PSYCHOTHERAPISTS' EXPERIENCES OF USING THE SEQUENTIALLY PLANNED INTEGRATIVE COUNSELLING FOR CHILDREN MODEL

Elsabé Nortje

DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

MAGISTER ARTIUM (CLINICAL PSYCHOLOGY)

in the

FACULTY OF THE HUMANITIES

DEPARTMENT OF PSYCHOLOGY

at the

UNIVERSITY OF THE FREE STATE

Supervisor: Dr. A. Botha

Co-supervisor: Dr. L. Nel

November 2016

DECLARATION

I, Elsabé Nortje, (2014132464) hereby declare that the dissertation *Psychotherapists' experiences of using the Sequentially Planned Integrative Counselling for Children model* submitted for the Magister Artium Clinical Psychology degree at the University of the Free State is my own independent work and has not previously been submitted to another university/faculty for assessment or completion of any other postgraduate qualification. I further cede copyright of the dissertation in favour of the University of the Free State.

_____ _____

Elsabé Nortje **Date**

PROOF OF LANGUAGE EDITING

LANGUAGE PRACTITIONING SERVICES

Anneke Denobili

BA (Communication Science), BA Hons (Communication Science)

2 Eloffstreet
Universitas, Bloemfontein

Tel: 084 244 8961
denobilia@ufs.ac.za

DECLARATION

I, Anneke Denobili, hereby declare that I edited the dissertation of Elsabé Nortje titled, *Psychotherapists' experiences of using the Sequentially Planned Integrative Counselling for Children model* for purposes of submission in fulfilment of the requirements for the degree Magister Artium in the Department of Psychology, Faculty of Humanities, at the University of the Free State. All changes suggested, including the implementation thereof was left to the discretion of the student.

Kind regards

Anneke Denobili

28 October 2016

ACKNOWLEDGEMENTS

"For every disciplined effort there is a multiple reward."

- Jim Rohn

I am blessed to have not done this on my own. I would like to thank the following people for their support throughout this journey:

- Dr. Anja Botha. Thank you for your patience, guidance, motivation and support. How comforting it was to know that there is indeed someone who reads every word I write. Thank you for being there for me every step of this journey - I am inspired.

- To my co-supervisor, Dr. Lindie Nel, thank you for your guidance and input over the past two years in shaping me as a psychotherapist. Your faith in me has impacted me in more ways than you will know.

- I would like to thank the participants for their time and commitment to help make this dream come true. Thank you for selflessly having allowed me to be a guest in your worlds.

- A mere 'thank you' to my parents will never suffice. I appreciate your unconditional support and continuous encouragement. I love you dearly.

- To my friends and colleagues, thank you for your support in sharing this experience with me. May we share many more.

- My beloved Jeandré, thank you for kind words, boundless cups of tea, and many nights of braaivleis. Thank you for always believing in me, for loving me the way you do, and for being my best friend.

Abstract

Every day, a large number of South African children are exposed to risk factors despite human rights assuming a prominent role in our country's constitution. Epidemiological studies indicate that approximately one in five children suffer from a mental disorder which often persists into adulthood. As mental health problems pose major risks for public health, childhood and adolescent mental health services assume a central role in reducing mental disorders. Early childhood intervention is therefore deemed essential and the need for therapeutic approaches to treat childhood mental disorders effectively have been highlighted.

The most contemporary notion in working with children therapeutically includes selecting from an array of practice methods in order to attain the best possible outcomes in the most economical way. An example of an integrative model that draws on various therapeutic approaches is the Sequentially Planned Integrative Counselling for Children (SPICC) model. This model integrates diverse theoretical frameworks and practical strategies belonging to various other well-established psychotherapeutic approaches with its associated theory of change. These approaches include Client-Centred Psychotherapy, Gestalt Therapy, Narrative Therapy, Cognitive Behaviour Therapy, and Behaviour Therapy. An extensive review of the literature on the SPICC model produced limited published articles on research conducted internationally; with no published articles in South Africa.

To fill the gap in the literature, the aim of this study was to explore and describe the experiences of South African psychotherapists using the SPICC model to counsel children. A qualitative multiple case study approach was chosen to elicit complex and rich descriptions made by the participants on their experiences of using the model. Three participants were recruited by means of purposeful sampling. Data was collected through individual research interviews and participants' reflections. From the data analysis six main themes emerged: 1) the SPICC model enhances psychotherapists' conceptualisation skills; 2) help clients faster; 3) the SPICC model requires and raises awareness of a therapeutic process; 4) the SPICC model enriches personal experiences; 5) the SPICC model's applicability within the South African context and 6) critique against the SPICC model.

By describing participants' experiences, this study aimed to address the paucity of South African research on using the SPICC model in child therapy. The insights gained from the research findings highlighted the SPICC model's applicability to the South African context, as well as its potential to be used by novice psychotherapists. The research findings have crucial implications for psychotherapists who counsel children, as well as higher

education professionals who can teach and supervise the SPICC model to students and novice psychotherapists.

Keywords: child counselling, SPICC model, childhood mental health, integrative psychotherapy, practice models

Abstrak

'n Groot aantal Suid-Afrikaanse kinders word daagliks blootgestel aan risikofaktore, ongeag menseregte wat 'n prominente rol in ons land se grondwet aanneem. Epidemiologiese studies het aangetoon dat ongeveer een uit vyf kinders aan 'n psigiese versteuring ly wat meestal tot in volwassenheid duur. Aangesien psigiese gesondheidsprobleme groot risiko's inhou vir openbare gesondheid, moet kinder- en adolessente geestesgesondheidsdienste 'n sentrale rol speel in die vermindering van psigiese versteurings. Vroeë kinderjare intervensie word dus as noodsaaklik gesien en die behoefte aan terapeutiese benaderings om psigiese versteurings tydens kinderjare effektief te behandel, word beklemtoon.

Die mees kontemporêre neiging tydens terapeutiese werk met kinders, sluit 'n wye reeks praktyk metodes in, wat ten doel het om die beste moontlike uitkomste op die mees ekonomiese manier te behaal. 'n Voorbeeld van 'n geïntegreerde model wat op verskeie terapeutiese benaderings geskoei is, is die *Sequentially Planned Integrative Counselling for Children* (SPICC) model. Hierdie model met sy verwante teorie van verandering, integreer diverse teoretiese raamwerke en praktiese strategieë wat gesetel is in verskeie ander goed-gevestigde psigoterapeutiese benaderings. Hierdie benaderings sluit in: Kliëntgesentreerde Psigoterapie, Gestalt Terapie, Narratiewe Terapie, Kognitiewe Gedragsterapie en Gedragsterapie. 'n Omvattende oorsig van die literatuur met betrekking tot die SPICC model het 'n beperkte aantal gepubliseerde artikels rakende navorsing wat oorsee uitgevoer is, opgelewer; met geen gepubliseerde artikels in Suid-Afrika nie.

Die doel van die studie was om die ervarings van Suid-Afrikaanse psigoterapeute wat die SPICC model gebruik tydens terapie met kinders, te verken en te beskryf ten einde hierdie gaping in die literatuur te vul. 'n Kwalitatiewe veelvuldige gevallestudie-benadering is gekies om komplekse en ryk beskrywings wat deur deelnemers gemaak word rakende hul ervarings in die gebruik van die model, te ontlok. Drie deelnemers is gewerf deur middel van doelgerigte steekproefneming. Data is ingesamel deur die individuele navorsingsonderhoude en die deelnemers se refleksies. Die data-analise het ses hooftemas opgelewer: 1) die SPICC model bevorder psigoterapeute se konseptualiseringsvermoë; 2) kliënte word vinniger gehelp; 3) die SPICC model bevorder en verhoog bewusmaking van 'n terapeutiese proses; 4) die SPICC model verryk persoonlike ervarings; 5) die SPICC model is van toepassing binne die Suid-Afrikaanse konteks en 6) die kritiek teenoor die SPICC model.

Die studie het met die beskrywing van die deelnemers se ervarings ten doel gehad om die tekort aan Suid-Afrikaanse navorsing rakende die gebruik van die SPICC model in terapie met kinders, aan te spreek. Die insigte wat verkry is uit die navorsingsbevindinge het die

toepaslikheid van die SPICC model in die Suid-Afrikaanse konteks beklemtoon, asook die model se potensiaal om deur beginner-psigoterapeute gebruik te word. Die navorsingsbevindings het indringende gevolge vir psigoterapeute wat berading met kinders doen, asook vir hoër opvoedkundige spesialiste wat die model aanbied vir studente en beginner-psigoterapeute, asook in hul supervisie daarvan.

Sleutelterme: berading met kinders, geestesgesondheid tydens kinderjare, geïntegreerde psigoterapie, praktykmodelle, SPICC model

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

LIST OF FIGURES

Chapter 1

1. General orientation to the study

The aim of this chapter is to orientate the reader to the research study. The first part of the chapter will focus on the research context, rationale, aim and questions. An overview of the research design and methodology will be discussed thereafter. The chapter will conclude with a brief summary of each subsequent chapter included in this study.

1.1 Research context

Childhood and adolescent mental health problems continue to be a global health challenge (Oh & Bayer, 2015) and research done on this topic in South Africa found that children with mental health disorders do not receive the necessary mental health care services (Flisher et al., 2012). The most contemporary notion when working with children therapeutically includes selecting from an array of practice methods to attain the best possible outcomes in the most economical way (Krueger & Glass, 2013; Krueger, Glass, & Arnkoff, 2011). Therefore, Geldard, Geldard, and Foo (2013) developed the SPICC model as an integrative model that draws on various therapeutic approaches. They argued that certain therapeutic approaches are more effective than others in achieving specific goals throughout the therapeutic process with children. The SPICC model thus integrates the use of well-established psychotherapeutic approaches with its associated theory of change to provide child counsellors with a short-term and cost-effective approach to therapy (Geldard et al., 2013).

1.2 Research rationale, aim, and questions

An extensive review of the literature on the SPICC model produced limited published articles on international research conducted on this topic; with no published articles in South Africa. In order to contribute to the knowledge on integrative therapy with children, the aim of this research study was to explore psychotherapists' experiences of applying the SPICC model in counselling children. To reach this aim, the following research question was explored: What are psychotherapists' experiences of applying the SPICC model in counselling children?

1.3 Overview of the research design and methods

A brief overview of the research design and methodology are discussed in this section. A more detailed and comprehensive discussion will be presented in Chapter 4.

The current research study is exploratory and descriptive in nature and a multiple case study approach was employed, based on an interpretivist paradigm (Merriam, 2009). This design enabled the researcher to explore and describe psychotherapists' personal experiences of using the SPICC model to counsel children.

Purposeful sampling (Yin, 2015) was used to sample participants for this study. Three female participants who have at least five years' experience in counselling children, and are trained in using the SPICC model, were recruited from the PhD Child Psychology database of the University of the Free State.

Data was gathered through individual research interviews and participants' reflections as collected objects. In order to explore the participants' experiences, a semi-structured interview schedule inclusive of open-ended questions (Mazanderani & Paparini, 2015) was used. The data was analysed through thematic analysis (Braun & Clarke, 2006) which uncovered and described the participants' experiences in rich detail.

Approval for this research was sought and obtained from the Research Ethics Committee of the Faculty of Humanities at the University of the Free State. Other ethical principles, such as autonomy and informed consent (Mertens, 2005; Pollock, 2012), non-maleficence and beneficence (Allan, 2008; Pollock, 2012), and confidentiality and anonymity (Greene & Hogan, 2005; Pollock, 2012) were also considered.

Trustworthiness was ensured by applying the principles of credibility, dependability, and confirmability, as proposed by Ryan, Coughlan, and Cronin (2007). The latter was achieved by means of triangulation, member checking, external audits, the keeping of a reflective journal on the research process, and eliminating research bias.

1.4 Delineation of chapters

The following section provides an overview of the seven chapters included in this report.

Chapter one. Chapter one is devoted to orientate the reader towards the research study. The chapter provides an overview of the research context, rationale, aim and questions, as well as the research design and methodology.

Chapter two. Chapter two consists of an extensive review on the existing literature on mental health in childhood, and specifically the need for effective childhood mental health

care services in South Africa. The chapter concludes with a discussion of integrative psychotherapy with children in order to address the aforementioned need.

Chapter three. Following the discussion in chapter two, chapter three focuses on the SPICC model as a tool to be employed when conducting integrative psychotherapy with children. The chapter provides an overview of the principles of the SPICC model, the model's theory of change, as well as a discussion on the principles of each treatment modality totalling the model.

Chapter four. This chapter consists of the research process, design, paradigm, and methodology. The sampling procedures of research participants, the data collection techniques, the process of data analysis, the ethical considerations, as well as the trustworthiness of the research is described.

Chapter five. The research results of this study are presented in chapter five. Main themes and sub-themes emerging from the data analysis are described and supported by verbatim quotations from the individual research interviews and participants' reflections. The chapter concludes with a summary of the main themes that have been discussed.

Chapter six. Chapter six discusses the themes presented in chapter five in relation to existing literature and research studies. Similarities and differences between the research findings and the objectives of the SPICC are pointed out and the findings are furthermore interpreted in the light of applying the model within the South African setting.

Chapter seven. Chapter seven concentrates on the most prominent research findings, strengths and limitations of the study, as well as recommendations for future research.

1.5 Chapter summary

The aim of this chapter was to orientate the reader towards the research study. It provided a brief overview on the context of the research, followed by the study's rationale, aim and research questions. A concise discussion on the research design and methodology followed by an outline of each chapter was also provided.

Chapter 2

Integrative psychotherapy to promote childhood mental health in South Africa

2.1 Childhood mental health

It is predicted that 30% of the global population have mental disorders, of which only one third receive treatment (Ravens-Sieberer et al., 2015). Ravens-Sieberer et al. (2015) found that 50% of these patients had the onset before the age of 15 and their research concluded that children are more likely to develop mental health problems between the ages of seven and 12 years. According to Lopez, Mathers, Ezzati, Jamison, and Murray (2006), mental disorders are expected to contribute to 15% of the global burden of disease by the year 2020.

A current health challenge for countries all over the world is the high incidence of childhood and adolescent mental health problems (Ravens-Sieberer et al., 2015). Globally, mental health problems affect one in five children with prevalence rates of up to 22% in preschool and school-aged children (Oh & Bayer, 2015). Less than a quarter of these children receive help from mental health professionals (Oh & Bayer, 2015; Oh, Mathers, Hiscock, Wake, & Bayer, 2014). This indicates that the promotion of childhood mental health remains weak regardless of the strong evidence of major public health risks as consequences due to the neglect thereof (Sawyer, Erskine, Sawyer, Morissey, & Lynch, 2015).

2.2 South African children

In mid-2014, children (under the age of 18) constituted 34% of South Africa's total population (Hall & Meintjies, 2016). According to Richter and Dawes (2008), a large number of these children continue to be exposed to risks daily despite human rights assuming a prominent role in our country's constitutional and legal framework. Epidemiological studies indicate that approximately one in five children and adolescents suffer from a mental disorder which often persists into adulthood (Flisher et al., 2012). Considering the aetiology of mental disorders, Cortina et al. (2013) argued that chronic adversity can be regarded as one of the greatest risk factors for children to develop psychological problems.

Stein et al. (2008) proposed various reasons which explain a high lifetime prevalence of psychiatric disorders, specifically in South Africa. These included stressors in South Africa such as racial discrimination, poverty, criminal violence, political violence, and high rates of

gender inequality. Other risk factors that increase South African children's vulnerability to develop mental disorders include HIV infection, substance abuse, and exposure to violence (Flisher et al., 2012). Liebenberg (2012) found that South African children are also vulnerable to various forms of negligence, exploitation, and abuse by adults and older children since they lack power and resources to challenge the violations of their rights. According to her, children are therefore exposed to inequality considering that their well-being is dependent on adult care and supervision (Liebenberg, 2012). Such inequality puts protective mechanisms for children under strain and places them at higher risk for developing psychological problems (Richter & Dawes, 2008).

The first national child homicide study established that 44,6% of child homicides occurred in the context of child abuse and neglect (Mathews, Abrahams, & Jewkes, 2013). According to Flisher et al. (2012), child abuse and neglect include physical and mental abuse, sexual abuse, exploitative work, and trafficking. The aforementioned study found that most child deaths occur at home. However, child abuse and neglect occur in various settings such as children's families, at school, in the community, and in statutory care (Flisher et al., 2012). Furthermore, the association between neglect and abuse with an increased risk for negative life factors led researchers to define neglect and abuse as a public health problem (Cambron, Gringeri, & Vogel-Ferguson, 2014).

Mathews et al. (2013) stated that child sexual abuse in South Africa is a widespread problem, especially considering that children often do not disclose abuse or that caretakers do not always act on their disclosure. Trauma associated with child sexual abuse is mainly psychological and can result in depression, anxiety disorders, substance abuse, and personality disorders (Maniglio, 2009; Mathews et al., 2013; Sorsdahl, Stein, Williams, Anthony, & Myers, 2015). Considering these foreseen consequences, it is noteworthy that South Africa strongly lacks availability of mental health care services for child victims of sexual abuse (Abrahams & Mathews, 2008; Mathews et al., 2013).

The lack of availability of mental health care services is indicative of South Africa's struggle with poverty. Regardless of being classified a middle-income country, South Africa's child poverty rates are remarkably high (Whitworth & Wilkinson, 2013). It has been reported that more than half of South Africans live below the poverty line, with 10% of South Africans living in extreme poverty; earning R15.85 per day (Writer, 2015). The latter is concerning, especially since countries with a lack of resources continue to neglect the topic of mental health, despite the fact that the poor are at greater risk of developing mental disorders such as depression and anxiety (Anakwenze & Zuberi, 2013; Komro, Flay, Biglan, &

Promise Neighborhoods Research Consortium, 2011; Plagerson, Patel, Harpham, Kielmann, & Mathee, 2011). In an article on the delivery of child and adolescent mental health services in South Africa, Flisher et al. (2012) emphasised the lack of attention devoted to the promotion of mental health (or the prevention of mental illness) as representative of the country's inadequate focus on these aspects.

The HIV endemic is another key risk factor for South African children. According to Shisana, Rice, Zungu, and Zuma (2010), a lot of South African children are affected by this health problem. The psychosocial impact of the HIV disease is a major stressor that may increase the prevalence of mental disorders (Myer, Smit, Roux, Parker, Stein, & Seedat, 2008). Children infected with HIV are more prone to develop severe mental illnesses such as depression, anxiety and substance abuse (Flisher et al., 2012; Rao, Sagar, Kabra, & Lodha, 2007). In turn, depression and anxiety disorders may cause the progression of the HIV disease (Myer et al., 2008) which creates a cycle of deterioration. Furthermore, children are psychologically indirectly influenced by HIV when living with infected family members. Infected mothers often develop depression, which results in their reduced parenting capability and impacts children's mental health (Cluver, Orkin, Garnder, & Boyes, 2012). Another adverse outcome of the HIV endemic include numerous children being orphaned as a result of infected parents or caretakers passing away; a concept referred to as AIDS-orphanhood. Cluver et al. (2012) found that one of the many negative psychological impacts of AIDS-orphanhood in South Africa are children experiencing internalising problems, such as depression and anxiety.

2.3 Childhood mental health care services

Early childhood years are known to lay the foundation for adult physical and mental health (Baker-Henningham, 2014). McDougall (2011) opined that mental health problems often go unnoticed and are generally only treated when they have become advanced. Childhood onset mental disorders have a high probability to persist into adulthood and pose various adverse effects and risk factors for other psychiatric disorders (Schmidt & Schimmelman, 2013). According to international research, untreated health problems in children lead to numerous poor outcomes which include poor educational achievement, family dysfunction, physical health problems, crime and antisocial behaviour (McDougall, 2011).

Despite individual and familial suffering, childhood mental health problems also impact numerous aspects of a country's society and economy irrespective of its level of wealth and

development (Insel, Collins, & Hyman, 2015). Poor childhood health has been proved to strongly correlate with poor physical health, low secondary education enrolment, substance abuse and violence (Huang et al., 2014). Other societal implications can include decreased productivity, increased costs in health care, demands on resources in criminal justice and welfare systems, and significant losses of human resources and economic potential (Havenaar, Geerlings, Vivian, Collinson, & Robertson, 2008; Ravens-Sieberer et al., 2015). Regardless of compromised economic development, these consequences also impact international resources (Huang et al., 2014). Globally, mental disorders are known to attract social stigma (Sawyer et al., 2015) which often results in caregivers overlooking children's mental health needs.

Although not all children have mental health problems, all children have mental health needs (McDougall, 2011; Patel, Flisher, Hetrick, & McGorry, 2007). The mental well-being of children should therefore be a key public health priority (Baker-Henningham, 2014; Cambron et al., 2014; Membride, McFayden, & Atkinson, 2015; Sawyer et al., 2015) with childhood and adolescent mental health services assuming a central role (Flisher et al., 2012; Sawyer et al., 2015). Considering that the onset of various mental health problems are in childhood, their enduring course, and the major risks posed to public health, early intervention is considered a preventative measure to ensure children's emotional well-being and positive outcomes later in life (Bakoula, Kolaitis, Veltsista, Gika, & Chrousos, 2009; Bhardwa, 2015; Flisher et al., 2012; Huang et al., 2014). The latter includes an improved life quality, increased life expectancy, improved social functioning, the prevention of co-morbid conditions, economic productivity, and a reduction in the negative impact of mental ill-health on life tasks accompanying the transition from childhood to adulthood (Kleintjies, Lund, & Flisher, 2010; McDougall, 2011).

Considering the progression and continuity of mental health problems (Bakoula et al., 2009), governments should focus on childhood mental health more strongly (Sawyer et al., 2015). The public health agenda should hence centre on promoting children's mental well-being by developing protective factors, reducing risk factors, focusing on the early detection of disorders and providing effective services for treating mental disorders (Kleintjies et al., 2010).

There is an emergent recognition of children with mental health problems that merit social and clinical intervention (Egger & Emde, 2011). Kieling and Martin (2013) stated that the increased interest in the forthcoming field of child and adolescent mental health is substantiated by the growing number of related journal articles. In addition to this, the

Movement for Global Mental Health (MGMH) emerged in 2007 with its purpose being the global expansion of the availability of services to people with mental disorders, particularly in low-income and middle-income countries (Lancet Global Mental Health Group, 2007).

