PSYCHOLOGISTS' PERCEPTIONS OF THE GROWTH AND CHANGE PROMOTING FACTORS IN PSYCHOTHERAPY WITHIN A CULTURALLY DIVERSE SOUTH AFRICA

By

Wilmie Heyneke

210027150

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Supervisor: Prof Y Ally

Declaration

Name:	Wilmie Heyneke
Student Number:	210027150
Qualification:	Master of Arts in Psychology (Counselling)
Title of Project:	Psychologists' Perceptions of The Growth and Change Promoting Factors in Psychotherapy Within a Culturally Diverse South Africa

Declaration:

In accordance with Rule G5.11.4, I hereby declare that the above-mentioned treatise/ dissertation/ thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

Signature:  **Date:** February 2022

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Abstract

The therapeutic relationship established between a psychologist and a client is considered one of the main factors determining successful psychotherapy outcomes. While this may be the case, there remain inconsistencies in the literature and debate regarding its influence, especially when contextual factors such as diverse beliefs, may influence the therapeutic relationship. Furthermore, there is a scarcity of information focusing on psychologists' experiences working within the culturally diverse South African context. This study aimed to better understand, from a psychologist's perspective, the growth and change promoting factors they feel are influencing successful therapeutic outcomes within the South African context. This was pursued recognising that the diverse belief systems in South Africa, which do not always adhere to biomedical conceptualisations of health and illness, may influence the therapeutic interaction. This study explored the following research question: What are the key factors that promote growth and change in individual psychotherapy within the diverse South African context? Drawing on a qualitative approach, an explorative descriptive research design was chosen as it enabled the researcher to explore the perceptions of the participants on the given topic. The sampling technique that was employed was non-probability purposive sampling and psychologists registered with the Health Professionals Council of South Africa formed part of the sample. In-depth online interviewing was employed as the data collection tool, using online platforms like Microsoft Teams and Zoom. Data were analysed using Braun and Clarke's thematic analysis guidelines and themes that were identified was reported.

Keywords: cultural adaptation, culture, growth and change, psychotherapy, thematic analysis, therapeutic alliance, therapeutic relationship

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CHAPTER 1: INTRODUCTION

In this introduction chapter, the rationale of the study is introduced. Thereafter the research aims and objectives, research question, locating myself in relation to the field of study, and contextualisation of the study are explored. Lastly, the outline of the study is given.

Rationale of the Study

In this qualitative study, the researcher explored psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context. Extensive support has been provided by psychotherapy research on the benefits that psychotherapeutic interventions offer (Cooper, 2007; Horvath et al., 2011; Lambert, 2013; Lambert & Ogles, 2004; Wampold, 2001). Numerous research studies have found the therapeutic relationship to be central to treatment success, irrespective of the theoretical stance or approach taken by the therapist (Horvath et al., 2011; Martin et al., 2000; Norcross, 2010; Wampold, 2001). The South African literature on psychologists' perceptions of the growth and change promoting factors that lead to successful outcomes in psychotherapy is limited. This is problematic, given that the culturally diverse South African context may require adaptations on the part of the psychologist to provide the client with therapy that is beneficial (Wolff, 2014).

It is noted that therapeutic healing practices have and are flourishing across the world amongst clients of diverse cultures (Dermendzhiyska, 2020). Cultural beliefs are noted as influencing how a person thinks, feels, and behaves towards people, situations, and experiences. Clients enter the therapeutic space with their cultural beliefs, diverse and unique personalities, racial or ethnic backgrounds and identities, social networks, economic resources, work histories, histories, and current life events. Thus, psychotherapy is grounded in a cultural context, providing clients with a frame of reference for understanding their way

of being in the world (Wampold & Imel, 2015). Hence the emphasis of psychotherapy is to be congruent with clients' cultural beliefs. It is thus important to explore psychologists' understanding of the key components of effective psychotherapy practice within the diverse cultural context of South Africa.

By keeping this in mind, the purpose of this study was to qualitatively explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context. This exploration is vital within a context as dynamic as South Africa. Therefore, this study aims to contribute towards the understanding of what works in therapy by gaining an understanding of the unique experience of the therapist during the psychotherapeutic interaction. The researcher hopes that this research will contribute to the South African knowledge base in this area, potentially guide practitioners in clinical practice, and facilitate improved treatment strategies and client-therapist relationships for therapists working in a diverse South African context.

Research Aims and Objectives

This research project aimed to explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context. The following objectives were met to reach this aim:

1. To explore and describe psychologists' experiences with the factors contributing to successful outcomes in psychotherapy;
2. To explore the characteristics and actions of effective therapists; and
3. To explore whether psychologists adapt their psychotherapeutic approach to the client's growth and change process, based on cultural beliefs.

Research Question

What are the key factors that promote growth and change leading to successful outcomes in individual psychotherapy within the diverse South African context?

Locating Myself in Relation to the Field of Study

My interest in what works in psychotherapy, what happens between the therapist and the client that leads to growth and change, is important and guided my choice of study. Soon after I started seeing clients for the first time as a counselling psychologist in training, I realised that how I work to a great extent makes use of the relationship formed with my client during therapy. The connection I form with a client is of the utmost importance and I find myself using this connection to delve into their lived experience, which essentially allows us to collaboratively work towards growth and change.

As a training psychologist, I am curious about what leads to successful outcomes in therapy. I remember when I started seeing clients for the first time, my supervisor encouraged me to focus on the relationship and connect with my client, instead of focussing too much on the technical elements. Although this eased my anxiety and took some pressure off me to perform, I was still uncertain of what it is that ultimately facilitates change and growth. What happens within the therapeutic exchange? What does the therapeutic relationship mean for the client? What am I offering my clients? What factors should I be aware of? These questions amongst others and my interests encouraged my choice of study.

Contextualisation

The existing evidence suggests that the state of South Africa's mental well-being is in severe crisis. The South African Depression and Anxiety Group (SADAG), a non-profit organisation that provides mental health services in South Africa, released a set of statistics that they have gathered in 2019 from their own experience (South African College of Applied Psychology [SACAP], 2019). Their findings indicated that as many as one in six South Africans suffers from anxiety, depression, or substance-use problems. In 2021 SADAG found that between January and September they received 466,607 calls which is an increase of 47% from 2020 (Heywood, 2021). Furthermore, their suicide helpline received approximately

2,200 calls per day from people with suicidal thoughts. South Africa demonstrates high rates of mental health disorders which underscores the need for psychological and psychiatric services to intervene meaningfully. It is time for the mental health situation in the South African context to be addressed by a uniquely South African solution (SACAP, 2019).

The therapeutic relationship between the therapist and the client had been examined and explored many times. However, this understanding in South Africa is still growing and in part, may be attributed to the diversity inherent to the South African populace, as each cultural group may have its own beliefs and practices that influence successful outcomes in psychotherapy. For example, in the African culture, depression is not considered to be an illness, there is not even a word for it (SACAP, 2019).

A report by the Health Professions Council of South Africa (HPCSA) (2017), found that 73.8% of psychology practitioners in the country are White, 12.3% are Black (African), 6.8% are Indian or Asian, 6.3% are Coloured, and 0.8% other. Furthermore, the 2011 South African census (Statistics South Africa, 2012) reflected that 79.2% of the population described themselves as Black (African), 8.9% as Coloured, 8.9% as White, 2.5% as Indian or Asian, and 0.5% as other. Thus, within a country of predominantly White psychology practitioners, they are expected to serve a society with more Black (African) people than any other ethnic group.

Psychotherapy in South Africa is influenced by the challenges related to South Africa's growing democracy. This follows the chaotic socio-historical and political landscape that defined South Africa. However, the redressing of racial inequities is not the only challenge faced by psychotherapists working within the South African context. Yalom (2002), an American existential psychiatrist and famous author, wrote that the field of psychology is in a crisis due to the pressures to streamline psychological therapy and treatment. He furthermore claimed that psychotherapy forms part of an economically driven healthcare system that

positions treatment to be inexpensive, perforce, brief, superficial, and insubstantial. Nonetheless, clients still expect and desire extensive growth and change and are willing to make an open-ended commitment to therapy. Thus, for psychotherapists, it is a continuous process of equipping themselves to intervene meaningfully without their values interfering with the outcomes (Cooper, 2007).

Psychotherapy, deemed as a product of Western individualism, may not be deemed fully appropriate to utilise as is in the African context, as it contradicts collectivist notions present in African cultures (Wolff, 2014). While the mechanisms of therapy are considered vital in the move toward improved treatment, these must be viewed in relation to the contextual factors that define South Africa (Kazdin, 2009). It has been widely acknowledged that psychology in South Africa should become relevant and in the 1980s, Retief (1989) already suggested that this has become the major value influencing psychological research. With a detailed understanding of the adaptations or challenges faced by psychologists in practice working with South African clients, psychotherapy may gain more relevance. According to Bantjies et al. (2016), it has been proven that psychotherapeutic models developed in Western contexts can be effectively adapted and applied in a variety of African settings. The onus thus rests on the psychologist to acknowledge the multi-cultural and multi-ethnic character of South Africa and to integrate the principles of multiculturalism without essentialising race and ethnicity. The responsibility now lies with psychologists in South Africa to engage actively with the indigenisation of counselling theory and practice (Bantjes et al., 2016).

Outline of the Study

Chapter Two introduces theoretical understandings and approaches to psychotherapy in a brief overview, providing a more detailed account of the growth and change promoting factors leading to successful psychotherapeutic outcomes. This chapter locates growth and change promoting factors in the contextual model.

Chapter Three describes the research methodology utilised in the present study. This description includes the details of the research design, the participants and the sampling procedure employed, the data collection method used, the research measure used, the research procedure followed, and an explanation of the data analysis techniques used. Lastly, the trustworthiness of the data and ethical considerations for the present study are described.

Chapter Four presents excerpts from the data to illustrate the findings of this study per the study's aims and objectives. Analysis was organised through the constant comparison of themes and categories. Findings are presented in the form of themes and subthemes that emerged from the data. Previous study findings and theoretical understandings of what leads to successful outcomes in psychotherapy have been included.

Chapter Five contains the conclusion and evaluation of the present study. The limitations and strengths of the study are discussed and suggestions for future research are offered.

A Final Note

The terms therapeutic relationship, therapeutic alliance, working alliance, and helping alliance have been used in the past to refer to specific aspects of the alliance or as synonyms for the alliance established between psychologist and client (Kazdin, 2009). Because the use of these terms is not always consistent, the terms therapeutic alliance and therapeutic relationship will be used in the present study to refer to all of the aforementioned constructs, unless otherwise specified.

In The Gift of Therapy, Yalom (2002) writes about his therapy goals for clients in his clinical practice. Ambitiously so, they include symptom removal, alleviation of pain, and the facilitation of personal growth and basic character change. For the proposed research, the researcher will use this description as a guidepost for what it means to achieve successful outcomes in psychotherapy. Additionally, successful psychotherapy will be considered as a client leaving with the satisfaction that he or she got what they came for, and no longer needs

or even wants to see the therapist. Thus, success in therapy is when clients come (in need) and go (improved), and when the therapist becomes obsolete (Reidbord, 2014).

This chapter provided an overview of therapeutic psychology theory and practice, both internationally and within the South African context. An overview of the rationale of the study, research aims and objectives, research question, locating myself in relation to the field of study, contextualisation, and outline of the study has been provided. The following chapter will cover the current empirical literature on the factors contributing to successful outcomes in therapy.

CHAPTER 2: LITERATURE REVIEW

The question of how people change through psychotherapy and what psychotherapists do to make them so effective has been the focus of various research studies (Dermendzhiyska, 2020; Kazdin, 2009; Wampold & Imel, 2015). Yet, Alan Kazdin, a professor of psychology and child psychiatry said, “It is remarkable that after decades of psychotherapy research we cannot provide an evidence-based explanation for how or why even our most well-studied interventions produce change” (Kazdin, 2009, p. 1). In clinical practice, there exist more than 400 varieties of psychotherapy approaches (Zarbo et al., 2016). Despite this, research advances are needed in studying the mediators and mechanisms of therapeutic change, as this will provide a better context of the effectiveness of different approaches cross-culturally.

Various studies have demonstrated the benefits of psychotherapy to clients (Lambert & Ogles, 2004; Wampold, 2001; Wampold & Imel, 2015). Psychological interventions have been shown to work just as well as, and possibly even better over the long term, than pharmacological interventions (Australian Psychological Society [APS], 2018). In some cases, psychotherapy approaches have been recognised as the preferred treatment across the range of psychiatric diagnostic categories (Dermendzhiyska, 2020).

In this literature review chapter, the researcher provides an understanding of psychotherapeutic interventions and the importance thereof. This chapter engages with existing research, as it relates to successful outcomes in therapy with a special focus on the contextual model. Therapist and client perspectives of therapeutic outcomes are also included, as well as various other contributing factors.

The Efficacy and Effectiveness of Psychotherapy

In psychotherapy history, the focus has always been on treatment differences. Norcross and Newman (1992, p. 3) wrote:

> Rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a "dogma eat dogma" environment . . . Mutual antipathy and exchange of puerile insults between adherents of rival orientations were much the order of the day.

In 1936, psychologist Saul Rosenzweig noted similar psychotherapeutic outcomes, despite using different therapies (Rosenzweig, 1936; Wampold & Imel, 2015). To concur, several studies over the last few decades have reached this similar conclusion: that all psychotherapies have roughly equal effects (Bohart, 2000; Wampold & Imel, 2015). This is said to be one of the most controversial conclusions possibly ever in the history of psychology known as the dodo bird verdict, referring to a race in *Alice in Wonderland* wherein contestants started when they wanted and ended when they wanted (Bohart, 2000). Rosenzweig used the following metaphor to comment on the competition between the different therapies and the equivalence of their benefits: "At last the dodo bird said, 'Everybody has won and all must have prizes'" (Wampold & Imel, 2015, p. 33). Little evidence exists to suggest that specific techniques or procedures have specific effects. Arthur Bohart (2000, p. 129) writes, "There is so much data for this conclusion that if it were not so threatening to special theories it would long ago have been accepted as one of psychology's major findings. Yet the enthusiasm for specific interventions continues".

In addressing the questions of why no single psychotherapy seems to provide unique advantages over any other, many researchers point to shared elements, especially the therapeutic alliance or relationship (Norcross et al., 2006). The therapeutic alliance, which is the emotional bond and the collaboration between client and therapist, seems to strongly predict improvement in therapy. This is also true for therapies that do not emphasise relational factors. The concept of the alliance has especially become one of the most

rigorously researched subjects in psychotherapy (Dermendzhiyska, 2020). For the most part, studies of the alliance could only show that it correlates with improved mental health. More recently evidence has been found for a causal link, suggesting that it is the therapeutic alliance that facilitates healing (Vocisano et al., 2004). Research furthermore shows that therapists with greater experience or a stricter adherence to a specific approach do not achieve improved outcomes whereas common factors such as empathy, warmth, hopefulness, and emotional expressiveness do (Goldberg et al., 2016; Wampold, 2015).

A New Model for How Psychotherapy Works

Rosenzweig, the forerunner of the term common factors, proposed that they were what produced the benefits of psychotherapy, as they are aspects of therapy that are common to all, or at least most psychotherapies, and include such aspects of therapy as hope, expectation, relationship with the therapist, belief, and corrective experience (Wampold & Imel, 2015). Rosenzweig noticed that “diverse forms of psychotherapy prove successful in similar cases” and he projected that there may be “unrecognized factors” in therapy that are “more important than those being purposely employed” (Rosenzweig, 1936, p. 413).

Several theoretical presentations of the common factors have been made over the years. The various common factor models gained the most acceptance during a period when humanistic treatments, with which they were most closely aligned, were also relatively popular. For the longest time, the medical (or treatment) metaphor has been the dominant metaphor underlying psychotherapy. Psychotherapy, like medicine, is regarded as a treatment for a pathological condition (or disorder), and treatments (or therapeutic techniques and procedures) are regarded as drugs (Wampold & Imel, 2015). Advocates for specific treatments have steadfastly resisted the common factor explanation, arguing that "true treatment lies in potent interventions rather than putative nonspecific factors such as the relationship or hope" (Bohart, 2000, p. 130). Accepting common factors as the cause of

psychotherapy's benefits and acknowledging that it may be more powerful than treatment, would collapse the entire scaffolding of modern psychotherapy's theoretical bases as conceptualised by the field and presented to the public (Wampold & Imel, 2015).

