no friends” and consequently “no social life” due to her anxiety. In addition, she mentioned that she does not sleep well at night and that she struggles with anger outbursts.

She is the eldest of two siblings and has a sister who is five years younger. Her parents divorced when Gloria was nine years old and the court decided that it was better for her to stay with her mother. Her father remarried, and Gloria has a stepbrother aged one. Her mother, on the other hand, did not remarry. Gloria stated that the last time she saw her father was seven years ago and that they currently do not have a relationship of any sorts. She also describes a very poor relationship with her stepmother.

Gloria described that her mother coped with the divorce by resorting to alcohol abuse and promiscuous sexual behaviour as a means to numb the emotional pain she experiences. As a result, Gloria was the one who had to take care of her little sister while her mother went out drinking. Since the age of 10, Gloria has seen numerous psychotherapists. Furthermore, she describes a trauma – an armed robbery at home – that occurred three years ago.

Gloria spends most of her time at home, all alone. She finds interpersonal relationships very difficult, be it friendships, family relationships or romantic relationships. She describes a history of failed romantic relationships during which she experienced betrayal, unfaithfulness, verbal abuse and exposure to inappropriate sexual behaviour. From the clinical interview, it became apparent that Gloria has body image concerns. She mentioned that she weighed 39 kg at the age of 18 years and verbalised a strong need or desire to gain weight, which she managed

to do as she currently weighs 52 kg. There are strong themes of being body conscious and a hypersensitivity to others' opinion of her body. She also added that she has to exercises four to five times per week (for approximately 60 to 90 minutes), with the aim to gain weight by attempting to increase her muscle mass.

After her parents divorced, Gloria was triangulated between her mother and father. Most of the communication between her parents occurred through Gloria, thus creating very high levels of tension at an age when she was not yet emotionally and/or cognitively ready to deal with it. Currently, Gloria finds herself living with her mother, sister and maternal grandmother.

Psychological understanding of the client.

General model on a macro level. According to the DSM-5 (American Psychiatric Association, 2013), Gloria best meets the criteria for a generalised anxiety disorder. Seeing that Gloria's presenting problems were anxiety-related, and her cognitive-emotive conceptualisation indicated that she has not mastered certain developmental tasks successfully (Erikson, 1982), schema therapy is indicated as the evidence-based treatment approach of choice (Edwards, 2019; NICE, 2019; NIMH, 2019). Since schema therapy focuses on therapeutically addressing unmet emotional needs by providing a corrective emotional experience (Rafaeli et al., 2011), the main aim of Gloria's psychotherapeutic process would be to heal her damaged child modes, to strengthen her healthy adult mode and to challenge and change her maladaptive coping modes and/or dysfunctional parent modes (Jacob et al., 2015).

Specific model on a micro level. Similar to Helen, all six of Gloria's needs (as described earlier) were unmet (see Figure 5.6). Consequently, Gloria often felt alone and viewed her parents as unavailable, unpredictable or inconsistent in meeting her needs. Gloria experienced her parents as failing to meet her needs for empathy, nurturance and protection. These unmet needs resulted in Gloria developing the following EMSs, as measured by the YSQ-L3 (Young, 2014) and also evident from the psychotherapy sessions: 1) negativity or pessimism (97%); 2)

mistrust or abuse (94%); 3) social isolation or alienation (93%); 4) enmeshment (92%); 5) emotional inhibition (89%); 6) failure (89%); 7) insufficient self-control (87%); 8) self-sacrifice (84%); 9) vulnerability to harm or illness (83%); and 10) abandonment (81%). It is concerning that ten of the 18 EMSs scored higher than 80%.

These EMSs are triggered in the here-and-now, resulting in different schema modes being activated. All of these schema modes were identified in sessions and also highlighted by the SMI (Young et al., 2008). In terms of damaged child modes, these EMSs have a tendency to activate Gloria's angry and enraged child modes. Then, in terms of maladaptive coping modes, she mainly resorts to schema avoidance (flight response) by means of the detached self-soother. Finally, regarding the dysfunctional parent modes, Gloria has a prominent demanding parent mode.

See Figure 5.6 for a visual presentation of Gloria's schema mode conceptualisation. This schema mode conceptualisation was shared with Gloria, and she was offered the opportunity to give her feedback in order to refine or amend the conceptualisation. In sharing the conceptualisation, a significant amount of psychoeducation regarding the schema therapy approach and constructs also took place.

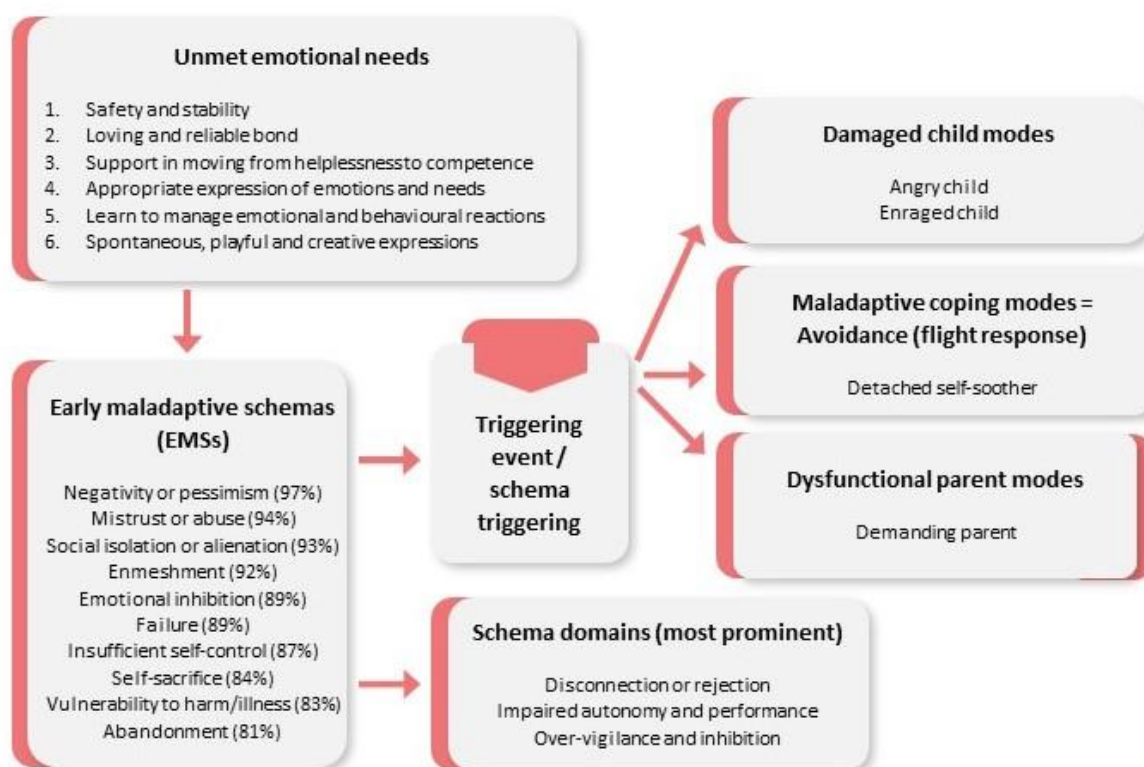


Figure 5.6 Gloria's schema mode conceptualisation

The following superordinate goals were formulated informing the schema therapy approach used in Gloria's case, namely: 1) building or strengthening her healthy adult mode; 2) healing her vulnerable child mode; 3) re-evaluating her maladaptive coping and dysfunctional parent modes; and 4) working with relationships (Edwards, 2016).

In addition, from her schema mode conceptualisation or configuration, the psychotherapist, in collaboration with Gloria, formulated the following subordinate therapeutic goals: 1) to decrease her levels of anxiety (addressing her presenting problem); 2) to improve her interpersonal relationship skills (working with relationships); 3) to gain better control of her anger (healing the damaged child mode); and 4) to create more optimism and hope regarding the future (building the healthy adult mode).

From the schema mode conceptualisation presented in Figure 5.6, it is clear that Gloria scored high on most of the EMSs. Seeing that working with almost all of the EMSs in

psychotherapy can become overwhelming and/or confusing, the psychotherapist conceptualised the EMSs in terms of domains (Young et al., 2003).

Six of Gloria's top-ten EMSs falls in two domains, namely the *disconnection (or rejection) domain* (mistrust or abuse, social isolation or alienation, and abandonment) and the *impaired autonomy and performance domain* (enmeshment, failure, and vulnerability to harm or illness). Two of the other remaining four EMSs above 80% resort under the *over-vigilance and inhibition domain* (negativity or pessimism and emotional inhibition), while the other two EMSs resort under the *impaired limits-* and *other-directedness domains* respectfully.

Case conceptualisation.

Unmet needs. In terms of Gloria's unmet needs, she did not perceive her home environment as being one characterised by safety and stability. Her mother abused alcohol and her father was uninvolved. In addition, her parents frequently argued and divorced when Gloria was in a crucial developmental phase. Seeing that it was a complicated divorce, with court proceedings, Gloria had to undergo psychological evaluations and also had to testify in court, which she also experienced as traumatic. Consequently, she did not experience a loving and reliable bond with her parents. After living with her father and stepmother for a couple of years, she was placed in the custody of her mother. During this time, her parents decided that it would be best if she stayed on at the girls' boarding school she attended at that point in time. Clearly, Gloria did not have a secure base to venture from. This also hindered her ability to receive the necessary support she required in order to move from helplessness to competence.

Due to the family dynamics being so much focused on her parents' divorce and their subsequent lives after the divorce, Gloria did not have the opportunity to express her own emotions and needs. This was mainly due to the fact that her parents did not regard Gloria's needs as important, seeing that they were preoccupied with their own lives. In line with this, Gloria could also not learn to manage her emotional and behavioural reactions, as her parents

were inconsistently available to model appropriate reactions to her. From the clinical interview with Gloria, as well as the background information revealed in subsequent psychotherapy sessions, it is very clear that she was not allowed to be a spontaneous, playful and creative child. During her parents' divorce, she was triangulated between her parents and, consequently, used as communication medium. In addition, seeing that her mother's coping with the divorce was mainly through avoidance (in the form of alcohol abuse and seeking sexual relationships), Gloria had to assume the role of a mother to her sister, resulting in Gloria developing into a 'parentified child'. In addition, Gloria had to assume adult responsibilities and had to take care of her mother, at times to a greater extent than her mother took care of her. It is thus clear that there is a parallel between the cases of Helen and Gloria in this regard (both being a 'parentified child' with subsequent role reversals).