In order to improve the availability of mental health care services to children and adolescents, South Africa made numerous legal and policy changes (Lund, Boyce, Flisher, Kafaar, & Dawes, 2009). The Mental Health Care Act (No. 17 of 2002) was the first effort to promote community-based mental health care services by terminating the apartheid legislation previously applicable to mental health care services. National Policy Guidelines for Child and Adolescent Mental Health were also developed (Department of Health, 2003).

However, despite the increase of young people using mental health services (Gearing & Charach, 2009), the prevalence of childhood mental disorders are not declining (Sawyer et al., 2015). This is a cause for concern, since it suggests the inefficacy of existing approaches to reduce childhood disorders (Sawyer et al., 2015). In highlighting the current physical, psychological, and socio-political effects of psychotropic interventions, Mills (2014) emphasised that the long-term use of psychotropic drugs is ineffective and harmful to children. This furthermore highlights the need for other approaches in treating childhood mental disorders effectively.

Children increasingly receive psychotherapy for mental disorders such as attention deficit hyperactivity disorder (ADHD), posttraumatic stress disorder (PTSD), anxiety disorders, and depression (Williams-Orlando, 2013). Although the development and evaluation of recent psychological treatments in children have generated several evidence-based interventions for mental disorders in children (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015; Ferrin et al., 2014; Schmidt & Schimmelman, 2013, 2015), the knowledge on child psychiatry is not yet sufficient to create evidence-informed judgments about psychotherapy for all mental disorders (Schmidt & Schimmelman, 2013).

2.4 Integrative psychotherapy

It has been accepted that the use of a variety of psychotherapy approaches is successful, and even the preferred choice of treatment, for treating an array of psychiatric disorders (Zarbo, Tasca, Cattafi, & Compare, 2016). An increase in the proposed use of an integrative approach to psychotherapy is evident in the increased number of practitioners joining the Society for the Exploration of Psychotherapy Integration (Zarbo et al., 2016). Increasingly more psychotherapists prefer to describe themselves as integrative or eclectic, opposed to identifying with a purist approach (Feixas & Botella, 2004; Zarbo et al., 2016). In a recent

survey on theoretical orientations, 85% of the participating clinicians indicated that they use an average of four different orientations in practice (Tasca et al., 2015).

The core of integrative psychotherapy lies in various theoretical orientations and approaches producing similar results (Barth, 2014). Feixas and Botella (2004) opined that the integrative psychotherapy movement aims to select theories and techniques from existing models to be used in a collaborative and integrative manner to foster a dialogue between various approaches. It therefore emphasises a flexible and comprehensive attitude toward various psychotherapy models (Greben, 2004) and is receptive to what other theoretical perspectives holds (Wampold & Imel, 2015; Zarbo et al., 2016). Zarbo et al. (2016) argued that integrative psychotherapy is effective, since it is both sensitive to a therapeutic alliance and flexible to various patients' needs. They furthermore added that psychotherapists and researchers increasingly agree that a purist therapeutic approach fails to be appropriate to all patients, problems and contexts. This is confirmed by evidence-based research that has concluded the efficacy of integrative treatments on various psychiatric disorders (Clarke, Thomas, & James, 2013; Hamidpour, Dolatshai, & Dadkhah, 2011; Kellett, 2005; Masley, Gillanders, Simpson, & Taylor, 2012; Miniati et al., 2014; Reay, Stuart, & Owen, 2003; Roediger & Dieckmann, 2012; Stangier, Schramm, Heidenreich, Berger, & Clark, 2011).

The theoretical, clinical and technical knowledge available on how to approach complex patients is limited (Castañeiras & Fernández-Álvarez, 2014). According to Castañeiras and Fernández-Álvarez (2014), complex patients experience complex dysfunction with a chronic course, adverse social circumstances, impairment in functioning, difficulties in adjusting, and being resistant to change. To clinically work with these patients, Fernández-Álvarez developed an Integrative Psychotherapy Model (Fernández-Alvárez, 2001). This model forms part of the movement toward theoretical integration and includes aspects such as psychodynamic, cognitive behavioural, humanistic existential and system theories (Castañeiras & Fernández-Álvarez, 2014). Lysaker and Roe (2012) also regarded the use of integrative psychotherapy useful in working with complex patients, especially those recovering from schizophrenia, as it assists them in regaining agency and a full sense of self. Edwards (2009) on the other hand, regarded integrative psychotherapy useful for working with patients with PTSD and Barth (2014) found the same to be true when working with patients with eating disorders. Ziv-Beiman (2015) highlighted the importance of being creative and flexible while conducting integrative psychotherapy with patients with complex symptoms. Furthermore, Harris, Kelley and Shepard (2015) found diverse treatments effective in integrative psychotherapy since the treatment addresses various aspects of a

problem on different characteristics of the client. They described their use of Multitheoretical Psychotherapy as an integrative approach which allows combining strategies from treatments that are already supported by research (Harris et al., 2015).

2.5 Integrative psychotherapy with children

There is an emergent use of integrative practices in working with children and adolescents, indicating its relevance as emphasised by Krueger et al. (2011). Despite an estimated 50% of child psychotherapists using a combination of techniques (Krueger & Glass, 2013), limited empirical research exist on integrative therapy with children (Krueger & Glass, 2013; Schottenbauer, Glass, & Arnkoff, 2005). The absence of a systematic review of integrative therapy with children to date might also explain the unknown inclusive scope of integrative psychotherapy approaches for children (Krueger & Glass, 2013).

In addition to the limitations of purist perspectives, Krueger and Glass (2013) regarded the integration of psychotherapy essential when treating children, since it offers psychotherapists opportunities to expand their conceptualisation of the child and allows for diverse interventions when addressing various problems. According to Sotskova, Carey, and Mak (2016), the integration of therapies increases the extent of interventions available and provides a theoretical framework that fosters the therapeutic components of acceptance and change. Krueger and Glass (2013) stated that most integrative treatment programs for children and adolescents are aimed at treating particular disorders such as traumatic stress, behavioural problems, ADHD and anxiety problems. The best developed integrative treatments are those designed for trauma, succeeded by treatments for behavioural problems (Krueger & Glass, 2013).

Some of the existing integrative models for treating children and adolescents include: Multimodal Treatment Strategy treatment of young children (Drell, 1992), a treatment model for treating children and families as proposed by Ellen Wachtel (2004), Active Multimodal Psychotherapy treatment of children and adolescents (Högberg & Hällsrtöm, 2008), Grehan and Freeman's (2009) integrative model for treating adolescents, and Trauma Focused Integrative Play Therapy (Gil, 2009). These models aim to purposefully integrate overarching theoretical paradigms in assisting psychotherapists with conceptualising patients and organising treatment (Krueger et al., 2011). However, despite the noticeable favourable outcomes of integrative psychotherapy, it is emphasised that "Research is needed to clarify how to combine or sequence existing interventions, and practitioners need better guidelines

for selecting the best possible treatment for a given individual" (Hollon, Thase, & Markowitz, 2002, p. 70).

According to Boswell, Casonguay, and Pincus (2009), novice psychotherapists lacking clinical experience have not established an effective approach to conceptualise cases and to plan treatment accordingly. Consequently, they might take a while before resorting to integrative psychotherapy as a result of discovering the limitations pertaining to a single treatment approach. Wolfe and Goldfried (1988) called for the training and supervision of integrative psychotherapists in order to ensure skill acquisition within this field. Accordingly, training directors are progressively supporting psychotherapy integration (Lampropoulos & Dixon, 2007) and as a result, graduate student trainees are increasingly subjected to integrative training early on in their professional development (Boswell et al., 2009; Lampropoulos, 2006). However, despite the existing integrative theories, there is a need for structuring the process and sequence of change for various kinds of patients (Wolfe, 2000). Therefore, Wolfe (2000) emphasised the need for a model used in the training of novice integrative psychotherapists, which illustrate how to organise the sequence of appropriate treatment interventions. He recommended that such a model should inform novice psychotherapists' decision making regarding "when to do what" (Wolfe, 2000, p. 235) by providing them with a framework of various treatment approaches that are conceptually integrated with an underlying theory which unifies the different treatment modalities.

2.6 Chapter summary

This chapter highlighted the importance of childhood mental health care, as well as the risk factors associated with South African children's vulnerability to develop mental disorders. The significant need for mental health care service delivery to South African children was subsequently emphasised. Therefore, an integrative approach to psychotherapy as a contemporary intervention to childhood disorders was included in the discussion. It was further highlighted that there is a need for a model that provides guidelines on how to integrate existing interventions. The following chapter will discuss the SPICC model as an integrative model that meets the abovementioned need.

Chapter 3

The SPICC model

Corresponding with the context of integrative models, and addressing the identified deficiency of integrative psychotherapy with children, Geldard et al. (2013) developed the Sequentially Planned Integrative Counselling for Children (SPICC) model. The model integrates diverse theoretical frameworks and practical strategies belonging to various other well-established psychotherapeutic approaches with its associated theory of change (Geldard & Geldard, 2009). These approaches include Client-centred psychotherapy, Gestalt therapy, Narrative therapy, Cognitive Behaviour therapy, and Behaviour therapy (Geldard et al., 2013).

Opposed to random integration of various approaches, the SPICC model's phases follow each other sequentially, producing therapeutic change and desired outcomes (Christie, 2007; Geldard et al., 2013). However, the appropriate transition between the stages is considered fundamental for therapeutic change to occur and for therapy to be effective. According to Geldard et al. (2013), the deliberate use of various theories in sequence, whilst conserving the respective theories of change, results in an "integrated theory of change" (p. 69). The latter can however be regarded as challenging considering a young psychotherapist's lack of experience in working with children and using the SPICC model (Geldard et al., 2013).

The prescribed conditions of an effective therapeutic process when employing the SPICC model include a trusting relationship, a safe space for the child's story to unravel, the use of appropriate media, opportunities and resources for meaningful play and suitable interventions or skills of the psychotherapist (Geldard et al., 2013). The ultimate goal of the model is to assist the child in acquiring new adaptive functioning skills. Once the child has resolved a problem in therapy, either the therapeutic process ends or a new cycle of the model starts in order to resolve something else. Considering that the child client is given the opportunity to experience one or more cycles of the model depending on the amount of presenting issues the child has to resolve, Geldard et al. (2013) refers to the SPICC model as a "spiral of therapeutic change" (p. 63). This unique quality indicates that the model is dynamic and process-driven with a brief solution-focused core, which is valuable considering the time constraints when working with children. Geldard et al. (2013) further proposed that

the SPICC model generally consist of 6-10 sessions; making it a brief and cost-effective therapeutic model significantly appropriate for use in counselling South African children.

3.1 Phase 1: Client-centred psychotherapy

The first phase of the model draws on client-centred counselling in order to connect with the child and to build rapport (Geldard et al., 2013). This enables the child to tell their story and to fully experience their feelings, while contained by the safety of the therapeutic relationship (Ward & Hogan, 2015). This empathic therapeutic relationship is expected to assist them in creating a positive internal working model of themselves, as well as their abilities in relationships, which results in them anticipating positive experiences in future relationships (Benedict, 2008). Characterised by an empathic and non-threatening relationship with the client, this approach conveys empathy, congruence and unconditional positive regard for a client (Rogers, 1951). The latter is the core conditions of constructive therapeutic change which have been widely researched and confirmed to ensure positive outcomes in therapy (Robinson, 2011).

The client-centred approach is widely used by psychotherapists and can be used separately or as a foundation for integrative psychotherapy (Kirschenbaum & Jourdan, 2005). Rooted in Rogerian client-centred therapy, and adapted to work specifically with children, non-directive play therapy or child-centred play therapy (CCPT) was developed to understand children from a developmental perspective (Wilson & Ryan, 2005). Thus, play is the primary mode of communication in CCPT (François, Powell & Dautenhahn, 2009), especially since children use play to learn and communicate in the world (Landreth, 2002; Piaget, 1962). In CCPT the child chooses the activities and types of play with carefully selected toys presented to him, and the psychotherapist progressively facilitates the child to spontaneously choose which emotions to focus on, as well as ways to explore these emotions (Ryan & Wilson, 1996). Rae (2012) considered the role of the psychotherapist and highlighted that professionals practicing CCPT should remain true to its well-established guiding principles as proposed by Axline (1947). These principles include:

1. Establish rapport by developing a warm, friendly relationship with the child.
2. Accept the child as he or she is.
3. Establish a permissive environment where the child can freely express his or her feelings completely.
4. Recognise and reflect the child's expressed feelings in such a way that the child gains insight into his or her behaviour.

5. Maintain a deep respect for the child's abilities to solve problems and consequently give the child the responsibility to make decisions and institute change.
6. Follow the child by avoiding directing his or her behaviour or conversation in any way.
7. Be patient with the gradual process and do not rush it.
8. Establish only necessary limitations as to anchor the therapy to reality, and to heighten the child's awareness of his or her own responsibility in the relationship (Axline, 1974).

CCTP is the approach most used by practitioners working with children (Lambert et al., 2007) and its effectiveness is demonstrated by its prosperous use with children from diverse populations (Bratton, Ray, Edwards, & Landreth, 2009). Another unique quality of CCPT is its principles which have been proven equally successful when practiced by either a mental health professional or a caregiver supervised by a professional trained in CCPT (Bratton et al., 2009).

In reaction to the critique against person-centred approaches being too individualistic in nature, and most probably unfitting for communalistic cultures (Kirschenbaum, 2004), Bratton et al. (2009) emphasised the need for CCPT psychotherapists to holistically view their child clients without having preconceived ideas of the child's reality. They furthermore highlighted that play therapists should be culturally responsive (practicing awareness of clients' cultural values and reality), which is evident in, for example, play materials that reflect cultural diversity. Despite research studies on the cross-cultural use of the CCPT, more research is needed on this topic (Bratton et al., 2009).

CCPT as a treatment modality has a strong international reputation (Ray, 2008) and is also the most extensively researched field (Bratton et al., 2009) despite small sample sizes of psychotherapy research lacking the generalisability of results (Ray, Bratton, Rhine, & Jones, 2001). According to Bratton et al. (2009), the strong research base of both meta-analytic and independent research studies infer that CCPT is an empirically supported treatment intervention for children with various problems. In conducting a meta-analysis of play therapy outcomes, LeBlanc and Ritchie (1999) summarised the results of 42 controlled studies and later concluded that the benefits of play therapy seemingly increase with the inclusion of parent involvement in the therapeutic process (LeBlanc & Ritchie, 2001). The largest meta-analysis on play therapy outcome research was conducted by Bratton, Ray, Rhine, and Jones (2005), who reviewed 180 documents dated from 1942 to 2000 on the efficacy of play therapy. Drawing from 93 studies, they found that children who receive play therapy interventions performed above children who did not receive these interventions.

Furthermore, these interventions had a moderate to large positive effect for children with internalising, externalising, and combined-type problems (Bratton et al., 2005).

Little research has been published on using CCPT in integrative psychotherapy with children. Josefi and Ryan (2004) remarked on the integration of non-directive play therapy and behavioural treatments, stating in their case study on treating children with autism that these two approaches complemented each other well. Ultimately it enabled them to provide clients with a more holistic treatment. However, research on a larger scale is needed, in order to replicate their research findings and to better inform integrative treatment modalities (Josefi & Ryan, 2004).

3.2 Phase 2: Gestalt therapy

The principles of Gestalt therapy focus on viewing a person holistically (Botha & Dunn, 2009) and originated from the German word *Gestalt* which means complete or whole (Corey, 2013). Gestalt therapy was originally developed by Frederick Perls and Laura Perls and it regards an individual to be in an on-going relationship with the environment (Corey, 2013). With reference to the mentioned relationship, Corey (2013) regarded the main aim of Gestalt therapy as enhancing a person's awareness of what they are experiencing in the present moment. This awareness ultimately allows them to get in touch with their strong emotions and allows for catharsis to occur (Christie, 2007).

Gestalt techniques therefore centre on drawing a client's focus to their experience of the present moment (Reilly & Jacobus, 2009). In order for a child to fully experience the present moment, Gestalt therapy activities include sensory-motor, emotional and cognitive aspects (Yontef, 1993). Awareness allows children to gain knowledge on who they are, emotions that they feel, and what they need and desire (Oaklander, 1992).

In addition to non-directive play therapy used in the first phase of the SPICC model, the second phase of Gestalt therapy also uses play as a powerful tool that allows children to experiment with their world and ways of being, and to symbolically convey their experiences (Oaklander, 2001). Oaklander (2001) further suggested that Gestalt therapy techniques for children might include the use of graphic arts, drawing, painting, making a collage, clay activities, music, dramatics, using of senses and bodily experiences, games, books, storytelling, sand tray, fantasy, and imagery.

Gestalt therapy has been used to treat various mental disorders, including schizophrenia (Dobson, Burley, Cook, & Haerich, 2015; Greenberg, 2015), chronic illness (Barlow, 2016), trauma (Taylor, 2014), PTSD (Butollo, Karl, König, Hagl, 2014; Cohen,

2003), abuse (Imes, Clance, Gailis, & Atkeson, 2002), and mood disorders (Van Baalen, 2010; Williams, 2010). According to Van Baalen (2010), Gestalt therapy proved to be effective in quickening recovery, maintaining stability, and delaying relapses in the treatment of clients with Bipolar Disorder. Furthermore, the cost-effectiveness of this therapeutic intervention is also an important aspect to consider, since Gestalt therapy interventions in his case study were costly (Van Baalen, 2010).

Qualitative assessment at the onset of Gestalt play therapy is essential to gather ample information of the child client and to strengthen the therapeutic relationship of trust (Botha & Dunn, 2009). Botha and Dunn (2009) identified a shortcoming with regards to Gestalt assessment tools used in therapy with children. The existing assessment tools are inadequate (Potgieter, 1996), as it consist of highly structured and standardised tests that provide only a framework for observation (O'Connor & Ammen, 1997). According to Botha and Dunn (2009), existing assessment tools such as incomplete sentences, questionnaires, drawings and the rose technique, and projective techniques are inappropriate for assessing younger children specifically. These tools are not enjoyable to children, do not provide a holistic view of a child client, often lengthen the therapeutic process, and do not consider the goals of Gestalt play therapy. Consequently, the use of a board game to assess children was suggested, as it addresses the aforementioned limitations and moreover combines various areas of assessment, for example social abilities and emotional intelligence (Botha & Dunn, 2009).

A limited number of research articles published on the effectiveness of employing Gestalt therapy interventions and techniques with children exist. The majority of published articles on Gestalt therapy focus on explaining Gestalt theory and its underpinning principles. Wagner-Moore (2004) summarised the latter by stating that Gestalt theory, although clearly defined in literature, holds poorly substantiated beliefs. According to her, this disconnection between theory and research causes the study of Gestalt theory to be confounding (Wagner-Moore, 2004).

Therefore, various academics have recently called for increased attention to critical research efforts in Gestalt therapy (Brownell & Melnick, 2008; Frew, 2013; Gold & Zahm, 2008; Greenberg, 2008). One possible explanation for the deficiency of research on Gestalt therapy might be the notion that the 'whole' of Gestalt therapy can be greatly compromised by the use of quantitative research methodologies (Frew, 2013). According to Frew (2013), various research methods exist that are considered compatible with Gestalt therapy. These can include, for example, extensions of literature studies, qualitative research, single case studies, process-orientated and common factor research. He furthermore advocated that

Gestalt therapy should be as alive in research as it is in tertiary educational institutions (Frew, 2013).

3.3 Phase 3: Narrative therapy

The third phase of the SPICC model is based on Narrative therapy with the aim to assist a child in changing their view of themselves through narration (Geldard et al., 2013). The assumption is thus that human experiences are organised and interpreted through stories (Hutyrová, 2016). Narrative psychotherapists typically use specific expressive language to edit and recreate a client's prevailing story to an alternative and more preferred story that includes previously ignored aspects of the client's experiences (Chen, 2012).

The most common techniques to achieve the aforementioned include externalisation of the problem, deconstruction, and authorisation (Hutyrová, 2016). Ramey, Tarulli, Frijters, and Fisher (2009) defined externalisation as the act of using language to locate problems outside of oneself; to separate the person from the problem. Naming, objectifying, and personalising a problem are all aspects of externalising a problem or aspects thereof (Ramey et al., 2009). Deconstruction entails the identification of gaps and inconsistencies in order to recreate the narration (Hutyrová, 2016). Authorisation on the other hand, refers to the integration of the new narration on a personal level (Hutyrová, 2016).

Narrative therapy is known to be effective when working with children and adolescents (Ricks, Kitchens, Goodrich, & Hancock, 2014) since it acknowledges the child client as the expert of their own life (Scaletti & Hocking, 2010). Child psychotherapists are increasingly using a Narrative approach to facilitate communication which consists of both verbal and non-verbal techniques (Ricks et al., 2014; Scaletti & Hocking, 2010). Storytelling, being familiar to children from all cultures and circumstances (Burns, 2005), therapeutically serves to aid problem resolution by rewriting internal stories (Waters, 2011). It can also be regarded as a playful approach that distances the problem from the child's identity (Turns & Kimmes, 2014) and ultimately empowers the child to face a problem perceived as less threatening (Freeman, Epston, & Lobovits, 1997). Stutey, Helm, LoSasso, and Kreider (2015) highlighted the value of the use of play therapy in a Narrative approach as it allows the child to convey their emotions in their native language of play at their own pace and to ultimately gain control over these emotions. Similar to this, Bennett (2008) proposed techniques such as puppet work, dollhouse play, sand play, drama, and art therapy when working with children.

Considering its flexibility, a Narrative approach is regarded suitable for individual psychotherapy, family therapy, and group therapy (Chen, 2012). Narrative therapy also

appears to be valuable when integrating different treatment modalities. In an article on integrative psychodynamic treatment, Sanchez and Shallcross (2012) illustrated their use of various treatment modalities in treating a client with anxiety and depression. In considering the need for shorter term therapy given the time constraints, they integrated focused psychotherapeutic techniques into a psychodynamic approach which included Narrative therapy and cognitive-behavioural therapy techniques. The integration of theoretical perspectives allowed them to establish a sense of safety for the client, to build a therapeutic alliance with the client, and for the client to experience initial symptom relief (Sanchez & Shallcross, 2012). Waters (2011) specifically recommended the integration of Narrative and Behavioural therapy and stated that a behavioural approach compliments the rewriting of internal stories as it focuses on altering external environmental factors and behaviours. The integration of Narrative and Behavioural approaches are especially suitable when working with young children who display attention-seeking behaviour (Waters, 2011).