Since Rosenzweig proposed that common characteristics of therapy were responsible for psychotherapy's benefits, researchers have attempted to uncover the aspects of therapy that are common to all psychotherapies (Wampold & Imel, 2015). In the 1960s, Frank first developed the most comprehensive model of the common factors (Frank & Frank, 1993). His work does not only look at the factors that lead to healing in Western psychotherapy but includes diverse cultures. Frank's universal components of effective healing are as follows: A bonded, confiding relationship with a helping person, which takes place in a designated healing setting, during which a theory or map is co-created that describes the origin and solution to a person's problem, which then leads to a ritual or healing task prescribed by the theory (Frank & Frank, 1993).

A particular common factor model derived from Frank's model and developed by Wampold, called the contextual model, has been recently proposed (Wampold, 2001; Wampold, 2017; Wampold & Budge, 2012; Wampold & Imel, 2015). Wampold presented a new model for how psychotherapy works, focussing on developing the therapist instead of developing techniques, and viewing all interventions as rituals. Although the medical model, focussed on seeking evidence-based treatments, dictates the worldview of most psychotherapies, contextual model theorists have highlighted various issues that refute the basic assumptions of the medical model, hence the development of a new model for how psychotherapy works (Bacon, 2020).

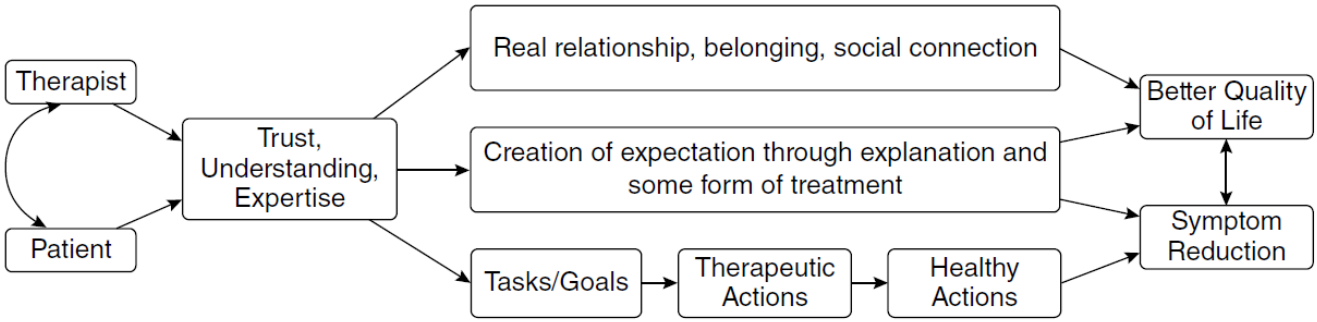
Wampold's research and theoretical reformulation of the therapeutic process has gained recognition worldwide. The contextual model is a meta-model and outlines a set of specific skills that should be the focus of deliberate psychotherapeutic practice (Wampold & Imel,

2015). It should not be viewed as an alternative treatment modality to for example cognitive behavioural therapy. Rather it should be viewed as a model that explains how all psychotherapies produce their benefits. Thus, it coherently identifies and organises the skills that therapists need to master to increase their effectiveness (Wampold, 2017). Essentially, this model presents the tasks and responsibilities that a therapist must unfold to create the conditions for a therapeutic alliance to be established.

The current version of the contextual model (Wampold, 2017) is presented in Figure 1 below. As demonstrated, it contains three pathways that must all be utilised for psychotherapy to be optimally effective. The model is based on the premise that psychotherapeutic benefits increase through social processes and that the relationship is at the core of psychotherapy effectiveness.

Figure 1

The Contextual Model



Note. This is the current version of the contextual model, demonstrating the three pathways that must all be utilised for psychotherapy to be optimally effective. From "What Should We Practice?: A Contextual Model For How Psychotherapy Works," by B. E. Wampold, in T. Rousmaniere, R. K. Goodyear, S. D. Miller, and B. E. Wampold (Eds.), *The Cycle Of Excellence: Using Deliberate Practice To Improve Supervision And Training* (p. 50), 2017, Wiley-Blackwell. Copyright 2017 by John Wiley & Sons.

The Initial Therapeutic Bond

First, an initial therapeutic bond must be formed between the therapist and client. Bordin, a pioneer in the development of the therapeutic alliance noted that "Some basic level of trust surely marks all varieties of therapeutic relationships, but when attention is directed toward the more protected recesses of inner experience, deeper bonds of trust and attachment are required and developed" (1979, p. 254). In this meeting of strangers, the initial bond is thus necessary before therapeutic work can begin (Horvath & Luborsky, 1993).

This might be a daunting task as people are evolved to discriminate between people they can trust and those they cannot. Based on just viewing the face of their therapist, clients make very rapid judgements (within 100 ms) about whether they can trust their therapist or not. Before the therapist has even taken their seat, the client makes an unconscious and out of awareness assessment of whether the therapist is trustworthy or not. More likely, these judgements also relate to the dress of the therapist and other features of the therapeutic environment. People come to therapy with beliefs of what is going to happen, with faith that it is going to be useful, maybe a friend recommended this therapist, or maybe there are some diplomas on the wall which seem impressive. Thus, clients do not come to the therapy session as a clean slate (Wampold & Imel, 2015). They carry expectations about the therapist and therapy. In general, individuals are predisposed to have a positive orientation toward healing, but only if the healing practice is in line with their culture. The initial interaction between therapist and client is thus of paramount importance as more clients drop out of therapy after the first session than at any other time of the therapeutic process (ISR, 2017).

After the bond is formed, the three pathways to client change can be utilised namely, the real relationship, the creation of expectation through explanation and treatment, and enacting health-promoting actions (Wampold, 2017).

Pathway 1: The Real Relationship

The real relationship between client and therapist refers to an intimate and emotional relationship between them. Psychodynamically, it is defined as an authentic relationship, based on realistic perceptions, that is free from transference (Gelso, 2009). It is two people meeting and having an intimate and genuine relationship (International Systemic Research Conference [ISR], 2017). The contextual model puts forth that the real relationship will be therapeutic (Wampold & Imel, 2015). Despite the distinct roles between the client and therapist, psychotherapy involves a deep and intimate relationship between two human beings who are able and willing to be who they truly are. It is a relationship based on genuineness, authenticity, openness, honesty, and realistic perceptions. Human connection otherwise referred to as attachment, belongingness, social support, or the lack of loneliness, is necessary for healthy functioning. It is a basic human need in much of the same way as food or shelter. Perceived loneliness is a significant risk factor for mortality (ISR, 2017). Psychotherapy provides the client, particularly for those who have disordered social relationships and poor attachments, an enduring, empathic, and understanding relationship (ISR, 2017). It furthermore provides the client with a human connection with an empathic and caring individual, enabling the client to talk about difficult material without the threat of termination. This connection in itself has the potential to be health-promoting, especially for clients who have impoverished or chaotic social relations. Empathy, a process by which an individual can be affected by and share the emotional state of another, forms part of the foundation of the real relationship. Empathy is one of the most reliable factors and predictors of psychotherapy outcome available (Wampold & Imel, 2015). Just as attachment is fundamental to the survival of humans, the real relationship is critical and even predictive of the outcomes and benefits of psychotherapy (Wampold, 2017).

The importance of the real relationship for clients should not be underestimated as treatments with only relationship factors have been shown to be remarkably effective (ISR, 2017). A meta-analysis of 15 studies shows that the effect sizes for aspects or factors related to the Rogerian conditions - real relationship, empathy, positive regard or affirmation, congruence or genuineness - are really large with the numbers providing robust, substantial relationships (Norcross, 2011).

Pathway 2: The Creation of Expectation Through Explanation and Treatment

Expectations have a strong influence on well-being and have a large effect on what is experienced. In psychotherapy, this works in several possible ways. Clients present to therapy feeling demoralized because of their distress and also because they have attempted to overcome their difficulties many times without success, as nothing seems to work. Seeking out psychotherapy is another attempt at finding a solution, one that the client will often believe to be beneficial. The positive effect that comes from believing that participating in psychotherapy will improve life has been labelled as “remoralization” (Wampold & Imel, 2015, p. 58). However, expectations in therapy are more than mere remoralization.

Clients come to therapy with an explanation, a maladaptive conception, for the difficulties they experience. These explanations are maladaptive in the sense that they do not lead clients to find solutions. For the greater part, these expectations are culturally influenced and acquired from family, friends, and the larger society (Wampold & Imel, 2015). Psychotherapy offers clients an explanation for these challenges they experience. This explanation is adaptive as it provides a means whereby the client can overcome or cope with the difficulties they experience. When combined with the belief that participating in and completing the tasks of therapy will assist in coping with their difficulties (or lead to a reduction in distress), clients’ expectations that they can do what is necessary to solve their problems gets enhanced (providing a sense of control over their difficulties). Expectations

influence clients' experiences and are central to the understanding of why placebos are so powerful (Wampold, 2017).

Critical for creating expectations is the acceptance of the explanation and therapeutic actions that are consistent with the explanation. The therapist and client must agree about the goals and tasks of therapy, which is not only predictive of the outcomes of treatment but also critical to the formation of the therapeutic alliance. As already mentioned, the therapeutic alliance is one of the most researched concepts in psychotherapy, and studies have found that there is a strong correlation between the therapeutic alliance and the outcome of psychotherapy (across all forms) (Wampold, 2017).

It is thus not sufficient to simply provide clients with an explanation for their distress and description of the treatment, i.e., to create an expectation. Clients must enact the therapeutic rituals; the explanation and the ritual go hand in hand. For example, just saying to a patient that a pill will make them feel less pain is not sufficient, they have to take the pill, and the same is true in psychotherapy, clients have to engage in and do the work of psychotherapy (ISR, 2017). To achieve a sense of control over their difficulties, clients must believe that therapeutic progress is a result of their efforts. This explanation is most powerful when it is created in interpersonal interaction (Wampold, 2017).

Pathway 3: Enacting Health-Promoting Actions

The effects of psychotherapy are divided between common factors and specific factors. The common factors are often described as a relationship with a wise and caring therapist, while the specific factors are the techniques embedded in the different therapeutic modalities (Bacon, 2020). In other words, there is a distinction between psychological treatments that contain components common to all psychotherapies, and psychological treatments that contain scientific specific ingredients that correct the client's deficit in a way that makes psychotherapy effective.

Together with the therapeutic relationship and an agreement about the goals and tasks needed to achieve those goals, clients need to engage in therapeutic actions (specific ingredients). The power of therapeutic actions does not merely depend on the expectations that are created; clients need to actively engage in the therapeutic tasks as the actual tasks may well have therapeutic benefits. Different treatments utilise different therapeutic actions for disorders as per their explanatory system (Wampold, 2017). Every treatment that adheres to the conditions of the contextual model will contain specific ingredients. What each therapy does with its specific ingredients is getting the client to do something which is health-promoting. In cognitive behavioural therapy, for example, the client thinks about the world in more adaptive ways. In interpersonal therapy, for example, the client works on their interpersonal relationships. In affect-oriented therapies, the client experiences an important affect that is useful in their life. All therapies induce the clients to do something helpful. Unstructured treatments without any therapeutic actions are less effective than focussed treatment (Wampold & Imel, 2015). The greater the client understands how the therapeutic actions are related to benefit, the more effective it will be. Not all treatments are effective. However, all treatments given by therapists who are trained to give them, believe in them, and have cogent treatment principles, work equally well. As long as more than one treatment has been studied for a disorder, they are all equally effective (ISR, 2017).

For pathways two and three a strong alliance is necessary. Without strong collaborative work, particularly agreement about the tasks of therapy, the client is less likely to engage in healthy actions (Wampold, 2015). Bacon (2020) concludes that therapy works not because of the inherent power of techniques, but because of common factors: the therapeutic alliance and the associated power of rituals, beliefs, and expectations. The rituals or interventions must be convincing and believable; however, their form and structure are unimportant as they are simply vehicles powered by expectations.

Based on the above and to enrich the therapeutic process, it seems important to understand the growth and change promoting factors within the South African context.

Common Factors with Strong Research Support

The Client

Long-standing assumptions in psychotherapy research have been that models, techniques, and therapists are the primary agents of change in psychotherapy. Most psychotherapy research has been guided by the long-held belief that therapists and treatment models are the active agents of change. Contrary to popular belief, research has also shown that clients are the most important contributors to successful psychotherapy outcomes (Norcross & Lambert, 2018). Although the therapist is often portrayed as the hero, a paper written by Bohart (2000) concurs with Norcross and Lambert (2018) that the most important common factor is the client rather than the therapist, depicting the client as the hero or heroine of their own story of change. Although the vast majority of common factors have to do with the therapist and therapy process, most therapists acknowledge that the client is the single most important variable (Bohart, 2000). What the client walks in the room with, a repository of resources and things that they have already overcome in their life needs to be incorporated and encapsulated. Clients become the historians of their change process. They are the centrepiece of the story of change, not the expert therapist (Behan, 2019). This necessitates therapists reconsidering the importance of their role, as well as the treatment models and techniques they utilise.

Another important determinant of outcome is the client's quality of participation in psychotherapy (Orlinsky et al., 2004). It is estimated that clients and factors outside of therapy, such as the client's motivation level, perceptions of the therapy, commitment to the therapy framework, and integration of concepts into daily life, account for approximately 40% of the change that occurs (Assay & Lambert, 1999; Bohart & Wade, 2013).

This, however, does not mean that the therapist's role gets diminished in the process. Therapist skills and expertise still bring a lot to the table. It is just a different role than what has been portrayed. It is the idea of being more patient and less anxious about being an expert or having an answer. Therapists sometimes want to solve problems fast and in so doing they stop listening and engaging because they feel like they want to be an expert, or they have to have an answer, or they have to give advice. This is not practical and good therapy is not done that way (Behan, 2019).

The Therapist

Therapist factors are defined as some therapists consistently achieving better outcomes than others. This seems to be true regardless of treatment and is also more important than the treatment (Norcross, 2011). Although some studies demonstrate therapist homogeneity, evidence indicates that therapist effects generally exceed treatment effects (Baldwin & Imel, 2013). Thus, the essence of therapy is embodied in the therapist.

There is data that shows that therapists deteriorate over time. However, when engaging in deliberate practice, the outcome over time showed an improvement (Goldberg et al., 2016). Thus, to get better, therapists need to do what all experts do; engage in deliberate practice. The common factors are critical to outcomes and give the specific ingredients (the treatment) their potency. Although the specific ingredients are important, it is how they are delivered that makes them work. Thus, the person, the therapist who delivers the treatment is more important than the particular treatment itself. Therapists should not be arguing about what is the best treatment, but they must practice improving (ISR, 2017).

It has been argued that it is how therapists conduct therapy rather than superior expertise in a model which allows some to outperform their peers in terms of outcomes. (Wampold, et al., 2017). In addition, the following therapist characteristics are associated with better outcomes:

Flexibility in Approach

Better outcomes are achieved by therapists who are willing and able to change their treatment approach and techniques to match the client's characteristics and problems (Norcross & Wampold, 2018; Owen & Hilsenroth, 2014; Stiles, 2009). According to the evidence, sticking to a single treatment strategy does not improve outcomes (Lambert, 2013).

Facilitative Interpersonal Skills

The ability of a therapist to understand, relate to, and persuade clients has been associated with effectiveness. Interpersonal facilitation skills include the ability to perceive, comprehend, and send a variety of interpersonal messages, and the ability to persuade others who are experiencing personal difficulties to implement proposed solutions and abandon maladaptive patterns (Behan, n.d.).

Therapist Behaviours

According to research, the following behaviours improve outcomes: projecting warmth, instilling trust and hope, conveying empathy, remaining present and focused on the client, being genuine, communicating competence, and drawing on the therapist's own inner experience (Wampold et al., 2017).

Ability to Connect with a Wide Range of Clients

The most effective therapists can form a treatment alliance with a diverse range of clients who present with a variety of clinical, cultural, and personal characteristics (Wampold et al., 2017).

Therapist Factors That Do Not Impact Outcomes

Research has repetitively shown that age, gender, ethnicity or culture, training, theoretical orientation, and experience are not related to therapist efficiency (Wampold & Imel, 2015).

Therapist Behaviours That Hurt Outcomes

Certain therapist behaviours have been shown in research to be ineffective and to harm outcomes including (Norcross & Lambert, 2018; Norcross & Wampold, 2018):

- Confrontation
- Criticising the client
- Causing the client to feel attacked
- Blaming the client
- Projecting cultural arrogance and insensitivity
- Acting on negative emotions
- Assuming client perceptions rather than inquiring about them
- Rigidity
- Creating a poor therapeutic alliance
- Privileging the therapist's perspective over the client's

In psychotherapy, the therapist's personality is an important therapeutic factor. Therapists should deliberately focus on the personal qualities they bring to therapy, as well as how well they build therapeutic relationships with clients. These elements should be regarded as an integral part of the treatment rather than merely a prelude to it. Therapists should also vary the use of evidence-based treatment approaches to meet the unique needs of each client rather than adhering rigidly to a single treatment approach (Behan, n.d.).