Early maladaptive schemas (EMSs). The unmet needs, as identified above, became a pattern in Gloria's life as they were perpetuated over time by both her parents, leading to the toxic frustration of her needs. In addition, she was exposed to trauma, not only in the form of an armed robbery at home but also in being part of court cases and the subsequent divorce of her parents. Consequently, Gloria developed specific EMSs, of which the most prominent EMSs were evident in psychotherapy sessions and also identified by the YSQ-L3 (Young, 2014). In the paragraphs to follow, these EMSs will be discussed under their relevant schema domains.

- *Disconnection or rejection domain:* Regarding the EMSs falling under this domain, Gloria scored high on the abandonment, mistrust or abuse and social isolation or alienation schemas.

In terms of *abandonment*, Gloria has the expectation that she will lose individuals closest to her. She has the belief that individuals will leave her in favour of someone better or will easily become bored with her because she is so uninteresting. Consequently, she is

hyper-vigilant for any subtle signs that someone might leave her (Skeen, 2014). The most common emotions associated with the perception of loss are anxiety, sadness and depression. Another common emotion is anger, which is associated more with actual loss (experienced when someone actually leaves). Anger, in its most intense form, manifests as terror, grief and rage. When this is applied to Gloria, one can easily see the anxiety, sadness and depression in reaction to the perception of loss, as well as the anger which, in her case, becomes rage she experiences towards her father and then, generally, towards all men. Her reaction towards the perception of loss is to become controlling and jealous, especially in her romantic relationships, in an attempt to prevent others from leaving her. She anticipates that the pain of loss is inevitable as “all men would cheat” and intend to “deliberately” hurt her.

Next, in terms of the *mistrust or abuse* schema, Gloria expects others to lie, manipulate, cheat or to take advantage of her in an attempt to humiliate and/or abuse her. Consequently, she does not trust other individuals and struggles to view them as honest and straightforward. She perceives others to have hidden agendas and to not have her best interest at heart (Young et al., 2003). As a result, she comes across as guarded and suspicious as she believes that others want to hurt her intentionally. When this schema is applied to her romantic or close relationships, she does not share her innermost thoughts and feelings or get too close to significant others, because she perceives them to be dangerous and even evil. Another consequence is that Gloria can become paranoid and, consequently, devices tests and gathers evidence to determine whether others are worthy of her love, trust and time. Unfortunately, the process of gathering evidence becomes very selective as only those evidence that confirms her EMSs are paid attention to (Riso et al., 2007).

Finally, the *social isolation or alienation* schema refers to Gloria’s belief that she is different from others. Consequently, she does not feel part of most groups and often feels isolated, left out or overlooked (Edwards, 2016). When alone, she engages in solitary

activities such as watching movies and series. The practical implication of this schema is that she feels disconnected from virtually everyone (Lobbestael et al., 2007).

- *Impaired autonomy and performance domain:* Regarding the EMSs clustering under this domain, Gloria scored high on the vulnerability to harm or illness, enmeshment and failure schemas.

In terms of the *vulnerability to harm or illness* schema, Gloria lives her life with the belief that catastrophe can strike at any moment. She is convinced that something terrible is going to happen and that it would be beyond her control as she would not be able to prevent it and to cope with it when it inevitably happens (Jacob et al., 2015). The most common emotion associated with this schema is anxiety, which can reach the point of full-blown panic attacks. The typical coping mode associated with this schema is avoidance. The anxiety, panic attacks and avoidance coping are all very clear in Gloria's case.

Next, Gloria also has a prominent *enmeshment* schema which basically refers to her undeveloped sense of self. Gloria is so fused with her mother that neither Gloria nor the psychotherapist can clearly say where Gloria's identity begins and her mother's (as the enmeshed others') identity ends. Consequently, she experiences extreme emotional involvement from her mother at the expense of Gloria's full individuation and her normal social development (Van Vreeswijk et al., 2014). This was very clear in the guided imagery and chair work when Gloria also wanted to be the "dangerously overprotective female lion" (the image she used to describe her mother). Gloria feels guilty when thinking about setting clear boundaries towards her mother and, consequently, stays enmeshed (or fused), even though it is clear that she feels overwhelmed and smothered by her mother. Gloria's undeveloped self is further evident through her opinions, interests, choices and goals merely being a reflection of those of her mother ("like looking into a mirror").

Finally, in terms of *failure*, Gloria beliefs that she fails when she compares herself to her peers in areas of achievement. She feels fundamentally inadequate compared to others and, consequently, feels stupid, untalented, boring or uninteresting (Riso et al., 2007). A typical coping with this schema is avoidance as evident through Gloria's procrastination. The implication of this schema is that it becomes a self-fulfilling prophecy in Gloria's life – she expects to fail and consequently fails.

- *Over-vigilance and inhibition domain:* Regarding this domain, Gloria scored high on two EMSs, namely negativity or pessimism and emotional inhibition.

The *negativity or pessimism* schema refers to Gloria being negativistic and pessimistic. She has a persistent focus on the negative aspects of life such as pain, loss, disappointment, betrayal, failure and conflict, while she minimises any positive aspects (Lobbestael et al., 2007). She has the exaggerated expectation that things will go seriously wrong when it comes to a wide range of situations, for example her studies and especially her interpersonal relationships. The most common emotion associated with this schema is anxiety, which manifests as chronic tension and worry in Gloria's case (Young et al., 2003). This schema is primarily learned through modelling and usually from a parent (Louis & Louis, 2015). Gloria internalised her mother's negative attitudes and this became a mode whereby Gloria always views the glass as being half-empty. Consequently, Gloria has a strong tendency towards depression, negativity and pessimism.

The second EMS clustering under this domain is *emotional inhibition*. This schema manifests in Gloria presenting as emotionally constricted and excessively inhibited. Consequently, she struggles to discuss and express her emotions and prefers to avoid her emotions (Edwards, 2016). This is also evident in her flat affect and self-controlled presentation in sessions (as well as the absence of spontaneous behaviour). Unfortunately, Gloria inhibits those emotions that would have been healthier to express (Bennett-Goleman,

2001; Dadomo et al., 2016). The implication of this schema is that she has become rigid and inflexible at the expense of her spontaneity. Gloria has the underlying belief that it is “bad” to show feelings, to talk about them or to act on them impulsively, and that it is “good” to keep feelings inside (Farrell et al., 2014). As a result of her unexpressed anger, she has the interpersonal impact of being hostile, cold and resentful.

- *Impaired limits domain:* Regarding this domain, Gloria scored high on the insufficient self-control schema. This might mean that Gloria lacks the self-discipline to be able to tolerate boredom and frustration long enough in order to accomplish tasks successfully (Young et al., 2003). She might find it difficult to delay shorter term gratification for the sake of meeting her longer term goals. In addition, she might not learn sufficiently from experiences and from the negative consequences of her past behaviour. Gloria seems to make active attempts at avoiding discomfort, which includes pain, conflict, confrontation, responsibility and overexertion (Jacob et al., 2015). Typical behaviours related to this schema, and evident in Gloria, are her unwillingness to persist at boring or routine tasks and the intense temper tantrums or hysteria she clearly describes when she experiences anger outbursts.
- *Other-directedness domain:* There is one schema on which Gloria scored high that falls under this domain, namely self-sacrifice. This schema refers to Gloria displaying an excessive focus on voluntarily meeting the needs of others at the expense of her own needs (Van Vreeswijk et al., 2012). She does so because she wants to prevent others from experiencing pain and so that she can maintain a connectedness with them (Skeen, 2014). Self-sacrifice often involves a sense of over-responsibility for others and, in Gloria’s case, this seems to apply to her mother and sister. As self-sacrifice often overlaps with co-dependence, the enmeshment with mother and the need to take care of her younger sister are relevant in terms of this schema. As psychosomatic symptoms

are common for clients with this schema, Gloria being admitted to casualties' after-hours on several occasions due to uncontrollable vomiting relating to extremely high levels of anxiety are relevant. Gloria frequently complains of headaches, gastrointestinal problems, chronic pain and fatigue (Young et al., 2003). All of these physical symptoms enable Gloria to draw attention to herself, without having to ask for it directly and without conscious awareness. These symptoms might also be a direct result of the high levels of stress that Gloria experiences from giving so much and receiving so little in return (referred to as the 'give-get ratio'). It might also be that Gloria experiences high levels of anger towards the objects of her sacrifice, namely towards her mother and sister. Common emotions associated with this schema are anger and resentment. It is also common for clients with a self-sacrificing schema to assume the role of a 'parentified child' and to do so from a young age – as is very clear in Gloria's case.

Schema mode conceptualisation. When schema triggering occurs, past EMSs are activated in the here-and-now and can, according to Arntz and Jacob (2012), take the form of one of several schema modes. The schema modes applicable to Gloria, as identified in psychotherapy sessions and confirmed by the SMI (Young et al., 2008), will be discussed next.

Healthy adult mode. According to the SMI, Gloria obtained a high score in terms of her healthy adult mode. High scores are indicative of individuals who are able to perform adult responsibilities and who are able to make informed decisions through a process of deliberation (Rafaeli et al., 2011). In addition, Gloria will most likely be able to solve problems as she has sufficient access to her logical and rational thinking abilities.

Child modes. Gloria's child modes were identified from the SMI. In terms of her healthy child modes, it is interesting that she scored high on the *contended child* mode, especially seeing that all six her emotional needs were unmet.

Then, in terms of Gloria's *damaged child* modes, she reports very high scores on the SMI for the *angry child* and the *enraged child* modes. The very high score on the angry child mode refers to the vulnerable part of Gloria that has a need to vent anger directly in response to her perceived unmet emotional needs and in response to being treated unfairly in relation to her EMSs (Young et al., 2003). Schemas commonly associated with the angry child mode, and also evident in her case, are abandonment and mistrust or abuse.

Then, in terms of Gloria's very high score on the enraged child mode, this refers to her experience of intense anger that results in the need to hurt or damage others (Kellogg & Young, 2006). When in enraged child mode, her anger can become out of control, and she is at risk of acting impulsively and becoming the "uncontrollable screaming child" (Young et al., 2003).

Maladaptive coping modes. Maladaptive coping modes refer to the damaged child attempting to adapt to living with unmet emotional needs in childhood within the context of a perceived harmful (and even dangerous or evil) environment. Even though her maladaptive coping modes were adaptive, functional and helpful when she was a young child, they are viewed as maladaptive, dysfunctional and unhelpful as an adult functioning in an environment where they are no longer required (Jacob et al., 2015).