Hutyrová (2016) also recommended a Narrative approach in working with children with behaviour problems, as the separation of the child's negative behaviour from the child unlocks a repertoire of intervention strategies which results in desired change to positive behaviour patterns. Furthermore, Narrative therapy is known to be utilised in the family counselling field (Etchison & Kleist, 2010) and has proven to be effective in, for example, reducing parent-child conflicts (Besa, 1994) and promoting personal agency in family members (St. James-O'Connor, Meakes, Pickering, & Schuman, 1997). According to Gwozdziewycs and Mehl-Madrona (2013), Narrative treatment methods are effective since it allows for short-term and cost efficient therapy. In a meta-analysis, reviewing of all qualitative studies associated with Narrative exposure methods used to treat trauma or PTSD in refugees confirmed the effectiveness of Narrative therapy (Gwozdziewycs & Mehl-Madrona, 2013).

Criticisms against Narrative therapy include: isolation (not willing to open itself to other traditions) (Crago & Crago, 2000), emphasising individual psychology (denying the importance of the family and ultimately systemic intervention) (Flaskas et al., 2000), imposing its own language (Flaskas et al., 2000) by avoiding uncomfortable realities (Crago & Crago, 2000), and it is regarded as ethically superior to other treatment modalities (Hayward, 2003).

Despite a noticeable appeal of Narrative therapy as a treatment modality, research on its effectiveness is scarce (Etchison & Kleist, 2000). According to Neimeyer (1993), this limitation is ascribed to the contemporary emergence of constructivism as a clinical and

empirical paradigm. In addition, McLeod (2014) encouraged Narrative psychotherapists to be open to wider fields of counselling and psychotherapy research in order to ultimately promote Narrative psychotherapy research.

3.4 Phase 4: Cognitive Behaviour therapy

The fourth phase of the SPICC model involves strategies from Cognitive Behaviour Therapy (CBT) which assist a child with getting in touch with their thoughts and behaviours, and deal with self-destructive beliefs. The CBT model (which follows a cognitive approach) suggests that one's thoughts influence one's beliefs, which consequently influence one's emotions and behaviours (Beck, 1995). Hence, disturbances of emotions and behaviours are rooted in maladaptive thought patterns. Subsequently, CBT aims to change these negative thought patterns in an attempt to change the client's emotions and behaviours (McDougall, 2011; Seligman & Ollendick, 2011). In learning to change self-destructive and unhelpful beliefs, attitudes, thoughts and ideas, the child client is less likely to repeat past maladaptive behaviours that result in emotional distress (Geldard et al., 2013).

Some of the main components of CBT in achieving the aforementioned aims include cognitive restructuring, skills development (for example, mindfulness, social skills, and problem solving techniques) and exposure training (Lyneham & Rapee, 2005; Sawyer & Nunez, 2014). According to McDougall (2011), a combination of these strategies is effective in treating individual children, groups or families. He furthermore stated that the use of CBT at a group level is beneficial, as participants share solutions and identify with each other (McDougall, 2011).

CBT is widely known as an evidenced-based psychological treatment for various childhood mental health disorders (Gearing, Schwalbe, Lee, & Hoagwood, 2013; McDougall, 2011; Powers, Jones, & Jones, 2005). Validated by standardised trials, CBT as a treatment modality dominates current psychotherapeutic practices (Hurley, Barrett, & Reet, 2006; Yontef & Jacobs, 2007). McLeod (2014) argued that research results which support the effectiveness of CBT should be considered carefully, since systematic reviews are likely to favour CBT when comparing its effectiveness to other treatment modalities considering that more research is conducted on the effectiveness of CBT. However, research comparing the effectiveness of CBT and other therapeutic approaches does not favour CBT (McLeod, 2014). Nonetheless, CBT has proven to be effective in treating children with autism (Van Steensel & Bögels, 2015), depression (Arnberg & Öst 2014), ADHD (Dobson, 2009; Mirnasab & Bonab, 2011), trauma (Feather & Ronan, 2010; Scheeringa, Weems, Cohen,

Amaya-Jackson, & Guthrie, 2011), and anxiety disorders (Gearing et al., 2013; Miller, Short, Garland, & Clark, 2010; Normann, Lønfeldt, Reinholdt-Dunne, & Esbjørn, 2016; Sawyer & Nunez, 2014; Urao et al., 2016; Van Steensel & Bögels, 2015; Vigerland et al., 2013).

Despite abundant research conducted on CBT as a treatment modality, countries worldwide are increasingly recognising the need for the development of CBT programmes and studies on its effectiveness as preventive educational material (Miller et al., 2010; Urao et al., 2016). 'FRIENDS' is a well-known universal-level CBT program used for preventing anxiety and depression in children, as recommended by the World Health Organisation since 2004 (Urao et al., 2016). Its efficacy in specifically working with anxious children has been researched and highlighted extensively (Barrett, Duffy, Dadds, & Rapee, 2001; Jongerden & Bögels, 2015; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Marriage & Henderson, 2012; McLeod et al, 2014; Sawyer & Nunez, 2014; Van Steensel & Bögels, 2015; Vigerland et al., 2013). However, Sawyer and Nunez (2014) found that many anxious children do not receive the evidence-based treatment they need. Possible barriers can include time constraints, unaffordability of treatment, unfeasibility of providing CBT in psychiatric settings, and long waiting lists of clients (Owens et al., 2002; Sawyer & Nunez, 2014). Sawyer and Nunez (2014) suggested that these barriers be addressed by employing affordable CBT programs with brief sessions and fewer visits. In order to specifically address childhood issues, Geldard et al. (2013) proposed incorporating techniques from Ellis's Rational Emotive Behaviour Therapy (Dryden, 1995), as well as Reality Therapy (Glasser, 2000).

3.5 Phase 5: Behaviour therapy

The fifth and final phase of the SPICC model draws on Behaviour therapy to help the child client experiment with and rehearse new behaviours (Geldard & Geldard, 2009; Geldard et al., 2013). Maladaptive cognitions and behaviours are identified and modified through a psychotherapist working collaboratively with the client (Powers et al., 2005). It is through the use of Behaviour therapy techniques that the child engages in new behaviours to extinguish old behaviours (Geldard et al., 2013). In this phase, the child is encouraged to rehearse new behaviours within the counselling setting and experiment with it to acquire new adaptive skills. According to Geldard et al. (2013), it can be assumed that the child will generalise new skills to their wider social environment and ultimately acquire more adaptive functioning.

There exists ample empirical evidence on the effectiveness of behaviour modification techniques to alter children's behaviour (Baer, 1962; Engeln Knutson, Laughy, & Garlington,

1968; Penn, 1978; Ross, 1974; Valero-Aguayo, Ferro-García, Kohlenberg, & Tsai, 2011; Williams, 1959). Research conducted by Gates, Newell, and Wray (2001) found that training for parents in the application of behaviour modification will result in improvement of their children with learning disabilities. In their study, parents who attended workshops on behaviour modification had less visits to their general practitioner compared to parents who did not attend the workshops. This suggests that behaviour modification workshops equip parents with amendable strategies to use in the family home. These research findings therefore further suggest that parental involvement might benefit a child's engagement in a therapeutic process (Gates et al., 2001).

3.6 Chapter summary

The SPICC model offers a brief therapeutic intervention which results in positive outcomes for children by moving sequentially through subsequent phases informed by the principles of Client-centred psychotherapy, Gestalt therapy, Narrative therapy, Cognitive Behaviour therapy and Behaviour therapy (Geldard et al., 2013). Geldard et al. (2013) found this integrative model to enable children to deal with suppressed emotions, and it has often succeeded when other treatment programmes on Cognitive Behaviour and Behaviour therapy have failed. Furthermore, Christie (2007) emphasised the efficacy of the model and concluded that the SPICC model was found to be the most useful and effective model to treat a case of a child suffering from anxiety. The model's elective components provided an evidence-based system of intervention for the complex presentations of the case (Christie, 2007).

Chapter 4

Methodology

4.1 Research purpose, aim and question

An exhaustive review of the literature on the application of the SPICC model in counselling children produced very limited published articles (according to a search conducted on EbscoHost Database, 2 June 2016), with no literature on the application of the SPICC model in South Africa. In order to fill this dearth, the aim of this study is to explore and describe the experiences of South African psychotherapists using the SPICC model in counselling children, by exploring the following research question: What are psychotherapists' experiences of applying the SPICC model in counselling children?

4.2 Research design and paradigm

Research design. The researcher considered the main elements totalling the research design throughout the designing of the research study in order to strengthen the validity of the study (Yin, 2011). These elements include: the aim of the research, the theoretical paradigm, the context of the research, and data collection and analysis techniques (Durrheim, 2006). The research design served as a guiding framework to ensure that the research questions were addressed (Babbie & Mouton, 2001; Gelo, Braakmann, & Benetka, 2008) by connecting the research questions, collection of data and strategies for data analysis (Yin, 2011). The aim of this study and the research question has been stated in the previous section. The following section will include a discussion on the research paradigm and data collection and analysis methodology.

Research paradigm. A research paradigm guides a researcher's thinking and actions (Joubish, Khurram, Ahmed, Fatima, & Haider, 2011). As proposed by Houghton, Hunter, and Meskell (2012), the research paradigm enabled the researcher to link the aim of the research with the methods to achieve the aim. In an attempt to understand how participants interpret their experiences, this study typically employed an interpretivist research approach (Merriam, 2009). Interpretivism recognises that no one truth exists, rather reality is experientially based (Guba, 1990). The researcher therefore appreciated that reality differs for every person and thus for every participant. As this study aims to explore individuals' experiences, the researcher acknowledged the subjectivity related to interpretivism as stated

by Houghton et al. (2012). The researcher was also aware of how her own perceptions could influence the research in employing this approach.

In line with interpretive research (Shah & Corley, 2006; Taylor & Callahan, 2005), this study employed methods that aim to apprehend the participants' subjective experiences. Maree (2007) proposed that a researcher can only explore participants' subjective reality through interaction, for example by asking questions. Therefore, qualitative methodologies were most suitable as it entail an open-ended approach to inquiry that values rich and descriptive data to capture each individual participant's perception (Houghton et al., 2012; Howitt, 2010). Qualitative research has gained an increased acceptance in specifically counselling and psychotherapy research (Williams & Morrow, 2009). This study therefore employed a qualitative research approach to pursue a holistic and exclusive understanding (Khankeh, Ranjbar, Khorasani-Zavareh, Zargham-Boroujeni, & Johansson, 2015; Miller, 2010; Tewksbury, 2009) of the participants' subjective experiences of using the SPICC model to counsel children in South Africa.

Case study research. A case study is a qualitative research tool used to gain more information on a topic of which limited knowledge exists (Leedy & Ormrod, 2005). Therefore, this methodology was especially suitable for this study. Qualitative case study methodology is also known to be used in health and social sciences (Anthony & Jack, 2009; Luck, Jackson, & Usher, 2006; Stake, 1995; Yin, 2003), since it is a valuable tool to ensure rigor and flexibility of the research (Baxter & Jack, 2008). This study subsequently employed a qualitative case study methodology by means of an explorative and descriptive multiple case study.

An explorative case study has no fixed or set outcomes (Yin, 2003) and can be used to uncover the phenomena that exist in a certain field of interest (Raeburn, Schmied, Hungerford, & Cleary, 2015). This methodology allowed the researcher to uncover the participants' experiences of using the SPICC model in counselling children; without her having formed preconceived ideas of the findings or having had expected fixed outcomes. A descriptive case study aims to describe different aspects of a phenomenon in its real-life context (Baškarada, 2014; Yin, 2003) and can identify variances between individual cases (Gerring, 2004). In Chapter 5, the researcher aimed to describe the different aspects of the participants' real-life experiences of using the SPICC model, and to highlight differences between participants' experiences. A multiple case study design is regarded as compelling and vigorous and can be employed to address the same research question in numerous settings through the use of the same data collection methods and analysis for all settings

(Herriott & Firestone, 1983). Hence, the researcher used the same data collection methods and analysis for each participant. Using this design increased the study's reliability as the researcher could analyse within each setting, as well as across various settings (Baxter & Jack, 2008).

In conclusion, this exploratory and descriptive research is aimed at exploring psychotherapists' experiences of applying the SPICC model in counselling children. Studying this topic lends itself to an explorative and descriptive qualitative multiple case study approach based on an interpretivist paradigm.

4.3 Sampling procedures and research participants

Coyne (1997) and Suri (2011) emphasised the profound ways in which sample selection can influence the quality of the research. In a discussion on purposeful sampling, Schatzman and Strauss (1973) stated that the selection of participants should complement the aim of the research. Therefore, purposeful sampling of participants was most appropriate for this study. Thus, the researcher intentionally identified and selected participants who were able to contribute plentiful to the most relevant data (Yin, 2011).

The following process was followed to sample research participants. Firstly, research participants who were able to provide information-rich data were identified. These included psychotherapists who have experience in applying the SPICC model in counselling children. The research supervisor served as a key informant (Suri, 2011) in the field who helped to identify these participants. As a result, six female participants were recruited from the University's database of PhD Child Psychology students. These students have at least five years' experience in counselling children and are trained in using the SPICC model. Purposeful sampling therefore allowed for the selection of participants with specific experience and knowledge on the research topic. Three of these identified participants declined to participate; two gave no reason, and one felt that she was no longer a relevant person to interview as she never utilised the SPICC model after her training. Table 1 provides information on the research participants involved in this study.

Table 1: A summary of information on the research participants

Participant	Gender	Age
1	Female	43
2	Female	50
3	Female	37

Participant 1 is a 43-year-old registered counselling psychologist employed by a South African university where she lectures and supervises Psychology Master's M1 students, interns and colleagues. In her 13 years of practice she has been working with children, adults and adolescents with presentations ranging from full clinical disorders to adjustment issues. She is also involved with various community projects, such as protective behaviour workshops and group work in schools.

Participant 2 is a 50-year-old registered Educational Psychologist who has been practicing for approximately 14 years. The typical clients she sees in practice include children who suffer from anxiety or depression pertaining to school, children with learning disorders, and children with chronic illnesses. She also works as a supervisor for educational psychologist interns and psychometrists, and often gives presentations to learners, teachers, parents and allied professionals.

Participant 3 is a 37-year-old Counselling Psychologist who has been practicing for 10 years. Other than her Psychology qualifications, she holds a BA degree in Publishing, as well as a diploma in Higher Education. As a counselling psychologist she currently works with children and adolescents in a remedial school set-up.

Linking with qualitative inquiry, this study had a small sample size as participants were purposefully chosen to ensure information-rich data (Borbasi & Jackson, 2012; Ingham-Broomfield, 2015; Patton, 1990). Muth et al. (2016) stated that small sample size issues, amongst other factors, are unavoidable in psychological studies. Despite a small sample size, the intensity of data collection can still be strong (Cronin, 2014). With reference to sample saturation and the use of qualitative interviews, Mason (2010) justified the use of small samples by arguing that merely one manifestation of a piece of data or code is potentially as valuable as several when aiming to understand processes of a topic. This is due to qualitative research valuing meaning, opposed to frequencies (Dworkin, 2012; Mason, 2010). Onwuegbuzie and Leech (2007) stated that qualitative researchers generally study a small representative sub-sample of individuals, carefully chosen from a total sample of possible research participants. Such a small sample can be representative and suitable if appropriate sampling processes are followed (Romney, Weller, & Batchelder, 1986; Weller & Romney, 1988). This is also often used to enhance the depth of the research (Barnham, 2015). Because the aim of the study is ultimately what drives the project design, and consequently the sample size (Charmaz, 2006), a small sample is deemed appropriate for this study.

In order to answer the research questions of this study, a small sample size was unavoidable. Carefully considered sampling procedures were followed to sample relevant participants trained in using the SPICC model and who could provide rich and in-depth data on their experiences. Thus, the intensity of data collection was strong which is evident from the amount of pages of transcribed data (this will be discussed later in this chapter). Moreover, the use of participants' reflections as collected objects deepened the participants' engagement with the research and contributed to the depth of the collected data. Since the researcher valued meaning in this study, all data was regarded as valuable and this resulted in the initial generation of a vast number of codes.

4.4 Data collection techniques

Qualitative research methodology enables various different sources of data (Ingham-Broomfield, 2015). Qualitative research can therefore use, amongst others, interviews, observations and interactional and visual texts to produce descriptive accounts of experiences (Miller, 2010; Parkinson & Drislane, 2011). According to, and in line with, an interpretivist approach, this study used individual interviews and collected objects as forms of data collection.

Semi-structured interviews. Individual interviews are a recognised data collecting methodology in qualitative health research (Brinkmann & Kvale, 2005; Hewitt, 2007) and an essential source of evidence for case study research specifically (Yin, 2009). During a qualitative interview, the researcher aims to obtain the interviewee's knowledge of a certain phenomenon (Haahr, Norlyk, & Hall, 2014), and to "see the world through the eyes of the participant" (Maree & Van der Westhuizen, 2010, p. 87). The use of qualitative interviews thus ensures richness of the data and provides the researcher with opportunities of insight into the participants' experiences (Seidman, 2013), as was the case for this study. The chapter on the research findings constitute the biggest part of this research report and thus reflect the richness of the data gathered from the individual interviews. Furthermore, Chapter 5 includes multiple verbatim statements from the interviews in support of the participants' experiences.

Semi-structured interviews is seen as the principal methodology used in qualitative social science research (Mazanderani & Paparini, 2015) and can be defined as a "focused, yet conversational two-way communication with the participants" (Pathak & Intratat, 2012, p. 4). This type of interview is more flexible and follows a conversational mode to understand the interviewee's perspective (Daymon & Holloway, 2002; Yin, 2011). A researcher is therefore able to refocus questions and prompt for additional information (Baškarada, 2014). During

the interviews with the participants in this study, the researcher was able to probe for more information on specific topics based on the information provided by the participants. The conversational mode of the interviews, as proposed by Yin (2011), also made reciprocal interactions between the researcher and participant possible. The use of open-ended questions (Barnham, 2015) further facilitated participants' use of their own words in order to convey their personal experiences. It was also vital that the researcher listened intensively in an attempt to truly understand the participant's world and what they were communicating (Rubin & Rubin, 1995).

For this study, each research participant was interviewed once. To prevent the researcher from steering the conversation in a particular direction, an interview protocol (Appendix A) was used as recommended by Knox and Burkard (2009). The guiding principles provided by Patton (2002) informed the interview process and questions in the interview protocol. The interview consequently included questions such as "What was your experiences of applying the SPICC model in counselling children?", "What do you regard most challenging/rewarding of applying the SPICC model in counselling children in South Africa?", and "How would you describe the SPICC model?".

In preparation of the interviews, Patton (2002) was used as reference in order for the researcher to familiarise herself with the ethical aspects regarding interviewing research participants, information gathering, and the closing of the interview. All interviews used the same interview protocol.

Table 2: Summary of the individual interview sessions

Participant	Length of interview	Transcribed data
1	01:08:18	20 pages
2	57:54	17 pages
3	49:39	14 pages

Collected objects. In addition to the collection of data by means of semi-structured interviews, participants' reflections on their interviews served as collected objects. Collected objects represent an additional form of primary evidence and are regarded as an invaluable data collection technique as it compliments information obtained from the interviews (Murray, 2009; Yin, 2011). According to Murray (2009), collected objects can include objects produced directly by the participants. Upon completion of the interview, each

participant was requested to write a reflection on their experiences in the application of the SPICC model used to counsel children. These were sent to the researcher via e-mail within a week after completion of the interview.

Reflection has increasingly been acknowledged in various professional fields, including health science professions (Nguyen, Fernandez, Karsenti, & Charlin, 2014). Reflections in these contexts are a vital component of personal and professional learning. Following a systematic review of the major definitions of *reflection*, Nguyen et al. (2014) constructed their own definition: "Reflection is the process of engaging the self in attentive, critical, exploratory and iterative interactions with one's thoughts and actions, and their underlying conceptual frame …" (p. 48). According to Ng, Kinsella, Friesen, & Hodges (2015), reflective practices emphasise processes of professional consideration. More specifically, it provides different ways in which nuances within an activity can be understood (Yanow & Tsoukas, 2009). In addition to being used as a technique to foster a deepened understanding of a fundamental issue (Hickson, 2016), critical reflection can also be used as a research methodology (Morley, 2011). Participants' reflections as collected objects ultimately served to elicit their attentive and critical thinking on the ways in which they experience the application of the SPICC model. Reflection facilitates the organisation of information and the connecting of different concepts (Ramsden, 2003) to better understand a subject (Kane, Sandretto & Heath, 2004), and therefore the participants' deepened engagement with the research ultimately provided the researcher with richer data on their experiences.

4.5 Data analysis

Thematic analysis is a well-known data analysis method used in Psychology, health care and social research (Fugard & Potts, 2015) in order to uncover a "level of patterned response or meaning" in a set of data (Braun & Clarke, 2006, p. 82). The adherence to the guidelines of this method, as proposed by Braun and Clarke (2006), enabled the researcher to identify, analyse and report main themes and sub-themes. Fitting the interpretivist approach, thematic analysis is seen as a realist method to unravel the surface of 'reality' and reflect participants' experiences, meanings, and reality (Braun & Clarke, 2006). Therefore, to uncover participants' experiences of applying the SPICC model, and to consequently describe the data in rich detail, data gathered from the interviews and reflections as collected objects was analysed by means of thematic analysis. The steps in the data analysis process, as adapted from Braun and Clarke (2006, p. 87), are summarised in Table 3.

Table 3: The steps included in the data analysis process

Guidelines for thematic analysis	
Phase 1	Familiarise yourself with the data.
	Transcribe the data, read and reread the data, and note down ideas.
Phase 2	Generate initial codes.
	Code the interesting features of the data systematically and collect data relevant to each code (or meaning labels).
Phase 3	Search for themes.
	Collate the codes into possible themes and gather all the data relevant to each potential theme.
Phase 4	Review the themes.
	Level 1: Check if the themes work in relation to the coded extracts. Level 2: Generate a thematic 'map' of the analysis.
Phase 5	Define and name the themes.
	Continue the analysis to refine specifics of each theme, the overall story told by the analysis, and produce clear definitions and names for each theme.
Phase 6	Produce the report.
	This is the final opportunity for analysis; select vivid and convincing extract examples, do the final analysis of the selected extracts, and relate the analysis to the research questions and literature. Finally the report can be produced.

Considering that this study is guided by the interpretivist paradigm, the thematic analysis was conducted through the use of inductive reasoning. This approach is also known as 'bottom up' analysis, as the researcher works from specific information to more general conclusions (Burns & Grove, 2009; Jirojwong, Johnson, & Welch, 2011).