The Therapeutic Alliance

A therapeutic alliance must be formed between the therapist and the client for psychotherapy to be effective (Behan, 2018; Horvath et al., 2011). The alliance consists of the following elements:

1. An affective bond formed between a therapist and a client, commonly referred to as the therapeutic relationship.

2. Agreement on the goals and objectives of therapy, commonly referred to as goal consensus.
3. Agreement on the tasks that will be used to achieve the goals.

Thus, in a warm and supportive relationship, the therapist and client must agree on what the problem is, what they will address in therapy, and how they will achieve this (Safran et al., 2009).

Norcross and Lambert report in their review of the research literature that "the psychotherapy relationship makes substantial and consistent contributions to client outcome independent of the specific type of psychological treatment" and that “the therapy relationship accounts for client improvement (or lack thereof) as much as, if not more than, the specific treatment method" (2018, p. 308). Clients do not ascribe the effectiveness of their treatment to a specific technique or method. Instead, they attribute it to the relationship they have with their therapists (Norcross, 2010).

A therapeutic alliance is considered strong when clients experience a sense of connection to their therapist and feel confident in the collaborative approach to resolving their concerns. One of the most researched aspects of psychotherapy is the therapeutic alliance. Decades of research have repeatedly demonstrated that the alliance significantly impacts treatment outcomes. A 2018 meta-analysis of 295 studies and over 30,000 clients confirmed the importance of alliance on psychotherapy outcomes – a relationship that was consistent across treatment approaches, client characteristics, and countries (Flückiger et al., 2018).

Building a strong therapeutic relationship is more than just laying the groundwork for the work to come; it is an essential component of the therapeutic process. The relationship is essential for effectively deploying treatment methods and techniques. The use of evidence-based and evidence-supported interventions to guide treatment is increasing. Their efficacy is dependent on their delivery within a strong therapeutic relationship, which is not typically

prescribed by the treatment guide. Even when the relationship is mentioned, specific evidence-based steps to achieve it are typically omitted, making the treatment guide potentially clinically and empirically misleading (Norcross & Lambert, 2018). Therapists must establish and maintain a strong therapeutic relationship with their clients, as well as be willing to adapt to the unique characteristics that each client presents with.

Various articles published in 2018 in the journal *Psychotherapy* focused on the therapeutic relationship (Elliott et al., 2018; Gelso et al., 2018; Miller, 2018; Tryon et al., 2018), disrupting business as usual. In summary, to increase effectiveness, therapists are urged to bypass focussing on the latest treatment technique. Rather, they are encouraged to improve their ability to respond emphatically, put more of themselves into therapeutic interactions, become better at working collaboratively on the goals, roles, and tasks of treatment, and assess the quality of the therapeutic relationship (Miller, 2018).

Eugster and Wampold state that “for no matter how proficient one becomes in the craft of psychotherapy, it is one's self that is the true instrument of healing” (1996, p. 1026). In a very interesting study, they found that therapists’ session evaluations are most strongly predicted by their level of expertise, whereas clients' evaluations are best predicted by the level of understanding offered by the therapist. While this might be unsettling, Miller (2018) suggests that such findings should surprise no one as therapists in training are valued for their theoretical knowledge and technical proficiency, rather than their humanness. A recent study conducted in Australia by psychologist Crystal McMullen whose research focusses on the absent alliance, found that no reference is made to relationship skills in the course syllabi, program descriptions, or list of training competencies in between 40% and 47% of graduate programs in psychology (International Center for Clinical Excellence [ICCE], 2018). Unfortunately, ample time is spent attempting to expand effectiveness by learning new diagnoses, therapy-related terminology, and treatment models (Miller, 2018).

Psychotherapy Models

A treatment model is necessary, but research shows that it is not the most effective change factor (Behan, n.d.). Most therapists begin with the assumption that effective therapy entails employing a theory or an evidence-based treatment approach. However, research has shown that theories and techniques account for only a small portion of the change that occurs in therapy (Wampold & Imel, 2015).

According to meta-analytic studies of the psychotherapy outcome research literature, no one psychotherapy model is superior to the others in the treatment of major psychological disorders (Lambert, 2013; Wampold & Imel, 2015). Lambert (1992) estimated that theory-based techniques account for about 15% of the change in treatment in a review of the psychotherapy research literature. In the treatment of mental health disorders, research has not revealed a model that is superior to others. According to research, it is preferable to tailor a model and techniques to the needs of each client rather than requiring clients to conform to a single model preferred by the therapist (Norcross & Wampold, 2018; Owen & Hilsenroth, 2014; Stiles, 2009).

Unfortunately, when it comes to clinical training, it is still very much focused on specific treatment techniques or modalities. Oversight on such a critical area as the therapeutic relationship contributes seven to nine times more to the outcome than treatment techniques. Students are being told that the therapeutic relationship is important, but they are not walking out with any additional knowledge, skills, or understanding of how much of a priority this is (ICCE, 2018).

Hope And Expectancy

Clients frequently enter therapy after their efforts to improve have failed, leaving them demoralized and hopeless. In this state, there is less motivation and agency to do the work necessary to improve things. A primary goal of psychotherapy is to alleviate a client's

hopelessness and instil new hope (Frank & Frank, 1993). When therapy restores hope in the possibility of a better future, the client is re-energized to make positive changes, often in unconventional ways not specifically prescribed by the therapist.

Belief can heal both the mind and the body. It has been demonstrated that substantial symptomatic relief occurs across a wide range of medical conditions when a person believes a supposedly inert treatment or placebo will help them (Brody & Miller, 2011). Frank (1993) investigated Non-Western healing practices with no scientifically discernible therapeutic agent, such as shamanic rituals, faith healing, and early (often physically harmful) medications, and discovered that people improved if they believed in them.

Lambert's review of the psychotherapy outcome literature discovered that hope and expectancy was one of the big four common factors (along with the client, the relationship, and treatment models), accounting for 15% of the improvement clients demonstrate in therapy (Asay & Lambert, 1999; Lambert 1992). A hopeful client is more likely to invest in and use therapy. Clients who lack hope or expectancy are more likely to discontinue treatment or have poor outcomes (Tambling, 2012). Recent meta-analytic studies of existing research on hope in psychotherapy show that when a client's hope is mobilised in the following three key areas, outcomes improve (Constantino et al., 2018):

1. Belief that they and their situation are not hopeless and that things can get better (hope).
2. Belief that the treatment approach being used is credible and will be effective (expectancy).
3. Belief in the therapist’s credibility and effectiveness (expectancy).

Common Factors and Working with Diverse Populations

The therapeutic relationship's deep level of person-to-person connection necessitates taking into account the intersectional identities of both the client and the therapist. A person's

request for, perception of, and use of help can be influenced by a unique combination of race, ethnicity, gender, sexual orientation, social class, place of origin, and many other factors. It would be naive to believe that an empirically derived treatment eliminates the need to consider these factors (Behan, n.d.).

A culturally sensitive and informed practice may include a common factors approach. The early identification of common factors is based on a review of effective healing practices outside of Western, positivistic medicine, with a focus on practices that may connect on a human or relational level rather than a technical or skills level. According to research, therapy is more effective when evidence-based treatments are adapted to be congruent with the beliefs of a cultural group (Benish et al., 2011; Wampold, 2015).

It is imperative that South Africans' psychotherapeutic needs be considered in terms of South Africa's multicultural ethnic dynamic. Differences between the therapist and client's ways of viewing the world, and the inability to be aware of these discrepancies probably account for much of the breakdown in the helping process (Hickson & Christie, 1989). In South Africa especially, there seems to be a mismatch between Western psychology theory and the third world environment. Cross-cultural competent therapists are thus vital in facilitating a meaningful therapeutic encounter.

The contextual model also emphasizes that the explanation given for the client's distress and the therapy actions must be acceptable to the client. Acceptance is partly a function of consistency of the treatment with the client's beliefs. This suggests that evidence-based treatments that are culturally adapted, and there are many ways to adapt treatment, will be more effective for members of the cultural group for which the adapted treatment is designed (Wampold, 2017). A meta-analysis published by the American Psychological Association confirms that culturally adapted psychotherapy is more effective than unadapted, psychotherapy (Benish et al., 2011).

Routine Outcome Measurement

Routine outcome measurement (ROM) entails therapists administering self-report scales to their clients throughout the course of treatment and analysing the data to ensure that treatment is meeting their clients' needs (Behan, n.d.). The research evidence supports the use of ROM across treatment modalities (individual, family, and group) throughout a psychotherapy course (Duncan & Reese, 2015; Whipple et al., 2003). Five meta-analytic studies examined the research on ROM approaches and discovered that therapists who used ROM-assisted therapy had better outcomes than those who used treatment as usual (Lambert et al., 2018). In other words, when ROM instruments were used, therapists were more effective, with more treatment gains and fewer client dropouts.

Early Dramatic Response

According to research, up to one-third of clients respond very quickly to therapy, showing dramatic improvement in the first one to three sessions (Bohart & Tallman, 2010; Gaynor et al., 2003). The transformation occurs even before any formal interventions are used. This unexpected finding begs the question of what exactly is causing the change in psychotherapy.

When clients respond to treatment before theory or research-based interventions are implemented, it suggests that early rapid progress may be due to common factors such as hope instillation, client factors (motivation, social support), catharsis, the therapeutic alliance, or therapist factors. These findings imply that therapists should be aware of common factors at the start of treatment (Behan, n.d.).

This chapter has outlined the importance of psychotherapeutic interventions, providing a brief theoretical understanding of the factors contributing to successful outcomes, with a specific focus on the contextual model. Moreover, existing research has been discussed, including therapist and client perspectives.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter outlines the methodology followed by the present research study. Provided is a detailed description of the research design and the assumptions upon which this choice is based. It details the participants, the sampling procedure, the research measure, and the research procedure of this study. The steps performed during the data analysis and verification are listed and discussed. Ethical considerations that underpin this research study are outlined. Throughout the study, the researcher aimed to base all decisions on informed reflections and methodological knowledge.

Research Methodology

Research Design

The researcher needed to choose a research paradigm congruent with her personal beliefs about the nature of reality. To address the research aims, the researcher believed that an exploratory descriptive qualitative approach was the most suitable as this would advance the researcher's inquiry. Qualitative research has proven to be essential to the advancement of health research (Sandelowski, 2004). Several published research articles have used an exploratory descriptive qualitative design and it has been argued that there is a place in health research when it is deemed the most appropriate methodology to employ (Hunter et al., 2018).

The intent and characteristics of qualitative research that most often appear in the literature include the following (Creswell & Creswell, 2018):

- Natural setting: Qualitative researchers collect data in the field and gather information up-close by engaging directly with people and having face-to-face interactions with them.

- Researcher as a key instrument: Qualitative researchers collect or gather their own data, using questionnaires or instruments that they have developed themselves, and interpret it themselves.
- Multiple sources of data: Qualitative researchers usually gather multiple forms of open-ended data whereafter they review and make sense of it and organise it into codes and themes.
- Inductive and deductive data analysis: Qualitative researchers begin by working inductively, building themes from the bottom up. Deductive thinking also plays a role as the process moves forward, as qualitative researchers then look back at their data from the themes to establish if they need to gather more information.
- Participants' meanings: Throughout the qualitative research process, the focus remains on the participants and the meaning that they hold about the topic under investigation.
- Emergent design: The nature of the qualitative research process is emergent in that the research plan cannot be forcefully prescribed. Qualitative researchers need to remain open to the idea that some or all phases of the process may change along the way.
- Reflexivity: Qualitative researchers reflect on their role in the study, especially on how their background may influence the direction of the study.
- Holistic account: Qualitative researchers aim to formulate a complex or larger picture of the problem being investigated.

De Vos et al. (2011) suggest that exploratory research is conducted to gain insight into a situation, phenomenon, community, or individual, and suggest that it is designed to uncover the full nature of a little-understood phenomenon. Neuman (2014) concurs suggesting that a qualitative exploratory design allows the researcher to examine a little understood issue or phenomenon to develop preliminary ideas and move toward refined research questions by

focussing on the “what” question. This research may be the first stage in a sequence of studies to formulate more precise questions that future research can answer as exploratory research rarely yields definitive answers. Hunter et al. put forth the following definition as a useful starting point for understanding exploratory research as a methodology: "a broad-ranging, purposive, systematic, prearranged undertaking designed to maximize the discovery of generalizations leading to description and understanding of an area of social or psychological life” (2018, p. 2).

The researcher set out to not only gain insight into a situation but also wanted to describe it accurately and present a detailed picture of the subject, aligning with descriptive research. Descriptive research focuses on “how” and “who” questions (De Vos et al., 2011; Neuman, 2014). When a research study aims to produce a description of the phenomena, Sandelowski (2000) suggests that a descriptive qualitative study should be the methodology of choice.

Exploratory and descriptive research have many similarities and often appear indistinct in practice. Hunter et al. (2018) have formally created a hybrid of the two methodologies, referring to it as exploratory descriptive qualitative research, and for brevity, have abbreviated it to EDQ research. They are however not the first to coin the term exploratory descriptive qualitative research, but the first to give it a significant theoretical underpinning.

Exploratory and descriptive researchers frequently use qualitative techniques for gathering data as they tend to be more open using a range of evidence and discovering new ideas (Neuman, 2014). This research design allowed the researcher to be creative, open-minded, and flexible, adopting an investigative stance, and exploring all sources of information. This research design furthermore allowed for high levels of richness and depth. The researcher formed an integral part of the research process by becoming the instrument through which the data were collected, analysed, and interpreted (Wagner et al., 2012). This research design was appropriate as it enabled the researcher to identify and investigate the interpretations that

psychologists construct to understand the growth and change promoting factors in psychotherapy within a culturally diverse South Africa.

Data Collection Procedures

The researcher followed Creswell and Creswell's (2018) guidelines on the steps of data collection, ensuring to include sampling and recruitment, collecting information through semi-structured interviews, as well as establishing the protocol for recording information.

Participants, Sampling, and Recruitment

The present study was presented to the Department of Psychology at the Nelson Mandela University (NMU) for departmental approval. Once approved, it was submitted to the Faculty Postgraduate Studies Committee (FPGSC) and the Research Ethics Committee – Human (REC-H) for ethical approval. Once ethical clearance was obtained (H21-HEA-PSY-005) (Appendix A), the researcher sourced the participants.

The most common and useful sampling strategy used in exploratory descriptive qualitative research is considered to be non-probability purposive sampling (Hunter et al., 2018; Wagner et al., 2012). This means that the researcher had limited knowledge about the larger group or population from which the sample was taken. Consequently, the probability for any individual subject to be included in the sample could not be calculated (Neuman, 2014). While purposive sampling lacks wide generalisability, it ensured that the sample chosen represented the attributes and characteristics of the population (maximizing representativeness of the population), to best answer the research question (Berg, 2009). This research design allowed the researcher to select unique cases with a specific purpose in mind, participants who were specifically informative, and participants who could provide the information required to address the aims of the study (Neuman, 2014). This research design thus allowed the researcher to purposefully select cases for in-depth investigation.

The COVID-19 pandemic and associated lockdowns forced the shift from traditional approaches of in-person data collection for research to remote, or mostly remote, practices. Sourcing the participants through online platforms have become necessitated by the COVID-19 lockdown and restrictions. Hence, the researcher was required to be creative and innovative in ways to source and recruit the participants and collect data while ensuring adherence to guidance on restricted movement.

Information regarding the study was advertised on publicly accessible South African psychology social media platforms (Facebook and WhatsApp) to source and recruit the participants (Appendix B). There are various psychology groups on social media applications where one can freely post information for research studies. Eligible participants were requested to contact the researcher via email. Additionally, the researcher relied on her own experience to find the participants in such a manner that they can be representative of the population and used specific selection criteria to identify the most suitable individuals. These health practitioners were directly contacted and invited via email to obtain a sample of psychologists. The researcher believed that her experience enabled her to make good decisions about which individuals to include in her sample.

Qualitative research is not prescriptive and there are no rules regarding the ideal sample sizes. Sample sizes tend to be small due to the in-depth nature of the data collected. The exact number of participants could thus not be predetermined, as it was dependent on data saturation, an idea that comes from grounded theory (Wagner et al., 2012). Data saturation is said to occur when no new information is shared and the pattern of responses from the participants becomes apparent (Neuman, 2014). It is suggested that there is no one-size-fits-all method to reach data saturation (Wagner et al., 2012). In the present study, the researcher stopped collecting data when the categories (or themes) became saturated (Creswell &

Creswell, 2018). When gathering new data no longer informed new insights, the researcher judged to have an adequate sample.