Gloria primarily resorts to *schema avoidance* (also known as the *flight-response*) by adopting a coping style of emotional withdrawal, disconnection, isolation and behavioural avoidance. She does so in an attempt to escape from the upsetting emotions generated by her schema activation and/or triggering (Farrell et al., 2014). Consequently, Gloria adopts a cynical stance and comes across as aloof and interpersonally distant. Furthermore, she avoids investing emotionally in others or even in activities. The implication is that she has the interpersonal impact of being socially withdrawn. According to the SMI, Gloria scored high on the *detached self-soother* coping mode. When in this mode, Gloria shuts off her emotions by way of activities that she finds soothing, stimulating and distracting. These behaviours are usually solitary

addictive or compulsive behaviours such as, in her case, binge-watching movies and series (Edwards, 2016).

Dysfunctional parent modes. Finally, in terms of dysfunctional parent modes, Gloria obtained a high score on the SMI for the *demanding parent* mode. This refers to parents that set unrealistically high expectations and levels of responsibility for their children. The implication is that she most likely experienced very high levels of pressure to achieve her parents' expectations while growing up (Jacob et al., 2015). According to research, the self-sacrifice schema is strongly associated with a demanding parent mode (Young et al., 2003). Consequently, Gloria probably internalised that there is a 'right' way to be and that it is 'wrong' to be fallible and spontaneous. Gloria shifts into a demanding parent mode when she sets unrealistically high expectations for herself and strives towards meeting these expectations. Her demanding parent mode is the part of her that expects a lot (too much) of her. It is clear that this is the voice of her mother, and what makes it maladaptive, dysfunctional and unhelpful is that she hears her mother's words, but in her own voice (she does not realise that it is her mother's words as she perceives these to be her own words).

Key change constructs.

Stage of change (or readiness for change). In Prochaska's transtheoretical model of change (Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska & Norcross, 2018), Gloria was in the pre-contemplation stage at the beginning of psychotherapy. This implies that she felt as though her situation was hopeless and that she did not intend to nor wanted to change. She also frequently made use of minimisations or rationalisations to downplay or dismiss the extent and impact of the 'problem'. In addition, she was extremely defensive and blaming, which fits very well within the pre-contemplation stage. Therefore, the psychotherapist made use of validation of her lack of motivation to change and encouraged self-exploration and re-

evaluation of her current behaviour in an attempt to increase her level of motivation to change (Prochaska & Norcross, 2018).

Gloria remained in pre-contemplation throughout most of the psychotherapy process. It was only in session 27 when the psychotherapist could identify that she showed signs of movement into the contemplation stage. Since then, she presents with ambivalence regarding the need to change and, for the first time, seems to entertain the pros and cons of the need to change. A clear manifestation hereof is the ambivalence that she is currently experiencing regarding her need for independence or separateness *versus* her need for dependence or togetherness with her mother (Skeen, 2014). The psychotherapist is currently focusing on consciousness raising and re-evaluations of the self in order to move from the contemplation into the action stage (Krebs et al., 2019).

Cognitive-emotive development of client. Erikson's theory of psychosocial development (Erikson, 1982) was used to formulate a developmental conceptualisation. According to this theory, Gloria was faced with different developmental tasks that she had to deal with at different ages. These developmental tasks can also be viewed as a crisis which she had to deal with in either an adaptive or maladaptive manner. Regardless of the outcome of the crisis, Gloria was propelled through a combination of biological maturation and social demands into the next developmental stage (or task). In terms of Erikson's first developmental task, *trust versus mistrust*, it is clear that Gloria experienced mistrust, which is evident from the fact that she did not develop the virtue of *hope*. She had feeding difficulties as a baby and frequently cried, leaving her mother feeling overwhelmed and actively demonstrating hostility towards her (which her mother still frequently reminds her of). Moving on to Erikson's second developmental task, *autonomy versus shame/doubt*, it is evident that she did not develop autonomy, as she frequently experiences high levels of shame and self-doubt. In addition, she frequently complains of procrastination and a lack of motivation in general, indicative of the

fact that she did not develop the virtue of *will* during this stage. In terms of *initiative versus guilt*, it seems as though Gloria successfully mastered Erikson's third developmental stage, seeing that she can take initiative and displays the virtue of *purpose* in her day-to-day life. Next, in terms of Erikson's fourth developmental stage, *industry versus inferiority*, it is apparent that she also succeeded in mastering the developmental task of this stage as she developed the virtue of *competency* and displays signs of industry. As an adolescent, Gloria found herself in Erikson's fifth developmental stage, namely that of *identity versus role confusion*. She has not succeeded in mastering this developmental task as she did not develop the virtue of *fidelity* and is currently still in the process of answering the two prominent identity questions, namely: 1) who am I? and 2) where am I going? The consequence is that she is prone to experience difficulties in her current developmental stage, *intimacy versus isolation*. Therefore, it makes sense that Gloria experiences difficulty in Erikson's sixth developmental task, as she still finds herself positioned between two important developmental tasks, namely *identity versus role confusion* and *intimacy versus isolation*. The ambivalence emanating from this developmental conceptualisation also forms the essence of her current process in psychotherapy, namely to move from a position of dependence to independence. In order to achieve independence, she has to, first of all, differentiate from her mother, then find her own identity and only then attempt to find someone to share her life with. Only then will Gloria be able to truly experience the virtue of *love*. This move from togetherness (with mother) to separateness (independence/autonomy) and then to togetherness (meaningful relationships with others), but in a redefined manner, forms the essence of Gloria's developmental conceptualisation (Skeen, 2014).

Mechanism of change. From a schema therapy perspective, EMSs are perpetuated through three primary mechanisms: 1) cognitive distortions; 2) self-defeating life patterns; and 3) schema coping styles (Young et al., 2003). These three primary mechanisms are further

maintained by relational patterns (Van Vreeswijk et al., 2012). Seeing that an in-depth discussion of Gloria's EMSs was already presented in terms of their relevant schema domains, the remainder of her mechanism of change can be punctuated on the level of damaged child modes, maladaptive coping modes and dysfunctional parent modes.

Damaged child modes. When Gloria's EMS activates her damaged child modes, it mainly activates either her angry or enraged child modes. When in *angry child* mode, Gloria tends to vent her anger directly in response to perceived unmet emotional needs or unfair treatment related to her prominent EMSs, mainly linked to her abandonment and mistrust or abuse schemas. When in *enraged child* mode, Gloria feels out of control due to the high levels of anger that she experiences, resulting in her being at an increased risk to act out impulsively and to hurt others (Kellogg & Young, 2006).

Maladaptive coping modes. As already mentioned, Gloria mainly resorts to schema-avoidance coping modes, and she does so through utilising the detached self-soother. When in *detached self-soother* mode, she avoids emotions by shutting off from them and engaging in activities that she finds nurturing and comforting, for example binge-watching movies and series (Edwards, 2016). This mode enables her to withdraw psychologically from the EMSs and to not only detach from her emotions but also from others, all in an attempt to protect herself from the emotional pain she associates with being vulnerable (Farrell et al., 2014).

Dysfunctional parent modes. From the YPI (Young, 1999), it was identified that Gloria experienced her parents, as a parenting unit, as utilising a perfectionistic parenting style. It was her experience that her father, in terms of parenting, most prominently used emotionally depriving, belittling, punitive and conditional (also known as narcissistic) parenting styles. She also experienced him to be a controlling and emotionally inhibiting parent. Then, in terms of her mother's parenting, she experienced her mother to be overprotective.

Therapy variables.

Relational variables. When reflecting on the therapeutic relationship, the psychotherapist (in conjunction with the input from individual supervision and from the reflective team) found the therapeutic alliance to be of a poor quality. Gloria frequently verbalised experiencing strong negative feelings (i.e. hostility) towards men in general. With the psychotherapist, also being male, a lot of these feelings were projected towards him. Also, given the strong negative feelings that Gloria experiences towards her father, it was a particularly difficult task to enable her to view the psychotherapist as a *good enough* parent figure (Louis & Louis, 2015; Winnicott, 1953; 1967). Rapport was difficult to establish as Gloria struggles to trust people in general, and men in particular. It was also challenging to get Gloria's cooperation within the context of the therapeutic process. This is also supported by her ambivalent reaction towards the psychotherapist's use of questioning, reflections, interpretations and empathic confrontation. She did, however, attend 86% of the scheduled sessions. A summative overview of the scheduled sessions and relevant themes discussed are presented in Table 5.3.

Table 5.3

Overview of Gloria's scheduled sessions

Session	Date	Description / Themes discussed
1	2018/08/10	DASS-21 (1); Clinical interview
2	2018/08/22	Clinical interview (continue); Therapeutic goals
3	2018/09/10	Schema therapy and anxiety: Psychoeducation;
4	2018/09/20	BAI (1); Schema Mode Inventory (SMI): administer and feedback
5	2018/10/18	Young Schema Questionnaire (YSQ): feedback
6	2018/10/24	Young Parenting Inventory (YPI): feedback
7	2018/10/30	Explore procedural beliefs (rules, assumptions and attitudes)
8	2018/11/06	DASS-21 (2); BAI (2); Explore romantic relationship history
9	2018/11/15	Did not attend (1)
10	2019/01/11	DASS-21 (3); BAI (3); Re-evaluate therapeutic goals
11	2019/01/15	Explore early maladaptive schemas (EMSs) and coping modes
12	2019/01/25	Explore dysfunctional parent mode; Guided imagery; Chair work

Session	Date	Description / Themes discussed
13	2019/02/07	Explore dysfunctional parent mode; Guided imagery; Chair work
14	2019/02/12	Explore dysfunctional parent mode; Guided imagery; Chair work
15	2019/02/19	Developmental timeline
16	2019/02/26	Break-up of romantic relationship
17	2019/03/06	Did not attend (2)
18	2019/04/05	Self-worth beliefs related to performance and relationships
19	2019/04/29	DASS-21 (4); BAI (4); Emotion focused therapy; Chair work
20	2019/05/07	Did not attend (3)
21	2019/05/17	Cost-benefit analysis: Expectations and needs
22	2019/05/24	Gender-specific beliefs and the influence thereof on her view of self
23	2019/06/12	Gender-specific beliefs and the influence thereof on her view of self
24	2019/07/26	Schema triggering; Emotion focused therapy; Guided imagery
25	2019/08/02	Explore relationship with her parents
26	2019/08/06	Did not attend (4)
27	2019/08/19	Triggers of anxiety; Psychoeducation
28	2019/08/30	Explore the link between the parenting styles of her parents and her EMSs, maladaptive coping modes and dysfunctional parent modes
29	2019/09/13	Discussion of vulnerabilities
Follow-up	2019/11/01	DASS-21 (5); BAI (5); Interview with individual supervisor

Technique variables. In terms of technique variables, a distinction was made between the top-down techniques used to strengthen the healthy adult of Gloria and bottom-up techniques used to heal her damaged child modes (Edwards, 2014). The psychotherapist found it difficult to create the atmosphere in which emotion-focused therapy could take place, seeing that Gloria's maladaptive coping modes and demanding parent mode continued to act as a barrier preventing communication between her damaged child and healthy adult modes (Bennet-Goleman, 2001). This, in combination with her readiness for change (namely being stuck between pre-contemplation and contemplation), necessitated the psychotherapist to focus more on creating awareness regarding her ambivalence towards change (Krebs et al., 2019).