Phase 1: Familiarise yourself with the data. The first phase of thematic analysis entailed the transcribing of the interviews and reading through the data several times. Despite being time-consuming, the researcher did the transcribing of the interviews herself in order to develop an in-depth understanding of the data. Furthermore, the rereading of the data allowed the researcher to familiarise herself with the content. Thereafter, initial ideas on the data were noted down and recorded in a reflective journal.

Phase 2: Generate initial codes. During this phase, the interview transcriptions were reread and interesting features were systematically coded. Participants' statements often received multiple codes in order to code as many themes as possible, recognise different meanings of the data, and indicate the connections between codes. To generate codes, the researcher made use of her computer to tag and name selected text. Some of the necessary remaining data was kept in order to conserve the context in which the statements were made. Thereafter, data relevant to each code was collected to organise the various codes with representing data. The initial generated codes are listed in Table 4.

Table 4: A list of initial generated codes

Code number	Description of code
1	Aids in conceptualisation (structured, purposeful)
2	Logical plan to therapy
3	Enhances treatment planning (planning beforehand)
4	A good tool for beginner therapists
5	Clients' progression/movement
6	Clients are less resistant
7	Therapist doesn't feel stuck
8	Working towards an end goal (= change)
9	Requires/raises therapist's awareness
10	Stay with a client and monitor change
11	Enriches client's experience
12	Enriches therapist's experience (self-confidence)
13	Therapist can be creative
14	Modify the model (work with tweens, adolescents, adults)
15	Integrative over purist approach (benefits of integrative)
16	Address specific needs
17	Work holistically; address various of a client's needs simultaneously
18	Working with groups (& psycho-education, feedback)
19	I don't feel comfortable in using all 5 modalities (and adjusting model accordingly) / novice / cannot supervise model well
20	Model is unknown (new)
21	Other professionals might take a while before embracing the SPICC model's integrative nature (prefer purist)
22	Light weight
23	Applicable to SA (accessible, flexible, culturally sensitive, time saving, no resources)

Phase 3: Search for themes. The codes were reviewed, analysed and collated to construct possible overarching themes. Sub-themes were also identified. At this stage in the research, seven main themes and 17 sub-themes were identified. All the data relevant to each potential theme was gathered and organised thereafter.

Phase 4: Review the themes. This phase consisted of two stages. Firstly, the themes were reviewed to determine if it worked in relation to the coded extracts. Consequently, some of the data was rearranged to compliment the identified themes. Secondly, the themes were rearranged to ensure a logical flow of data. The latter resulted in six main themes and 14 sub-themes being identified.

Phase 5: Define and name the themes. Once a logical flow of the data was established, the themes were named to accurately represent the coded extracts. The names of the themes were also reviewed and adjusted to produce a clear definition of the theme. A table was constructed listing the themes and sub-themes, with complimenting statements from the participants which provided a clearer understanding in support of each main and sub-theme. The researcher's supervisors reviewed the table.

Phase 6: Produce the report. This phase provided a final opportunity for analysis (Braun & Clarke, 2006). The researcher selected vivid and convincing extract examples in support of each main and sub-theme by conducting the final analysis of the selected extracts and relating the analysis to the research questions. The analysis was supported by integrating complimenting literature and the report could finally be produced.

4.6 Ethical considerations

An essential aspect of planning and conducting the research was the continuous consideration and implementation of ethical principles guiding the research process (Allan, 2008; Mertens, 2005). Approval for conducting this research was sought and obtained from the Research Ethics Committee of the Faculty of Humanities at the University of the Free State. Other ethical principles that were considered include autonomy and informed consent, non-maleficence and beneficence, and confidentiality and anonymity. These principles are discussed below.

Autonomy and informed consent. To respect the research participants' autonomy (Mertens, 2005; Pollock, 2012), participation was voluntary and informed consent was given by each participant. However, participants had the right to withdraw from the research process at any given time. Broome and Stieglitz (1992) defined informed consent as an interactive process whereby the researcher and participant discuss all aspects of the proposed

research activity, followed by the participant's voluntarily expression of a desire to participate. All participants were informed on the purpose of the study, the proposed methods used in the study, and the demands of participating in the research. As prescribed by Allan (2008), participants were given the opportunity to ask questions and give informed consent to participate afterwards. They were also informed about their participation being voluntary, that they were under no obligation to take part in the study, and had the right to withdraw from the research at any given moment.

Non-maleficence and beneficence. Pollock (2012) emphasised that research should be beneficial for the broader community and should not cause any harm. The researcher's intention is to use the produced research findings of this study to inform practices of counselling children in South Africa and thus benefiting the broader community. Confidentiality and anonymity ensured the protection of individual privacy and identity, subsequently causing no harm to research participants.

Confidentiality and anonymity. Confidentiality is regarded as a means of protecting participants from adversities resulting from participating in the research process (Pollock, 2012). Promotion of confidentiality ensured participants' anonymity throughout the research process. Ensuring privacy was a continuous priority and each participant received a correlating number to be referred to when reporting on the research findings, for example *Participant 1*, and their personal information will not be revealed in research reports or presentations, as proposed by Greene and Hogan (2005). Confidentiality in this study also applied to the participants' clients, to which they referred to at times when speaking about their experiences of applying the SPICC model in practice. Since the participants are registered psychologists, they were aware of client-confidentiality and consequently never revealed any of their personal information.

4.7 Trustworthiness

Applying the principles of credibility, dependability, and confirmability ensured the trustworthiness of this research (Ryan et al., 2007).

Credibility. Credibility refers to how well the data analysis processes compliment the proposed focus of the research (Polit & Hungler, 1999). Increasing the credibility of the research (Patton, 1987) included identifying participants with knowledge and experience on applying the SPICC model to council children. The most appropriate methods and techniques of data collection, as proposed by Graneheim and Lundman (2004), were used to establish the research credibility.

Further promotion of the credibility of the research involved following three steps, as suggested by Pitney (2004). Firstly, triangulation entailed employing multiple data collecting strategies which included individual interviews and participants' reflections as collected objects. According to Pitney (2004), the cross-checking of information and findings is a way of obtaining rich and accurate understandings of the phenomenon being studied. Secondly, member checking included rephrasing of participants' answers in order to verify the initial meanings. According to Chang (2014), member checking promotes participants' active participation in the research process as it provides them with the opportunity to assess the researcher's interpretations, to rectify misinterpretations, and to volunteer additional information that has been stimulated by the process of member checking. Lastly, external audits were conducted by the researcher's supervisors to validate and verify the researcher's findings. According to Maree and Van Der Westhuizen (2010), this practice also serves as a form of peer review.

Dependability. Lincoln and Guba (1985) defined dependability as seeking "means for taking into account both factors of instability and factors of phenomenal or design induced changes" (p. 299). Graneheim and Lundman (2004) highlighted the importance of being aware of possible changes in the research over time, as well as consequent alterations to decision-making processes. Keeping a reflective journal on the research process, as proposed by Ryan et al. (2007), ensured dependability. The decisions made throughout the research process were also continuously discussed with the researcher's supervisors to ensure an informed decision-making process. Offering evidence in the presentation of how interpretations fit the data can also ensure the integrity of the data (Williams & Morrow, 2009). The latter was accomplished by means of including verbatim statements which demonstrated how the researcher concluded the interpretations. According to Merriam (2009), the employment of techniques to promote the credibility of the research also contributes to the dependability of the research. The credibility techniques employed in this study were discussed in the previous section.

Confirmability. Promotion of confirmability (Cope, 2014; Shenton, 2004) entailed exemplifying the participants' responses represented in the data, rather than the researcher's own viewpoints or biases. Merriam (2009) suggested that the researcher clarifies all pre-assumptions in order to clear researcher bias. Research bias in this study included the preconceived idea that the SPICC model can be applied effectively to counsel children in South Africa. According to Maree and Van der Westhuizen (2010), the problem of bias can be remedied if the researcher is constantly aware of it. The researcher's constant self-

awareness was promoted by keeping a reflective journal and continuously receiving feedback from her supervisors. Rich statements from the participants illustrating emerging themes, were included in the reported research findings. According to Merriam (2009), the analysis of the data should carefully consider the context in which these statements were made to prevent not forcing any interpretations in the text onto the reader.

4.8 Chapter summary

This chapter included discussions on the research paradigm, design, and methodology (including data collection techniques and data analysis processes) applied in this study. Ethical considerations and ways of increasing the trustworthiness of the research were also included. The research results will be discussed in the next chapter.

Chapter 5

Research findings

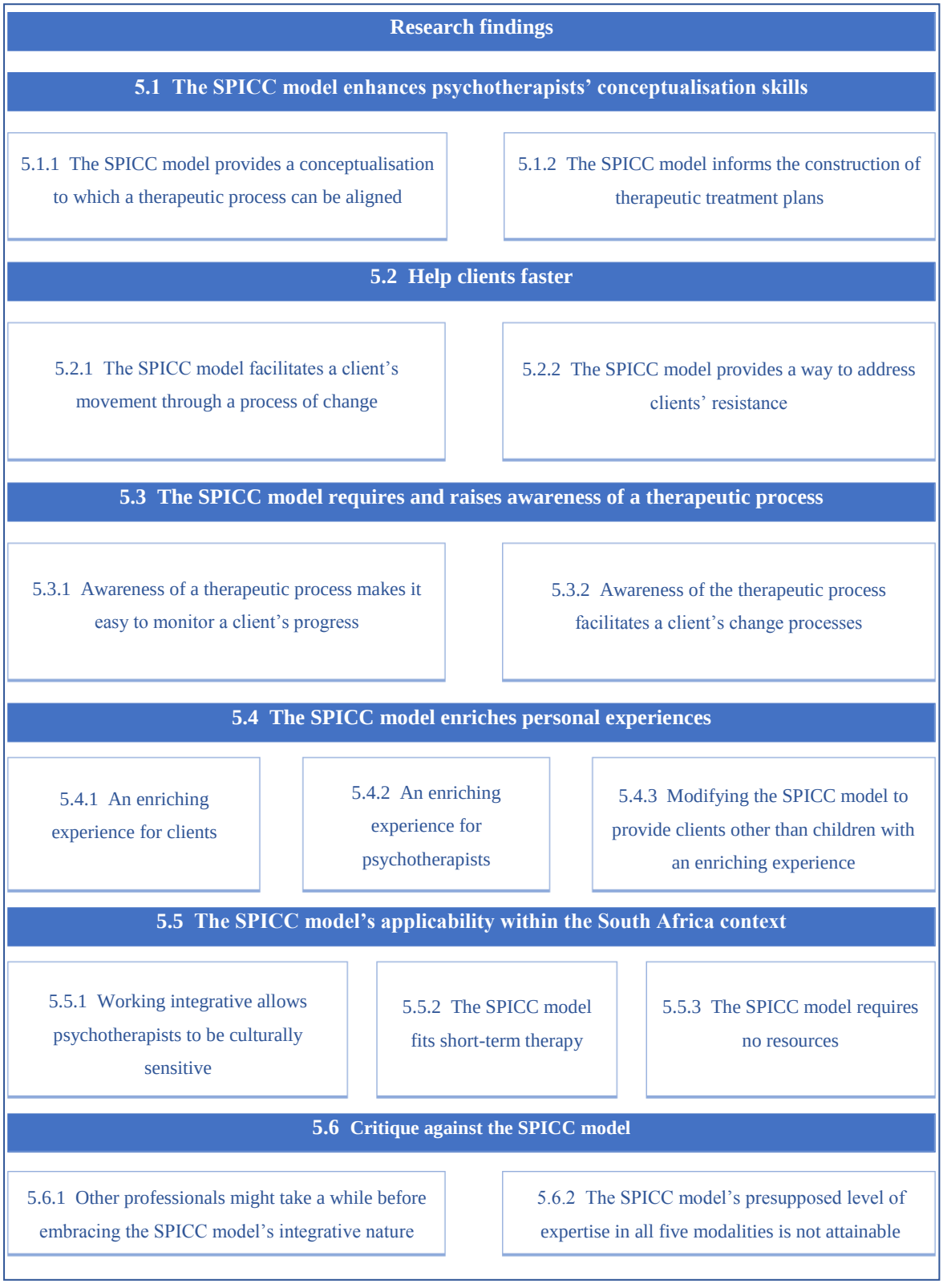

Figure 1. Visual display of research findings

This chapter includes the themes that emerged from the interviews and reflections (see Figure 1). Using participants' direct statements, the researcher arranged their experiences of using the SPICC model into themes. This final phase of data analysis produced six main themes and 14 sub-themes, which will subsequently be discussed. In order to substantiate the themes, and ultimately promote the credibility of the research, participants' direct statements form part of the discussion. Dotted lines … indicate omitted information and square brackets [ ] indicate added information.

5.1 The SPICC model enhances psychotherapists' conceptualisation skills

This theme included participants' descriptions of the SPICC model's sequential integration of various treatment modalities as easy to understand, since it complements the process of change during a therapeutic process. As a result, the model provides participants with a conceptualisation of both the client and the therapeutic process. Participants stated that they are now able to align their therapeutic processes to the conceptualisation provided and ultimately develop a good treatment plan. The use of the SPICC model also enabled Participants 1 and 2 to plan their therapeutic processes towards an end goal.

5.1.1 The SPICC model provides a conceptualisation to which a therapeutic process can be aligned

Participants reported that the SPICC model informs their understanding of the course of a therapeutic process. In addition to combining various treatment modalities, the SPICC model's integration of these modalities is "*structured*" (Participant 2) and purposeful (Participant 1). This is illustrated in the statement of Participant 1: "[the model has] *a nice combination of a variety approaches but it's also got quite a solid understanding of why you would be implementing each of them at various points*". Both Participants 2 and 3 described how the integration of different modalities follows a logical order which complements the course of therapy. Participant 2 explained that the model "*integrates* [various modalities] *very nicely; moving from building the rapport to getting through the emotions to the narrative, then the cognitions, and then the behavioural changes*". Participant 3 similarly noted: "*the integrated approach facilitates a logical flow of what happens in therapy. I don't know of another model that is so logical*". Since the model's structured integration of modalities is "*really straight forward*" (Participant 2), Participant 2 regarded the flow of the model, and consequently the flow of the therapeutic process, as easy to understand.

The participants reported the use of the SPICC model as an overarching understanding of the course of therapy enabling them to comfortably align a therapeutic process to the conceptualisation provided. Participant 1 stated that she does not know of any other model with "*the combination of the therapeutic process being part of the conceptualisation*". As a result, the use of the SPICC model for conceptualisation purposes helps her to structure a therapeutic process, and determine and facilitate a client's readiness to transition into the next phase of therapy. Ever since she has been using the SPICC model, she finds it easy to conceptualise a therapeutic process as the model helps her to understand the purpose of employing a specific treatment approach at a specific point in time: "*So I think that's the part that was new to me; is to be able to actually conceptualise. You know, what is the purpose of … using Gestalt at this particular time? Or what is the purpose of a Narrative approach right now? What am I trying to achieve in terms of the process of change?*" (Participant 1). Having previously worked eclectically as a social worker, she felt comfortable with working integrative. She however did not have a theoretical understanding in support of integrating various strategies and techniques, which is evident in her statement: "*But I certainly did not have the overarching understanding of why I was doing that*" (Participant 1). She added that the SPICC model provides her with an "*umbrella conceptualisation of the therapy process*" as an "*overarching … theoretical understanding of where you are in the process of change*" (Participant 1). Therefore, she has an understanding of where a therapeutic process with a client is headed. This is reflected in her statement: "*it does give me a sense of where we're trying to go*" (Participant 1). As a supervisor, she also values the SPICC model as a conceptualising framework providing her students with a sense of where they are in a therapeutic process and what they would like to achieve, regardless of whether they use the model to inform their therapeutic processes. Participant 3 similarly experienced the SPICC model to inform her conceptualisation of a therapeutic process. This is apparent in her statement: "[the model] *just gives you a bit more of a grounding of 'oh, but I know what I'm actually busy doing"*" (Participant 3).

5.1.2 The SPICC model informs the construction of therapeutic treatment plans

Participant 2 reported that an understanding of the purpose of implementing each treatment modality at a specific point in time helps her to "*plan* [therapy] *better*" (Participant 2). Before she was introduced to the SPICC model, she would plan a therapeutic process intuitively without good reasons in support of her treatment plan: "*If I look back to the way I used to work and now the way I work with the SPICC model, I reckon that I, although I*

would plan and prepare for my client, I wouldn't always have a very good reason as to why. It would sometimes be a gut instinct - let's go on this, let's see what if that works, or whatever. Whereas the SPICC model - it's very helpful for planning" (Participant 2).

She added that the SPICC model currently aids her in selecting which techniques and strategies to employ at a specific point in time: "*I find it very rewarding that when I'm sitting there and I'm stuck, I can go back to their book and look at the model, see what they've done and I can go 'oh, why don't I try this, let's see if this gets a shift. Okay no … let me go back, I need to go back' or 'you know what, this child is not into this stuff, let me skip this step and see what happens'. That is nice because I can do that and not feel like I'm being naughty*" (Participant 2).

Having the model inform her treatment plan of a therapeutic process was, for Participant 2, the most rewarding aspect of the SPICC model: "*I actually love having a plan. I really do love having a plan. … I've not really had that before*" (Participant 2). Participant 1 also reported that the framework of the model helps her in planning a therapeutic process. She referred to a case where she had applied the SPICC model to group work and stated: "*What the model offered me in terms of where I was going with the process was actually very valuable as a therapist*" (Participant 1).

According to the participants, the SPICC model guides them through a therapeutic process. Participant 1 stated that it provides her with a framework "*to map* [a therapy process] *onto*" (Participant 1) and as a result has started to form her thinking around the process of therapy. Participant 2 similarly stated: "*I can't think of working with a client that I wouldn't have it at the back of my head*" (Participant 2). Participant 3 added that she became more inclined to use the SPICC model since it provided her with a template for any therapeutic process. She appreciated constructing a standard treatment plan beforehand which can be adjusted to suit each of her clients. This is illustrated in her statement: "*that is why I became more inclined to* [use] *the SPICC model; because I feel you can almost go think beforehand, you can create therapies beforehand*" (Participant 3). She explained that she had once mapped the SPICC model onto several A3 papers; each map representing the therapeutic process of a specific type of client (for example, a child suffering from depression, a child that are presenting behavioural problems, a child grieving a loss, etc.). She had constructed standard treatment plans by indicating specific techniques to be used in each stage for each type of client. She described this way of working having been especially useful when working in government schools where a psychotherapist receives large numbers of referrals and has limited time to conceptualise and implement treatment planning for every

client. She and her colleagues had also shared their mapped treatment plans to divide the work load of constructing various treatment plans, thus ensuring that their clients receive the same quality of therapy. Each colleague had the liberty of adjusting the treatment plan to their specific clients.

Participants 1 and 3 regarded the SPICC model as a tool which empowers both students and beginner psychotherapists with little theoretical background or practical experience in therapy, since the model provides clear guidelines on how to integrate various treatment modalities. This is reflected in the statement of Participant 3: "*the SPICC model is definitely a good tool for a beginner therapist to approach therapy with more self-confidence, because you have a map of what will happen in the therapeutic process*". According to Participant 1, the SPICC model equips master students "*to work with the majority of cases that they come across, whereas the other models tend to equip them for a portion of the cases they come across*" (Participant 1). She concluded that the SPICC model can therefore be useful to help students do "*at least something*" (Participant 1) for a client when they feel stuck in doing community service.

Working integrative furthermore allows participants to plan therapy towards an outcome and an end goal. Participant 2 referred to unimodal approaches and stated: "*I think the danger with the models is you just carry on but you're not necessarily achieving anything*". She commented on how the SPICC model accommodates her preference to work more directive: "*I'm also much more aware of that it's okay to come out with an end strategy. I mean I know it's not necessarily an end but I think it's more goal-directed in a way. Whereas* [with] *Narrative therapy, although it's supposedly goal-directed, I find that … you could just get lost in exploring the stories and externalising the problem. And I also think too much time with that is spent externalising, finding the sparkling moments, rebuilding the story. That's great, but you've actually gotta move on sometime and fix it. So … that is where the SPICC model is much better for me, because you have an outcome that you are working towards*" (Participant 2).

Participant 1 also appreciated how the SPICC model enables her to work towards an outcome, as she does not "*see the point of therapy unless it makes shifts in the client*". She therefore values the SPICC model's integrative nature seeing that a purist approach, such as non-directive play therapy, for example, "*lends itself towards just going to the room and just being in there*" (Participant 1). Participant 2 noted that the SPICC model provides psychotherapists with a map of the therapeutic process as "*an outcome you are working towards*". She concluded that the model therefore allows that as a psychotherapist, "*you have*

got an aim and a goal in mind, and you have a plan of action in order to get there" (Participant 2).

Both Participants 1 and 3 reported that they find treatment planning easier when they construct visual images of the SPICC model which represents the flow of a therapeutic process. Participant 3 explained that "*having a visual picture in mind of a possible way to help the child, on different levels, helps one do therapy more effective, as you know where the therapy is heading*". Participant 1 similarly based treatment planning on a visual image of the SPICC model, as illustrated in her statement: "[I] *think very visually, so it appeals to me in terms of the circularity of the model as well. ... if I were to paint a therapy process it would be circular. So we'd start with the central point and it would open out, probably into like a rainbow of colours so ... it might start with something fairly dark in the middle and then eventually it will become quite a spectrum of colour and become quite expansive. So I think that visually, this model, works for my personal sense of what we're trying to do in therapy. So by the end there's kind of a whole mirage of colours that belong to the client, not to us, but we've been part of that process or kind of opened it up*" (Participant 1).

5.2 Help clients faster

Participants regarded the SPICC model as a dynamic model which generates movement in the therapeutic process. Participant 3 described this movement as "*rhythm*" and "*flow*" in her therapy. Participants 2 and 3 posited that they can facilitate a client's movement through a process of change, as they do not feel stuck in the process. The cyclical nature of the SPICC model, according to participants, contributes to clients' movement in therapy. Clients' movement through a process of change can be characterised by a change within themselves, regardless of change having occurred in their environment. Since the model fosters movement in both the therapeutic process and within clients themselves, the use of the SPICC model, according to participants, is a way to circumvent clients' resistance.