The participants were selected from psychologists (counselling or clinical) registered with the Health Professions Council of South Africa (HPCSA) practising individual psychotherapy with adult clients within the perimeters of South Africa. A final number of 10 participants fit the necessary inclusion criteria and were included in the study. Two of these participants contacted the researcher via email after engaging with the social media posts. The other eight were selected and personally invited by the researcher via email to take part in the study. The researcher had two non-responses to email invitations. Conducting individual interviews with a smaller sample size allowed the researcher to undertake a deep and meaningful study. This was done through thorough scrutiny of each of the participant's accounts of the phenomena. The participants were selected according to their relevance for the study rather than their representativeness of the population (Neuman, 2014). Their cases were not randomly selected, they were gradually selected, based on specific criteria. This was achieved through strict adherence to the inclusion criteria. The following inclusion and exclusion criteria were set:

Inclusion:

- Participants must interact with different cultural groups (i.e., black, white, coloured, Indian, etc.).
- Participants must be registered with the HPCSA as a clinical/counselling psychologist.
- Participants must be working with adult clients.
- Participants must be practising within the perimeters of South Africa.
- Participants must have access to a stable Wi-Fi connection and device for the interview.

Exclusion:

- Participants not working with adult clients.
- Participants not registered with the HPCSA as a clinical/counselling psychologist.
- Participants not practising within the perimeters of South Africa.

In recruiting the sample, inclusion, and exclusion criteria were adhered to by asking the participants to complete the following questions on the consent form: Gender, race, category of registration (clinical/counselling), years of practice, years of working with adult clients in individual psychotherapy.

Data Collection

For the proposed research study, the researcher became comfortable with and prepared to employ socially distant methods of data collection. The COVID-19 pandemic has forced the researcher to transition from face-to-face data collection to some other form of data collection (internet-based) as social distancing mandates were restricting traditional face-to-face investigations of all kinds (Lobe et al., 2020).

In the South African context, written informed consent should always be obtained (Greeff, 2020). The process of obtaining informed consent was complicated and time-consuming due to physical distancing and travel restrictions. To abide by safety regulations and protocols the traditional statement of informed consent was replaced by emailing the information letter (see Appendix C) and informed consent form (see Appendix D) to the individuals who were interested in participating in the study (Lobe et al., 2020). Internet access for both the researcher and the participants was essential.

The information letter explained in detail the nature and scope of the study. It also contained information about participant rights, the anticipated amount of time needed to complete the interviews (45 minutes to one hour), and the potential risks and benefits of participating in the study. To avoid misunderstanding or misinterpretations, the participants

were encouraged to ask additional questions or seek clarification about the consent form and its contents before providing their consent. This was addressed by directly communicating via email. The informed consent process emphasised the voluntary nature of participation in the study. The participants were ensured that there would be no consequences should they choose not to participate. The participants were also informed that they were free to withdraw from the study at any point of the data collection and further. The participants who agreed to partake in the present study were requested to sign the consent form either electronically or by printing out, signing, and scanning the documents to email them back to the researcher before the commencement of the interviews.

Once the participants have agreed to participate in the study, online interviewing using a semi-structured schedule was employed as a data collection tool (Adams, 2015). Online platform interviews are synchronous in nature and consist of computer-mediated interactions (Greeff, 2020). Online interviewing as a data collection type was quite useful as the participants could not be directly observed, the participants could provide historical information, and it allowed for researcher control over the line of questioning (Hunter et al., 2018). Disadvantages of this method include dropped calls and pauses, poor audio or video quality, and the inability to read non-verbal cues as a result of inconsistent and delayed connectivity – possibly sacrificing the authenticity and depth of direct interaction (Greeff, 2020; REC-H, 2020). This implies that greater effort is needed to connect with the participants and places a stronger focus on active listening. The researcher allowed sufficient time for technical preparation (such as technical and computer skills and downloading and managing different online platforms) to prevent the risk of loss of data as repeating an interview would not be possible.

Dates and times suitable to the participants were arranged, and either the Microsoft Teams or Zoom platform was used. This depended on the participant's preference and was arranged

at times that were convenient to the participants to help reduce the researcher-participant power imbalance that may exist (Hunter et al., 2018).

Before the commencement of the interview, the researcher emailed the set of questions (Appendix E) that would be used during the interview to the participants. The participants were reminded about their interviews a day before their scheduled times and an invitation link to their preferred platform was shared with them. The participants were reminded that their interviews would take approximately 45 minutes to one hour.

Each interview opened with a greeting. Thereafter the researcher re-informed the participants of certain features of the research. The participants were reminded thereof that they can withdraw from the study at any given time, without any consequences. All of the participants consented to their interviews being audio-recorded on their chosen platform of choice (Microsoft Teams or Zoom) and with an audio recorder for the information to be transcribed and that their recorded interviews will only be accessible to the researcher and an independent transcription company. The participants were informed that all information would be kept confidential and that a pseudonym would be given to each. The researcher then enquired whether the participant is ready to start and informed the participant when the recording began.

Five of the participants indicated that they would prefer to conduct their interviews over the Microsoft Teams platform and the other five indicated that they would prefer to make use of Zoom. Two of the participants indicated that the time most suitable for them would be during lunch, two indicated that they would prefer an evening after work, and the other six indicated their availability in between their clients and/or other responsibilities throughout their day. The data were collected over one month. During this time, two of the interviews had to be rescheduled due to unforeseen circumstances. During the data collection process, the researcher had to be flexible and able to think on her feet. In three instances, where the

participants indicated that they would prefer to make use of the Microsoft Teams platform, they were unable to successfully follow the invitation link to join the virtual meeting. In case something like that would happen, the researcher had the alternative platform on standby in all cases. The three participants were able to successfully join meetings on Zoom instead. The researcher made sure to continually confirm whether the participants were comfortable with the process. It was advantageous that most of the participants were familiar with the use of these online platforms, especially Zoom. With two of the interviews, the use of video was limited as it compromised voice quality. In these instances, it was the researcher's clinical judgement that the quality of sound is extremely important for recording and transcription purposes, and that it would be better if the cameras were turned off. The researcher aimed to be as transparent as possible throughout the process and discussed this with the participants.

At the end of the interviews, the participants were thanked for their contribution to the study and informed that the results of the study would be made available upon request once completed in the form of a treatise or a journal article. While the study was not likely to elicit an emotional response from the participants, the participants were informed that they would be referred to Nelson Mandela University's Clinic (UCLIN) for debriefing sessions should they find the questions emotionally distressing in any way. The researcher has consulted the manager of Nelson Mandela University's Clinic (UCLIN) and referral permission was granted.

Data Recording

The interview protocol (Appendix E) that was utilised was informed and developed by the researcher through the reading of the literature. It included several important components; basic information about the interview, an introduction, the interview content questions with probes, and closing instructions. During the development of the interview protocol, the researcher mostly included open-ended questions that were few to elicit rich responses. The

questions were organised and constructed in such a way as to enable the researcher to obtain the necessary information from the participants as per the research aim and objectives:

- Questions 1 to 3 were linked to research objective one.
- Question 4 was linked to research objective two and.
- Question 5 was linked to research objective three.

As per Creswell and Creswell's (2018) suggestion, the interview protocol was two pages in length. The researcher made sure to leave spaces between the questions to write short notes and quotes in case the audio-recording failed. The questions were prepared in advance of the interviews and used consistently in all of the interviews. The researcher memorised the questions so as not to appear to be reading the interview protocol. The researcher allowed the interview protocol to guide, rather than dictate the interviewing process. As the experts of the subject, the participants were allowed the necessary time they required to tell their stories.

Recording sessions were advantageous as they ensured that the researcher was fully attentive to the participants during the interviews. It also provided a full record of the interviews, which were transcribed at a later stage (Wagner et al., 2012). It is recommended that more than one type of recording is used to ensure data capturing, thus all interviews were audio-recorded on the participants' online platform of choice (Microsoft Teams or Zoom) and with an audio recorder (Greeff, 2020). By doing so, all the details of the participants' lived experiences were recorded, and nothing was omitted. All of the participants consented to and indicated that they were comfortable being recorded. The digital audio-recording device used was tested before each session to ensure its functionality. As a precautionary measure, the researcher always carried spare batteries. Each participant had different coded files on the researcher's computer and recording device that were backed up at the end of every day of data collection.

Special preventative measures were in place and care was taken when selecting Microsoft Teams and Zoom as online platforms to collect data. The security of the online platforms and data collected was essential. The researcher geared all efforts to avoid possible data loss, confidentiality issues, and identity theft (Greeff, 2020). For example, data was stored as soon as possible and deleted from the online platforms. A key advantage of Zoom and Microsoft Teams is the ability to securely record and store sessions without recourse to third-party software (REC-H, 2020). This feature was particularly important as the protection of highly sensitive data was required in this research. The researcher was aware that technical difficulties could easily creep in when using Microsoft Teams and Zoom, such as low internet bandwidth, outdated hardware, or limited webcam and/or microphone functionality resulting in dropped calls and lost call connection. Overall, the quality of sound, recording, and transcription of the interviews remained extremely important as the researcher could not purely depend on memory (Greeff, 2020).

A pilot interview was conducted, and this data is not included in the research study. The researcher has a completed master's degree, has interviewed participants in the past, has previously conducted transcriptions, and has also conducted thematic analysis.

In terms of the Protection of Personal Information (POPI) Act, the researcher safeguarded that identifying information be kept confidential and safe (Kandeh et al., 2018). No identifying names were shared, and the participants' details and information were not shared with anyone. Only the researcher and research supervisor have access to the participants' information.

Upon completion of the online interviews, the audio files were labelled with each participants' pseudonym to ensure confidentiality. The audio data was then transcribed by an independent transcription company and a digital copy was made available to the researcher

for analysis. No identifying information was included in the transcript. To ensure confidentiality the transcriber signed a confidentiality agreement.

Data Analysis

There is no specific formula for the process of qualitative data analysis, but there are guidelines and principles to facilitate the process (Hunter et al., 2018). After the data were collected, the transcripts were prepared and analysed through thematic analysis. Thematic analysis focuses on the use of codes and categories, identifying patterns in the data (Wagner et al., 2012). Hunter et al. (2018) postulate that thematic analysis is the chosen approach to data analysis in exploratory descriptive qualitative research. Based upon the work of Braun and Clarke (2006), the researcher followed their detailed, six-phased, step-by-step guide to undertaking thematic analysis. Thematic analysis is put forward as "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). This qualitative method of data analysis is widely used within psychology as it allows for the conversion of qualitative information into quantitative data and the researcher to analyse data in a flexible manner (Braun & Clarke, 2006). The researcher justified the use of thematic analysis as an approach to data analysis for the present study as (Hunter et al., 2018):

- It is suited to explore and describe the experiences of the participants in relation to the phenomena under investigation.
- It facilitates the discovery of generalisations by identifying the core of the participants' experiences.
- The work of Braun and Clarke is considered in research textbooks, they are referred to as respected thematic analysts, and thematic analysis has worked in other studies.

It was essential that the researcher clearly state the process and practice of thematic analysis, and indicate what, why, and how the analysis was done. The role of the researcher in thematic analysis is an active one, identifying themes, choosing those of interest, and

reporting on them. The researcher attempted to steer clear of a passive interpretation of the analysis process, not claiming to have discovered themes or that several themes have emerged from the data. The researcher coded and analysed the data, which was verified by the supervisor of the research study.

What Counts as a Theme?

"A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). The researcher had to carefully consider what constituted a theme and what size the theme needed to be. Ideally, the theme would occur several times across the data. However, rigid rules do not apply, and no standard guidelines indicate what proportion of the data is required to provide evidence for the theme to exist. The researcher wanted to maintain consistency in determining themes and their prevalence, hence the emergence of a theme was considered when it was consistent in five of the ten transcripts.

Phases of Thematic Analysis

The researcher followed the phases of thematic analysis as prescribed by Braun and Clarke (2006). The researcher kept in mind that these phases are flexible and that they are guidelines, as opposed to rules. The analysis was not a linear process, but a process that required continuous back-and-forth movement throughout the phases. The process of analysis already commenced during data collection and occurred when certain themes and noteworthy patterns became consistent in the data. Writing formed a crucial part of the process and commenced in phase one and continued through the analysis process. The researcher continuously made notes of ideas and hunches regarding coding schemes.

Phase One: Familiarising Yourself with Your Data. The researcher worked with the verbal data from the interviews. This data required transcription, and although this provided the researcher with the ideal opportunity to become familiar with the data, the

transcriptions were done by an external company. The researcher checked the transcripts back against the original audio recordings as it was imperative that the transcripts accurately reflect the verbal information. Through repetitive and active reading, the researcher became familiar with the content of the data and constantly searched for patterns. Braun and Clarke (2006) recommend that it is ideal for the researcher to read through the data set at least once before coding the data to become very familiar with all aspects of the data. Reading and re-reading the data was very time-consuming, thus the smaller sample size allowed for thorough scrutiny of the data. This phase was highly important as it laid the foundation of all subsequent phases. The researcher also took notes during this phase.

Phase Two: Generating Initial Codes. Phase two commenced after the researcher had read through the data, become familiar with the data, and created a preliminary list of ideas about what the data contained. This phase required the production of initial codes from the data. The coding process organised the raw data into meaningful ideas. It involved identifying certain elements of the data that represent the most basic pieces of the raw data; that is recognising an important element and encoding it (Fereday & Muir-Cochrane, 2006). "A good code is one that captures the qualitative richness of the phenomenon" (Fereday & Muir-Cochrane, 2006, p. 4).

There are numerous ways to code transcripts. In this research, the researcher coded manually and systematically and worked consistently through the entire data set. The researcher made use of highlighters, coloured pens, and sticky notes to code. Following the coding process, the researcher's supervisor was invited to also code the documents. The results were compared, and no modifications were required. It is important to note that the coded data are not the themes - themes are much broader and only start their development in the next phase (Braun & Clarke, 2006).

Phase Three: Searching for Themes. After the researcher produced a list of the different codes, the development of themes took place in this phase. This included a broader interpretative analysis of the data whereby the researcher organised the different codes into potential themes and assembled all the coded data extracts within the identified themes. The researcher decided to utilise visual representations such as tables and mind maps to distinguish the relationships between codes, themes, and the different levels of themes. This phase ended off once the researcher had identified themes and sub-themes, and organised elements of data that had been coded in support of these. Nothing was discarded yet, as themes could still take different forms as the process progressed.

Phase Four: Reviewing Themes. This phase involved the refinement of the possible themes identified in phase three. Braun and Clarke (2006) state that this is important because some themes may not have enough data to support them whereas others may be better suited combined or separated. It is furthermore advised that themes should clearly differ from each other and that the data within the themes should be supported meaningfully.

Coding remained a continuous process. The researcher re-read the data set to allow for the opportunity to discern whether the themes work in relation to the data set and to code any overlooked data. The codes were reviewed and refined until the researcher was satisfied with the identified themes and had enough data to support them. This could be a never-ending process so when the refinements were no longer significant the researcher discontinued the process. At the end of this phase, the researcher more or less identified the different themes, how they fit together, and the overall story they tell about the data.

Phase Five: Defining and Naming Themes. This phase of analysis consisted of defining and further refining themes. It was important for each theme to tell a story and relate to the initial research question. The researcher did not merely paraphrase the content of the

data extracts, but identified what and why these pieces were noteworthy. Themes were considered in relation to each other and also included sub-themes.

At the end of this phase, the researcher had a clear picture of what the themes included and excluded, successfully being able to describe the content of the themes in a few sentences. The researcher also considered what names to give to themes, in the final analysis, keeping in mind that names need to be brief and specific, and clearly state what the theme is about.

Phase Six: Producing the Report. After thorough analysis, the themes were finalised, and the researcher engaged in the write-up of the report. This phase aimed to narrate the complexities of the data in such a way that it convinces the readers of the soundness of the analysis. The analysis had to provide a "concise, coherent, logical, non-repetitive and interesting account of the story the data tells" (Braun & Clarke, 2006, p. 93).

In the write-up, all themes were supported by sufficient evidence. The extracts formed part of a broader analytic narrative (or story being told) that put forth an argument regarding the research question. All statements need to be grounded in and go beyond the face value of the data. The researcher carefully considered Braun and Clarke's (2006) 15-point checklist of criteria for good thematic analysis as outlined in Table 1.