Therefore, the focus of psychotherapy sessions was more on consciousness raising and the re-evaluation of the self than it was on the superordinate psychotherapeutic goals. In order to achieve the superordinate goals, Gloria needs to be in either the preparation or action stage of change (Prochaska & Norcross, 2018).

Measurement.

Process and outcome measures. A summative overview of the process and outcome measures used is presented in Table 5.4.

The DASS-21 (Lovibond & Lovibond, 1995) was used as an outcome measure as it was administered during the first session and also at follow-up. In addition, the DASS-21 also doubled up as a process measure as it was administered at different intervals throughout Gloria's psychotherapeutic process. In terms of the outcome measure scores, Gloria had initial scores of extremely severe on depression, anxiety and stress at the first session and reported moderate scores on depression and anxiety and a mild score on stress during the follow-up (which was after 25 sessions of psychotherapy). This clearly represents a significant decrease in her levels of depression and anxiety and also a noticeable improvement in her levels of stress.

When interpreting the DASS-21 findings as a process measure, it is clear that her levels of depression fluctuated throughout the process from initial extremely severe levels in session one to moderate levels across sessions eight to 19. At follow-up she still reported moderate levels of depression. Next, in terms of anxiety, Gloria reported extremely severe levels during session one, severe levels during session eight and again extremely severe levels during session 10, with severe levels being reported again in session 19. At follow-up, however, her levels of anxiety measured on the DASS-21 were within the moderate range. Finally, in terms of stress as measured on the DASS-21 as process measure, Gloria initially reported extremely severe levels of stress in session one, which changed to moderate levels across session eight

to 10. During session 19 and at follow-up, her levels of stress reported were within the mild range as measured on the DASS-21.

The BAI (Beck et al., 1988) was also used as a process measure with the exclusive purpose of monitoring Gloria's levels of anxiety throughout the process of psychotherapy. The BAI was initially administered in session four when Gloria reported potentially concerning levels of anxiety. Her scores shifted to the moderate levels of anxiety range between sessions eight and 19. During follow-up, her score on the BAI decreased even further into the low levels of the anxiety range.

In addition, seeing that schema therapy was used as evidence-based treatment approach of choice (Edwards, 2019; NICE, 2019; NIMH, 2019), the YSQ (Young, 2014) was administered between session four and five, with the SMI (Young et al., 2008) being administered in session four. The YSQ was administered to identify Gloria's most prominent EMSs (that formed in the past) and the SMI was administered to determine her schema modes activated in the here-and-now when schema triggering occurs (Farrell et al., 2014). Seeing that a prominent demanding parent mode was highlighted in the SMI, the YPI (Young, 1999) was also administered in order to formulate an in-depth conceptualisation of the parenting styles that Gloria experienced while growing up.

Table 5.4

DASS-21 and BAI for Gloria

	Session	Score / Interpretation
*DASS-21	Session 1	Depression = 17 (extremely severe) Anxiety = 16 (extremely severe) Stress = 18 (extremely severe)
	Session 8	Depression = 7 (moderate) Anxiety = 8 (severe) Stress = 10 (moderate)
	Session 10	Depression = 8 (moderate) Anxiety = 10 (extremely severe) Stress = 12 (moderate)
	Session 19	Depression = 9 (moderate) Anxiety = 8 (severe) Stress = 8 (mild)

	Session	Score / Interpretation
	Follow-up	Depression = 10 (moderate) Anxiety = 7 (moderate) Stress = 9 (mild)
**BAI	Session 4	50 (potentially concerning levels of anxiety)
	Session 8	22 (moderate levels of anxiety)
	Session 10	24 (moderate levels of anxiety)
	Session 19	22 (moderate levels of anxiety)
	Follow-up	17 (low levels of anxiety)

*DASS-21 (Depression Anxiety Stress Scale; Lovibond & Lovibond, 1995)

**BAI (Beck Anxiety Inventory; Beck et al., 1988)

Develop, test and monitor the change process framework.

Identify significant events (helpful and hindering factors). When reflecting on helpful factors, Gloria's session attendance of 86% of the scheduled sessions as well as the fact that she attended 25 sessions of psychotherapy are regarded as helpful factors. In addition, her ambivalence between pre-contemplation and contemplation in terms of readiness for change (Prochaska & Norcross, 2018), as well as her position between dependence and independence is regarded as helpful factors, seeing that it holds significant potential for change. Another helpful factor is that she is ambitious and has a vision of herself making a meaningful difference in and contribution to society.

The over-involvement of her mother in her life is viewed as a hindering factor, as well as Gloria's strong negative feelings towards men.

Identify empirical markers (or themes). Gloria's *levels of anxiety* were regarded as an important empirical marker, because her presenting problems were anxiety-related and she reported high scores on the DASS-21 and BAI in terms of anxiety. A shift in this empirical marker would be when Gloria experiences lower levels of anxiety as confirmed by multiple sources, for example process and/or outcome measures (i.e. DASS-21 and BAI), client feedback, the psychotherapist's clinical judgement and the clinical judgment of the individual supervisor and/or reflective team.

As schema therapy was the evidence-based approach of choice (Edwards, 2019; NICE, 2019; NIMH, 2019), Gloria's *schema mode conceptualisation* serves as an empirical marker as it provides a configuration of what maladaptive and unhealthy functioning looks like (Jacob et al., 2015). A shift in this empirical marker will be evident when there is a reconfiguration of Gloria's schema mode conceptualisation with subsequent adaptive and healthy functioning (Young et al., 2003).

Another empirical marker would be her *emotional regulation* ability, as she has a strong tendency to suppress emotions (Bennett-Goleman, 2001). A shift in this empirical marker would be when she challenges the detached self-soother, as a schema-avoidance coping mode, by decreasing her suppression of emotions. This might be evident through a change in frequency and intensity of this form of maladaptive coping, which will manifest as Gloria being able to be more emotionally expressive and more willing to tolerate and engage with the experiential nature of emotion-focused therapy techniques (Van Vreeswijk et al., 2012).

As the abovementioned empirical markers are all intrapersonal by nature, it is also deemed necessary to add an interpersonal empirical marker. Seeing that Gloria experiences interpersonal difficulties with all types of relationships, this empirical marker is applicable in a broad sense. A shift in this empirical marker would be when Gloria succeeds in improving the quality of her relationships with family members, with friends and with new potential romantic partners.

Evidence-informed responses to empirical markers. A schema therapy perspective was used as evidence-based treatment approach of choice to respond to all the identified empirical markers (or themes) highlighted in Gloria's case (Edwards, 2019; NICE, 2019; NIMH, 2019).

Monitor change process framework. When looking at the identified empirical markers, it is clear that a distinction can be made between intrapersonal and interpersonal empirical

markers. Furthermore, it is clear that the empirical markers link back to the superordinate and subordinate therapeutic goals.

First, and directly related to Gloria's presenting problem, is her levels of anxiety. In terms of this intrapersonal empirical marker, this was monitored through a combination of process and outcome measures, client feedback, the psychotherapist's clinical judgment and feedback during individual supervision and reflective team discussions. This empirical marker links with the second therapeutic goal of healing the damaged child and the first subordinate therapeutic goal, namely to decrease Gloria's levels of anxiety. When interpreting the DASS-21 as an outcome measure, it is clear that her levels of anxiety decreased significantly from extremely severe levels in session one to moderate levels during the follow-up. When interpreting the DASS-21 as a process measure, however, it appears that her anxiety levels fluctuated throughout the psychotherapy process between moderate, severe and extremely severe levels. However, the findings of the BAI, as another process measure, highlight a steady decline in Gloria's levels of anxiety throughout the therapeutic process where she reported potentially concerning levels of anxiety in session one and low levels of anxiety during follow-up. This is in line with the client feedback obtained as well as the clinical impressions of the psychotherapist, the individual supervisor and the reflective team.

The second empirical marker, namely Gloria's schema mode conceptualisation, succeeds in encapsulating all the superordinate and subordinate therapeutic goals. This empirical marker covers both the intrapersonal and interpersonal aspects of Gloria's functioning. The psychotherapist, in collaboration with the individual supervisor and reflective team, monitored this empirical marker by determining if a reconfiguration in her schema mode conceptualisation occurred. This would be evident if 1) the strength of Gloria's healthy adult increases; 2) there is healing of her damaged child modes (specifically referring to her anxiety, anger and rage); 3) she can re-evaluate the effectiveness of her maladaptive coping modes

(specifically referring to the detached self-soothing mode) and dysfunctional parent modes (specifically referring to the demanding parent mode); and 4) when she redefined the relationship she has with herself and others to increase the meaningfulness thereof. From the client feedback obtained and according to the clinical judgment of the psychotherapist in conjunction with the individual supervisor and reflective team, Gloria has not yet reached the point where a schema reconfiguration has been achieved. However, it is promising that she is currently in a state of ambivalence regarding the need to change.

In terms of the third empirical marker, namely her emotional regulation ability, the intention was to address her second superordinate therapeutic goal (namely to heal the damaged child) as well as her first and third subordinate therapeutic goals (namely to decrease her levels of anxiety and to control her anger better). A shift in this empirical marker would be when Gloria decreases her suppression of emotions and increases her emotional expression. This will be evident when she decreases the frequency and intensity of the detached self-soother as a form of maladaptive avoidance coping. From the client feedback obtained, and the psychotherapist's clinical judgment in collaboration with the individual supervisor and reflective team, this shift was not observed in the psychotherapy process. Even though Gloria reports lower levels of anxiety, her anger and rage are still very prominent and she still has the interpersonal impact of hostility which manifests as passive aggressiveness.

Finally, the quality of her interpersonal relationships was used as an interpersonal marker to address her fourth superordinate therapeutic goal (namely to work with relationships) and also her second subordinate therapeutic goal (namely to improve her interpersonal relationship skills). A change in this empirical marker would be evident if Gloria succeeded in forming new meaningful interpersonal relationships in the form of friendships or romantic relationships. Another change in this empirical marker would be when Gloria improves the quality of her existing relationships. Upon reflection regarding this empirical marker, it is clear from the

client feedback obtained, the psychotherapist's clinical judgment and the feedback received from the reflective team that there was no noticeable change in terms of this empirical marker.