5.2.1 The SPICC model facilitates a client's movement through a process of change

Participant 3 described the SPICC model as a dynamic model that facilitates movement in the therapeutic process: "*The movement within the model creates movement in therapy. I find that the SPICC model gives rhythm or movement to my therapy*". She became aware of the lack of movement in her therapeutic processes before being introduced to the SPICC model. Many of her colleagues dislike therapy as they also experience a lack of movement in therapy. According to her, the SPICC model can prevent psychotherapists from feeling stuck

as the model creates movement in the therapeutic process. This is supported by a statement of Participant 2: "*I don't lose my way in the therapeutic process. I don't sit there in my chair going like 'okay so this discussion of externalising the problem isn't working so well, what do I do now?' And then just kind of get stuck on that*".

Participants 1 and 3 reported that the use of the SPICC model in conceptualising therapy as a dynamic process of change enables them to facilitate a client's progression through various phases of the therapeutic process. Participant 1 states: "*there's a sense of movement, maybe in the way the therapist is thinking, ... that's conveyed in some way to the child, like 'we're going somewhere together'. There's a feeling of a journey and a process*". Participant 3 added that she can see clients benefiting from a process which comfortably flows from one stage to another. As a result, she views therapy based on the SPICC model as a positive encounter. Participant 1 stated that she prefers to employ the SPICC model over a purist approach, as clients benefit more from a "*proactive*" psychotherapist who conceptualises the therapeutic process as "*a working moment and a working space*" (Participant 1). This understanding ultimately facilitates a client's change in therapy, as it is unconsciously communicated to the client in the following respectful manner: "*'We're here to ... move and to work, and we can do that slowly and gently if that's what's needed, or we can do it at a quick pace if that's where you're at, but nevertheless that's where we're headed'*" (Participant 1).

Participant 1 regarded the movement in therapy to bring about change within a client, and not necessarily a change in their environment: "*It could be change in the sense that nothing changes in the actual world but within themselves they are better able to manage it, cope with it or understand it*" (Participant 1). She had applied the SPICC model to a group process within a school system and found it rewarding to have received feedback from teachers on how they have perceived the change within the group members, and how it had filtered down into the classroom. She shared feedback from one teacher on the change within a client: "*the one teacher said to me ... 'it's like a flower that's opened when I look at her'. It's just the difference between what the child was like before*" (Participant 1). As these group members had been victims of sexual abuse, their movement entailed a change within themselves, as opposed to change in their environment. Participant 1 described an incident where one of these group members commented on having changed within herself: "*Because we live in a small community, some of ... their perpetrators are still out at large. And one of them was in a taxi ... and this guy got into the taxi. And fortunately for her, somebody from the school was also in the taxi and just kind of realised what had happened and just put their*

hand on her hand and ... she turned to them and she said to them 'It's all right, I'm strong now"" (Participant 1).

Participant 1 furthermore considered the SPICC model as a process of change suitable for a referral she had received of a boy who was diagnosed with Type 1 diabetes. According to her, he would benefit from the SPICC model's process of change: "*nothing's gonna change in terms of his diagnosis, but within himself we could get him to a space where ... his feelings, his actions are just in a very different place*" (Participant 1). She explained that the model will allow for him to have a period of "*acting out and exploring all his anger and rage, but eventually get to a point where he's able to implement skills that are going to be life preserving, quite literally, for him*" (Participant 1).

According to Participants 2 and 3, the cyclical nature of the SPICC model also facilitates clients' movement in therapy. Participant 3 added that despite working towards an end goal when using the SPICC model, the completion of the model is "*never the end*". This is due to the model's spiral of therapeutic change which allows psychotherapists to end therapy open ended, move back and forth between phases of the model, and have clients disengage and continue the process at any given time. According to Participant 2, the latter is very valuable taking into account that children and adolescents often want to disengage from therapy for periods of time: "*What I found with working with kids is that you'll get them to a certain stage and then because they're kids, they don't wanna keep coming, you know. So they disengage for a while but then when they come back, ... it's a continuous sort of cycle upwards*". (Participant 2).

These clients might later resume their previous processes or start over and possibly complete certain phases of the model faster (Participant 2). Participant 3 has a preference for short-term therapy with children and therefore regarded clients' temporary disengagement from the therapeutic process beneficial seeing that it allows changes to slowly occur within several of the child's ecological systems.

5.2.2 The SPICC model provides a way to address clients' resistance

Due to the SPICC model facilitating movement in both the therapeutic process and within clients themselves, participants regarded the use of the model as a way to circumvent clients' resistance. Participant 1 shared her experience of having applied the SPICC model to a therapeutic process with a group and have encountered some resistance from certain group members at one stage. She reflected how she experienced clients as resistant in this case and stated that "*you might be able to couch that from a SPICC model perspective*" (Participant 1).

As she had been aware of the phases of the therapeutic process, and able to direct and facilitate the group's movement, she managed the members' hesitance towards progress by consciously slowing down the therapeutic process. With the purpose of moving all group members into the next phase, she backtracked and revisited skills learned in previous phases. She added that this decision possibly resulted in the group members' enhanced development of skills learned in those particular phases of the process. Participant 3 experienced children as receptive to therapy based on the SPICC model, since its integrative nature allows involving the child client "*spontaneously and easily*". Specific reference was given to Gestalt therapy as an initial phase of therapy to lessen clients' defence mechanisms due to its non-invasive way of working. She furthermore appreciated that the SPICC model guides a psychotherapist where to move a client next, "*even if it appears* [to the therapist] *that the client cannot really go further*" (Participant 3). According to Participant 2, the model's spiral of therapeutic change is helpful in dealing with a client's resistance to a specific phase of the therapeutic process. She explained that the model allows moving back and forth between phases in order to resolve a client's resistance: "*You can either go backwards and go revisit something that maybe you hadn't encountered or … you can do that loop around*" (Participant 2). In addition, the integrative nature of the SPICC model ensures that a psychotherapist will find something that is appealing to a client to counter their resistance, opposed to a purist approach which might not resonate with all clients (Participant 3).

5.3 The SPICC model requires and raises awareness of a therapeutic process

The current theme addresses participants' experiences of how the use of the SPICC model requires and raises their awareness of a therapeutic process. Participants reported that it is easy to monitor and facilitate their clients' progression through the various phases of therapy when they employ the SPICC model; better than they would have been able to do when employing a purist approach.

5.3.1 Awareness of a therapeutic process makes it easy to monitor a client's progress

The SPICC model requires psychotherapists' awareness of where they are in the therapeutic process. This is illustrated in the following statements: "*I think the SPICC needs you to be very conscious of where you are in the process*" (Participant 2) and "*the therapist needs to be very mindful of every step that they are doing*" (Participant 1). Participant 1 regarded the model's explicit understanding of purposefully using specific strategies at a specific point in time as requiring a psychotherapist to continuously reflect on the therapeutic

process. She explained that as a psychotherapist: "*You're kind of challenged to think … about what you're doing and how you make sense of what actually happened in the room. So … there's almost a metacognitive capacity that's required the therapist to really reflect on that, and not just make it a content based*" (Participant 1).

Both Participants 1 and 2 regarded this required awareness of the therapeutic process to be the most challenging aspect of the SPICC model. Participant 2 emphasised the importance of remaining focused throughout the therapeutic process: "*So it's very easy if you're not remaining focused, just to fall back onto a Narrative conversation instead of 'what am I supposed to be doing?' So challenging is making sure that you are preparing for the steps … and forcing yourself to do that, and sticking to that. It requires a lot more thought and preparation*" (Participant 2).

According to Participant 3, awareness is key and she thus finds it easy to monitor a client's transition through different phases of the therapeutic process by frequently asking herself "*How am I doing? Where am I*?" (Participant 3). She can therefore easily determine where a client is heading without forcing her own agenda onto the client. Participant 1 stated that the SPICC model provides her with an increased awareness of a client's progress in a therapeutic process as a whole. She can therefore be a proactive psychotherapist who does not get "*lost in the moment*" (Participant 1). Participant 2 added that the SPICC model's structured integration counteracts her "*tendency to drift*". Instead, she is more conscious of which phase in the process the child is in, what type of interventions she should be doing with the child accordingly, whether the employed interventions are effective, and whether the client is ready to transition to the next phase. Participant 2 stated that she often draws on the principles of Prochaska and Norcross's (2010) Transtheoretical Model to increase her awareness of a therapeutic process and which phase a client is at. The Transtheoretical Model, like the SPICC model, is an integrative model of change that postulates various stages of change to assess and foster a client's readiness for change (Prochaska & Norcross, 2010). Although the Transtheoretical Model is not applicable to children, Participant 2 often combines the SPICC model with the Transtheoretical Model in order to ultimately heighten her awareness of what she does in a therapeutic process: "*if you combine that with the Transtheoretical model … I think you're a lot more conscious of what you are doing*" (Participant 2). She explained that she uses the Transtheoretical Model's principles to assess and conceptualise a client's readiness for change, after which she implements the SPICC model to facilitate the client's readiness for movement to a next stage. She provided an example of this way of working: "*If you're working with a kid who's … gaming too much …*

[you should ask yourself] *is he really ready to stop gaming? If he's not ready to stop gaming, where do I need to work with him? And there I can start the SPICC thing. You can actually kind of use them together*" (Participant 2).

Participant 2 regarded the ability to evaluate the progress of therapy, and to assess when a client is ready to transition to a next phase, as one of the most rewarding aspects of the SPICC model. This is reflected in her statement: "*I am more conscious of working through the sequence and assessing where I am in the process, and to what extent the child is ready to change to the next step*" (Participant 2). A client's readiness for change became clearer to Participant 1, as she knows "*what to look for*". She no longer intuitively evaluates a client's progress: "*So my ability to evaluate has become clearer and in some ways maybe a little bit more outside of me. I've got a little bit of something to actually say 'it's progress because; this, this, and this'. So that for me I think has been very valuable*" (Participant 1).

In applying the SPICC model to group work, Participant 1 finds it easier to monitor the group's readiness for transitioning between phases, prepare the group for transitions, and identify specific group members' need for individual treatment.

5.3.2 Awareness of the therapeutic process facilitates a client's change processes

A heightened awareness of the therapeutic process also enables psychotherapists to facilitate a client's progression through various phases of the therapeutic process. For Participant 2, an awareness of the different steps in the therapeutic process is what brings about change faster in her clients as she is guided by the phases of the model. She explained: "*I personally think you get shifts faster using the SPICC model. … I think it's because you don't lose your way. ... With the SPICC model I don't lose my way in the therapeutic process*" (Participant 2). She furthermore regarded the SPICC model to bring about change faster than a purist approach. This is reflected in her statement: "*Because you you're actually conscious of making the different change steps and shifting and shifting the child, you get more done in less time. … You could do SPICC for 8 weeks and I could do Narrative therapy for 8 weeks, and in 8 weeks I will have done more with the SPICC model than I would have done with Narrative therapy*" (Participant 2).

She provided a specific example of a case in which her awareness of the therapeutic process resulted in her client's change quicker: "*I was more conscious of the steps. I was very conscious of first taking enough time to get her to trust me and to build the relationship*" (Participant 2). In her experience, a purist approach does not provide a psychotherapist with

an awareness of a therapeutic process and the needs of the client. This is reflected in her statement: "*it's much easier to drift in, say, Narrative therapy. Without actually achieving anything. Because you're not … necessarily matching where your client is or what your clients need*" (Participant 2). What ultimately enables psychotherapists to "*get more done in less time*" (Participant 2), is being mindful to a client's needs, employing specific required interventions, and directing the therapeutic process in order to shift the client towards change (Participant 2).

Facilitating a client's movement through various phases of the therapeutic process, psychotherapists should ask themselves questions such as "*This is a process, there should be movement; what am I doing to contribute to that? Where am I getting in the way?*" (Participant 1). Participants 1 and 2 experienced a sense of control over the therapeutic process when they were able to evaluate a client's readiness to transition to a next phase with increased awareness. The following statement illustrates the aforementioned: "*The SPICC model helped me to judge when was it time to move … on to the next stage. Because you're aware of the process, you have more control over the process*" (Participant 2). Participant 1 referred to a case where she had applied the SPICC model to a group process and stated that she had felt comfortable preparing the members to transition to a next phase and learn skills in subsequent phases: "*That sort of sense that there was a progression meant that it was nice for me to prepare the group to be ready for the skills that are gonna come right at the end*" (Participant 1).

5.4 The SPICC model enriches personal experiences

Participants reported that an integrative approach to therapy as a process of change ensures that therapy is an enriching experience for both the client and the psychotherapist. Participants regarded the SPICC model as a safe container within which they can be creative. Hence, they are able to creatively modify the model according to a therapeutic intervention needed, for example working with tweens, adolescents, adults and groups. The model can also be used as a framework to inform and structure psycho-education or feedback on the therapeutic process.

5.4.1 An enriching experience for clients

Participant 3 emphasised the importance of a child perceiving therapy as an enriching experience. According to her, the SPICC model ensures clients of an enriching experience better than a purist approach. This is due to the SPICC model being a compilation of the best

available treatment approaches which provides a psychotherapist with "*a wealth of techniques*" (Participant 3) to choose from. According to Participant 3, psychotherapists' use of different techniques derived from various therapeutic approaches ensures that therapy is stimulating to clients. Furthermore, exposure to an abundance of elite interventions, is ultimately beneficial to clients regardless of their referral problem having been addressed. The SPICC model is therefore not problem- or pathology-focused, but rather allows children to positively experience therapy, which they would not have had otherwise. This is reflected in Participant 3's statement: "*When a child has finished the full process of the SPICC model, they usually had an enriching experience or at least a positive experience, regardless of whether the referral problem is resolved. The child will be at a better place if you work with him through that model*" (Participant 3).

Participant 3 reported that she felt that she can guarantee a client an enriching experience of therapy. She concluded that a psychotherapist "*can terminate* [the therapeutic process] *after 8 sessions and know that the client somewhere benefitted from the process*" (Participant 3). Evidence of her clients' enriching experience of therapy will include plentiful tangible objects such as drawings and clay figures which provides a child with a meaningful representation of their involvement in the therapeutic process. She furthermore emphasised that an enriching experience for a client should entail growth and such an experience is indeed achievable when using the SPICC model. Psychotherapists can progressively introduce techniques that move clients beyond their comfort zones: "*You can start with techniques that moves a child out of his comfort zone a little less, and then move to techniques that move him more out of his comfort zone because that results in his growth*" (Participant 3).

In the participants' experience, children benefit more from integrative psychotherapy than from therapy informed by a purist approach. Participant 1 regarded the SPICC model to be "*a worthy beginning for integrated psychotherapy with children*". Participant 2 explained that because "*we live in multiple systems,* [and] *we have multiple systems within ourselves*", her approach to therapy with children has transformed from a purist Narrative approach to working integrative. She explained her preference for working integrative: "*Working with a kid with learning disorders; you'd be referring to an O*[ccupational] *T*[herapist]*, you'd be referring to a speech* [therapist]*, you'd be referring to maybe remedial* [education], *even the doctor if there's a physical illness. Why on earth would you want to do therapy in one modality*?" (Participant 2).

She further added that it makes more sense to have a specific approach, for example Narrative therapy, "*integrated into something else*" (Participant 2) when working with children as the SPICC model provides elements to working with children which a purist approach lacks. These include, for example, building rapport (Phase 1 of the SPICC model), raising awareness (Phase 2 of the SPICC model), and developing constructive strategies that the child can use. Participant 2 provided such an example: "…*Narrative therapy* … [is] *a lot of talk therapy so you might not necessarily get a cathartic moment, and the child might not be able to work through the emotions*". Participant 3 similarly argued that a child might not necessarily benefit from a therapeutic process informed by a purist approach that offers a limited amount of techniques, but that "*an integrated approach such as the SPICC will give you a better outcome*" (Participant 3). Participant 3 added that she is delivering a high quality service to her clients based on the SPICC model, as it provides her with a solid and research-based understanding of the purpose of implementing each treatment approach at a specific point.

According to Participant 1, clients suitable for engaging in a therapeutic process based on the SPICC model include, for example, depressed clients, clients who suffer from anxiety, clients who experience relational problems and cognitively impaired children. She further explained that a therapeutic process based on the SPICC model can easily be employed with cognitively impaired clients, as it does not require their symbolic capacity and abstract thinking as would be in the case of a psychoanalytic approach. Thus, the SPICC model presents a psychotherapist with various alternative "*interventions that are very meaningful in nature*" (Participant 1). Participant 3 also suggested using the SPICC model with clients who have learning disorders, as the model can accommodate their preference for non-verbal therapy. Participant 1 stated that she would not feel comfortable in using the model for clients with extreme pathology, since compliance might pose a problem. When working with an oppositional defiant child or a client with Conduct Disorder, the psychotherapist "*might need to move quite quickly into a pragmatic CBT kind of frame, and the emotional expression might be less*" (Participant 1). Participant 2 suggested that the SPICC model be applied in therapy with clients that have a combination of emotional and behavioural problems.

Regardless of the diverse preferences of different clients regarding treatment modalities, the SPICC model is flexible enough to accommodate these. Participant 2 explained that in her experience, some children might thrive in the Client-centred phase, whilst others might enjoy Gestalt therapy more. Some of her teenage clients do not necessarily have emotional problems, and other clients find certain stages of the SPICC

model unappealing. Whichever the case, the participants experienced the SPICC as enabling them to adjust the model to meet their clients' specific needs and provide them with an enriching experience of therapy. As a result, psychotherapists might therefore move through certain stages faster, spend more time on other stages, omit certain stages, or adjust the use of techniques within a stage to accommodate clients' preferences accordingly. Participant 2 provided a practical example of such an instance; she explained that a 5-year-old client with thyroid disorder and language delays had "*made remarkable progress with just Client-centred* [Pet Assisted Therapy] *and Gestalt (sand tray)*", as these modalities complimented her non-verbal nature. Still adhering to the principles of the SPICC model, Participant 2 involved the child's parents and teacher in the cognitive and behavioural phases of therapy, "*as they were able to intervene* [on these levels] *on a daily basis*" (Participant 2).

5.4.2 An enriching experience for psychotherapists

In the participants' experiences, the SPICC model further enables psychotherapists to experience the therapeutic process as enriching. Participant 3 stated that the use of the SPICC model ensures that the therapeutic process "*… is like playing. Together, you and the child play through all of this and both of you benefit from it*". She commented on the important role it has played in her development and growth as a psychotherapist: "*I don't think the SPICC is the best existing therapeutic model, but I can definitely testify of the value it has added to my therapeutic processes and the role it has played in my own development as a therapist*" (Participant 3). She reported that the most remarkable of therapeutic processes she facilitated to date, were based on the SPICC model. Also, she initially felt uncomfortable using the model in her Master's year of training, compared to how naturally its application currently flows. Participant 2 similarly became more comfortable in using the SPICC model: "*But it's a learning process so I mean I'm getting more familiar with it, it's getting easier*". An important aspect of the SPICC model which contributes to a psychotherapist's experience of therapy as enriching includes enabling psychotherapists to employ various treatment modalities within a single therapeutic process. Being exposed to the different treatment approaches included in the model, which Participant 3 regarded to be the "*cream of the crop*", allows a psychotherapist to include their preferred techniques which each treatment modality has to offer. Psychotherapists can also spend more time on their favoured treatment modality from those available in the model: "*if you love Narrative* [therapy]*, you can really include a big part* [of it]*, and really intensively*" (Participant 3).

Participant 1 regarded the integration of various treatment modalities as "*a much more holistic way of working*". In all participants' experiences, the SPICC model enables a psychotherapist to consider and employ multiple therapeutic approaches, and address several of a client's needs simultaneously. This is supported by Participant 2's statement: "*Integrated* [psychotherapy] *is more flexible, it suits more clients,* [and] *you can cater to more people's needs*". She commented on what other psychotherapists might expect from using the SPICC model: "*they will be very pleasantly surprised at how much more they can get done because you can work on … so many* [things]" (Participant 2). Participant 3 added that many of her colleagues dislike doing psychotherapy, as they feel their framework prevents them from treating clients' specific problems optimally. She however stated that "*even if the child has multiple problems, the SPICC* [model] *can address various things*" (Participant 3). Moreover, working integrative "*allows you to address multiple things like self-esteem, like strategy building, cognitions, emotional venting … all of that*" (Participant 2), as opposed to other therapeutic approaches addressing only one of the aforementioned aspects.

Participant 3 reported that the SPICC model's integrative nature calls for psychotherapists to be flexible. According to her, the application of the SPICC model can be challenging as it "*moves the therapist out of their comfort zone a little bit*" (Participant 3). She explained that the use of the model requires psychotherapists' openness to integrate different modalities and incorporate new ways of doing. However, openness towards the model's integrative nature is an enriching experience for a psychotherapist, as "*being exposed to various things, you also grow. … It moves your boundaries to incorporate new things*" (Participant 3). The SPICC model does however also equip psychotherapists with self-confidence to facilitate a client's process of change assertively. Participant 3 described the model as "*a tool with which you can go to your client with self-confidence that you can add value to him, and that you can help him be at a different place compared to when therapy was initiated*".

Participant 3 further described the SPICC model as a safe container within which psychotherapists can be creative. She emphasised that psychotherapists should be allowed to be creative in a therapeutic process: "*I feel very strong about* [therapists] *being able to include creative techniques*" (Participant 3). She added that she appreciates the SPICC model as a framework within which a psychotherapist has boundless opportunity to be creative in choosing from a "*wealth of techniques*" (Participant 3). She explained: "*It's not boring, it's creative. You can use your own creativity within the model. I mean I never do*

things the same way, I like change and I like to do things differently, and the model allows for it. The model provides you with a map of what to do, you have great freedom to be creative and choose what to do from a wealth of techniques. I have never come across such a model" (Participant 3).

According to her, most often psychotherapists dislike doing therapy due to feeling bored in therapy. The SPICC model however provides various strategies that are useful to psychotherapists which prevents them from "*feeling bored in therapy*" (Participant 3), such as being confronted with change often, the ability to do things in different ways and the ability to incorporate creativity into therapy.

5.4.3 Modifying the SPICC model to provide clients other than children with an enriching experience

Participants reported feeling comfortable using their creativity to modify the SPICC model according to various clients' specific needs. The flexibility of the SPICC model therefore allows them to use the model for other purposes than was intended initially in order to provide various types of clients with an enriching experience of a therapeutic process. Examples of the latter include the modification and application of the model to therapeutic processes with tweens, adolescents, adults and groups, as well as informing psycho-education and feedback on the therapeutic process.

Participant 1 called for a way of conceptualising work for defensive tweens, or children in middle childhood is needed and further stated that the SPICC model is appropriate due to its accessible, pragmatic, and pro-active interventions. She added that the SPICC model "*sits on the fence between directive and non-directive approaches*" (Participant 1), and hence makes the model suitable for working with tweens. To modify the use of the SPICC model to effectively work with this type of client, she suggested using Gestalt therapy and CBT combined with interventions such as board games, opposed to non-directive and play therapy.