Table 1

A 15-Point Checklist of Criteria for Good Thematic Analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.

	4	All relevant extracts for each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Note. From "Using Thematic Analysis in Psychology," by V. Braun and V. Clarke, 2006, *Qualitative Research in Psychology, 3*(2), p. 96 (https://doi.org/10.1191/1478088706qp063oa). Copyright 2006 by Edward Arnold.

Strategies of Trustworthiness

Qualitative research can never be completely value-free. It was thus important to ensure that the results of this research study adhere to the criteria for good research. The researcher needed to recognise subjectivity and biases, consider how they may influence the findings, and incorporate strategies to overcome them (as much as possible). To establish the truth value (or trustworthiness) of a qualitative research project, qualitative researchers Lincoln and Guba (1985), whose criteria remain the gold standard, propose the following four constructs (Cope, 2014):

Credibility

The goal of credibility is to demonstrate that the subject has been accurately identified and described (De Vos et al., 2011). It deals with the question of how congruent the results obtained are with reality (Shenton, 2004). Lincoln and Guba (1985) posit that credibility is one of the most important factors in establishing trustworthiness. The following provisions have been made by the researcher to promote confidence in the accuracy of the recorded phenomena under scrutiny (Shenton, 2004):

- The adoption of research methods that are well established in a qualitative investigation, such as the line of questioning pursued in the data gathering sessions and the methods of data analysis.
- Familiarity with the culture of the participants as the researcher is a psychologist in training herself.
- Triangulation (via data sources) involving the use of a range of participants.
- Tactics to help ensure honesty in the participants, such as allowing each participant to refuse to participate in the project, encouraging the participants to be frank with the researcher, emphasising the independent status of the researcher, making it clear to the participants that they have the right to withdraw from the study at any point.

- Frequent debriefing sessions between the researcher and her supervisor to provide a sounding board for the researcher.
- Peer scrutiny of the research project by peers.
- Background, qualifications, and experience of the researcher.
- Thick description of the phenomenon under investigation.
- The examination of previous research findings.

The same process of discovery was be followed with each participant. For example, the same questions were asked in series. The researcher furthermore made use of probes.

Transferability

Transferability is concerned with the extent to which the findings of the research can be transferred from one specific situation to another (De Vos et al., 2011). The present study's transferability (or generalisability) to other settings may be problematic due to its qualitative nature (Shenton, 2004). To address possible challenges, the researcher conveyed to the reader the parameters of the research, referring back to the original theoretical framework. As per Shenton's (2004) suggestion, the researcher provides the following information:

- Any restrictions on the type of people who contributed data.
- The number of participants involved in the fieldwork.
- The data collection methods that were employed.
- The number and length of the data collection sessions.
- The period over which the data was collected.

The present study's transferability was furthermore enhanced through triangulating multiple cases or informants (Creswell & Creswell, 2018).

Dependability

In addressing the issue of dependability, the researcher asked whether the research process is logical, well documented, and audited (De Vos et al., 2011). This will allow a future

researcher to repeat the work, not necessarily to gain the same results (Shenton, 2004). The qualitative assumption is that the social world is always being constructed, making the concept of replication problematic (De Vos et al., 2011). To enable readers of the research report to develop a thorough understanding of the methods and their effectiveness, the processes within the study are reported in detail, such as the research design and its implementation, the operational detail of data gathering, and reflective appraisal of the project (Shenton, 2004). Throughout the entire study, the researcher aimed to base all decisions on informed reflections and methodological knowledge.

Confirmability

The concept of confirmability is the qualitative researcher's comparable concern to objectivity. Steps were taken to help ensure as far as possible that the research's findings are the result of the experiences and ideas of the participants, rather than the characteristics and preferences of the researcher (Shenton, 2004). The researcher promotes confirmability by providing evidence that corroborates the findings and interpretations using triangulation, admitting her predispositions, engaging in reflective commentary, and providing a detailed methodological description (De Vos et al., 2011; Shenton, 2004). Furthermore, the researcher's supervisor independently peer-reviewed all the transcripts and results to increase the objectivity of the findings.

For the current study, the researcher attempted to take equally great care in how the data was analysed and how the steps were described, relative to the actual application of techniques and procedures (De Vos et al., 2011). It was important that the researcher recognised personal subjectivity and biases, considered the impact of these on the findings, and used strategies to counter them as far as possible.

Ethical Considerations

The researcher was challenged with the numerous issues arising from the COVID-19 pandemic. Yet the researcher had to find ways to bridge these unprecedented circumstances and challenges and meet expected dates and outcomes. The researcher made use of online platforms for data collection to try and virtually replicate the face-to-face interviews (Greeff, 2020). This needed to be done whilst still protecting the privacy and confidentiality of the participants. Most of the fundamental ethical issues in online interviewing are the same as in face-to-face contexts (Lobe et al., 2020). The researcher directed all efforts towards an increased awareness of and commitment to already established ethical principles that apply across traditional research. The researcher had a moral responsibility to strictly consider the rights of the participants who were the sources of information.

The ethical considerations in research are extensive and are reflected in all the stages through the research process. The researcher aimed to anticipate and actively address the ethical issues as they related to the different phases of inquiry.

Before beginning the study, the researcher considered the code of ethics and applied to the relevant South African Research Ethics Committee - Human (REC-H) (Creswell & Creswell, 2018; De Vos et al., 2011; Wagner et al., 2012). The researcher had to adopt the regulations, protocols, and guidelines that flowed from the National Disaster Management regulations and adhere to the restrictions imposed by the risk-adjusted approach (alert levels) from the government (Higher Health, 2021). In addition, the researcher needed to obtain necessary permissions from the participants and have them sign informed consent forms.

At the beginning of the study, it was the researcher’s responsibility to identify a beneficial research problem, disclose the purpose of the study, and avoid forcing the participants to sign the informed consent form.

During the data collection phase, ethical measures that were taken included doing no harm to the participants, avoiding deception of the participants, respecting potential power imbalances, avoiding exploitation of the participants, and avoiding the collection of harmful information. The researcher also had to consider the possible technical difficulties that can occur and possible responses, such as the recording of interviews and the security of the online platform and data (REC-H, 2020).

When analysing the data, the researcher avoided disclosing only positive results and respected the privacy of the participants. However, when it came to the reporting on, sharing, and storing of data the researcher aimed to protect the identities of the participants, to provide an accurate account of the information, not to plagiarise, to avoid disclosing information that would harm the participants, to communicate in clear straightforward, and appropriate language, to release and share the details of the research study with others, and to keep the raw data.

This chapter provided an outline of the research methodology relating to this study. An exploratory descriptive qualitative design was used. The participants were asked to participate in interviews and the data was analysed using thematic analysis which guided the development of themes. The research methodology allowed the researcher to investigate the nuances of the lived experiences of the participants.

CHAPTER 4: RESULTS AND DISCUSSION

This chapter presents the results and discussion of the present study as obtained from the data analysis. Thematic analysis was used to highlight the essential themes derived from the interview data collected to gain a rich account of the participants' experiences of the factors promoting growth and change in psychotherapy. By searching for themes using Braun and Clarke's (2006) phases of thematic analysis, the researcher arrived at three core themes with sub-themes. The thematic analysis process that was applied to the transcripts elicited key themes that were evident in the data. These themes are viewed as essential in determining the understanding of the participants. The researcher allowed the data to lead the research outcome, avoiding any bias or preconceived ideas. Table 2 below outlines the core themes and sub-themes accordingly.

Table 2

Summary of the Participants' Core Themes and Sub-Themes

Core Themes	Sub-Themes
Theme 1: The Relationship Trumps All	• First and Foremost • The Nature of the Therapeutic Relationship
Theme 2: The Process Within Psychotherapy	• The Importance of the Moment of Meeting • Measuring Success • Client Elements
Theme 3: Therapist Effects	• General Therapist Qualities • Support • Therapeutic Actions • Navigating Clients' Beliefs

Note. This table illustrates the present study's findings in terms of themes and sub-themes.

Operationalisation of the Study

The total time of the audio-recorded conversations was approximately 7-hours and 30-minutes. Following the interviews, the audio recordings were transcribed verbatim. The researcher also captured additional notes and observations in as much detail as possible. Subsequently, the researcher conducted thematic analysis by adhering to the guidelines of Braun and Clarke (2006).

Description of the Participants

Purposive sampling was employed, and ten participants were selected and consented to take part in the study. The participants consisted of different cultural groups in South Africa; five were white, three were African, one was coloured, and one was Indian. Furthermore, three were male and seven were female. All of the participants were registered with the Health Professions Council of South Africa (HPCSA) as clinical or counselling psychologists at the time of data collection; five were registered as clinical psychologists and five were registered as counselling psychologists. Their years of working with adult clients in psychotherapy ranged from two to 36 years. Additionally, five of the participants indicated that they predominantly prescribe to psychodynamic therapy and the rest indicated that their approach is more eclectic or integrated.

Relevant extracts from the participants' interviews (transcripts) have been included in the sections below. The transcript extracts are indicated with a number. Each extract has been assigned a number referring to the specific participant the extract was taken from.

The Analytic Narrative

In order the address the research problem, to identify the factors contributing to growth and change in psychotherapy within a culturally diverse South Africa, the researcher had to formulate an argument that went beyond the mere description of the data. This was achieved

by providing extracts that captured the essence of the themes being developed by the researcher.

The researcher became immersed in the data through repeated and active reading, while constantly searching for meanings and patterns. The raw data was organised in a meaningful way to form codes. The development of themes followed the analysis of codes. Each theme required analysis and write-up, and each theme had to tell a story and relate to the initial research question. The themes and sub-themes presented in this chapter are done so in an attempt to shed some light on the growth and change promoting factors in psychotherapy in South Africa. However, many of the themes and sub-themes do not have sharp borders and often merge and overlap with other therapeutic factors. The codes were categorised according to three core themes, namely:

1. The Relationship Trumps All
2. The Process Within Psychotherapy
3. Therapist Effects

Theme 1: The Relationship Trumps All

The first core theme includes several sub-themes that serve the broad function of the participants' experience with the most important factor that promotes growth and change in psychotherapy. Following is a discussion of the sub-themes that were found within this theme.

Sub-Theme 1: First and Foremost

The first sub-theme of theme 1 explores the participants' perceptions of whether it is the therapeutic relationship or their theoretical orientation that has the greatest impact on therapy outcomes. Regardless of subscribing to different theoretical orientations and treatment modalities, all of the participants were of the notion that therapy cannot be successful without a therapeutic relationship and that it is the most important factor that promotes growth and

change – contributing to successful therapy outcomes. Similarly, many studies have indicated for the therapeutic relationship to be the most important part of beginning psychotherapy and that it is the best predictor of the treatment outcome (Horvath & Symonds, 1991; Martin et al., 2000; Safran et al., 2009). The participants situated the therapeutic relationship at the core of their therapeutic work and change. This is supported by existing literature stating that the therapeutic relationship is the foundation for therapy (Ackerman & Hilsenroth, 2003; Bender, 2005).

> To me, it's the most important thing: To build the therapeutic alliance. (3)
>
> The therapeutic alliance is of paramount importance – if there is no chemistry between the therapist and client you have lost the battle. (5)
>
> It is the relationship between you and the client that essentially leads to change in psychotherapy. (2)
>
> If you can't develop some kind of working alliance in the first 10 or 15 minutes, you're not going to get anywhere. (9)
>
> You are asking someone not only to take in what you are saying (words) but also the presence of you. If the person is not engaged in the relationship in a committed way, they won't even hear what you are saying. If the patient is not in the relationship, it is a losing battle for sure. (6)

One of the participants did refer to the fact that some therapeutic relationships may not be as strong, especially because trust and vulnerability, which forms an integral part of the therapeutic relationship, are not as readily available for some clients as it is for others. Literature on the contextual model (Wampold & Imel, 2015) says that the human connection between the client and the therapist only creates some of the benefits of psychotherapy, thus people can also make changes in their life without a therapeutic relationship with a therapist.

However, the participants indicated that some kind of relationship is essential even when it just serves the purpose of trying to teach a skill.

> I think a therapeutic relationship or any relationship means you are vulnerable and that's hard for a lot of people. If people are drawn to the kind of therapies where it is less about the relationship in the room and more about activities and monitoring, I think that can also work. And it meets the person on their level, where they feel comfortable. If they come to me and I ask them to talk about their deepest darkest childhood secret, they might feel violated. (3)

> It will be very difficult. You would want therapy to be a collaborative space. If there isn't an alliance you would be working very hard as a therapist without any buy-in from the patient. If the patient doesn't trust you as the therapist, it's hard for them to engage. They might not be able to access some of those emotions if they don't trust the space. So, if they don't trust that you can hold all of those emotions, I think it would make therapy very difficult. Maybe you might be able to engage with the patient on an intellectual more rational level but. Not a definite no, but I suspect it would be a very frustrating process for both the therapist and the patient. (7)

> You might be able to achieve something, but you will not be able to do any deep work or anything on a meaningful level. (5)

> Even if you're seeing someone who is very reserved and essentially have come in saying 'I need a skill to address this' you still talking some kind of working alliance. (2)

> Apart from all the knowledge that therapists might have and all the training and skill in applying techniques and knowledge of different instruments and techniques, they might have a huge toolbox full of tools and assessments and exercises they can pull

> out of their cupboard, but I think if that therapeutic alliance is not there the chances are slim that it will have the same impact. I'm not saying it, it won't work at all, but I think that is the most important thing. (1)

Participant 4 believed that although such instances can be considered as "effective interactions", he does not consider them to be "therapeutic" in nature.

It appears that no one type of theoretical orientation or therapeutic modality is superior to another. Various participants highlighted this important point about how the therapeutic relationship is crucial in carrying change, regardless of theory. This corresponds with Wampold and Imel's (2015) work on the first pathway of the contextual model, describing the therapeutic relationship as the vehicle towards change, and suggesting that while theory is useful it is cosmetic without an established therapeutic relationship.

> There is not one perfect theory. (7)

> I think that we have to use the right therapy at the right time. (5)

> I believe that theory serves as a guide, but it should never cage the client in. (4)

> It's not like there is this one good approach and the others are inferior. I think they all have their place. (1)

> At the end of the day, it is two people sitting in a room, talking. And if you can talk it doesn't matter what theory is at the back of your mind – you will get somewhere. (6)

Participant 2 suggested a causal link, describing the therapeutic relationship as being a predictive factor of successful outcomes in psychotherapy, more so than theory or intervention.

> I don't think technique is terribly important. Despite all the work done on evidence-based interventions, the relationship stays more important than interventions. So, I

> don't think a particular model does it. I think quite frankly much of the time it's irrelevant. (2)

Sub-Theme 2: The Nature of The Therapeutic Relationship

The second sub-theme of theme 1 relies on the participants' descriptions of the therapeutic relationship. All the participants shared a similar experience of the therapeutic relationship as intimate, yet to some degree, formal. For example, participant 5 captured this by stating that "it's not a braai relationship, it is a therapeutic relationship, and it should never become a braai relationship".

The participants agreed that the therapeutic relationship allows for collaboration, rapport, and synchronicity between the client and therapist. Participant 10, for example, illustrates this notion by putting forth that it is "not a power relationship". The majority of the participants described the therapeutic relationship as the coming together of therapist and client. Teyber and McClure (2011) define the therapeutic alliance as a partnership where both therapist and client agree on shared goals, work together on tasks designed to bring a positive outcome, and establish a relationship built on trust, acceptance, and empathy. Several participants illuminate this.

> It's being on the same side - a close relationship, based on shared interests or shared goals. A therapeutic alliance is when there's a sense of trust between therapist and client and they both feel that we are kind of in this together. (1)

> It's a mutual engagement of persons - generally the therapist and the client - within a defined setting. With their roles are clear and an outcome has been agreed upon. The purpose of this interaction is therapeutic. And that's what actually makes it to an alliance or partnership. And it's a partnership that will be conducive to a transformational process. You know, something needs to change between the present where we start and where we end, so it's dynamic. (4)

> What it means to me is that whomever I'm seeing, we can achieve whatever they have set as goals. And to do whatever I need to that is reasonable to get it in place. And preferably, as soon as possible, which means obviously you read the person who comes in and get some idea of what they're going to need in order to be comfortable working with you. (2)

A common theme that emerged from the participants' perspectives is that trust is at the core of the therapeutic relationship. The participants showed agreement on various other factors, such as a client's willingness to share and be forthcoming, body language, and when clients show up on time and start looking forward to coming to therapy, but trust was unanimously identified by all. Cabaniss (2012) also describes the therapeutic relationship as the trust between the client and therapist that enables them to work together effectively. The therapeutic relationship helps the client to believe that their therapist is trustworthy and has their best interest at heart.