Seeing that it appears as though Gloria did not respond well to the evidence-based responses to her empirical markers, the psychotherapist and individual supervisor critically reflected on possible changes in Gloria's SP-CPP formulation. Since Gloria did not respond well to any notion to change the approach, a decision was reached to adhere to the SP-CPP but to aim to increase her readiness for change and to assist her in moving from the contemplation into the preparation and then to the action stage of change (Krebs et al., 2019; Prochaska & Norcross, 2018). Given this understanding, the presence of ambivalence regarding the need to change serves as a significant empirical marker.

In the follow-up interview Gloria reflected on her experience of the therapeutic process, the therapeutic relationship and the therapeutic techniques used during the process. The most prominent themes identified by the reflective team regarding her experience of the therapeutic process in the follow-up interview were: 1) it was helpful in general; 2) it varied as it was difficult at times, but not always; 3) she pushed herself with a lot of effort due to her introverted personality and her lack of trust in others; 4) she was mindful throughout of her previous bad experiences with psychotherapists; 5) she appreciated the fact that her parents were not involved in the process; 6) she learned certain skills in the process; and 7) she has improved insight into her own dynamics and the influence her past has on her functioning in the here-and-now. Next, in terms of the therapeutic relationship, Gloria 1) described it as an average-quality therapeutic relationship; 2) experienced the psychotherapist as patient and 3) found it difficult to trust the psychotherapist due to her history and the psychotherapist's gender. When reflecting on the therapeutic techniques, the following themes were identified: 1) she learned to fight against and, consequently, prevent anxiety attacks from occurring; and 2) she could not identify (or name) specific helpful therapeutic techniques.

She did not mention any significant extra-therapeutic factors and also could not make any recommendations on how the process could be improved further. She identified some hindering factors, of which the following were the most prominent themes: 1) she was too time conscious and/or preoccupied with her routine; 2) she often experienced that her thoughts were drifting away from what was being discussed in sessions; and 3) she was compelled to cancel some sessions as it interfered with her routine and/or study time. To conclude, however, she mentioned that she would recommend psychotherapy to her friends, as she found it helpful.

Reflection

Seeing that the psychotherapy was provided by the same psychotherapist in collaboration with the same individual supervisor and reflective team by using a schema therapy approach within the SP-CPP framework, a comparison of the two cases would yield important implications for psychotherapy research and clinical practice. When reflecting on the cases of Helen and Gloria, it is clear that the outcome of the two cases was significantly different. While Helen met most of her therapeutic goals, Gloria did not do so. Therefore, the case of Helen can be regarded as a good-outcome case and the case of Gloria can be described as a poor-outcome case.

When using the SP-CPP as framework to reflect on possible reasons why there was such a difference in the outcome of the two cases, certain variables were identified. Firstly, regarding the key change constructs, it is clear that there was a significant difference in the cognitive-emotive developmental conceptualisation of Helen and Gloria. This resulted in Helen developing more of the virtues associated with the successful mastering of the psychosocial developmental tasks (Erikson, 1982). In addition, Helen's readiness to change was at a higher level compared to Gloria. While Gloria cycled between the pre-contemplation and contemplation stage, according to Prochaska's transtheoretical model (Prochaska & Norcross, 2018), Helen moved from the preparation into the action stage (Krebs et al., 2019).

Another important aspect relates to the mechanism of change. When comparing their schema mode conceptualisations (or configurations), it is evident that Gloria had significantly higher scores on more EMSs: Helen only had two EMSs above 80%, while 10 of the 18 EMSs in Gloria's case were above 80%. This appears to have important implications for prognosis, as Gloria's EMSs seem to be deeply ingrained and reinforced over time and, consequently, were more difficult to challenge and change. Another important difference was that even though both clients presented with an angry child as a damaged child mode, Helen did not also report an enraged child as Gloria did. This finding indicates that Helen had a higher capacity for emotional regulation and emotional experiencing in comparison with Gloria (Bennett-Goleman, 2001; Dadomo et al., 2016). These hypotheses regarding the mechanism of change can explain to a large extent the differences in outcome between the two cases.

When reflecting on the therapy variables, it was clear that Helen responded much better to the use of questioning, interpretations and emphatic confrontation than Gloria did. In addition, Helen appreciated and valued the use of guided imagery, chair work and the experiential nature of emotion-focused therapy, while Gloria did not echo the same sentiment. Thus, even though the same therapeutic techniques were used in both cases, Helen responded much better to them. This led the psychotherapist, individual supervisor and reflective team to consider the quality of the therapeutic relationship and the client's readiness for change as important variables in possibly explaining this difference. In terms of the therapeutic relationship, as a relational variable, there was a significant difference between the two cases. While rapport was easy to establish with Helen, it was more difficult to establish with Gloria. Consequently, the quality of the therapeutic alliance with Helen was much better. Even though Gloria's session attendance was slightly better than Helen's (86% vs 84%), the research team did not interpret this finding to be significant. It was very clear that Gloria was less motivated

to change, and her poor outcome can partially be explained by her lack of readiness for change (Prochaska & Norcross, 2018).

From the abovementioned, it is clear that the SP-CPP can not only be used as a reflective framework to conceptualise the change processes of clients throughout the psychotherapy process (similar to a *process measure*) but also as a reflective framework to reflect on change when comparing the first and last or follow-up sessions (similar to an *outcome measure*). Using the SP-CPP in both of these instances, the criteria for being a change process research framework have been met since the SP-CPP succeeded in integrating both process and outcome measures in the context of a single case. In addition, it also succeeded in combining quantitative and qualitative data, as is recommended for change process research frameworks. The quantitative data was mainly gathered through the use of process and outcome measures, which were administered throughout the process, as recommended by evidence-based assessment findings. The qualitative data was gathered by observing recorded psychotherapy sessions in the context of individual supervision and in a reflective team context where critical reflections and discussions took place. In addition, the clients' feedback in conjunction with the psychotherapist's clinical notes and clinical impressions were also used as qualitative data.

Recommendations for Psychotherapy Research and Clinical Practice

The research team recommends that future research explore the application value of the SP-CPP in different contexts with different clients and from different therapeutic approaches. In addition, the application value of the SP-CPP should also be explored in the context of group psychotherapy, family therapy and couples therapy. The research team also recommends that the SP-CPP be tailored for clients of different ages presenting with similar presenting problems, for example exploring how the SP-CPP conceptualisation for a child presenting with anxiety would differ from that of an adolescent or an adult. Finally, the research team recommends that future research should attempt to increase the level of

collaboration between psychotherapy researchers and psychotherapy practitioners in an attempt to narrow the research-practitioner gap even more and to enhance the knowledge, skills and values of all scientist-practitioners involved in the field of psychology.

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CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction

In this chapter, the findings of this study will be summarised, conclusions will be made and recommendations will be offered that have the potential to improve psychotherapy research and clinical practice.

The aim of this study was to explore change process research (CPR) in psychotherapy and to develop and evaluate a new CPR approach to psychotherapy. The following specific objectives were formulated in order to realise this aim: 1) to conduct a systematic review to identify critical themes and issues emerging from literature on CPR; 2) to develop a new CPR approach to psychotherapy based on the findings from the aforementioned systematic review; 3) to gather and synthesise experienced psychotherapists' and psychotherapy researchers' critical evaluations of the newly developed CPR approach; 4) to refine and/or modify the newly developed CPR approach based on the findings from the critical evaluation of experienced psychotherapists and psychotherapy researchers; and 5) to explore a qualified psychotherapist's experience of employing the newly developed CPR approach within multiple case studies.

An intervention research design (De Vos, Strydom, Fouché, & Delpont, 2011; Rothman & Thomas, 1994) was used as overarching research methodology for the study as a whole. In the following paragraphs, a brief summary of the most prominent findings stemming from each manuscript submitted as part of this study will be presented within the larger scope of the study.

Chapter 2 / Manuscript 1

The aim of manuscript 1 was to explore what current scientific literature reports regarding change process research in psychotherapy. Systematic review methodology (Grant

& Booth, 2009; Petticrew & Roberts, 2006) was applied to realise this aim. Scientific rigour was ensured throughout all phases ranging from devising the search strategy to screening, critical appraisal, data extraction and the synthesis of findings (EEPI, 2010). A total of 38 academic records formed the final dataset and included 37 articles and one chapter from a book, all evaluated as being of high scientific quality and highly relevant in relation to the research question that guided the systematic review, namely: *What does current scientific literature report regarding CPR in psychotherapy and how can this information be used in the context of psychotherapy practice and research?*

From the narrative synthesis presented in manuscript 1, eight themes emerged which were grouped into two clusters, namely research- and practice-related themes. The four prominent sub-themes clustering under the research-related theme were: 1) research methodologies in CPR; 2) outcome measures; 3) process measures; and 4) existing CPR approaches. In terms of practice-related themes, the following four sub-themes emerged: 1) therapeutic relationship; 2) therapeutic techniques; 3) change concepts; and 4) psychological understanding of the client.

Next, a discussion of the most prominent findings from the systematic review will follow. The systematic review highlighted the need to integrate the abovementioned research- and practice-related themes within a scientist-practitioner approach (Chwalisz, 2003) to change process in psychotherapy (Elliott, 2010). It is recommended that this integration should occur in a context of increased collaboration between psychotherapy researchers and practitioners in order to not only address the scientist-practitioner gap but also to advance the field of CPR. Within such an integrative framework, the need to integrate process and outcome research was highlighted in a context where evidence-based practice (EBP) (APA, 2006) and practice-based evidence (PBE) (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014) should be regarded as valid sources of evidence.

In line with this finding, it is recommended that more case studies be conducted and published by scientist-practitioners, namely psychotherapy researchers and practitioners, and that these publications should include mixed-method approaches within which quantitative and qualitative data are collected and analysed at different intervals and from different perspectives throughout the psychotherapy processes (Edwards, 2019; Pfeifer & Strunk, 2015; Stiles, Hill, & Elliott, 2015; Watson & McMullen, 2016).

Chapter 3 / Manuscript 2

The aim of manuscript 2 was to develop a new change process research approach to psychotherapy. This aim was realised through the use of an intervention research design (De Vos et al., 2011) and, in particular, the design and development methodology thereof (Rothman & Thomas, 1994). From the findings of the systematic review on CPR in psychotherapy (see manuscript 1), the research team developed a pilot version of the new CPR approach to psychotherapy, known as the Scientist-Practitioner Approach to Change Process in Psychotherapy (SP-CPP). The pilot version of the SP-CPP was critically evaluated by 12 key informants (or experts), who met strict inclusion criteria. Prominent themes were identified by means of a thematic analysis (Clarke & Braun, 2013) of the critical evaluations gathered from experienced key informants (or experts in the field). Subsequently, the prominent themes were critically discussed and considered by the research team in the process of amending (and further refining) the SP-CPP.