Participant 1 questioned the model's usefulness specifically with older adolescents. However, in their experiences, Participants 2 and 3 reported that despite the model being intended for use with children only, it is suitable to work with adolescents as well. Participant 2 explained that it might be because "*teenagers regress emotionally as well*". She added that adolescents might be more resistant to therapy compared to children: "*the big difference between child therapy and adolescent therapy is you're gonna get a lot more resistance with adolescents*" (Participant 2). Adolescents' compliance to therapy can however be influenced by how the psychotherapist presents some of the activities.

Accordingly, Participant 2 stated that she is more directive when working with adolescents. She explains the reason for using specific modalities, negotiates with them, and encourages them to take responsibility of the therapeutic process and voice their preferences. This is evident in her statement: "*... but they choose the modalities that are best working for them*" (Participant 2). For the purpose of working with adolescents, she consults books with practical ideas on REBT and Gestalt which helps to shift her focus and enables her to better plan for the application of the model.

Participant 3 similarly regarded the use of the SPICC model with adolescents and adults appropriate when a psychotherapist evaluates each client before carefully considering the appropriate techniques to be used in the therapeutic process. Participants 2 and 3 commented on applying the model to therapy with adults and concluded that psychotherapists can apply the SPICC model to clients of any age, "*as long as you're making it developmentally appropriate*" (Participant 2). Examples include, for instance, using sand tray as part of the Gestalt phase when working with adults, or omitting certain phases of the model not appealing to a client. Participant 2 however stated that clients of all ages have similar emotional needs: "*So developmentally* [there are] *definite differences, but at the same time there is a lot in common all the way through. ... every single teenager I have that I see, wants to stroke the bunnies. Every single one of them. Some things do not change. The parents want to stroke the bunnies*" (Participant 2).

Both Participants 1 and 3 commented on the possibility of applying the SPICC model to a group as a client. According to Participant 3, a group moves faster through the different stages, as individual group members foster the impetus for change by sharing in the group identity. Participant 1 stated that she would not ascribe the group's process of change specifically to the use of the SPICC model, since it would also have happened otherwise. She added that she does however appreciate the model as a framework to conceptualise the therapeutic process, address the group's needs, be mindful of why she is doing certain interventions at a specific time, and prepare the group for the outcomes they are working towards. Both Participants 1 and 3 acknowledged the importance of being mindful to group members which can be at different stages and to identify members in need of individual treatment.

Participant 1 suggested that the SPICC model be used to structure and inform psycho-education. She had used "*a looser form*" (Participant 1) of the SPICC model to facilitate an eight-session long process of psycho-education with a group of sexually abused children on safety. The model had served as framework for the process in order to achieve certain

outcomes. She experienced Gestalt therapy to have had less of a place in this process of psycho-education, and she consequently focused greatly on incorporating music in that phase: "*Gestalt had less of a place … I wanted to bring in … rhythm and music and those kind of things, so we used that*" (Participant 1).

According to Participant 3, the SPICC model enables a psychotherapist to easily convey to the client what is happening in each phase of therapy. This is evident in her statement: "*Because you have a better overview of what happens in therapy, it is easier for you to tell the child what happened in therapy*" (Participant 3). She draws on the SPICC model's framework to provide her clients with feedback at the end of their therapeutic process and compiles a therapy profile which helps the child understand the therapeutic process. This is illustrated in her statement: "*I like to say to the child 'this is what you have done in therapy; I put it together for you'. And the SPICC model makes a lovely whole of what happened in therapy. So it is then also a frame of reference that the child can share with their parents if they want to*" (Participant 3). She thus draws on the cyclical nature of the SPICC model which allows psychotherapists to end the therapeutic process with Narrative therapy.

Participant 1 proposed that the structure of the SPICC model be used to also illustrate the therapeutic process to clients' parents providing them with feedback on the therapeutic process. She regarded this way of working as an accessible means for psychotherapists to easily help parents understand the therapeutic process, seeing that "… *you're not divulging confidential material, but you're actually taking them through the process*" (Participant 1). In order to provide feedback on a group therapeutic process to a community of parents involved, she explained to the parents the group members' therapeutic process using the cyclical nature of the SPICC model: "[I explained to parents that] *'the girls and I started on a journey and we had … started out without knowing each other. And we gradually told each other our stories and some of the stories were quite heart sore and sad, and we worked together to make a better ending to all of these stories'. But I did very much have that spiral in mind; as I speak to them I could come back* [to complete the model's] *full circle;* [ending with] *'and we're in a better place now'*" (Participant 1).

Participants 2 and 3 emphasised the importance of involving child clients' parents to intervene effectively in all systems. Participant 2 stated that "*Sharing with parents …* [feedback] *at different stages through therapy … enables quicker and more profound shifts* [in the child] *when parents are able to engage*". Participant 3 also commented on influencing the child's environment and added that the SPICC model allows a psychotherapist to

intervene on multiple systems of the child. This is due to the psychotherapist knowing in what phase the child is in the therapeutic process and therefore what the child needs at a specific point in time. Both Participants 2 and 3 suggested that psychotherapists also involve other key figures in a child's life in the therapeutic process, as "*working with a child in isolation would be a very last option*" (Participant 2). Participant 2 stated that the use of the SPICC model allows a psychotherapist to easily involve, for example, the client's teacher and parents. This can be done by requesting that classroom activities and homework focus on strengthening what is dealt with in therapy.

5.5 The SPICC model's applicability within the South Africa context

The SPICC model fits the South African context, since it is culturally sensitive, enables short-term therapy, and can be used in instances where there are limited resources.

5.5.1 Working integrative allows psychotherapists to be culturally sensitive

According to Participant 2, the flexibility of the SPICC model allows psychotherapists to adjust their interventions to accommodate clients' cultural needs. Participant 1 explained that she finds the model to be culturally sensitive, especially since there is a suitable way of working within each treatment modality: "*... because you've got different types of interventions, if you're being culturally sensitive, you could pick up either ways of working with any each of those areas. You've got a variety of different ways of being ... and that's nice for the South African setting*" (Participant 1).

Participant 2 similarly regarded the model's integrative nature to allow her to be culturally sensitive. She explained that psychotherapists can adjust their treatment plan according to the cultural needs of the clients: "*You can change what you are doing depending on the culture of the child, I mean it's really so flexible*" (Participant 2).

As psychotherapists can be culturally sensitive, they are therefore able to adjust the SPICC model to circumvent language issues. A psychotherapist can find ways to do therapy with, for example, a child who speaks very little English. Participant 1 suggested that a psychotherapist adapts a therapeutic process to include interventions that do not require language processing: "*It doesn't need to be highly verbal, because you've got ... the option of working with different mediums. So you can possibly circumvent some of the language issues*". These interventions can include, for example, clay work as part of Gestalt therapy, or having clients express themselves through movement and music. Participant 2 similarly

noted that the SPICC model can overcome language barriers: "*if the child is not very verbal, it's great, it works brilliantly … I mean you can alter* [the model] *quite nicely*".

5.5.2 The SPICC model fits short-term therapy

A valuable aspect ensuring short-term and cost-effective therapy with children in South Africa is the SPICC model's integration of various treatment modalities. Participant 1 emphasised the importance of professionals getting their "*heads around shorter term therapy*", as South Africa has limited resources that are needed for long therapeutic processes. Participant 2 stated that her "*intervention process is a lot shorter*" since employing the SPICC model. According to her, the model is valuable to the South African context as it enables psychotherapists to get more therapeutic work done in a shorter amount of time, opposed to employing a purist approach. This is illustrated in her statement: "*I personally think you get shifts faster using the SPICC model which means that the therapeutic process is a lot shorter. Which in South Africa is important 'cause it's cost effective*" (Participant 2).

Contrasting with Geldard et al. (2013) stating that a therapeutic process based on the SPICC model generally lasts six to 10 sessions, Participant 1 opines that this length is too short and rather suggests approximately 12 sessions. Participant 2 added that she usually has between four and 16 sessions when working with difficult cases. Participant 3 emphasised the need for short-term therapy in South Africa and reported that the SPICC model allows therapeutic processes lasting eight sessions. Since "*children change so quickly developmentally*" (Participant 1), and are resilient in working through problems themselves, integrative short-term therapy provided by the SPICC model is regarded appropriate. To prolong the duration of the holding that the therapeutic process provides the child, Participant 1 suggested the following strategy: "*In terms of the SPICC model, the termination phase; I would start cutting down on the frequency of sessions within that space. So you might have, let's say, 12 sessions, but the last two or three would be spaced with 2 weeks between. So you also get that benefit of partly assessing and consolidating, just to see how the child manages, and then also just to be able to extend it a little bit so that the holding is there but they are also able to try their wings*" (Participant 1).

She opined that working with children over school holidays also prolongs the therapeutic holding, considering that 12 sessions can be extended over a four month period. The client therefore "*has had the benefit of that therapeutic holding for a longer period than they've actually been in therapy sessions, which … is also helpful*" (Participant 1).

5.5.3 The SPICC model requires no resources

Participant 3 emphasised South Africa's scarcity of resources and large need for child mental health interventions: "*Many environments in our country just do not have resources and there are extremely many children that need to be helped*" (Participant 3). A strength of the SPICC model includes that psychotherapists can "*take the model and use it anywhere*" (Participant 2). Participant 1 similarly reported that "*you can take your model to a clinic and be in a corner somewhere …* [using the model] *doesn't require specific equipment or anything fancy*". This aspect distinguishes the SPICC model from purist approaches which can hold limitations. In reference to psychotherapists who employ purist approaches, Participant 1 stated: "*Whereas if they're trained in … child-centred play therapy and they don't have a room, and they don't have privacy, … then they are stuck*". With regards to the importance of community work in South Africa, she described the SPICC model as "a *model that's accessible … for probably the majority of people*" (Participant 1).

5.6 Critique against the SPICC model

Criticism against the SPICC model included that it requires greater depth for sound implementation, many professionals find its integrative nature unappealing, the model presupposes a psychotherapist's required level of skill in all five modalities, and psychotherapists do not feel competent to employ the model effectively as prescribed.

5.6.1 Other professionals might take a while before embracing the SPICC model's integrative nature

Participant 1 described the SPICC model as "*very unknown*" and would like to see it being implemented more. With regards to psychotherapists' preference for purist approaches, she reported that in her circle, "*people aren't rushing out to embrace the model*" (Participant 1). Participant 3 had a similar experience after having introduced the model to her colleagues: "*my colleagues felt that it was very sensible and* [they] *were very interested in it. But … in the real world, I don't think they necessarily persevered with it*" (Participant 3). Generally, professionals are hesitant to the SPICC model's integrative nature. This is reflected in Participant 1's statement: "*So there's still quite a strong push to be very purist in your approach and I'm aware in supervisors' meetings that when I talk about the need to work more integratively, everybody's very tolerant of me, but some eyebrows are raised. So I think it's gonna take a while for people to embrace this way of being*" (Participant 1).

The reluctance of other professionals to start using the model might be due to them regarding the model, like Participant 1, to be "*a bit 'light weight'*". On reflection, Participant 1 described the SPICC model to require "*greater depth for sound implementation*", and that it should therefore be "*taught in conjunction with some foundational theory for psychotherapy*" (Participant 1). She nonetheless regarded professionals' perception of integrative psychotherapy as being "*a diluted form of therapy*" (Participant 1) as inaccurate, since they are minding it with eclecticism. Hence, they do not comprehend "*the depth that an integrated understanding and approach of the process of change brings to therapy*" (Participant 1). She added that she therefore hopes that professionals will soon understand integrative psychotherapy, as informed by the SPICC model, as "*a perfectly viable and actually useful way of working*" (Participant 1). Participant 3 was also of the opinion that professionals might experience employing the SPICC model challenging due to their preference for a purist approach: "[Using the SPICC model] *will probably be challenging to some therapists …* [because] *they are stuck in their ways and they use one type of therapy and that is what they do and that is all they know and that is what all the CPD courses they attend are about*" (Participant 3).

Participant 3 further explained that working integrative can be demanding as it requires a psychotherapist to, for example, attend various CPD courses in order to become more knowledgeable on different therapeutic frameworks.

5.6.2 The SPICC model's presupposed level of expertise in all five modalities is not attainable

According to Participant 1, the SPICC model presupposes a psychotherapist's required expertise in all five treatment modalities. This is illustrated in her statement: "… *the model speaks specifically about certain interventions and although it does say that you don't have to use all of them and you can use them different, for different periods of time, it does presuppose that in order to do it optimally you're gonna be really skilled in each of those areas*" (Participant 1).

Psychotherapists might therefore have to improve their skills in certain modalities. Participant 1 added that despite her being able to work quite effectively without the supposed level of skill in each modality, she would want to feel competent in using each phase as indicated. She explained that such a level of expertise should be attainable if it is prescribed by a model, yet she questioned the attainability seeing that the various modalities are very dissimilar.

Both Participants 1 and 2 regarded themselves as lacking the necessary therapeutic skills in various treatment modalities in order to apply the SPICC model proficiently. Participant 1 referred to specific modalities she does not feel comfortable with: "*While I feel satisfied with the way I have used the model to date, given the purpose for which I used it, I am also aware that it has been a little like using a drug 'off label'! I think that my lack of in-depth knowledge of Gestalt and Narrative therapy renders me a novice, and it is important to me that my input is treated in this way*" (Participant 1).

With regards to the skilfulness in using the SPICC model, Participant 2 described herself as "*not very good at it yet*", despite becoming more familiar with the model. She explained that she finds the Gestalt phase most difficult due to her preference for working directive. Although Participant 3 does not like all the treatment modalities of the SPICC model equally, she acknowledged the need for it within the sequence of the model: "*My preferred therapies include Gestalt, Narrative therapy and expressive creative therapy,… but the client won't necessarily benefit from it. So that is why an integrated approach like the SPICC is better, it will give you a better outcome and you have an ethical responsibility towards your client*" (Participant 3).

She made specific reference to her dislike of Behaviour therapy and explained that she is more willing to use this treatment modality bearing in mind that clients will benefit from an integrative approach which includes this approach: "*In a way the SPICC forces me to use techniques from approaches that are not my preferred way of working, but I can understand the logic behind using the approach and I can see that it works for the client*" (Participant 3).

Participant 1 compared the SPICC model to the Transtheoretical Model of Prochaka and Norcross (2010) and argued that in using the Transtheoretical model, a psychotherapist has more liberty to employ their preferred treatment approach in order to achieve the model's prescribed strategies. She referred to the Transtheoretical model and stated: "*... when they talk about … consciousness raising; you could do that in a million different ways. So I can do a psychodynamic intervention, somebody else could do something else, but we still achieve the same purpose*" (Participant 1). Participant 3 however regarded the SPICC model's carte blanche as one of its strong characteristics considering its lack of prescription of specific techniques to be used in each modality: "*I actually think that is the model's strength; that it is so open ended. … it is not very prescribing, so you can* [choose] *what you include, it is your decision*" (Participant 3).

Since Participants 1 and 2 do not feel competent in all treatment modalities, they adjust the model accordingly by omitting specific phases of the model. Participant 3 reported that

the model allows psychotherapists to only briefly touch on a specific treatment modality they do not feel as comfortable with, and to rather include a great deal of their preferred treatment modality which is available in the model: "*if you don't know much about Gestalt, you can do it very cursorily*" (Participant 3). Participant 1 added that the blurred boundaries between various approaches make it difficult to conclude that she does not implement techniques or facets from these omitted approaches: "*I don't know that I don't do Narrative. I think I do do stuff that's got Narrative edges to it, I just don't say 'well now I'm doing Narrative and now I'm doing Gestalt'*" (Participant 1). She further added that she uses Schema therapy extensively, which aligns with various phases of the SPICC model, (for example Gestalt therapy, CBT, and Behaviour therapy aspects), to achieve the same purpose.

Participant 1 described herself as a novice considering her lack of experience in applying the SPICC model, and her insufficient expertise in each of its phases. She therefore feels inadequate to supervise the model to her students, despite wanting to include such a model in their formal or practical training. The latter is evident in the following statements: "*… because I'm a novice with it, I don't feel like I can really supervise it as well as I would want to. I would want more knowledge about it before I did* [supervise] *it*" (Participant 1) and "*it will be interesting to see what comes out of the research. Particularly as I am also involved in training psychologists and would like to include a model like this in their practical or formal training*" (Participant 1).

5.7 Chapter summary

This chapter presented the six main themes and 14 sub-themes that emerged from analysing the data gathered from the participants' interviews and reflections. In the first theme, 'The SPICC model enhances psychotherapists' conceptualisation skills', it became evident that the participants align their therapeutic processes to the framework of the SPICC model as a template for a therapeutic process. The model enables them to plan treatment better and was therefore regarded a good tool for students and beginner psychotherapists with limited experience in doing therapy. The second theme, 'Help clients faster', centred on participants' experiences of the SPICC model to generate movement in therapy. This movement results in a client's change. In the theme 'The SPICC model requires and raises awareness of a therapeutic process', participants experienced the use of the model to both require and raise their awareness of the therapeutic process. Participants hence find it easy to monitor and facilitate their clients' progression in therapy. The fourth theme, 'The SPICC model enriches personal experiences', encapsulated participants' experiences of using the

model as enriching their clients', as well as their own, experiences of therapy. Participants reported that they can modify the use of the model to provide a specific required intervention. In the fifth theme, 'The SPICC model's applicability within the South Africa context', participants regarded the model suitable for application in South Africa specifically as the model enables them to circumvent cultural issues, ensures short-term therapy, and does not require any resources. The last theme, 'Critique against the SPICC model', centred on participants' criticism of the model. These included that the model lacks foundational theory for sound implementation, many professionals do not embrace an integrative approach to therapy, and that the model's presupposes level of expertise in all five modalities is not attainable. These findings will be integrated with supporting theory in the next chapter.

Chapter 6

Discussion of the research results

In this chapter, the themes identified in Chapter 5 will be interpreted in relation to the current research and literature. Similarities and differences between the findings and existing research studies will be highlighted. Moreover, similarities and differences between the research findings and the objectives of the SPICC model will be pointed out. Another important aim of this chapter includes considering the findings in the light of the model's applicability within the South African context.

6.1 The SPICC model enhances psychotherapists' conceptualisation skills

In this study, participants regarded the structured and purposeful integration of various treatment modalities in the SPICC model as a map of what happens in psychotherapy. Their understanding of a therapeutic process has been experienced as enhancing their conceptualisation skills, which aided them in aligning a therapeutic process to the case conceptualisation. This finding is supported by the notion that case conceptualisation is a fundamental psychotherapeutic skill (Bernard & Goodyear, 2013; Betan & Binder, 2010; Dobson & Shaw, 1993; Ellis, Hutman, & Deihl, 2013; Fuertes, Spokane, & Holloway, 2012; Ingram, 2006; Kuyken, Padesky, & Dudley, 2008; Liese & Esterline, 2015; Persons, 1989) which might improve psychotherapist competence and treatment efficacy (Haarhoff, Flett, & Gibson, 2011). The SPICC model, as an integrative approach, also enhanced participants' understanding of the purpose of employing a specific therapeutic approach at a specific point in time. Therefore, the SPICC model meets the requirements with regards to the need for grounding the integration of various treatment approaches within a structure that offers justified rationales for the specific interventions used, as emphasised by Cameron (2011).

The SPICC model justifies the use of each treatment modality at a specific point in time and this furthermore informed and aided in the participants' treatment planning. Ample research found that treatment planning is an important feature of case conceptualisation (e.g. Bieling & Kuyken, 2003; Betan & Binder, 2010; Kuyken et al., 2008; Levenson & Strupp, 1997). According to Henry and Williams (1997), a case conceptualisation should include a guiding framework which provides a psychotherapist with a selection of interventions, especially when a client presents with multiple problems. Based on the participants' accounts, the SPICC model also meets the aforementioned criteria. Firstly, participants

experienced the model as providing them with various treatment modalities to choose suitable techniques from. Secondly, participants regarded the model useful to work holistically in addressing several of a client's needs simultaneously. The latter will be discussed in 6.4.

The ability to conceptualise is an essential therapeutic skill for beginner psychotherapists to acquire (Liese & Esterline, 2015). Bernard and Goodyear (2013) found that novice psychotherapists need to be taught conceptualisation skills effectively within the setting of supervision. In comparing case formulation skills of experts and novice psychotherapists, Dudley, Ingham, Sowerby, and Freeston (2015) acknowledged that novice psychotherapists tend to include inappropriate or superficial information and irrelevant treatment options in their conceptualisations. This might be ascribed to beginner psychotherapists having little theoretical background and practical experience in doing therapy (Eells & Lombart, 2003; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Liese & Esterline, 2015). There has been a call for more theory-driven supervision interventions (e.g. Bieling & Kuyken, 2003; Ellis, 2010) in order to equip future mental health professionals to uphold the standard of the Psychology profession (Falender & Shafranske, 2004). According to Witte, Gordon and Joiner (2009), graduate coursework teaches student psychotherapists specific therapeutic techniques; however it does not focus on training students how to integrate these techniques with other crucial clinical activities, for example monitoring the progress of treatment. As a result, novice psychotherapists feel ill prepared in coping with difficult situations in practice (Witte et al., 2009). Similarly, Ellis et al. (2013) found that there is a lack of tools to facilitate the development of case conceptualisation skills, which includes a psychotherapist's ability to develop effective treatment plans. The SPICC model can address and fulfil this need, especially since the model provides psychotherapists with clear guidelines on how to integrate various treatment modalities and hence enhance their treatment planning skills. The SPICC model therefore has the potential to be used as a tool to address the need for teaching novice psychotherapists conceptualisation skills effectively in having psychotherapists, who are trained in the SPICC model, supervise the model as a conceptualisation tool to their supervisees.

In addition to being a valuable tool that can be used by novice psychotherapists, the use of the SPICC model as a conceptualisation tool also has implications for mental health care service delivery in South Africa. According to Osborn, Dean, and Petruzzi (2004), comprehensive case conceptualisations can easily be disregarded due to large client caseloads. This is concerning given the South African context where psychotherapists have large caseloads, limited time, and few resources. These aspects will be discussed later in this

chapter. However, the construction of thorough and personalised case conceptualisations and treatment plans is an ethical responsibility (Osborn et al., 2004). South African psychotherapists are therefore faced with the challenge of developing and employing effective tools to aid in the latter. Seeing that the SPICC model can empower a psychotherapist with enhanced conceptualisation and treatment planning skill, the model can be regarded a worthy beginning of such.