> I think the therapeutic alliance implies a lot of trust. (6)

> Trust is very important. The relationship must be one with trust from both sides. They always say 'do you lead with respect or trust' and I think trust is more important than respect. (5)

> It's a process, so one of the indicators would be, I think trust is being formed here, right? So when they are willing to share the secret, something they've not told anybody before, I mean, we know that one of the things we hear over and over, uh, reframe in counselling, is 'no one else knows'. 'You're the first person I've told apart from this person'. (4)

Participants 2 and 6 highlighted trust's progressive nature and that in as much as it forms part of the therapeutic relationship, it lies on a continuum. Cabaniss (2012) concurs that trust

takes time to develop and as participant 1 said, “sometimes it actually doesn’t happen”. Although it is widely agreed upon that the therapeutic relationship and trust form an integral part of the psychotherapeutic process, there seems to be no guarantee of its presence.

> I see many people who've been very, very badly traumatized. I've worked with trauma for 30 years, so things like trust don't simply just develop not with complex trauma. So you can't really think I'm going to spend a session developing trust that's not going to work like that. It's going to be tested over the entire time that you're working. (2)

> The therapeutic alliance is a complicated thing. It is fundamentally about trust, but with certain patients working through mistrust can also be part of the therapeutic alliance. It is not to say that when a patient arrives and is feeling brittle or disconnected from the therapy that there is not a therapeutic alliance. Almost pre-trust it feels like the capacity to come so that the patient arrives – that feels like the start of the therapeutic alliance in my mind. (6)

Another common theme among the participants was that they use their “gut” or “feeling” to inform them whether a therapeutic relationship or rapport has been established and clients are comfortable and connected.

> There is something about being able to feel when something is happening between you and that patient. (6)

> It’s more of a gut feeling and trying to perceive where your client is at and whether they appear to be trusting. (1)

> It is a feeling of warmth, understanding, and privilege that this person has decided to trust me. (3)

Theme 2: The Process Within Psychotherapy

The second core theme includes several sub-themes that relate to the growth and change promoting factors embedded in the process of psychotherapy. Following is a discussion of the sub-themes that were found within this theme.

Sub-Theme 1: The Importance of the Moment of Meeting

The first sub-theme of theme 2 describes the importance of the moment of the participants' first interaction with their clients. Most of the participants indicated the significance of the first encounter with a client and how it holds meaning in the therapeutic relationship and journey that they are embarking upon. Good therapists will begin to establish trust and a therapeutic relationship during the first meeting with their clients (Cabaniss, 2012).

> 15 to 30 seconds. Really, that is how quickly people would sum you up. People quickly make a summary. It starts the minute when you speak over the phone with a client. That is why I make my own bookings. I would not want a secretary to book my clients for me. So, you're already starting that therapeutic relationship over the phone when you first speak to the client. I can already estimate the trust over the phone. (5)

> You can probably have patients who in the screening process already attach to their therapist in a particular way, or during the first session. (6)

> You've got 15 minutes to develop a relationship. (2)

Participant 4 spoke about how she will never forget the moment of meeting with a lady a couple of years ago. It appeared as if this moment was memorable for participant 4 as she could sense the client's desperation which activated a sense of responsibility in her.

> There was this client, I was at the front desk, and so she wanted to make an appointment and I said, ah it looks really full, the diary is really full, but I can

> accommodate, you know, we'll see what we can do and then she said, but I want you. So, I said listen, I'm available in three weeks' time, but would it be fine for you to go to someone else and if you work out your process by then, it's fine. If you still want to continue with me, I will leave you in my diary. And so, uh, three weeks later, she rocked up in my office and we did quite a lot of deep work. And so right at the end, at the end of my sessions, when I terminate, I reflect, you know, how did the process go, what helped, etc, and she said, and she, she said, I choose you. I wanted you. When I spoke to you, I knew I needed to be with you. And so sometimes they come with an open heart. They come ready for you. (4)

The moment of meeting their clients for the first time is held dearly by most participants as it seems to lay the foundation for the journey ahead. Some of the participants mentioned the importance of making sure they were their clients' first point of contact as opposed to, for example, a secretary. The start of the relationship seems to have a special place in the therapeutic journey. This corresponds with the concept of the initial therapeutic bond as described by the contextual model (Wampold & Imel, 2015) whereby the initial interaction and client engagement early in therapy are critical to the success of therapy.

Sub-Theme 2: Measuring Success

The second sub-theme of theme 2 explores how the participants measure success in therapy. All of the participants indicated in some way or another that they consider their clients' growth and change as an integral part of the therapeutic process. It appeared challenging for some of the participants to reflect on growth and change within the therapeutic process because they seemed to have difficulty explicitly expressing how they measure it, i.e., how they measure success in therapy. All of the participants agreed that there is no one true measure of therapeutic success and that it very much depends on client variables and how their clients interpret their success.

> We meet people at different levels. What might be a success for one person, might not be a success for another person. (10)

> People come for different things. We cannot say someone who comes in for like general life issues will have similar goals to somebody who's like got serious substance use or severe childhood trauma. So, I think that's very individual. (8)

> The measure of success is wholly based on the patient's experience. (6)

They seem to suggest that what makes therapy effective is that it provides an experience that moves their clients to change. Some of the participants reflected on growth and change within the therapeutic process in a very concrete manner. Most of these participants mentioned the importance of "goal-setting" early in the therapeutic journey to measure success later on. They described goal-oriented movement which is largely linear. There is a vast body of psychological knowledge that supports the notion that goal-setting has the potential to contribute towards client progress (Lloyd et al., 2019). Some of the participants also mentioned the "remission of symptoms" and "behaviour change" as indicators of success in therapy.

> Whether or not we've managed to achieve the goals we've set. Basically, that's what it's going to come down to you and I work with clearly defined goals. So, I simply don't work broadly at all. It's defined very as exactly as I possibly can in the first or second session. This is what we're going to be doing and is relatively easy then to check have we actually done this or not. (2)

> In my intake, I would ask my client what his or her expectations are. What would we want to achieve here, how would we know we have been successful. Throughout the session, I would be referring back to what we contracted for initially. So that we do

> not move into other areas until we have done what we contracted for so that we have a clear goal in mind of what we are aiming for. (5)

> It's important to set goals or objectives. Whatever you want to call it but to find out what clients' needs are early. You can't say whether a person is a successful person if you don't know what they were aiming at. Then you can measure later on to what extent did you reach those goals. (1)

The other participants did not reflect on therapeutic success in such a concrete manner. For them, things like "gaining insight" and "lightbulb moments" are their guideposts to therapeutic success. Rather than overtly grounding themselves in language, they spoke of "feeling" certain elements that would indicate growth and change. These participants indicated that they measure therapeutic success by "feeling", "perceiving", or "sensing" their clients' "movement" throughout the therapeutic journey. Lyons-Ruth (1998) concurs that something more than interpretation is needed to bring about change in psychotherapy. It is proposed that the implicit relational knowing of client and therapist, knowledge regarding how to do things with intimate others, intersects to create an intersubjective field that includes reasonably accurate sensings of each other. This is different from using language and from the unconscious.

> I don't do it in such a concrete way. There are various things you must keep in mind. I am going to talk in a psychoanalytical way. Are they taking up the relationship in a way that you start to form a transference relationship with them. Where they can start to represent you as something, and then navigate what that might mean. For example, I get really happy when a patient brings their anger towards me. Then something is happening because as much as possible I am trying to be benign in a way. So, if they are angry with me generally, I think okay there is something internally happening

> with the representation of me here. We are doing stuff here, we are doing the work, we are figuring out what those internal representations of your objects are. (6)

> I measure the movement. For me, it's when they start settling. When they can come back and talk about the same things that we used to talk about before, but it doesn't feel as painful. When they get some understanding from it, nothing changes in their lives, all the other factors are still the same. But something inside them has solidified and they get some greater capacity to wither those things and find joy in their lives. (3)

> As long as there has been movement, there has been success. But this is for the client to decide, together with my input as well, if I agree with them thinking they have achieved their goals. (5)

> The first step will be to check with the client as well, how far their movement has gone. (7)

In listening to participant 3, it seemed rewarding for her to witness her patient's healing and to be part of a process that offered her client a different way of being in the world.

> There was a client I saw whose therapy varied from once a week to once every two weeks and then at one point, it was twice a week. I could really see the difference from the start to the finish. Before there were some things that were so hurtful to talk about that her mind would go blank and by the end of it, we could talk about those things. The movement was so clear to me.

Whether making use of more concrete or sensing-based techniques to measure growth and change, most of the participants concurred that therapeutic success is a collaborative exploratory journey between the client and the therapist. The participants especially emphasized the importance of ensuring "client buy-in". Research has found that the

agreement between clients and therapists on the goals of therapy is associated with successful outcomes and that matching therapeutic activities with client preferences is associated with improved outcomes (Lloyd et al., 2019). This phenomenon could also be understood in terms of the second pathway of the contextual model (Wampold & Imel, 2015) which proposes that acceptance of an explanation given for the client's difficulties and agreement about the actions needed to overcome those difficulties fosters expectations that have a powerful influence on subjective experiences (Wampold &Imel, 2015).

> I tell people when we start that our goal and the way I work is collaboratively and through exploration. (3)

> And that must be negotiated between the therapist and client. It's a collaborative process – deciding how successful we've been. I would always check with the client because coming back to the therapeutic relationship, it's kind of a joint relationship. (1)

> And in that way collaboratively looking at how much progress has been made in achieving those goals. (7)

"Movement", however it is measured is, therefore, a highly significant phenomenon for the participants in this study who - through their therapeutic journeys - have made meaning for themselves in the growth and change seen in their clients throughout their respective therapeutic processes.

Sub-Theme 3: Client Elements

The third sub-theme of theme two describes the elements that clients bring into the therapeutic space. Most of the participants commented on the power of client qualities and how they can either facilitate or hinder therapeutic outcomes. This is in line with research suggesting that therapists place high expectations on what their clients bring forth to the

therapeutic process (Bachelor, 2013). The participants all emphasized the importance of remaining cognisant of the unique qualities that every single client brings into the therapeutic space. The participants seemed to suggest that the clients they see come to them at "different levels". Therefore, participant 6, among others, strongly suggested that the client must be suitable for therapy to increase its effectiveness.

> I think that if someone has indicated for therapy. You want this alliance in the interest of the patient. The therapeutic alliance is 100% about relational dynamics. It asks you to commit to a relationship. Some patients don't have the ability relationally to come into a therapeutic engagement.

Clients seem to vary in terms of their readiness and willingness for therapy, their desire to change and thirst for personal growth, their commitment, and especially in terms of their capacity to form a therapeutic relationship (trust).

> It's population-based, or person to person, every single person coming into my office is unique and should be treated as such. (8)

> With some people it happens right then and there, it feels more intense, and I feel like I can start making what I think is stronger interpretations. With others, I feel like I have to go quite slow, maybe because they struggle to trust people. And I am very aware of our relationship and not to push too hard. (3)

> Trust versus mistrust is a very significant psychological thought for people. With certain patients, you have to give it time. It can be six months. It can take time. It can take even more. It depends. (6)

> I think we all come with different traumas and different ideas about being in different relationships. Some patients might be very ill, and some may not be that ill. Some may

> have really good insights, and some's insight might be poor and may need a bit more working with. (9)

Client variance furthermore seems to dictate that there is no "blanket", no "one-size-fits-all", and no perfect "recipe" that can be applied as the therapeutic process unfolds. Participant 1 reiterated this:

> I don't think there is a recipe. You know you can't, say someone comes in with a gender-based violence thing, then you will do A, B, and C. And if someone comes in with depression, then you will do D, E, and F. It just doesn't work like that at all.

A common notion held by several participants was that of time constraints dictated by medical aid schemes and the affordability of psychotherapy in South Africa. The participants seemed to suggest that clients do not enter into the therapeutic process with ample time and financial resources. This is a major constraint that dictates many clients' therapeutic journeys. Thus, participant 9 concludes that "therapists should do the very best they can with the time that is given to them". It almost seems contradictory. As already mentioned, some clients simply need more time to get "therapy fit" than others, yet it is not always possible as there is not always time within the context of South Africa.

> You're working with medical aid. You've got five sessions, six sessions. You've got to be finished with the work you are going to do. So, we simply don't have the luxury of time. And it does help that patients are aware of this because they applied for the medical aid, they know they've got six sessions. (2)

> We are talking very very short because there simply isn't time when you are working with medical schemes. And even if you are working with private patients, very very few people have a disposable income, especially now. To say I am going to pay you a thousand plus every week, they simply cannot do it. (10)

> If people can stay in therapy and how often they can come. It is not often that people can afford to come once a week. A lot of people I see once every two to three weeks because they are limited by their medical aid funds and they can't pay out of their pocket. Some people I see once every three weeks to stretch out the 15 PMB sessions they get per year. At times I feel it is really hard to get anywhere. The time in between sessions for me is very important. (3)

Client elements that were reported to positively contribute to the therapeutic process were "commitment", their ability to "open up", their ability to bring "difficult emotions" into the therapeutic space, and having had "good experiences in the past". Several participants mentioned the client's capacity for "self-reflection" and their "ability to gain insight". They seemed to be referring to the concept of psychological mindedness, a healthy psychological construct associated with adaptive functioning that is an important predictor of good therapeutic outcomes (Rai et al., 2015). Elements that have the potential of leading to successful outcomes in psychotherapy thus include clients who can access feelings, are open to new ideas, are willing to try and understand themselves and others, and have an interest in the meaning and motivation of their own and others' behaviour.

Theme 3: Therapist Effects

The third core theme includes several sub-themes that relate to the essence of therapy which is also embodied in the therapist.

> The other thing that is also important is to think about the therapist's role in the therapeutic alliance. In a way, we sometimes define just about the patient. But actually, the therapeutic alliance is also around the commitment of the therapist, so can the therapist arrive in the moment and actually have space in their mind, personally or in relation to the amount of work they are holding, to commit to really engaging with the patient in front of them. (6)

Following is a discussion of the sub-themes that were found within this theme.

Sub-Theme 1: General Therapist Qualities

The first sub-theme of theme three describes the characteristics of effective therapists. Listening, "listening to listen", was identified as the top therapist quality that contributes to successful outcomes in psychotherapy. In the participants' descriptions of listening to their clients, they seemed to describe it as a skill that often gets underestimated and that when executed with intention, has immense therapeutic power.

> Most of this time is making sure that whoever come into the room feels actually listened to, and that they hear that I actually hear what they are saying. Uhm, most people will accept that as pretty meaningful. (2)

> The capacity to listen seems like a simple thing but patients take it up exceptionally well, and it's not a simple thing. (6)

References were also made to therapist qualities such as "offering clients some sense of connection or safety", "warmth", "empathy", "acceptance", "curiosity", "being non-judgemental", "unconditional positive regard", being "open" and "open-minded", "genuineness", "understanding", being "honest", and being "authentic and congruent". These qualities however are not distinct. For example, participant 6 pointed out that "in the link between warmth and the capacity to listen I think you might find empathy and all of those things go under the umbrella of authenticity". The therapist qualities identified in the present research align with facilitative therapist skills which have been found to correlate with better outcomes with clients: verbal fluency, interpersonal perception, affective modulation and expressiveness, warmth and acceptance, empathy, and focus on others (Wampold and Imel, 2015). These skills are also related to aspects described in the first pathway of the contextual

model (Wampold & Imel, 2015), which involves the benefits gained by the human interaction with an empathic and caring therapist.

All of the participants to some extent reported that the Rogerian principles - empathy, congruence, and unconditional positive regard - form part of their therapeutic foundation, creating some of the benefits in therapy. Top among those was empathy, a variable that is more highly correlated with the outcome than any other variable studied in psychotherapy (Wampold & Imel, 2015). Two of the participants however seemed uncomfortable with and challenged the idea of unconditional positive regard, questioning whether it allows for authenticity and movement. They seemed to relate the concept of unconditional positive regard to a sense of condonement of everything the client brings into the therapeutic space. This appears to be problematic since challenging unworkable thinking patterns inherently forms part of the therapeutic process when wanting to foster growth and change.

> I don't agree with unconditional positive regard. If you can hold those things that I have spoken about you can have a clear confrontation that feels safe. Unconditional positive regard sometimes feels like a move away from confrontation. Things can become intense in a way that feels safe. It is too false. Something of the genuineness feels lost to me. (6)

> You have to be honest and congruent because I think that helps to build trust. If everything is just hunkey dorey and the therapist just agrees with everything you know, it's kind of not honest. (1)

Some of the participants concurred that it is important to show care but also to develop the ability to be "direct" and "confront in a constructive way". Participant 1 quoted from a book she read that "caring plus confrontation equals growth".