Two versions of the SP-CPP were presented, namely: 1) a broad overview (recommended to be used by practitioners); and 2) a detailed overview (recommended to be used by psychotherapy researchers). The main finding of manuscript 2 is the presentation of the amended SP-CPP framework, consisting of a trans-theoretical (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Kolden, 1996; Reiter, 2010) and trans-diagnostic (Beutler, 2014; Constantino & Bernecker, 2014; Knobloch-Fedders, Elkin, & Kiesler, 2015)

framework that can be used to conceptualise change processes in the context of psychotherapy.

Manuscript 2 concluded by making the following recommendations: Firstly, there is a need to apply the SP-CPP practically with different clients with different presenting problems and being treated from different therapeutic approaches. Secondly, the potential application value of the SP-CPP for couples' and family therapy, as well as group psychotherapy, should also be explored. Finally, future research should explore the possibility of specific change process formulations for specific presenting problems and for specific age groups and/or client populations.

Chapter 4 / Manuscript 3

The aim of manuscript 3 was to apply the SP-CPP practically in the context of two clients presenting with anxiety-related difficulties who received cognitive behavioural therapy (CBT) (Beck, 2011; Clark & Beck, 2010) as evidence-based treatment (NICE, 2019; NIMH, 2019). The two cases were that of Cindy, a 20-year-old female who received 12 sessions of psychotherapy, and Mark, a 28-year-old male who received 22 sessions of psychotherapy. A multiple case study research design (Yin, 2009) was used to realise the aforementioned aim, during which quantitative and qualitative data was gathered and analysed from multiple perspectives and at different time intervals (Aaboen, Dubois, & Lind, 2012; Nonthaleerak & Hendry, 2008; Stake, 2013).

In both cases, the first author was the psychotherapist, with the second author acting as individual supervisor and all four authors, along with an independent member, forming the reflective team. The SP-CPP was used as structure for the write-up of the two cases.

From the case write-up, it was clear that the case of Cindy can be described as a good-outcome case, while the case of Mark was a fair-outcome case. These differences in outcomes were determined by a combination of quantitative and qualitative data with the inclusion of:

recordings of sessions; process and outcome measures; client feedback; critical discussions and reflections during individual supervision and during reflective team meetings; and data obtained from the follow-up interviews with both clients.

The SP-CPP was then used as framework to reflect on possible reasons for these differences in outcomes, which were mainly found in the key change constructs and therapy variables sections. In terms of the key change constructs, it was clear that Cindy was in the formal operational phase of cognitive development (Piaget, 1964; 1972) and moved from preparation to action in terms of her readiness for change (Prochaska & Norcross, 2018). Mark, on the other hand, was in the concrete operational phase of cognitive development (Piaget, 1964; 1972) and remained in the contemplation phase in terms of his readiness for change (Prochaska & Norcross, 2018). These differences in cognitive-emotive developmental formulations and stages of change also explain the differences in levels of insight noticed (Krebs, Norcross, Nicholson, & Prochaska, 2019). Then, in terms of therapy variables, Cindy attended 100% of her scheduled sessions and was committed to do therapeutic work between sessions, while Mark only attended 64% of his scheduled sessions and did not display Cindy's level of commitment to do therapeutic work between sessions. Finally, there was a significantly better therapeutic alliance with Cindy than with Mark.

Manuscript 3 concluded by recommending that the SP-CPP be used both in psychotherapy research and clinical practice during the psychotherapeutic process of different clients with different presenting problems and from different therapeutic approaches. It was also recommended that the use of the SP-CPP be explored in couples' and family therapy, as well as in group psychotherapy, and be appropriately amended (or adjusted).

Chapter 5 / Manuscript 4

The aim of manuscript 4 was to apply the SP-CPP practically in the context of two case studies presenting with anxiety-related difficulties where schema therapy was used (Young,

Klosko, & Weishaar, 2003) as the evidence-based treatment approach of choice (Edwards, 2019; NICE, 2019; NIMH, 2019). The two cases were that of Helen and Gloria, both 21-year-old females. To realise this aim, a multiple case study research design (Yin, 2009) was used and quantitative and qualitative data was gathered from multiple perspectives (Aabo, Dubois, & Lind, 2012; Nonthaleerak & Hendry, 2008; Stake, 2013). Psychotherapy sessions were recorded and critically discussed in the context of individual supervision (provided by the second author) and also in the context of a reflective team (consisting of all four authors as well as one independent member). Process and outcome measures were administered at different intervals throughout the psychotherapeutic processes. In addition, the second author also conducted follow-up interviews with both clients to ascertain their experience of the psychotherapeutic process, therapeutic relationship and use of therapeutic techniques (amongst others). The choice of treatment approach was based on the clients' cognitive-emotive developmental formulation (Erikson, 1982) and case conceptualisation, with particular reference to their mechanism of change which was based on their schema mode configurations (Young et al., 2003). Both cases were presented according to the structure provided by the SP-CPP.

It was clear from the case write-up that there were differences in outcomes between the two cases, with Helen reporting a good outcome and Gloria a poor outcome. By reflecting on the elements within the SP-CPP framework, certain possible explanations for the difference in outcomes can be offered, mainly in terms of the key change constructs and therapy variables sections. Firstly, in terms of key change constructs, it was clear that Helen succeeded in mastering more of the developmental tasks and, consequently, developed more of the virtues as highlighted by Erikson (1982) than Gloria did. In addition, Helen moved from the preparation to action stage (Prochaska & Norcross, 2018), while Gloria cycled (or were stuck) between pre-contemplation and contemplation (Krebs et al., 2019). Also, in terms

of the mechanism of change, it was evident that Gloria reported significantly more and stronger early maladaptive schemas (EMSs) than Helen did, which clearly had negative implications in terms of her prognosis. Then, moving on to therapy variables, Helen responded much better to the therapeutic techniques used than Gloria did; consequently, the quality of the therapeutic alliance with Helen was much better than with Gloria.

Manuscript 4 concluded by recommending that the SP-CPP be tailored for clients of different ages, genders and cultures presenting with similar or different problems who receive treatment from different treatment approaches. Finally, it is recommended that future research endeavours increase collaboration between psychotherapy researchers and practitioners in order to narrow the researcher-practitioner gap further and to enhance the evidence-based nature of psychotherapy.

Limitations

Regarding manuscript 1, it was a limitation that no African (and therefore also no South African) studies were found on change process research in psychotherapy. In addition, it was a limitation that the systematic review mainly yielded conceptual-theoretical articles, with a lack of empirical studies on CPR in psychotherapy. It is also a limitation that no prior systematic review on CPR in psychotherapy was identified in the systematic review conducted in manuscript 1.

Moving on to manuscript 2, it is a limitation that the SP-CPP was mainly developed with individual psychotherapy in mind, seeing that the SP-CPP also shows promise in being used and adapted for the purpose of couples' and family therapy as well as group psychotherapy. However, the aim of this study was to develop a broad CPR framework, mainly to be used with individual psychotherapy in mind. Thus, the findings of this study provide a starting point to serve as guideline from which other applications of the SP-CPP can (and ought to) be explored.

Finally, from manuscripts 3 and 4, a possible limitation might be that the SP-CPP was only applied practically to clients presenting with anxiety-related difficulties. However, this can also be regarded as a strength in the sense that these two manuscripts, when viewed together, provide practice-based evidence for the use of the SP-CPP particularly regarding the treatment of anxiety-related difficulties from two prominent evidence-based treatment approaches, namely cognitive behaviour therapy and schema therapy. It can be argued that in an attempt to reach specificity, the researcher had to compromise generalisability. Another potential limitation is that the four cases that were presented do not represent an age-, gender- or culturally-diverse client population: They were all white students, three female and one male, in approximately the same developmental phase. This does not, however, limit the potential value and use of the SP-CPP with age-, gender- or culturally-diverse client populations, especially seeing that the SP-CPP was based on a systematic review of CPR in psychotherapy. Therefore, the concepts (or elements) used in the development of the SP-CPP proved to not only be universal, scientific and evidence-based but also common across different psychotherapeutic approaches.

Integrated Conclusion

In terms of the application value of the SP-CPP, it is very important to be cognisant of the different ways in which the SP-CPP can be used. Firstly, and most importantly, the SP-CPP was developed with the aim to serve as a dynamic instrument to be used throughout a psychotherapy process as framework to conceptualise change process formulations for clients. The psychotherapist is, therefore, encouraged to use the SP-CPP throughout a psychotherapy process, on a session-to-session basis, as a dynamic instrument guiding case conceptualisation, informing treatment planning and monitoring clients' responses to therapeutic techniques, amongst others. Therefore, it is important that the psychotherapist needs to be able to identify when a client is not responding well to treatment and to make

relevant amendments and refinements if, when and where necessary. This highlights one important use of the SP-CPP, namely during psychotherapy with clients, and this can be equated to using the SP-CPP as a process measure of sorts (Elliott, 2010; Greenberg, 1986; Margison et al., 2000).

Another recommended use of the SP-CPP is as a reflective instrument to be used to evaluate the outcome of cases, similar to an outcome measure (Kazdin, 2008). When used for this purpose, the SP-CPP can provide possible explanations for the difference in outcomes between cases (namely poor, fair or good). The difference in outcome can then be understood through a critical reflection on the elements highlighted within the SP-CPP framework. As an example, it was noticeable in this study that the differences between good, fair and poor outcomes were mainly related to the *key change construct* and *therapy variables* sections.

Upon further reflection regarding the use of the SP-CPP in this study, it appears that, regardless of the way the SP-CPP was used, differences in outcomes should be conceptualised on two levels, namely that of the psychotherapist and that of the client. More specifically, the conceptualisation can be punctuated separately on the levels of the psychotherapist or client, but also simultaneously on the level of both. As an example, if the SP-CPP highlights that the client is not responding well to the treatment, it might be that – *on the level of the psychotherapist* – the psychotherapist needs to amend the SP-CPP formulation *or* that there is a therapeutic alliance of a poor quality. It might also indicate that – *on the level of the client* – the client's readiness to change is very low *or* the client is not responding well to the therapeutic techniques used. It might even indicate a combination of the aforementioned – *on the level of both*.

Another useful example would be if there was a mismatch in the alignment between the client's cognitive-emotive developmental formulation and the selection of therapeutic techniques used. To make it even more specific, if a client is in the sensory-motor phase,

according to Piaget's theory of cognitive development (Piaget, 1972), and the psychotherapist opts to use cognitive behavioural therapy (Beck, 2011) as evidence-based treatment approach (NICE, 2019; NIMH, 2019), there might be a risk of such a mismatch. The choice of schema therapy (Young et al., 2003) as evidence-based treatment approach (Edwards, 2019; NICE, 2019; NIMH, 2019) would have been a more informed decision, seeing that it aligns better with the cognitive-emotive developmental level of the client.