6.2 Help clients faster

Participants experienced the dynamic nature of the SPICC model as creating movement in a therapeutic process and ultimately within clients. Clients' movement might be characterised by a change within themselves regardless of whether any change occurs within their environment. This is in line with Geldard et al. (2013) positing that a psychotherapist's actions will elicit internal processes within a child resulting in the child experiencing therapeutic change. Furthermore, the finding that the use of the SPICC model facilitates a client's change suggests important implications regarding the value of the model while taking into consideration that many counsellors regard clients' change to be the primary goal of therapy (Lambert, 1992). There is little consensus over the mechanisms of change across various treatment approaches (Dene, 1980; Geldard et al., 2013) and this problem can be ascribed to a lack of *a theory of therapeutic change* (Gelo & Salvatore, 2016; Salvatore & Gennaro, 2015). It is here that the SPICC model fills this identified gap, especially since the model was developed as "an integrative theory of change" (Geldard et al., 2013, p. 69). According to Geldard et al. (2013), each of the therapeutic approaches included in the SPICC model holds its own unique theory of change. Using each of these approaches purposefully in a specific sequence, the theory of change of each treatment modality contributes to the general theory of change in the SPICC model. This is likely to result in positive therapeutic change within a child more quickly (Geldard et al., 2013), as confirmed by the experiences of this study's participants. To facilitate a client's change faster holds implications for the use of the SPICC model in ensuring short-term therapeutic processes within the South African context. The latter will be discussed later in this chapter.

According to the participants, the SPICC model enables them to facilitate clients' movement through a process of change and can therefore be used as a way to circumvent clients' resistance to therapy. Markowitz (1959) emphasised that the difficulties involved in preparing a child for psychotherapy are often underestimated and frequently result in clients' resistance to therapy. Participant 3 highlighted that the use of the SPICC model might

counter the latter. Firstly, the integrative nature of the SPICC model allows her to increase children's receptiveness to therapy by involving them in the therapeutic process easily. This is in accordance with the notion that a cyclical process of change is an appealing approach to children, as it includes all the features typical of children's play and the way in which children learn about interpersonal relationships (Geldard et al., 2013; Heidemann & Hewitt, 1992). Secondly, the model provides her with a discreet way to employ the initial phases of the model, as Client-centred and specifically Gestalt Therapy decreases clients' defence mechanisms in her experience. The latter links with Christie (2007) who stated that the use of the SPICC model enabled her to address her client's resistance and avoidant behaviour. She similarly ascribed the decrease in her client's resistance to the initial phases of the therapeutic process to the inclusion of activities that are less threatening than talking (Christie, 2007). Marshall (1972) also suggested that child and adolescent clients' resistance to therapy can be addressed and opposed by the use of 'joining techniques'. Although the content of these techniques differ to what Geldard et al. (2013) intended with 'joining the client' in the first stage of therapy, these two approaches to circumvent clients' resistance coincide in that both place emphasis on meeting the client where he or she is at. Geldard et al. (2013) furthermore proposed that psychotherapists can draw on the spiral of therapeutic change to assist children in dealing with resistance. Participant 2 emphasised that she finds this way of working helpful since she can revisit previous phases and, as pointed out by Geldard et al. (2013), have the client "continue around the spiral" (p. 127).

Besides the SPICC model enhancing participants' conceptualisation skills, as discussed earlier, it also supports their experience of using the model to address clients' resistance. According to Abel, Hayes, Henley, and Kuyken (2016), a comprehensive case conceptualisation guides the therapeutic process when a psychotherapist is dealing with a non-responsive client. It can therefore be inferred that the SPICC model, as a tool which enhanced participants' conceptualisation skills, could also have helped them deal with difficult cases and ultimately oppose clients' resistance to therapy.

6.3 The SPICC model requires and raises awareness of a therapeutic process

While using the SPICC model, participants experienced a heightened awareness in a therapeutic process. This resulted in their ability to monitor and facilitate a client's change. An assertion by Camilleris (2001) that self-awareness adds quality and depth to a psychotherapist's work supports these experiences. She found that awareness enables a psychotherapist to be authentic, available, fully present, able to gain a deep understanding of

a client through empathy, and being able to meet a client's needs (Camilleri, 2001). Numerous studies have described other positive effects of a psychotherapist's self-awareness (e.g. Fauth & Williams, 2005; Jennings & Skovholt, 1999; Mojta, Falconier, & Huebner, 2014; Williams, 2008; Williams & Fauth, 2005). According to Williams and Fauth (2005), a psychotherapist's self-awareness is a crucial aspect of clinical practice. Research on psychotherapists' self-awareness in therapy sessions found that participants regarded in-session self-awareness helpful (Mojta et al., 2014; Fauth & Williams, 2005; Williams & Fauth, 2005). Furthermore, the more self-aware participants reported feeling, the more their clients experienced them as helpful (Fauth & Williams, 2005; Williams & Fauth, 2005). According to Carter et al. (2012), an important aspect which contributes positively to a client's meaningful change includes the ability of a psychotherapist to identify a client's shifts and improvement. These findings thus confirm that participants in this study could monitor and facilitate a client's progress in therapy when they experienced increased awareness facilitated by the use of the SPICC model. The latter is also supported by Geldard et al. (2013) as they stated that psychotherapists will benefit from referring back to the spiral of change when evaluating a therapeutic process. By doing this, psychotherapists can make informed decisions about the process onward in order to consider the child's needs (Geldard et al., 2013).

However, being aware of a client's progress not only relies on the psychotherapist's evaluation of the client during therapy sessions. According to Prochaska, Rossi, and Wilcox (1991), clients' change in psychotherapy also necessitates assessment between therapy sessions, as a therapy session represents less than 1% of a client's waking week, and the majority of a client's time is spent on activities which occur between therapy sessions. For a more accurate conclusion on a client's process of change, Prochaska et al. (1991) suggested that a client's change be monitored both within and between therapy sessions. The SPICC model can be used to achieve the latter. Both Geldard et al. (2013) and the participants in this study regarded it helpful to involve key figures in clients' lives (for example their parents and teachers) in the therapeutic process, and to monitor a client's process based on continuous feedback from these figures. The manner in which Participant 2 involved her client's parents and teacher in the two final phases of the therapeutic process, or how Participant 1 monitored her group's process of change based on feedback from the school teacher, is proof of how the SPICC model can be used in this instance.

Participant 1 uses the SPICC model's framework to help her students conceptualise a therapeutic process, regardless of whether they use the model in therapy. Her students likely benefit from this practice in developing increased awareness on their clients' therapeutic process, considering that case conceptualisation prevents psychotherapists from "just wandering aimlessly" (Hill, 2014, p. 240). Her practice furthermore suggests the potential of the SPICC model to be a useful tool for supervisors in facilitating their students' in-session self-awareness, seeing that novice psychotherapists might lack the competency to self-monitor their performance and adjust accordingly (Chi, Glaser, & Farr, 1988).

6.4 The SPICC model enriches personal experiences

In the participants' experiences, an integrated approach to therapy as a process of change ensures that therapy is an enriching experience for both the client and the psychotherapist. In studying the history of integrative psychotherapy, Norcross and Newman (1992) found eight interrelating variables which contribute to the inclination towards psychotherapy integration. These identified variables are considered applicable in supporting the development and utilising of the SPICC model and include: 1) there is a significant increase in the amount of single psychotherapies; 2) single therapies fail to confirm noteworthy efficacy; 3) there is a lack of theory to sufficiently explain and predict a client's change in behaviour; 4) the field of Psychology is in need of short-term focused therapies; 5) psychotherapists in training should be given the opportunity to experiment therapeutically; 6) psychotherapists are accountable for delivering effective therapies with inadequate socio-economic support; 7) common factors in various therapies have been identified to produce favourable therapeutic outcomes; and 8) evident in the academic field, such as research publications, there is an increase in the discussion of integrative psychotherapy (Norcross & Newman, 1992). The integration of different empirically-based approaches in conducting psychotherapy is indeed advancing (Cameron, 2011; Goldfried & Newman, 1986; Levant, 2004; Manickam, 2013; Norcross, 2005; Norcross, Karpiak, & Lister, 2005; Solomonov, Kuprian, Zilcha-Mano, Gorman, & Barber, 2016; Wiser & Goldfried, 1998; Ziv-Beiman & Shahar, 2015). The participants in this study employ the SPICC model which was developed by Geldard et al. (2013), based on the notion that integrative approaches are justified. Participants' experiences that children benefit more from therapy informed by the SPICC model than from therapy that is informed by a purist approach is consistent with Krueger and Glass (2013) who acknowledged the limitations of pure form perspectives in working with children and adolescents. Cameron (2011) similarly concluded that psychotherapy as a

discipline has expanded in knowledge to such an extent that "it makes little sense to work in such dogmatic ways" (Cameron, 2011, p. 70) such as employing a purist approach.

Participants experienced the SPICC model as flexible enough to be modified in order to meet various clients' specific needs. This finding is supported by the notion that the systematic integration of various approaches allows a psychotherapist to meet "the unique needs of clients without getting lost by moving outside of unified theoretical paradigms" (Cameron, 2011, p. 63). In order to employ an identified required intervention, the participants in this study adapted and applied the SPICC model to work with tweens, adolescents, adults, as well as clients' parents and/or caregivers. These examples emphasise the SPICC model's potential to be applied in different contexts. Furthermore, its potential to be tailor made to suit each of these contexts is in agreement with the principles of integrative psychotherapy (Betan & Binder, 2010), as the approach encourages psychotherapists to be "more flexible and creative in tailoring interventions to meet the diverse needs of clients" (Cameron, 2011, p. 64). The latter is also evident in Rankanen (2014) stating that "psychotherapists who strictly follow manuals are less efficient than flexible psychotherapists who are able to tailor their work and build an alliance which matches their varying clients' needs" (p. 193). Flexibility in terms of timing, emphasis, and technique in the implementation of an intervention is not new to the integrative psychotherapy perspective (Eagle, 2000). To adapt the SPICC model to provide a required intervention, the participants used their creativity within a safe enclosing provided by the SPICC model. Participants' creativeness is supported by Shiflett and Remley (2014) who acknowledged that the counselling community encourages the use of creativity in both counselling and supervision. Deacon (2000) also emphasised the importance of training psychotherapists in utilising their own creativity in therapy, as it will aid in their ability to identify their clients' creative problem solving skills. Furthermore, participants' liberty to use their creativity in employing the SPICC model might contribute to their experiences that the model fosters their personal growth, seeing that there exists an interconnectedness between a psychotherapist's creative processes, personal change, and henceforth therapeutic processes (Zinker, 1977).

According to the participants in this study, the use of the SPICC model is regarded as enriching clients' experiences of therapy by enabling a psychotherapist to address several of a client's needs simultaneously and ultimately work more holistically. These experiences are supported by Corey (2015) who acknowledged that a therapeutic conceptualisation that combines various approaches can attain a more holistic treatment which prevails over what could be attained by employing a purist approach. The Institute for Integrative

Psychotherapy (2016) further added that an integrative approach to psychotherapy unifies various different systems within a person and facilitates a holistic approach. These include the cognitive, affective, behavioural, and physiological systems, as well as the client's social aspects (Institute for Integrative Psychotherapy, 2016).

Types of clients that have been identified by the participants as suitable for engaging in a therapeutic process informed by the SPICC model can be supported by research that confirmed that these clients benefit from an integrative approach to psychotherapy. These clients include: clients who suffer from depression (e.g. Andrews, 1991; Banasiewicz & Kemper, 2013; Constantino et al., 2008; Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005; Van Rijn & Wild, 2013), clients who suffer from anxiety (e.g. Eagle, 2000; Gold, 2011; Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008; Van Rijn & Wild, 2013), clients who experience relational problems (e.g. Baucom, Baucom, & Christensen, 2015; Baucom, Sevier, Eldridge, Doss, & Christensen, 2011; Guerchenzon, 2014; Kenny & Winick, 2000; Mairal, 2015), clients who present with behavioural problems (e.g. Baucom et al., 2011; Brenner, Hodel, Roder, & Corrigan, 1992; Guerchenzon, 2014; Hendricks & Thompson, 2005), as well as clients who experience learning disorders or are cognitively impaired (e.g. Bogas, 1993; Brenner et al., 1992; Galicia-Connoly, Shamseer, & Vohra, 2011; Glickman, 2009).

In the experience of Participant 3, the use of the SPICC model can enrich psychotherapists' experiences of therapy by equipping them with self-confidence to facilitate a client's process of change. This finding is significant pertaining to novice psychotherapists who are known to be anxious about their performance, and foster feelings of insecurity and a lack of confidence in their therapeutic skills (Ronnestad & Skovholt, 2003; Thériault & Gazzola, 2006, 2008, 2010; Tryssenaar & Perkins, 2001). Skovholt and Ronnestad (2003) highlighted some of the challenges novice psychotherapists face. These include: preparing for meeting with clients, the interaction between them and the client during sessions, and conceptualising the experience of therapy into a theoretical framework. According to the participants in this study, the SPICC model guides them through all the aforementioned aspects of therapy. The model can therefore be regarded valuable to equip novice psychotherapists to feel more confident in their abilities.

6.5 The SPICC model's applicability within the South African context

South Africa has a limited availability of child and adolescent psychiatric care (Berg, 2012; Lund et al., 2009) and there exists a need for interventions to be applied effectively

within these contexts. An important economic pressure in South Africa includes that mental health care services continue to be persistently under resourced despite mental health being a key health issue (De Kock & Pillay, 2016; Joska & Flisher, 2005; Lund et al., 2009). South Africa also faces an imbalanced distribution of mental health care resources across all provinces which results in fragmented mental health care services (Bhana, Petersen, Baillie, Flisher, & Mhapp Research Programme Consortium, 2010; Sukeri, Alonso-Betancourt, & Emsley, 2014). As such, a scarcity of community mental health providers in rural settings in South Africa prevails (Collins, Kondos, Pillai, Joestl, & Frohlich, 2016; De Kock & Pillay, 2016). According to Lund et al. (2009), there exists insufficient knowledge on the resources that would be required to provide children and adolescents with sufficient mental health care services in low and middle-income countries. Regardless of the latter, the SPICC model is regarded an appropriate tool in addressing the need for mental health care services in any South African setting. According to the participants in this study, the use of the SPICC model does not require the use of any resources. This is supported by Geldard et al. (2013) who described the model as a "cost-effective therapeutic counselling approach" (p. 76). The latter can also be ascribed to the notion that the SPICC model ensures short-term therapy. Geldard et al. (2013) proposed that therapeutic interventions based on the SPICC model will generally consist of six to 10 sessions. The SPICC model therefore fits the South African context, seeing that a key factor that contributes to psychotherapists' inclination towards integrative psychotherapy includes the identified need to develop time-limited interventions that effectively meet clients' needs despite economic pressures (Eagle, 2000; Goldfried & Norcross, 1995).

According to the participants, the SPICC model offered them a variety of techniques to choose from and hence allowed them to be culturally sensitive in finding a suitable way of working in order to attend to, and accommodate, the cultural needs of their clients. This finding is supported by the viewpoint that an integrative approach to mental health care is essential when working with individuals from diverse cultural backgrounds (James & Prilleltensky, 2002). The SPICC model also allowed participants to be culturally sensitive, which is another important strength of the model considering that racial and ethnic matters impact the therapeutic relationship (Sue, Arredondo, & McDavis, 1992). Chang and Berk (2009) studied clients' experiences of cross-racial therapy and found that clients acclaimed psychotherapists who could circumvent racial or cultural dynamics, and disapproved of psychotherapists who demonstrated cultural ignorance or insensitivity. These findings are in line with Zayas, Torres, Malcolm, and DesRosiers (1996) who acknowledged that cultural

differences between clients and psychotherapists often result in ethnic and racial minorities' underuse of mental health care services, as well as their premature termination of treatment. Participants' emphasis on how the SPICC model aids them to be culturally sensitive can possibly be ascribed to their geographical information. South Africa's historical racial patterns have resulted in the production of mainly white female psychotherapists (Cooper, 2007). According to Cooper (2007), these psychotherapists often have difficulty in dealing with issues related to the socio-economic and racial reality of their black clients. Therefore, the sub-theme of 'Working integrative allows psychotherapists to be culturally sensitive' could possibly have emerged as a result of the participants in this study facing challenges regarding working with culturally diverse clients. In equipping themselves to provide meaningful interventions in these instances (Cooper, 2007), participants thus experienced the SPICC model to meet this challenge as the model allowed them to flexibly exert their multicultural counselling competence. The latter can be regarded a major strength of the SPICC model, as it suggests the model's ability to be used as a tool to provide clients from diverse cultures with the necessary mental health care services. More specifically, the use of the model can possibly circumvent the challenge of delivering these health care services to black African people who constitute the majority of the South African population (Marketline, 2014) and who are known to have limited access to culturally appropriate services (Cooper, 2007; Pillay, Wassenaar, & Kramers, 2004).

6.6 Critique against the SPICC model

Since the beginning of psychotherapy there has been a strong opposition between those who promote competing theoretical approaches (Solomonov et al., 2016). Participants in this study highlighted the strong contrast between professionals who prefer employing a purist approach and professionals who are inclined towards integrative psychotherapy. As a result, it was anticipated by Participants 1 and 3 that particularly professionals who prefer a purist approach might not welcome the SPICC model's integrative approach to therapy. This is in accordance to Manickam's (2013) assertion that psychotherapists oppose a unified theory despite attempts to technically integrate diverse treatment methods to address individual clients' needs. It is however noteworthy that an integrative approach does not require a psychotherapist to discard their theoretical paradigm or its principles of application (Cameron, 2011). Geldard et al. (2013) stated that psychotherapists can utilise ideas, strategies, and interventions from other therapeutic approaches without feeling obliged to accept the practical methodology of the approach in total. Rather, what participants

highlighted as possibly challenging to psychotherapists, working integrative requires psychotherapists to be flexible in expanding their theoretical knowledge and to enhance their clinical skills to ultimately prioritise the diverse needs of a client. According to Cameron (2011), and in support of the use of the SPICC model, the best suited approach to achieve the latter is integrative psychotherapy.

Participants 1 and 2 both questioned their competency in the application of the SPICC model. The model is rather new and unfamiliar to the field of integrative psychotherapy which might account for their experiences. Despite feeling inadequate to do so, Participant 1 specifically reported that she wants to use the model in supervising her students and include such a model in their practical training. This finding illustrates the identified lack of practical tools to develop trainees' competency during clinical supervision (Ellis et al., 2013), which is regarded the primary means of teaching clinical skills (Bernard & Goodyear, 2013; Watkins, 2012). Liese and Esterline (2015) studied supervision strategies for novice psychotherapists and found that novice psychotherapists value an approach to supervision informed by an integrative approach. Thus, as more research on the SPICC model contribute to the knowledge of the application of the model in various contexts, including the supervision of students in training, psychotherapists might feel more equipped and open to use the SPICC model increasingly.

6.7 Chapter summary

This chapter presented a discussion of the research results where the themes identified in Chapter 5 were interpreted in relation to the current research and literature. This chapter aimed to highlight similarities and differences between the research findings and the objectives of the SPICC model, as well as the model's applicability within the South African setting. The following chapter will summarise the research findings and provide concluding remarks.

Chapter 7

Conclusions and recommendations

There are limited published articles available on the application of the SPICC model in counselling children. In order to fill the identified gap in the literature, this study aimed to explore psychotherapists' experiences of applying the SPICC model in counselling children in South Africa. This chapter will provide a summary of the research findings, followed by the limitations pertaining to this study. Recommendations for further research will also be discussed and concluding remarks will be made.

7.1 Summary of the research findings

Six main themes and 14 sub-themes emerged from the data analysis. The six main themes included: 1) the SPICC model enhances psychotherapists' conceptualisation skills, 2) help clients faster, 3) the SPICC model requires and raises awareness of a therapeutic process, 4) the SPICC model enriches personal experiences, 5) the SPICC model's applicability within the South African context, and 6) critique against the SPICC model.

It is evident that the participants in this study use the framework of the SPICC model as a conceptualisation to which they align their therapeutic process. The latter is an interesting finding that adds to the potential ways in which the SPICC model can be used, considering that Geldard et al. (2013) intended the SPICC model to be a model of practice opposed to a conceptualisation model. This ultimately enables the participants to better conceptualise a client and a therapeutic process, and to construct effective treatment plans. This finding can hold important implications for psychotherapists, as the aforementioned skills are considered essential psychotherapeutic skills that are required from psychotherapists. The SPICC model as a structured framework provides clear guidelines on the integration of various treatment modalities and can therefore be regarded as a sufficient tool for students and beginner psychotherapists with limited experience in doing therapy. The SPICC model can also be used by clinicians to teach their supervisees conceptualisation skills. This practice can result in psychotherapists being equipped to effectively conceptualise cases and formulate treatment plans. In training psychotherapists these important psychotherapeutic skills is a worthy beginning in addressing the need for mental health care services in South Africa.

The SPICC model is seen as a dynamic model which creates movement in a therapeutic process. This movement can be evident in clients' transition between phases of the model, as

well as movement within clients themselves. The SPICC model consequently helps psychotherapists to not feel stuck in a therapeutic process, and furthermore provides a way to circumvent clients' resistance. This aspect of the model is significant within the South African context, as the use of the model can ensure short-term therapeutic interventions.

According to the participants in this study, the SPICC model raises and requires a psychotherapist's awareness of a therapeutic process. Participants reported that by being more aware, they find it easier to monitor and facilitate their clients' progress in therapy. This was another aspect of the model considered to enable psychotherapists to ensure shorter and more effective therapeutic processes. This aspect of the model also makes it a good tool for use by supervisors in facilitating students' and novice psychotherapists' in-session self-awareness which is regarded as another essential psychotherapeutic skill.

It became evident that the SPICC model ensures therapy being an enriching experience for both the client and psychotherapist. The participants in this study regarded children to benefit more from an integrative approach to therapy than from a therapeutic process informed by a purist approach. It was reported that the SPICC model enables psychotherapists to employ a holistic approach to therapy and address several of a client's needs simultaneously. The model furthermore allows psychotherapists to be creative in therapy and the participants consequently reported that they have the liberty to modify the use of the model in order to provide a specific required intervention. They are consequently able to provide various types of clients, such as tweens, adolescents, adults, and groups with an enriching experience of therapy. The latter illustrates the SPICC model's potential to be tailor made and applied in various different contexts. Different types of clients identified as suitable for engaging in a therapeutic process informed by the SPICC model include clients who suffer from depression and anxiety, clients who experience relational problems, clients who present with behavioural problems, and clients who experience learning disorders or are cognitively impaired. Research supports that these type of clients benefit from therapy informed by an integrative approach and it can therefore be concluded that these types of clients will benefit from a therapeutic approach based on the SPICC model. The SPICC model was furthermore found to provide a psychotherapist with self-confidence to facilitate a client's process of change. This finding is significant relating to novice psychotherapists who are generally anxious and insecure about their competence.