Other factors that were mentioned included “humour”, “self-disclosing in order to establish rapport, although they teach you not to”, and having a “certain cognitive ability to keep up with the patient and hold in your mind something about theory and history”.

Sub-Theme 2: Therapeutic Actions

The second sub-theme of theme 3 describes the actions of effective therapists. The participants found how or the way in which they apply their theoretical orientation or technique to be of greater significance in the facilitation of therapeutic growth and change than the specific ones which they prescribe to. This is in line with the contextual model (Wampold & Imel, 2015) which recognises that how the therapy (treatment) is delivered is critical to the success of therapy, rendering the therapist critical to the therapeutic process. The participants seemed to suggest that therapy is most successful when authentically offered to the client. Most of the participants shared participant 6’s notion that:

> It’s about the therapist’s capacity to ground themselves in the theory. If the therapist is comfortable in their skin, their modality as skin, that is where I think the work is done. If the therapist can find an anchoring in the theory and the modality in their mind, then they can safely navigate what it means to be in the room with the patient.

Participant 5, in a similar fashion, highlights the importance of the therapist to be comfortable with their theoretical orientation or technique when wanting to achieve successful outcomes.

> Your therapeutic approach has to resonate with you as a therapist. You can’t just have something that someone taught you and try and spout it out your mouth, it’s not going to work.

Not only is it important for the therapist to be comfortable with their theoretical orientation or technique, but the participants were also of the opinion that it must be suitable

to address the client's needs. Wampold and Imel (2015) postulate that if the technique fails to engage the client in purposive work, the technique is not working properly, and changes must be made to engage the client effectively. These findings are aligned with pathway two (expectations) and especially pathway three (specific ingredients) of the contextual model, which emphasises the participation in the specific ingredients.

> I think that we have used the right therapies at the right time. (5)
>
> I must not be so worried about the theory that I am not focused on the client. I mustn't make the client fit the theory. (9)
>
> I think it all depends on the patient or client's problem. You cannot use the same therapy for everybody. (7)
>
> I don't like it when people religiously stick to one theory, because people are not rigid. (3)

The participants furthermore highlighted the importance of continuous professional development as a factor that influences growth and change in their clients. Participant 2 elaborates by saying "read the research and apply it", suggesting that only being knowledgeable is not sufficient. It has to be followed by doing, engaging with, or practising what was learnt. Research indicates that the amount of time therapists reported spending on improving their therapeutic skills (outside of therapy) predicted their outcomes (Chow et al., 2015). The participants were also of the opinion that it is more advantageous to be knowledgeable about various theories, modalities, and techniques, in other words building an "intervention toolbox" to draw from to best serve their clients.

> If you are not up to date with what is actually happening in the field, it's very difficult to know what you are doing or to update your skills. (9)

> I think one needs to look at the research. But also to have self-knowledge to know what you are comfortable with as a therapist. Based on your knowledge of the client and who they are to sort of, be able to gauge what might work for that. (1)

> Continuous learning and being a lifelong learner is such an important thing. (10)

Sub-Theme 3: Support

The third sub-theme of theme three reflects the participants' descriptions of how challenging therapeutic work can be. Participant 1 described how important self-care is and how being fatigued can have an impact on the therapeutic journey.

> Take your breaks. You need to look after yourself, mentally, socially, spiritually, and physically. You have to have the energy to deal with your clients.

Therapists 6, 7, and 8 reflected on how important it was for them to have supportive structures, such as their own personal therapy or supervision to maintain perspective and a reflective function regarding the therapeutic process. This aligns with countertransference literature suggesting that therapists should reflect on their reactions towards their clients to determine if these reactions are reasonable given the client presentation or if they are based on therapist issues (Cabaniss, 2012).

> A therapist who is in supervision and a therapist who is in their own therapy for the long term. I think we, I think as therapists we don't know everything. We have our own blind spots. We don't become a therapist 'cause our lives were so fantastic. So, we gotta understand what are we activating in ourselves and certain clients may activate things coming from our own stories. So, I think it's important that we are constantly reflective about what may be activating. (8)

> One of the biggest things I have learnt is your own awareness as a therapist is very important. To have a certain level of insight about yourself, and to understand when it

> is your stuff and when is it the patient's stuff and being able to distinguish the two. It's very important to be able to recognise countertransferences that are present and how your stuff may be coming into the space. Self-awareness is a very big part of being a therapist. (7)

> We always say this as therapists, we go, "trust the process" and we say "you are the tool". So if you are the tool and you don't have the capacity to reflect on your history, your hooks, what gets evoked in you, then you are going to go in blind and I think it is going to be destructive. Not just denied, but actively destructive. (6)

The descriptions of these participants allude to the fact that they work with challenging material and sometimes powerful projections. It is thus crucial for therapists to also have a space to call their own, a holding environment. This partnered reflective space allows them to think about the therapeutic process, create self-awareness, and act in the best interest of their clients. This space also allows them to reflect on their experience as a person and as a therapist which allows them to be present for their clients within the therapeutic process, contributing to successful therapeutic outcomes.

Participant 8 described being the client in her own therapy process and how it helped her to relate to her clients' experiences. It has been most valuable for her to experience the other side, which is often anxiety-provoking and uncomfortable.

> I've been seeing my therapist for a very long time, but I recently had to change to Zoom and I remember I was, and I'm working at home on Zoom all day so I'm used to just clicking and going, and I remember her name came up on the screen and I got frightened. I think in that moment I realized like this is, you know, talking to a person about the deepest parts of yourself. It's not a walk in the park, it's not an easy thing to do in any way.

Sub-Theme 4: Navigating Clients' Beliefs

The final sub-theme of theme 3 explores the therapists' orientations toward their clients' belief systems. Most of the participants indicated that clients' belief systems do influence the therapeutic process and possibly the outcome. They indicated that the decisions their clients make and how they view their worlds are shaped by their experiences and by their belief systems. They seemed to reflect that their clients' belief systems are like lenses through which they view and interpret the world and that they come into the therapeutic space wearing these lenses. This finding is aligned with pathway two of the contextual model (Wampold & Imel, 2015) in that clients come to therapy with cultural conceptions or explanations for their distress. Participant 4 provided an alternate metaphor when talking about her clients' belief systems and why it is important to be respectful thereof by saying that, "they want to hold on to their belief system and so that's an anchor and they tailor themselves to that anchor". Therapist 7 reflected that he does not "know if therapy would be successful if you would say forget your lived experience and trust my judgement". Participant 1 also reflected and elaborated on the impact a client's belief system can have on the therapeutic process and why it is of paramount importance to acknowledge and respect it.

> I do think that clients' belief systems play a very important role. To me every individual is different, and you know every individual may have a different belief system. And so, I don't want to fall into the trap of just dividing clients based on demographic variables. So, for me it's a matter of, with each individual to be, tuned into where they are at and what they are about and not to make assumptions. Maybe for some individuals or in some subcultures, it might even indicate a sign of disrespect if you do look someone directly in the eye. I know that in some cultures., how older people are viewed you know, and that one needs to respect older people and sort of listen to what they say and not talk back. While I don't think in a

> therapeutic alliance where two people must like work together collaboratively that it's very useful if one has that kind of relationship where a person feels you know they should sort of listen to you and they're not allowed to talk back or say what they think or be assertive. And so, I think that a therapeutic relationship and therapy, therapy success could be very much influenced by the views and the cultural beliefs and so on. I know that you know, in, in some cultures even it's looked down upon when people go for therapy. And it's sometimes not only related to culture but sometimes to gender. Sometimes males feel, but it's a sign of weakness. And oh, it's not on to talk about one's problems or it's not right to speak to women about one's problems or to someone from a different culture or race group. So, I'm very aware that the clients' belief systems are really important. And I need to be tuned in because that could completely derail therapy. It could also cause for it not to happen at all, for people not to come for help. (1)

Not all of the participants shared the notion that clients' belief systems necessarily impinge on the therapeutic process. Some of the participants reflected on the phenomenon of urbanisation in South Africa and the associated flood of information that goes with it. They indicated rarely seeing clients who prescribe to a single African culture. From observing their clients, the participants seemed to suggest that South Africa houses a blend of African and Western cultures. Participant 10 said, "Perhaps that is why I don't experience it so strongly, perhaps we are more similar than different, or perhaps we have been integrated". Bantjies et al. (2016) posit that African and Western cultural contexts are not that uniquely distinct from one another, cautioning against an essentialist view of culture. They support the participants' notion that South Africa occupies a hybrid cultural space of African and Western cultures.

Three of the participants suggested that conflict arising in the arena of the clients' belief systems is not unique and is similar to any other conflict that emerges within the therapeutic space and that it should be dealt with accordingly.

> The conflict that might arise in relation to that might need to be worked through. But that is the point of therapy right. To navigate the conflict of that thing. It's about navigating the patient's subjectivity in relation to what they believe. So no, I don't think it would be a hindrance in relation to positive outcomes. (6)

Whether or not the participants thought that clients' belief systems influence the therapeutic process, all of them indicated that they are comfortable working with different cultures and religions. Literature has found that therapists who are better able to form therapeutic relationships with a variety of clients are more effective (Wampold & Imel, 2015).

When asked whether they adapt their therapeutic approach to address conflict that may arise in terms of their clients' belief systems almost all of the participants indicated that they do not. Rather than adapting their approach, they indicated that inherent in their approach is an element of respect towards their clients' cultural and religious orientations. Their psychotherapies seem to already include actively engaging with their clients and ensuring that healing processes fit within the context. The participants used words such as, "accommodate", "holds that difference", and being "more holistic" when referring to their approaches.

> What I would probably end up doing most of the time is indicate that I accommodate it. Then I have no difficulty whatsoever with what people want to bring in. (2)

> No, I never adapt my approach, because I think my approach inherently holds that difference. It is about the patient and it is about you taking a more opaque position. I

> am in the room but my moralistic stuff is not in the room, so I don't think I have to adjust the therapy. It's about holding in mind what the patient brings and if that's significant to them, it's to know that and to know that you think about that in a way that is respectful. Everything needs to be done in a respectful way because it's the patient's internal world, that's also their experience of themselves being in this life. To confront that is talking to not being self-reflexive. Your own hooks, you have to defend yourself against something that does not fit you - well that is your stuff, not the patients. (6)

> You have to be a bit more holistic in your approach to these things. In my experience, while theories are important it is also important to consider the patients lived experience as well. What is appropriate in terms of the patient's culture, different cultures may have different mourning periods that they have. Is it appropriate to say that a person has chronic depression if perhaps they are mourning for more than a year. It is important to go through your systematic enquiry. The theories are important as a baseline. Ultimately, we use psychology as a science so that is the base that we work from but I think it is important to be holistic and to not discount the person's cultural beliefs. So, while this may have elements that are pathological it is not to say it doesn't play a function or that it is not important culturally. Some things are important not to just discard as pathological. You run the risk of doing that when something doesn't completely fit into a theory perfectly. (7)

A common mitigating factor, when faced with challenges in terms of clients' belief systems, was the importance of being open and willing to have challenging or difficult conversations. Participant 9 highlighted the importance of "asking" when uncertain. Miller (2018) also suggests that therapists and clients need to learn about, from, and with one another.

> I'm not so much adapting my approach because everything to me is a conversation. And nothing is off bounds. If something is sitting weirdly in the room then I will bring it up. The biggest cultural difference I've had is me, who I am. A 34-year-old female of colour who is a psychologist. And I saw this older white man who was in his 60s and he had a military background. You can imagine, we were worlds apart. But we talked about it and it was out in the open and it helped. (3)

> I think it's our jobs as therapists to maybe stay curious about one's cultural beliefs and spirituality and what that means therapeutically. I'm Catholic, I was raised Catholic, so I can assume a certain thing about Catholicism, but I don't know what that would mean for another person. Cultural perceptions need to be spoken about within the therapeutic alliance to better understand outcomes. I think if we're not speaking about one's culture or one's language or one's spirituality. Or having a female therapist or having a black therapist or a white therapist. Or, you know, you won't know the impact of what it is going to have on someone unless you ask them. You gotta speak about that and see if we can get past that. And usually, we can. So, it's just about being the therapist that can contain the possible anxieties that can be in the room. Hopefully, we can be the people who can have the difficult conversations. With clients who are brave enough to do the the work in the 1st place, and I mean if we can't talk about it, how on Earth are we expecting our clients to do it? (8)

As evident from the participants' descriptions of how they negotiate multicultural tensions with their clients, most of them seemed to have adopted a constructivist narrative perspective as the broad basis for intervention (Eagle, 2005). It seems that by taking a respectful stance and being willing to engage sincerely with the clients' interpretations of their beliefs, they create a therapeutic space for clients to reconceptualise and rewrite their own narratives. Meichenbaum and Fitzpatrick (1993) suggests that if therapists keep these principles in mind,

seeking to co-construct with clients narrative versions that are both meaningful and acceptable in all senses, then they will in all likelihood be able to negotiate the often difficult pathways of multicultural psychotherapy with integrity.

Research Aims, Objectives, and Themes

This research project aimed to explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context. Overall, it was found that themes similar to those elicited from a review of the relevant literature were discussed by the participants that were interviewed. The findings of this research project significantly correspond with the literature of the contextual model (Wampold & Imel, 2015). This is perhaps the most noteworthy finding of this study; the applicability of the contextual model (Wampold & Imel, 2015) to the South African context. Psychotherapy is rooted in a Western cultural context and may not always be applicable and relevant to healing practices in South Africa. The findings of this study clearly suggest that the South African context calls for culturally responsive psychotherapy, inclusive of communities and culture in the healing process. The contextual model (Wampold & Imel, 2015) accounts for this; psychotherapy is a healing practice designed from a specific cultural context and for a specific culture (Benish et al., 2011). It can be concluded that one of the most important factors promoting growth and change in psychotherapy is therapists who make themselves relevant to South Africa's complex context, and the contextual model (Wampold & Imel, 2015) can help them on their way there.

To address research objective one, to explore and describe psychologists' experiences with the factors contributing to successful outcomes in psychotherapy, the researcher organised the data into three meaningful themes with sub-themes as discussed in this chapter. Most of the factors facilitating growth and change discussed among the participants aligned with the contextual model (Wampold & Imel, 2015) as outlined and discussed in the literature review

chapter (Chapter 2). Please see Table 3 for an outline of the similarities between the contextual model and the present study's findings.

Table 3

Similarities Between the Contextual Model and Present Study Findings

The Contextual Model	Present Study Themes and Sub-Themes
The Initial Therapeutic Bond	• The Importance of the Moment of Meeting
Pathway 1: The Real Relationship	• First and Foremost • The Nature of the Therapeutic Alliance • General Therapist Qualities
Pathway 2: Creation of Expectation through Explanation and Treatment	• Measuring Success • Therapeutic Actions • Navigating Clients' Beliefs
Pathway 3: Enacting Health-Promoting Actions	• Therapeutic Actions

Note. This table outlines the correlation between the present study's findings (themes and sub-themes) and the phases of the contextual model.

The researcher allocated one of the core themes, theme 3, to the discussion of research objective 2, to explore the characteristics and actions of effective therapists. One of the sub-themes in theme 3 also encapsulates research objective 3, to explore whether psychologists adapt their psychotherapeutic approach to the client's growth and change process, based on cultural beliefs.

This chapter has highlighted the major themes and sub-themes that capture the lived experiences of the participants in terms of the factors that promote growth and change in

psychotherapy in the diverse South African context. This chapter presented an integration of the findings alongside the literature.

CHAPTER 5: CONCLUSION

This chapter reflects the key elements that have emerged from the study, focussing on a summary of the findings. It highlights its significance, limitations, and future directions for studies in this research area.

Major Findings in the Study

The participants' lived experiences of what leads to successful outcomes in psychotherapy clustered around three major themes, with various sub-themes. The findings of this study suggest that the measure of a client's success in therapy is subjective. Furthermore, the way in which success is measured is tailored to the unique and individual qualities of every client attending therapy. Upon asking the participants to describe how they measure success with a client in therapy, they unanimously seemed to describe some or other form of "movement" which has been collaboratively constructed, but to a greater extent is based on how the client feels they have succeeded.