If the difficulty is identified more on the level of the psychotherapist, then it is recommended that the psychotherapist rethinks (or reformulates) the client according to all the elements of the SP-CPP as guiding framework. If the difficulty is identified to be more on the level of the therapeutic alliance, for example, then the psychotherapist should engage in rupture-repair strategies (Hilsenroth, Cromer, & Ackerman, 2012; Safran & Muran, 1996). Finally, if the difficulty is identified to be related to the client's lack of motivation to change (Prochaska & Norcross, 2018), the psychotherapist can consider using motivational interviewing techniques (Westra, 2012) as a means to increase the client's readiness to change (Krebs et al., 2019).

As a final thought, it is also recommended that the SP-CPP should be considered to be introduced and discussed in psychotherapy sessions with clients where indicated and if developmentally appropriate. It might be that such use of the SP-CPP, within the context of psychotherapy sessions, might also increase not only the client's readiness to change but also, potentially, the quality of the therapeutic alliance.

Contribution of the Study

One of the most significant contributions of this study is that it provides an evidence-based framework for psychotherapists in training – from conceptualisation to monitoring and evaluation of psychotherapeutic processes – to be used with different clients with different presenting problems and from different treatment approaches. The same applies to

psychotherapists in practice, with the aim to further improve (or enhance) the effectiveness of their clinical practice, regardless of their levels of experience and theoretical orientations. In short, this framework can also be used by psychotherapists in practice for ‘troubleshooting’ and ‘problem-solving’ purposes to assist them with new and existing clients (including difficult or challenging cases).

The SP-CPP is equally useful in psychotherapy research as it provides an evidence-based conceptual methodological framework that succeeds in integrating process and outcome research within the context of a single study.

In terms of manuscript 1, the intended contribution is that this manuscript provides the first systematic review on CPR in psychotherapy (to the best knowledge of the research team).

Regarding manuscript 2, the contribution is that a new CPR approach to psychotherapy was developed, known as the SP-CPP. The SP-CPP is a change process framework with a high level of rigour, seeing that it was developed from the findings of a systematic review and critically evaluated by experienced scientist-practitioners in the field of psychology. In addition, it is a well-grounded, scientifically-validated, evidence-based framework that is not only presented in a pilot version but also offered as an amended version. To add further value, the SP-CPP was not only presented theoretically but also applied practically, as illustrated in detail by way of four case studies.

The significant contribution of manuscripts 3 and 4 is that examples are offered of the practical application of the SP-CPP with four case studies of clients being treated from two prominent evidence-based treatment approaches. In addition, these two manuscripts serve as an example of how increased collaboration between psychotherapy researchers and practitioners can be achieved. Incorporating individual supervision and a reflective team, and

gathering and analysing quantitative and qualitative data at different intervals during the psychotherapy processes, significantly increased the rigour of this study.

In addition, the practical application of the SP-CPP occurred over the context of four cases and amounted to 91 attended psychotherapy sessions (of approximately one hour each), 20 individual supervision sessions (of approximately two hours each) and 15 reflective team discussions (of approximately two hours each). In addition, four follow-up interviews of approximately 30 minutes each were also completed (one for each client). This highlights the comprehensive and in-depth nature of the research processes followed – which the research team regards as a unique strength.

To conclude, an essential overarching contribution of the SP-CPP is that it holds value for scientist-practitioners in psychology to directly (or indirectly) increase the effectiveness of psychotherapy by enhancing the evidence-based nature of psychotherapy research and clinical practice to the benefit of clients.

Recommendations for Future Research and Clinical Practice

It is recommended that more empirical studies be conducted within the field of CPR in psychotherapy in general, but also particularly within the African (and therefore South African) context. It is also recommended that the SP-CPP be applied in the context of couples' and family therapy, as well as group psychotherapy, and that appropriate amendments be made. Within the context of individual psychotherapy, the practical application of the SP-CPP is encouraged for clients of different ages, genders and cultural groups, being treated for different presenting problems and from different evidence-based treatment approaches.

Furthermore, it is recommended that the SP-CPP be used extensively during psychotherapy research and clinical practice. In terms of the potential use in clinical practice, it is recommended that the SP-CPP be used during training of psychologists, during

supervision and also by registered psychologists in practice. It is strongly recommended to develop continuous professional development (CPD) training programmes for registered psychologists, based on the SP-CPP, in order to potentially improve the effectiveness and evidence-based nature of psychotherapy.

Critical Reflection

When reflecting on this study, the researcher regards himself as highly privileged since he has the opportunity to work in the dynamic field of psychotherapy research and practice. In addition, the researcher is highly appreciative of the collaborative nature in which this study was conducted with the continuous input and involvement of a dynamic research team.

During the planning phase of this study, the researcher got very excited when he stumbled on the topic of CPR in psychotherapy, referring to the article by Elliott (2010), and was immediately intrigued by the possibilities it offered. The first year was spent on reading numerous scientific articles and conceptualising a possible research topic that would be suitable for the purpose of a PhD. From there, the study started flowing, and the 18 months invested in completing the systematic review were worth all the effort, as it provided the researcher (and research team) with an in-depth understanding of CPR in psychotherapy, and all the related constructs or elements thereof.

Once the SP-CPP was developed, the researcher appreciated the contributions of the local and international key informants since their contributions enhanced the clarity and intended purpose of the SP-CPP by addressing certain misunderstandings highlighted in the critical evaluation of the pilot version of the SP-CPP. The amended version of the SP-CPP succeeds in providing a more accurate representation of what featured prominently in the findings of the systematic review.

The researcher, as a scientist-practitioner, really enjoyed the 14 months during which the practical application of the SP-CPP took place across the four case studies presented. It is

the clinical impressions of the researcher that all parties involved in this study experienced the process as very meaningful. With all parties, the researcher includes himself, the four clients, the individual supervisor, all the reflective team members and the key informants (or experts).

It makes a difference when research is not just merely conducted for the sake of doing research but with the practical application value thereof and the best interest of clients in mind. The researcher intends to use the findings of this PhD as a starting point, or platform, to develop this into a potential research focus area (or specialisation) in the foreseeable future. Seeing that the researcher is currently supervising several master's students on CPR-related topics, this intention is already starting to become a reality. With the necessary empirical support, this topic can significantly advance the field of psychotherapy research and practice.

To conclude, the researcher is thankful for the opportunity to be able to complete a study of this magnitude and would like to extend his immense gratitude to everyone enabling him to do so. He experienced the research process as very stimulating and learned a lot. The researcher intends to integrate what he has learned through this study and use it not only in his training of psychotherapists but also in his future psychotherapy research and clinical practice, with the aim to increase the effectiveness of psychotherapy, most importantly, to the benefit of clients.

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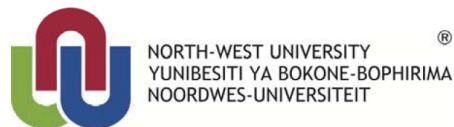
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Annexure A1: Ethics Approval



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom,
South Africa, 2520

Tel: (018) 299-4900

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Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel: +27 18 299 4849

Email: Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by Health Research Ethics Committee (HREC) on 19/01/2017 after being reviewed at the meeting held on 16/11/2016, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The development of a new Change Process Research (CPR) approach to psychotherapy.														
Study Leader/Supervisor: Prof KFH Botha														
Student: R Kok														
Ethics number:														
N	W	U	-	0	0	3	6	3	-	1	6	-	A	1
Institution			Study Number			Year			Status					
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation														
Application Type: Single Study														
Commencement date: 2017-01-19														
Risk: Medium														
Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.														

Special conditions of the approval (If applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:
 - annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study
 - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- Annually a number of studies may be randomly selected for an external audit.
- The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviation from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.
 - withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,
 - the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.
- HREC can be contacted for further information or any report templates via Ethics-HRECAppl@nwu.ac.za or 018 299 1206.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

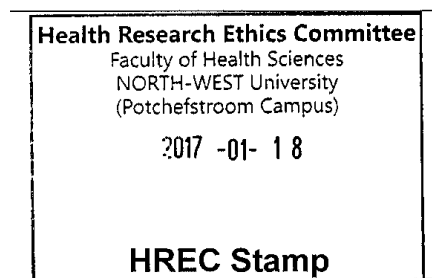
Yours sincerely

Prof LA Du Plessis
Digitally signed by
Prof LA Du Plessis
Date: 2017.02.06
07:53:39 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

Annexure A2: Informed Consent Documentation for Experienced Psychotherapists and Psychotherapy Researchers (Key Informants or Experts)



**INFORMED CONSENT DOCUMENTATION FOR
EXPERIENCED PSYCHOTHERAPIST AND
PSYCHOTHERAPY RESEARCHERS (KEY INFORMANTS OR
EXPERTS)**

TITLE OF THE RESEARCH STUDY: The development of a new Change Process Research (CPR) approach to psychotherapy

ETHICS REFERENCE NUMBERS: NWU-00363-16-S1

PRINCIPAL INVESTIGATOR: Prof. Karel (KFH) Botha

POST GRADUATE STUDENT: Mr. Rümundo (R) Kok

ADDRESS: North-West University, Potchefstroom Campus, Private Bag X6001

CONTACT NUMBER: 018 299 1726

You are being invited to take part in a **research study** that forms part of my PhD. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect

you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00363-16-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- *This study will be conducted at the North-West University: Potchefstroom Campus;*
- *We plan to enable psychologists, in practice and/or research, to gain a better understanding of change process in psychotherapy, in other words what to do in psychotherapy and how to do it*

Why have you been invited to participate?

- *You have been invited to be part of this research because you are a registered psychologist with more than five years practical experience post-registration and additional accredited post-graduate training in recognised evidence-based therapies;*
- *You also fit the research because of your involvement in a group-based practice and/or academic affiliation with a training institution;*
- *You will not be able to take part in this research if you have not been registered as a psychologist with the relevant board for at least five years, if you have no additional accredited post-graduate training in recognised evidence-based therapies and if you are not involved with a group-based practice and/or academic affiliation with a training institution;*

What will be expected of you?

- *You will be expected to complete two semi-structured open-ended questionnaires. The first questionnaire will be completed during the development phase of the new Change Process Research (CPR) approach to psychotherapy, while the second questionnaire will be completed during the evaluation phase of the new Change Process Research (CPR) approach to psychotherapy;*
- *It is expected to take no more than 30 minutes of your time per questionnaire and the questionnaires will be administered with a time interval in between;*
- *The second questionnaire will only be administered approximately 8 weeks after the first questionnaire was administered;*

Will you gain anything from taking part in this research?

- *The gains for you if you take part in this study will be that you will, most likely, have an increased understanding of change process in psychotherapy as you will be provided with a conceptual framework of what to do in psychotherapy and how to do it;*
- *The other gains of the study is the potential to increase the effectiveness of psychotherapy with the possible benefit of cost-effectiveness for clients, seeing*

that fewer sessions might be required to obtain the desired therapeutic outcome. Furthermore, this research does not only aim to close the practitioner-researcher gap, but also to increase the science (and art) in psychotherapy.

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *In the event where you withdraw from the study, the research team will request you to provide a reason for early termination and/or withdrawal from the study as to provide important scientific information. It still remains your decision to provide this information or not.*
- *There are more gains for you in joining this study than there are risks.*

How will we protect your confidentiality and who will see your findings?

- *Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorders. Data will be stored for seven years.*

What will happen with the findings or samples?

- *The findings of this study will only be used for this study for examination and/or publication purposes.*

How will you know about the results of this research?

- *We will give you the results of this research when the study is completed after examination of the PhD by providing you with the articles*
- *You will be informed of any new relevant findings by e-mail.*

Will you be paid to take part in this study and are there any costs for you?

No you will not be paid to take part in the study, neither will there be any costs involved for you to take part in this study.

Is there anything else that you should know or do?

- *You can contact Rūmando Kok at 018 299 1743 / 071 471 1863 / rumando.kok@nwu.ac.za if you have any further questions or have any problems.*
- *You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.*
- *You will receive a copy of this information and consent form for your own purposes.*

Declaration by participant

By signing below, I agree to take part in the research study titled: ***The development of a new Change Process Research (CPR) approach to psychotherapy***

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (place) on (date)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (name) declare that:

- I clearly and in detail explained the information in this document to

.....

- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.

- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*)
20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to
or I had it explained by who I trained for this purpose.
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them
or I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*)
20....

.....
Signature of researcher

.....
Signature of witness

Annexure A3: Informed Consent Documentation for Psychotherapy Clients



INFORMED CONSENT DOCUMENTATION FOR PSYCHOTHERAPY CLIENTS

TITLE OF THE RESEARCH STUDY: The development of a new Change Process Research (CPR) approach to psychotherapy

ETHICS REFERENCE NUMBERS: NWU-00363-16-S1

PRINCIPAL INVESTIGATOR: Prof. Karel (KFH) Botha

POST GRADUATE STUDENT: Mr. Rümendo (R) Kok

ADDRESS: North-West University, Potchefstroom Campus, Private Bag X6001

CONTACT NUMBER: 018 299 1726

You are being invited to take part in a **research study** that forms part of my PhD. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00363-16-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health

Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- *This study will be conducted at the North-West University: Potchefstroom Campus at the Institute of Psychology & Wellbeing (IPW), Building E8, Office 227 (Family Therapy Room) and will involve a psychotherapeutic process with an experienced clinical psychologist trained in scientifically proven interventions. Three participants will be included in this study.*
- *We plan to enable psychologists, in practice and/or research, to gain a better understanding of change process in psychotherapy, in other words what to do in psychotherapy and how to do it*

Why have you been invited to participate?

- *You have been invited to be part of this research because you have completed an application form at the Institute of Psychology & Wellbeing (IPW) for psychotherapy for a presenting problem on the anxiety disorder spectrum*
- *You also fit the research because your presenting problem fits the criteria to be regarded as a typical case and you are older than 18 years*
- *You will not be able to take part in this research if you are younger than 18 years, don't meet the criteria to be regarded as a typical case and don't have a presenting problem on the anxiety disorder spectrum. Furthermore, if you present with psychosis and/or mental retardation, you will also not be able to take part in this research*

What will be expected of you?

- *You will be expected to complete a psychotherapy process with an experienced psychotherapist making use of scientifically proven interventions. This process will commence in July 2018 and will end, by the latest, in March 2019. During this nine-month period you can expect to receive weekly/bi-weekly psychotherapy sessions of approximately 60 minutes per session. The process can range from a couple of sessions to a maximum of 30 sessions, depending on your needs and the complexity of your presenting problem. This process will be recorded (audio and video) and will be observed by a supervision team consisting of three senior clinical psychologists and one research psychologist. The aim of the supervision team is to provide the psychotherapist with input as to improve the effectiveness of the psychotherapeutic process and to facilitate the process of change*

Will you gain anything from taking part in this research?

- *The gains for you if you take part in this study will be that you receive an evidence-based treatment for your presenting problem from an experienced psychotherapist (with the support of an expert supervision team) with the direct benefit that you obtain a clearer understanding of your presenting problem and personal dynamics, the mechanisms thereof and that you are equipped with skills to empower you to cope with similar or different situations in the future and to sustain the progress made during psychotherapy.*

- *The other gains of the study is for psychotherapists' and/or psychotherapy researchers who might gain a better understanding of change process in psychotherapy by receiving a conceptual framework to understand what to do in psychotherapy and how to do it. This has the potential to increase the effectiveness of psychotherapy with the possible benefit of cost-effectiveness for clients, seeing that fewer sessions might be required to obtain the desired therapeutic outcome.*

Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study are a risk of your privacy being compromised due to the supervision team observing your sessions, but this will be limited by requesting the supervision team to sign confidentiality agreements indicating that they will not speak about your case to others (apart from the research team). Furthermore, your personal information will be disguised and you will be requested to read and comment on the finished case study before being submitted for examination and/or publication purposes. This will take place in the context of a consultation process with you. In addition, you will also be requested to give permission that the content of your case can be used in the article for examination and/or publication purposes. It is also important to highlight that the psychotherapist and supervision team involved in your case is bound by the ethical code of the Health Professions Council of South Africa (HPCSA) due to their professional registration and therefore required to adhere to aspects such as privacy and confidentiality.*
- *Another possible risk is the likelihood of harm during psychotherapy. This risk is, however, highly unlikely and only a few articles can be found indicating the possibility of harm due to psychotherapy. The researcher, however, still finds it necessary to account for this possibility and to implement necessary precautions in this regard. To ensure this, an experienced psychotherapist is selected to conduct the psychotherapy from an evidence-based framework. Furthermore, the researcher will ensure that the process of psychotherapy is monitored, not only by the supervision team, but also by means of process and outcome measures. In addition, an independent senior clinical psychologist will conduct individual interviews with you and the psychotherapist separately at the end of the psychotherapy process. If the likelihood of harm is suspected in any way, additional psychotherapy will be offered by the Institute of Psychology & Wellbeing (IPW) at the North-West University: Potchefstroom Campus, at no additional cost to you;*
- *There are more gains for you in joining this study than there are risks.*

How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by requesting you to engage in a consultation process with the research team during which you will have the opportunity to take part in the process of disguising your personal information, be requested to read and comment on the finished case study article and provide written permission for the content of the case to be used in the case study article for examination and/or publication purposes. Your privacy will be respected by ensuring that the supervision team signs confidentiality agreements and adheres to the ethical code as provided by the HPCSA where*

they are registered. Your results will be kept confidential by ensuring that only the psychotherapist and the research team has access to your personal data. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorders. Data will be stored for seven years.

What will happen with the findings or samples?

- *The findings of this study will only be used for this study for examination and/or publication purposes.*

How will you know about the results of this research?

- We will give you the results of this research when the study is completed after examination of the PhD by providing you with the case study article.
- You will be informed of any new relevant findings by e-mail.

Will you be paid to take part in this study and are there any costs for you?

No you will not be paid to take part in the study because you will receive psychotherapy from an experienced psychotherapist at the Institute of Psychology & Wellbeing (IPW) for the presenting problem you indicated on your application form and for which you indicated you are willing to pay. You will, however, receive psychotherapy sessions at the standard IPW fees (see IPW application form).

Is there anything else that you should know or do?

- You can contact Rūmando Kok at 018 299 1743 / 071 471 1863 / rumando.kok@nwu.ac.za if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: ***The development of a new Change Process Research (CPR) approach to psychotherapy***

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (place) on (date)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (name) declare that:

- I clearly and in detail explained the information in this document to
.....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above

- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*)
20....

.....
Signature of person obtaining consent

.....
Signature of witness

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to
or I had it explained by who I trained for
this purpose.
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer
them
or I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the
research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished
to do so.

Signed at (*place*) on (*date*)
20....

.....
Signature of researcher

.....
Signature of witness

Annexure B: Letter of Permission

Permission to submit the manuscripts for degree purposes

The student is hereby granted permission to submit his thesis for the purpose of obtaining a PhD degree in Psychology.

The student's work has been submitted to TurnItIn and a satisfactory report has been obtained.

Promoter

Co-promoters



Prof. Karel Botha

Prof. Pieter Kruger

Prof. Werner de Klerk

Annexure C: Language Editor Declarations



20 NOVEMBER 2019

TO WHOM IT MAY CONCERN

DECLARATION: LANGUAGE EDITING OF THESIS –

The development of a new Change Process Research approach to psychotherapy

I hereby declare that I have edited the thesis of Mr. Rümendo Kok and found the written work as well as in-text citations and referencing to be free of glaring and obvious errors.

Daleen Groenewald

APTrans (SATI)

PO Box 386

Kleinmond

7195

South Africa

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Language Editor's / Translator's Declaration

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Language editing – Translation – Transcription – Simultaneous interpreting

Date: 21 November 2019

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Deo Volente 28
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Potchefstroom
2531

To whom it may concern,

This document certifies that the manuscript/title/summary listed below was edited for proper usage, syntax, grammar, punctuation, spelling and the overall stylistic requirements of the English language by one or more editor(s) at Language Matters. All revisions made by the editor are recommendations; the overall quality and content of the final manuscript remain the responsibility of the client/author. This document further certifies that the manuscript/title/summary entitled below has been translated from English to Afrikaans, having taken into consideration the rules, norms and audience of the target language in rendering an equivalent version of the source text.

Manuscript title: The development of a new Change Process Research approach to psychotherapy

Author(s): Mr Rūmando Kok

Date Issued: 21 November 2019

Issued by: Simone Barroso

B.A. Language Practice and Communications (2010)

B.A. Hons. Language Practice (2011)

Associate Member of the Professional Editors' Guild (PEG)

Accredited Member of the South African Translators' Institute (SATI)

Annexure D: Guidelines for Authors

The Journal of Psychology

About the Journal

The Journal of Psychology is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's [Aims & Scope](#) for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

The Journal of Psychology accepts the following types of article: original articles.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees. Find out more about [what to expect during peer review](#) and read our guidance on [publishing ethics](#).

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

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