There seems to be no definite answer to the question of what makes therapy successful, but from the participants' perceptions, several themes emerged regarding factors they believed to contribute to the therapeutic process and therapeutic success. The therapeutic relationship was found to be the most important factor in increasing successful outcomes in therapy. Although it remains key to producing favourable outcomes, it can be concluded from this study, that elements within the process of psychotherapy and therapist effects also contribute to successful psychotherapy outcomes. The findings of this study are comparable to existing literature, especially the contextual model (Wampold & Imel, 2015). It can be concluded that one of the most important factors promoting growth and change in psychotherapy is therapists who make themselves relevant to South Africa's complex context, and the contextual model (Wampold & Imel, 2015) can help them on their way there.

Limitations of the Study

Limitations are present in all studies and these possibilities were considered before the commencement of this research. The limitations presented in this research are mostly relative to the methodology. This research was conducted at a particular moment when online research became pandemic-induced.

In the present study online data collection limited participation only to those who had a web-enabled device, good quality internet connection, and relatively high data usage. People without access to these possibly found it less appealing to participate, thus some groups may have been excluded because they do not feel comfortable with or have access to the technology required.

A sample size of ten is considered relatively small in qualitative terms and may be a limitation. Extending the length of the semi-structured interviews may have allowed a more detailed account of the participants' lived experiences, thus deepening the understanding already provided. However, both time and availability limitations would have been an issue. The small sample size allowed for thorough scrutiny of the participants' perspectives thorough analysis of the data.

Interviews come with the threat of interviewer bias. Although the researcher tried to remain as objective as possible, the risk of misinterpreting the participants' answers due to personal feelings about the topic was possible, especially since the researcher is a psychologist in training herself. Researcher and participant characteristics could also have affected the answers given and the direction of the conversation.

The researcher coded the data in the present study and identified the themes. Once this was completed, the analysis was discussed with the research supervisor. The nature of this research only allowed one analysis to be possible. The findings thus represent only one analysis, the researcher's analysis. Although this process allowed for consistency, it did not

provide a variety of perspectives from a variety of people with differing expertise. The coding of data did not involve several individuals and the development of themes did not involve discussions with other researchers, expert panels, or the participants. With that being said, the consistency with existing theories was significant.

Lastly, the data collected is based on the opinions of the participants' own experiences and omits the clients' views on what makes therapy successful. The participants' measures of therapeutic "success" are also subjective.

Strengths of the Research

In this qualitative study, the concern was transferability rather than generalisability. Although the sample was not random, and the data was collected through non-standardised, semi-structured interviews, this study focused on how the findings transfer from one context onto a similar context which is believed is possible for this study. It is important to note that the sample incorporated racial and contextual diversity among the participants. The context to which these findings could be transferable is perhaps onto a diversity of settings in South Africa. Thus, this study may carry applicability and relevance.

Transitioning to online data collection broadened access to the participants by lifting geographic limits. It also reduced time and cost burdens as no one had to travel and the interviews were conducted at times convenient to the participants. The researcher did not need to consider aspects such as travel, distance, or safety.

Although the loss of non-verbal cues is often considered to be a limitation during online interviewing, the researcher could see and observe the participants completely or partially, depending on how the person was placed in front of the camera, and interpret facial expressions, body language, and to some extent other non-verbal signals. The participants felt secure enough in the confidentiality of their interviews, fully aware that they were being audio-recorded.

A good level of consistency was achieved during the interview process. Although the nature of semi-structured interviews allows freedom and flexibility during the interview process, the questions on the interview schedule were consistently posed to the participants.

Culture impacts the therapeutic process in important ways; thus, it was actively explored in the interviews with the participants and formed part of a significant theme.

Future Directions

Based on the findings of this investigation, there is a great need for more extensive studies on the growth and change promoting factors in psychotherapy in South Africa. The significance of this topic lies in its relevance and applicability. The application of these studies has the potential to improve the lives of South Africans. Studies with larger sample sizes could potentially inform the development of guidelines for practitioners in clinical practice and facilitate improved treatment strategies and client-therapist relationships for therapists working in a diverse South African context. Research should also include clients as participants to gain a rich understanding and insight into the different views regarding the growth and change promoting factors in psychotherapy for both client and therapist in a multi-cultural South Africa.

Reflexive Commentary

Throughout this entire research process, I have engaged reflectively in an effort towards self-awareness. My interest in what works in psychotherapy began during my first year of training as a counselling psychologist. I had a vague idea of the potential contributing factors but lacked the descriptive language that enabled me to articulate what was happening within the therapeutic encounter. Through training and supervision, I began to form an understanding of what encourages change in working with clients. I soon realised how crucial the therapeutic relationship is, after having felt the impact thereof within my work with clients. I was astonished at its power to bring about change. My experience prompted my

curiosity to investigate what other therapists' experiences might be with growth and change promoting factors in psychotherapy.

An important dynamic in this study was my own identification with the participants. Although I felt like a novice in comparison to their experience, there was still a connection on a professional level. Although it facilitated rapport, I was cautious for the interaction not to appear too familiar, especially when I felt myself identifying with the participants.

I thoroughly enjoyed the research interviews themselves. Partly I think because the inner workings of psychologists always seemed so mysterious to me. I felt honoured and privileged to have the participants share their experiences of their psychotherapeutic work with me. I am certain that much of what they shared with me will stay with me for a very long time, perhaps even forever. I conducted the interviews during my internship year and noticed how they influenced the way I work as a therapist.

This chapter concluded this research study's major findings. Thereafter study limitations, strengths, and future directions were explored. Following this, a reflexive commentary from the researcher was offered.

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Appendix A

Ethical Clearance Certificate

NELSON MANDELA
UNIVERSITY

Summerstrand South
Faculty of Health Sciences
Tel.+27(0)41 504 2114
Joanne.Naidoo@mandela.ac.za
Chairperson: Faculty Postgraduate Studies Committee (FPGSC) Health Sciences

Ref: [H21-HEA-PSY-005] /Approval]

Date: 08 September 2021

Prof Y Ally
Department of Health Sciences
Faculty of Health Sciences

Dear Prof Ally

PRIMARY RESPONSIBLE PERSON (PRP):	Prof Y Ally
PRIMARY INVESTIGATOR (PI):	Ms W Heyneke
STUDENT NUMBER:	210027150
QUALIFICATION:	MA in Counselling Psychology
TITLE:	**PSYCHOLOGISTS' PERCEPTIONS OF THE GROWTH AND CHANGE PROMOTING FACTORS IN PSYCHOTHERAPY WITHIN A CULTURALLY DIVERSE SOUTH AFRICA**

Your above-entitled application served at the 05 August 2021 Faculty of Health Sciences Postgraduate Studies Committee meeting for approval. The study is classified as a negligible/low risk study. The ethics clearance reference number is **H21-HEA-PSY-005** and approval is subject to the following conditions:

1. The immediate completion and return of the attached acknowledgement to Thembeka.Sdinane@mandela.ac.za, the date of receipt of such returned acknowledgement determining the final date of approval for the study where after data collection may commence.
2. Approval for data collection is for 1 calendar year from date of receipt of above-mentioned acknowledgement.
3. The submission of an annual progress report by the PRP on the data collection activities of the study (form RECH-004 to be made available shortly on Research Ethics Committee (Human) portal) by 15 November this year for studies approved/extended in the period October of the previous year up to and including September of this year, or 15 November next year for studies approved/extended after September this year.
4. In the event of a requirement to extend the period of data collection (i.e. for a period in excess of 1 calendar year from date of approval), completion of an extension request is required (form RECH-005 to be made available shortly on Research Ethics Committee (Human) portal).
5. In the event of any changes made to the study (excluding extension of the study), completion of an amendments form is required PRIOR implementation (form RECH-006 to be made available shortly on Research Ethics Committee (Human) portal).
6. Immediate submission (and possible discontinuation of the study in the case of serious events) of the relevant report to RECH (form RECH-007 to be made available shortly on Research Ethics

Committee (Human) portal) in the event of any unanticipated problems, serious incidents or adverse events observed during the course of the study.

7. Immediate submission of a Study Termination Report to RECH (form RECH-008 to be made available shortly on Research Ethics Committee (Human) portal) upon unexpected closure/termination of study.
8. Immediate submission of a Study Exception Report of RECH (form RECH-009 to be made available shortly on Research Ethics Committee (Human) portal) in the event of any study deviations, violations and/or exceptions.
9. Acknowledgement that the study could be subjected to passive and/or active monitoring without prior notice at the discretion of the Faculty Postgraduate Studies Committee (FPGSC).

Please quote the ethics clearance reference number in all correspondence and enquiries related to the study.

We wish you well with the study.

Yours sincerely,

Prof J Naidoo: Faculty Postgraduate Studies Committee (FPGSC) Chairperson
Faculty of Health Sciences
Nelson Mandela University

Appendix 1: Acknowledgement of conditions for ethical approval

Appendix B

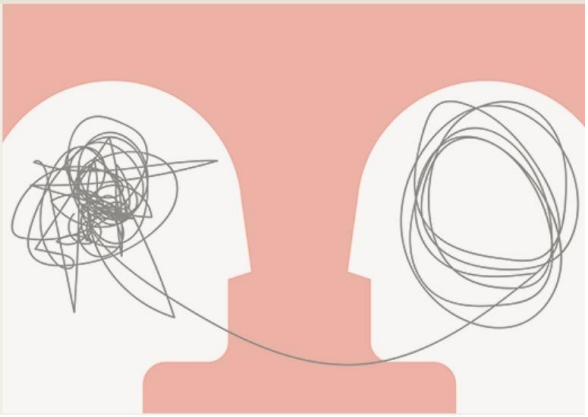
Research Advertisement

RESEARCH PARTICIPANTS NEEDED

You are being invited to take part in a research project which aims to explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context.

AFFILIATIONS

My name is Wilmie Heyneke and I am a Masters student in Psychology (Counselling) at the Nelson Mandela University (NMU). As part of my course, is the completion of a research project.



CRITERIA

- Participants must be registered with the HPCSA as a clinical/counselling psychologist
- Participants must be working with adult clients
- Participants must interact with different cultural groups
- Participants must be practising within the perimeters of South Africa
- ·Participants must have access to a stable Wi-Fi connection and device for the interview

PROCEDURES

If you agree to be in this study, I wish to request you to answer questions pertaining to individual psychotherapy. The online interview will take approximately 45 to 60 minutes and will be completed via MS Teams or Zoom, depending on your preference.

If you are interested in taking part in this study or would like more information please contact me at wilmie.scholtz@gmail.com.

Your participation in the above-mentioned study will be greatly appreciated and will provide invaluable insights.

Appendix C

Information Letter

Faculty of Health Sciences
Department of Psychology
NMU (South Campus)
Researcher: Mrs Wilmie Heyneke
Tel: +27 (0) 60 506 5171
E-mail: wilmie.scholtz@gmail.com

Dear Participant

My name is Mrs Wilmie Heyneke and I am a Master's student in Psychology (Counselling) at the Nelson Mandela University (NMU). As part of my course, is the completion of a research project.

Factors Influencing Successful Psychotherapy Outcomes

The title of my study is *"Psychologists' perceptions of the growth and change promoting factors in psychotherapy within a culturally diverse South Africa"*. This research project aims to explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context. I would like to invite you to participate in this research. You were selected as a possible participant because of your background as a psychotherapist who is currently practising individual therapy with adults. Please read this form and ask any questions you may have before agreeing to be in the study.

Procedures

If you agree to be in this study, I wish to request you to answer questions pertaining to individual psychotherapy. The online interview will take approximately 45 to 60 minutes and will be completed via Microsoft Teams or Zoom, depending on your preference. The data collected will then be analysed and displayed in the findings section of the research.

Risks and Benefits of Being in the Study

The study has no risks and no direct benefits. Should you find the questions emotionally distressing in any way, debriefing will be arranged through Nelson Mandela University's Clinic (UCLIN).

Confidentiality

The records of this study will be kept confidential. There will be no identifying information on the transcription.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop your participation at any time. Your decision whether or not to participate will not affect your current or future relations with Nelson Mandela University (NMU). If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, the information that you provided will be destroyed.

Contacts and Questions

If you have questions, you may contact me at wilmie.scholtz@gmail.com.

Statement of Consent

If you have read the above information and your questions have been answered to your satisfaction, please complete the consent form to participate in the study.

Your participation in the above-mentioned study will be greatly appreciated and will provide invaluable insights.

Kind regards

Mrs Wilmie Heyneke
Primary Researcher
wilmie.scholtz@gmail.com

Prof Yaseen Ally
Research Supervisor
yaseen.Ally@mandela.ac.za

Appendix D

Consent Form

Faculty of Health Sciences
Department of Psychology
NMMU (South Campus)
Researcher: Mrs Wilmie Heyneke
Tel: +27 (0) 60 506 5171
E-mail: wilmie.scholtz@gmail.com

Dear Participant

If you have read the information letter and your questions have been answered to your satisfaction, please complete this consent form to participate in the study. The completion of this consent form will verify that you are aware of, understand, and agree to the terms and conditions of the research study.

RESEARCHER'S DETAILS	
Title of the research project	***Psychologists' perceptions of the growth and change promoting factors in psychotherapy within a culturally diverse South Africa***
Principal investigator	Mrs Wilmie Heyneke
Contact details	060 506 5171 wilmie.scholtz@gmail.com

DECLARATION BY OR ON BEHALF OF PARTICIPANT		**INITIAL**
I, the participant, and the undersigned (full names)		

HEREBY CONFIRM AS FOLLOWS		INITIAL
I, the participant, was invited to participate in the above-mentioned research project		
that is being undertaken by	Mrs Wilmie Heyneke	
from	the Department of Psychology	
of the Nelson Mandela Metropolitan University.		
Gender		
Race		
Category of Registration		
Years of Practice		
Years Of Working with Adult Clients in Individual Psychotherapy		

THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT				INITIAL
Aim	This research project aims to explore psychologists' perceptions of the growth and change promoting factors influencing successful therapeutic outcomes within a diverse South African context.			
Procedures	I understand that the questions will take approximately 45 to 60 minutes and will be completed online via Microsoft Teams or Zoom, depending on my preference.			
Risks and possible benefits	The study has no risks and no direct benefits.			
Confidentiality	My identity will not be revealed in any discussion, description, or scientific publications by the investigators.			
Voluntary participation / refusal / discontinuation	My participation is voluntary.	**YES**	**NO**	
	My decision whether or not to participate will in no way affect my present or future care/employment/lifestyle.	**TRUE**	**FALSE**	

I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT		
Signature of participant:		
Full name of participant:		
Signed/confirmed at	on	2021

Mrs Wilmie Heyneke
Primary Researcher
wilmie.scholtz@gmail.com

Prof Yaseen Ally
Research Supervisor
yaseen.Ally@mandela.ac.za

Appendix E

Interview Schedule

Dear Participant

Thank you for agreeing to participate in this study about psychologists' perceptions of the growth and change promoting factors that lead to successful outcomes in psychotherapy within the diverse South African context. Your contribution to this important research is invaluable. We appreciate your honesty and willingness to assist with this important research. Please answer the following questions. You are kindly requested to answer these questions openly, earnestly and to the best of your ability and to provide as much detail as possible. Please ensure that all questions are answered. If at any point in your participation in this study you would like to withdraw, please know that you are free to do so.

Name and Surname:
Gender:
Race:
Category of Registration:
Years of Practice:
Years Of Working with Adult Clients in Individual Psychotherapy:

1. In your own words, can you describe what the 'therapeutic alliance' means to you?

    1.1 Can you list and describe the factors that you believe contribute to the therapeutic alliance?

    1.2 How do you know when you have formed a therapeutic alliance?

    1.3 How long does it take to form a therapeutic alliance with a client?

    1.4 Can therapy be successful without a therapeutic alliance?

2. How do you measure success in therapy with a client?

2.1 When or how do you know a client has achieved their goal or therapy has been successful?

2.2 Do you measure success differently for different clients? Please elaborate.

3. What other factors do you believe contribute to successful therapy?

3.1 Is therapy more successful when a particular theory is used?

3.2 Do you use a particular type of theory when working with your clients? Please elaborate.

4. What characteristics do you believe clients look for in a therapist?

4.1 What are some of the skills and actions that therapists need to master to increase their effectiveness?

5. Does the client's belief system influence the outcomes of psychotherapy? Please elaborate.

5.1 How do cultural beliefs influence the way clients interpret the techniques you use to establish a therapeutic alliance? Please elaborate.

5.2 Do you find that often you have to adapt your approach? Please elaborate.

You have reached the end of the questions. Thank you once again for your participation in this study.

Kind regards

Mrs Wilmie Heyneke
Primary Researcher
wilmie.scholtz@gmail.com

Prof Yaseen Ally
Research Supervisor
yaseen.Ally@mandela.ac.za