It is evident that the SPICC model is applicable within the South African context. According to the participants, the model's integrative nature allows psychotherapists to consider their clients' cultural needs and adjust their interventions accordingly. Participants

reported that the model allows them to, for example, circumvent language issues. Being able to accommodate a client's cultural needs in therapy impacts a therapeutic relationship positively and also addresses the identified need for providing children and adolescents from diverse cultures in South Africa with the necessary mental health care. The use of the SPICC model further ensures cost-effective and short-term therapy that does not require any resources. Geldard et al. (2013) posited that therapeutic processes informed by the SPICC model will generally last between six and 10 sessions. The participants in this study proposed that a therapeutic process based on the SPICC model continues on average between four and 16 sessions. This finding is significant since it confirms that the use of the SPICC model can circumvent economic challenges which South Africa faces. Furthermore, due to the model being accessible for the majority of people, it provides an effective way of doing community work.

Criticism against the SPICC model included it being somewhat 'light weight' as it lacks foundational theory for sound implementation, other professionals do not embrace the model's integrative nature, and some of the participants do not feel competent in employing the model. As a result of a prevailing opposition between professionals who promote competing theoretical approaches, participants reported that the model is not embraced by professionals who prefer employing a purist approach to psychotherapy. It was highlighted in Chapter 6 that the use of the SPICC model as an integrative approach, however, does not require a psychotherapist to discard their preferred theoretical paradigm. Geldard et al. (2013) rather encouraged professionals to flexibly expand their theoretical knowledge and clinical skills in order to ultimately prioritise their clients' needs. The latter might however be challenging for professionals, as it requires a lot of their time and effort. The lack of research and academic publications on the use of the SPICC model might contribute to the proposition that the model be taught in conjunction with foundational theory. Accordingly, it was intended that this research study is a first to contribute to the knowledge on the application of the model. It was furthermore reported that the SPICC model presupposes a psychotherapist's required level of expertise in all five modalities. Feeling incompetent in using the model, participants concluded that they wish to improve their therapeutic skills in various treatment modalities. The latter supports the finding that professionals are required to broaden their theoretical knowledge in all relevant treatment modalities when utilising the model. This finding could also be ascribed to the notion that all psychotherapists, as confirmed by research, foster feelings of insecurity about their competence. To counter their

feelings of incompetence in applying the SPICC model, participants reportedly omit specific phases of the model, or employ certain stages cursorily.

It is interesting that the participants in this study made multiple comments about the SPICC model being a good tool to be utilised by novice psychotherapists, while none of the participants are novice psychotherapists themselves. This phenomenon can possibly indicate that the participants regard the SPICC model as a training model additional to being a therapeutic model. This might be due to two of the three participants' supervising student psychotherapists in training and are therefore more likely to appreciate the model's potential for training purposes. The participants might also acknowledge the model's potential for training purposes as the University of the Free State is the first to train Psychology Master's students in the application of the model, and also as the participants themselves are experienced psychotherapists who can in hindsight appreciate the value of the model for novice psychotherapists.

7.2 Limitations of the research

Various limitations found in this study need to be considered. This study had a small sample size which was unavoidable since participants were purposefully sampled to ensure that the research questions be answered, and to elicit complex and rich descriptions from the participants. Furthermore, few psychologists are trained in integrative psychotherapy with children, which also limited the group of potential participants for this study. This study's small sample size likely prevented the researcher from achieving data saturation and can, according to Fusch and Ness (2015), consequently impact the study's content validity negatively.

It is noteworthy that one of the individual interviews was conducted in Afrikaans. The interview in itself did not pose any challenges pertaining to language, considering that Afrikaans is the researcher's mother tongue. Also, the researcher carefully translated the research questions in the interview schedule to preserve the essence of what was asked. During the data and thematic analysis, the researcher also carefully considered the context in which the Afrikaans speaking participant made each statement. This participant's statements were thus handled carefully to ensure accurate translations thereof. However, despite the researcher having conducted the interview in Afrikaans in order to accommodate the participant, and to ensure that she had a fair opportunity to express her true experiences, it is possible that the full extent of her experiences were not represented. As emphasised by Moss (2010), a precise translation into English often does not exist. It should therefore be

considered that some of the participant's initial meaning could have been compromised once translated.

It should also be added that the researcher was a novice in conducting individual research interviews. Although the researcher took precautions to enhance these abilities, she could have made more use of rephrasing, clarifying, member checking, and probing for richer information in hindsight.

7.3 Future research and recommendations

It is recommended that this research study be replicated on other and possibly bigger groups of participants in order to obtain a more accurate view of South African psychotherapists' experiences of applying the SPICC model. Future research studies can concentrate on studying psychotherapists' experiences of applying the SPICC model in community work, or to therapeutic processes with clients from diverse cultures, to focus more on the South African setting. Based on the research findings of this study, future research could employ a greater focus on the experiences of supervisors in using the SPICC model in their supervision of students. Moreover, both students' and novice psychotherapists' experiences of being introduced to the SPICC model in supervision could also be explored. Furthermore, students' and novice psychotherapists' experiences of applying the SPICC model are worth exploring. In future it would become imperative to study children's experiences of a therapeutic process informed by the SPICC model, and later to determine the effect of this model on the child client's functioning.

7.4 Concluding remarks

This concluding chapter was devoted to providing an overview of the central research findings, the limitations pertaining to this study, and recommendations for future research studies. The aim of this study was to explore psychotherapists' experiences of applying the SPICC model to counsel children in South Africa. A qualitative multiple case study approach was chosen to elicit rich data on the participants' experiences. Data was collected by means of individual research interviews and participants' reflections. The insights gained from the research findings highlighted the SPICC model's applicability within the South African context, its potential to be tailor made and applied in various contexts, its potential to enhance several of psychotherapists' psychotherapeutic skills, as well as its potential to train, and be used by, novice psychotherapists. The research findings therefore have crucial implications for psychotherapists who counsel children, as well as higher education

professionals who can teach and supervise the SPICC model to students and novice psychotherapists. It is the hope of the researcher that the research findings of this study has contributed to the knowledge on the effective counselling of children, in order to address the large need for mental health care services to these clients in South Africa.

References

Abel, A., Hayes, A. M., Henley, W., & Kuyken, W. (2016). Sudden gains in cognitive-behavior therapy for treatment-resistant depression: Processes of change. *Journal of Consulting and Clinical Psychology, 84*(8), 726-737.

Abrahams, N., & Mathews, S. (2008). Services for child sexual abuse are lacking. *South African Medical Journal*, *98*(7), 494.

Allan, A. (2008). *Law and ethics in psychology: An international perspective* (2nd ed.). Somerset-West, South Africa: Inter-Ed.

Anakwenze, U., & Zuberi, D. (2013). Mental health and poverty in the inner city. *Health & Social Work, 38*(3), 147-157.

Andrews, J. D. (1991). Integrative psychotherapy of depression: A self-confirmation approach. *Psychotherapy: Theory, Research, Practice, Training*, *28*(2), 232-250.

Anthony, S., & Jack, S. (2009). Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing 65*(6), 1171-1181. doi:10.1111/j.1365-2648.2009.04998.x

Arnberg, A., & Öst, L. G. (2014). CBT for children with depressive symptoms: A meta-analysis. *Cognitive Behaviour Therapy, 43*(4), 275-288.

Axline, V. (1947). *Play therapy*. New York, NY: Ballantine Books.

Babbie, E., & Mouton, J. (2001). *The practice of social research.* Cape Town, South Africa: Oxford University Press.

Baer, D. M. (1962). Laboratory control of thumbsucking by withdrawal and re-presentation of reinforcement. *Journal of the Experimental Analysis of Behavior*, *5*(4), 525-528.

Baker-Henningham, H. (2014). The role of early childhood education programmes in the promotion of child and adolescent mental health in low-and middle-income countries. *International Journal of Epidemiology, 43*, 407-433. doi:10.1093/ije/dyt226

Bakoula, C., Kolaitis, G., Veltsista, A., Gika, A., & Chrousos, G. P. (2009). Parental stress affects the emotions and behaviour of children up to adolescence: A Greek prospective, longitudinal study. *Stress*, *12*(6), 486-498. doi:10.3109/10253890802645041

Banasiewicz, B., & Kemper, K. J. (2013). Integrative care for adolescent mood problems: Brief report from a pediatric second opinion clinic. *Clinical Pediatrics, 52*(1), 89-91. doi:10.1177/0009922811430723

Barlow, S. E. (2016). Gestalt therapeutic practice, physiotherapists and people with chronic

pain: A literature review. *Gestalt Journal of Australia and New Zealand, 12*(2), 47-70.

Barnham, C. (2015). Quantitative and qualitative research perceptual foundations. *International Journal of Market Research*, *57*(6), 837-854. doi:10.2501/IJMR-2015-070

Barrett, P. M., Duffy, A. L., Dadds, M. R., & Rapee, R. M. (2001). Cognitive-behavioral treatment of anxiety disorders in children: Longterm (6-year) follow-up. *Journal of Consulting and Clinical Psychology, 69*, 135–141.

Barth, F. D. (2014). Putting it all together: An integrative approach to psychotherapy with eating disorders. *Psychoanalytic Social Work, 21*, 19-39. doi:10.1080/15228878.2013.865245

Baškarada, S. (2014). Qualitative case study guidelines. *The Qualitative Report, 19*(40), 1-25.

Baucom, K. J., Baucom, B. R., & Christensen, A. (2015). Changes in dyadic communication during and after integrative and traditional behavioral couple therapy. *Behaviour Research and Therapy, 65*, 18-28.

Baucom, K. J., Sevier, M., Eldridge, K. A., Doss, B. D., & Christensen, A. (2011). Observed communication in couples two years after integrative and traditional behavioral couple therapy: Outcome and link with five-year follow-up. *Journal of Consulting and Clinical Psychology*, *79*(5), 565-576. doi:10.1037/a0025121

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, *13*(4), 544-559. Retrieved from http://nsuworks.nova.edu/tqr/vol13/iss4/2

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York, NY: Guilford.

Benedict, H. E. (2008). Object relations play therapy. In C. E. Schaefer & H. G. Kaduson (Ed.), *Contemporary play therapy: Theory, research and practice*. New York, NY: Guilford.

Bennett, L. (2008). Narrative methods and children: Theoretical explanations and practice issues. *Journal of Child and Adolescent Psychiatric Nursing, 21*, 13-23. doi:10.1111/j.1744-6171.2008.00125.x

Berg, A. (2012). Infant-parent psychotherapy at primary care level: Establishment of a service. *South African Medical Journal*, *102*(6), 582-584.

Bernard, J. M., & Goodyear, R. K. (2013). *The fundamentals of clinical supervision* (5th ed.). New York, NY: Pearson.

Besa, D. (1994). Evaluating Narrative family therapy using single system research designs.

Research on Social Work Practice, 4, 309-326.

Betan, E. J., & Binder, J. L. (2010). Clinical expertise in psychotherapy: How expert therapists use theory in generating case conceptualizations and interventions. *Journal of Contemporary Psychotherapy, 40*(3), 141-152. doi:10.1007/s10879-010-9138-0

Bhana, A., Petersen, I., Baillie, K. L., Flisher, A. J., & Mhapp Research Programme Consortium. (2010). Implementing the World Health Report 2001 recommendations for integrating mental health into primary health care: A situation analysis of three African countries: Ghana, South Africa and Uganda. *International Review of Psychiatry, 22*(6), 599-610. doi:10.3109/09540261.2010.536152

Bhardwa, S. (2015). Why children's mental health should be high on the agenda. *British Journal of School Nursing, 9*(10), 510-512.

Bieling, P. J., & Kuyken, W. (2003). Is cognitive case formulation science or science fiction? *Clinical Psychology: Science and Practice, 10*(1), 52-69.

Bogas, S. M. (1993). An integrative treatment model for children's attentional and learning problems. *Family Systems Medicine, 11*(4), 385-396. doi:10.1037/a0017969

Borbasi, S., & Jackson, D. (2012). *Navigating the maze of research*. Sydney, Australia: Mosby Elsevier.

Boswell, J. F., Castonguay, L. G., & Pincus, A. L. (2009). Trainee theoretical orientation: Profiles and potential predictors. *Journal of Psychotherapy Integration, 19*(3), 291-312. doi:10.1037/a0017068

Botha, E., & Dunn, M. (2009). A board game as Gestalt assessment tool for the child in middle childhood years. *South African Journal of Psychology, 39*(2), 253-262.

Bratton, S. C., Ray, D. C., Edwards, N. A., & Landreth, G. (2009). Child-centered play therapy (CCPT): Theory, research, and practice. *Person-Centered & Experiential Psychotherapies, 8*(4), 266-281.

Bratton, S. C., Ray, D.C, Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4), 376–390.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brenner, H. D., Hodel, B., Roder, V., & Corrigan, P. (1992). Treatment of cognitive dysfunctions and behavioral deficits in schizophrenia. *Schizophrenia Bulletin, 18*(1), 21-26.

Brinkmann, S., & Kvale, S. (2005). Confronting the ethics of qualitative research. *Journal of*

Constructivist Psychology, *18*(2), 157-181.

Broome, M. E., & Stieglitz, K. A. (1992). The consent process and children. *Research in Nursing & Health*, *15*(2), 147-152.

Brownell, P., & Melnick, J. (2008). Gestalt therapy research communities. In P. Brownell (Eds.), *Handbook for theory, research, and practice in Gestalt therapy* (pp. 278-291). Newcastle, UK: Cambridge Scholars.

Burns, G. W. (2005). *101 healing stories for kids and teens*. New Jersey, NJ: Wiley.

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence*. Maryland Heights, MO: Saunders Elsevier.

Butollo, W., Karl, R., König, J., & Hagl, M. (2014). Dialogical exposure in a Gestalt-based treatment for posttraumatic stress disorder. *Gestalt Review*, *18*(2), 112-129.

Cambron, C., Gringeri, C., & Vogel-Ferguson, M. B. (2014). Physical and mental health correlates of adverse childhood experiences among low-income women. *Health & Social Work*, *39*(4), 221-229.

Cameron, A. (2011). Utilising choice theory/reality therapy's conceptualization of total behavior and the major tenets of the philosophy and approach in facilitating integrative psychotherapy. *International Journal of Choice Theory and Reality Therapy*, *31*(1), 62-72.

Camilleri, V. A. (2001). Therapist self-awareness: An essential tool in music therapy. *The Arts in Psychotherapy*, *28*(1), 79-85.

Carter, J. D., Crowe, M., Carlyle, D., Frampton, C. M., Jordan, J., McIntosh, V. V., ... & Joyce, P. R. (2012). Patient change processes in psychotherapy: Development of a new scale. *Psychotherapy Research*, *22*(1), 115-126.

Castañeiras, C., & Fernández-Álvarez, H. (2014). Complex and difficult clinical patients: Reflections on Fernández-Álvarez's integrative psychotherapy model as applied to the case of "Sonia". *Pragmatic Case Studies in Psychotherapy*, *10*(1), 40-47.

Chang, D. F. (2014). *Increasing the trustworthiness of qualitative research with member checking*. Paper presented at the American Psychological Association Convention.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521-536. doi:10.1037/a0016905

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Chen, R. (2012). Narrative therapy for Chinese adults raised as an only child. *Contemporary Family Therapy, 34*(1), 104-111. doi:10.1007/s10591-012-9177-7

Chi, M. T. H., Glaser, R., & Farr, M. J. (1988). *The nature of expertise*. Hillsdale, NJ: Lawrence Earlbaum Associates.

Christie, A. (2007). Childhood anxiety: Occupational disruption. *New Zealand Journal of Occupational Therapy, 54*(2), 31-39.

Clarke, S., Thomas, P., & James, K. (2013). Cognitive analytic therapy for personality disorder: Randomised controlled trial. *The British Journal of Psychiatry, 202*(2), 129-134. doi:10.1192/bjp.bp.112.108670

Cluver, L. D., Orkin, M., Gardner, F., & Boyes, M. E. (2012). Persisting mental health problems among AIDS-orphaned children in South Africa. *Journal of Child Psychology and Psychiatry, 53*(4), 363-370. doi:10.1111/j.1469-7610.2011.02459.x

Cohen, A. (2003). Gestalt Therapy and post traumatic stress disorder: The irony and the challenge. *Gestalt Review, 7*(1), 42-55.

Collins, P. Y., Kondos, L., Pillai, A., Joestl, S. S., & Frohlich, J. (2016). Passive suicidal ideation and community mental health resources in South Africa. *Community Mental Health Journal, 52*, 541-550. doi:10.1007/s10597-016-0003-9

Constantino, M. J., Marnell, M. E., Haile, A. J., Kanther-Sista, S. N., Wolman, K., Zappert, L., & Arnow, B. A. (2008). Integrative cognitive therapy for depression: A randomized pilot comparison. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 122-134.

Cooper, S. (2007). Psychotherapy in South Africa: The case of Mrs. A. *Journal of Clinical Psychology, 63*(8), 773-776. doi:10.1002/jclp.20392

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91.

Corey, G. (2015). *Theory and practice of counseling and psychotherapy* (2nd ed.). Belmont, CA: Brooks/Cole.

Cortina, M. A., Fazel, M., Hlungwani, T. M., Kahn, K., Tollman, S., Cortina-Borja, M., & Stein, A. (2013). Childhood psychological problems in school settings in rural Southern Africa. *PloS ONE, 8*(6), 1-9. doi:10.1371/journal.pone.0065041

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing, 26*(3), 623-630.

Crago, H., & Crago, M. (2000). The courage to enter dialogue. *Australian and New Zealand Journal of Family Therapy, 21*(3), iii-iv.

Cronin, C. (2014). Using case study research as a rigorous form of inquiry. *Nurse Researcher*, *21*(5), 19-27.

Daymon, C., & Holloway, I. (2002). *Qualitative research methods in public relations and marketing communications*. London, England: Routledge.

De Kock, J. H., & Pillay, B. J. (2016). Mental health nurses in South Africa's public rural primary care settings: A human resource crisis. *Rural and Remote Health, 16*(3), 3865-3874.

Deacon, S. A. (2000). Using divergent thinking exercises within supervision to enhance therapist creativity. *Journal of Family Psychotherapy, 11*(2), 67-73.

Dene, M. (1980). Paradoxes in the therapeutic relationship. *The Gestalt Journal, 3*(1), 5-7.

Department of Health. (2003). *National policy guidelines for child and adolescent mental health*. Pretoria, South Africa: Department of Health.

Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. (2015). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry*, *24*(2), 227-236.

Dobson, K. S. (2009). *Handbook of cognitive-behavioral therapies* (2nd ed.). New York, NY: Guilford.

Dobson, K. S., & Shaw, B. F. (1993). The training of cognitive therapists: What have we learned from treatment manuals? *Psychotherapy: Theory, Research, Practice, Training*, *30*(4), 573-577.

Dobson, L. A., Burley, T., Cook, W., & Haerich, P. (2015). "Schizophrenia" part V: A Gestalt approach to group treatment of incarcerated schizophrenic patients. *Gestalt Review, 19*(1), 90-101.

Drell, M. (1992). A multimodal treatment strategy for behavior problems in toddlers. *Infant Mental Health Journal, 13*(3), 231-244.

Dryden, W. (1995). *Brief rational emotive behaviour therapy*. London, England: Wiley.

Dudley, R., Ingham, B., Sowerby, K., & Freeston, M. (2015). The utility of case formulation in treatment decision making; the effect of experience and expertise. *Journal of Behavior Therapy and Experimental Psychiatry, 48*, 66-74.

Durrheim, K. (2006). Research design. In M. Terre Blanche, K. Durrheim, & D. Painter (Ed.), *Research in practice: Applied methods for the social sciences*. Cape Town, South Africa: University of Cape Town Press.

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior, 41,* 1319-1320. doi:10.1007/s10508-012-0016-6

Eagle, G. T. (2000). The shattering of the stimulus barrier: The case for an integrative approach in short-term treatment of psychological trauma. *Journal of Psychotherapy Integration*, *10*(3), 301-323.

Edwards, D. J. (2009). Treating posttraumatic stress disorder in South Africa: An integrative model grounded in case-based research. *Journal of Psychology in Africa*, *19*(2), 189-198.

Eells, T. D., & Lombart, K. G. (2003). Case formulation and treatment concepts among novice, experienced, and expert cognitive-behavioral and psychodynamic therapists. *Psychotherapy Research*, *13*(2), 187-204.

Eells, T. D., Lombart, K. G., Kendjelic, E. M., Turner, L. C., & Lucas, C. P. (2005). The quality of psychotherapy case formulations: A comparison of expert, experienced, and novice cognitive-behavioral and psychodynamic therapists. *Journal of Consulting and Clinical Psychology, 73*(4), 579-589.

Egger, H. L., & Emde, R. N. (2011). Developmentally sensitive diagnostic criteria for mental health disorders in early childhood: The diagnostic and statistical manual of mental disorders - IV, the research diagnostic criteria - preschool age, and the diagnostic classification of mental health and developmental disorders of infancy and early childhood - revised. *American Psychologist, 66*(2), 95-106. doi:10.1037/a0021026

Ellis, M. V. (2010). Bridging the science and practice of clinical supervision: Some discoveries, some misconceptions. *The Clinical Supervisor, 29*, 95–116. doi:10.1080/07325221003741910

Ellis, M. V., Hutman, H., & Deihl, L. M. (2013). Chalkboard case conceptualization: A method for integrating clinical data. *Training and Education in Professional Psychology, 7*(4), 246-256. doi:10.1037/a0034132

Engeln, R., Knutson, J., Laughy, L., & Garlington, W. (1968). Behaviour modification techniques applied to a family unit - a case study. *Journal of Child Psychology and Psychiatry, 9*(3-4), 245-252.

Etchison, M., & Kleist, D. M. (2000). Review of Narrative therapy: Research and utility. *The Family Journal, 8*(1), 61-66.

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency based*

approach. Washington, DC: American Psychological Association. doi:10.1037/10806-000

Fauth, J., & Williams, E. N. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology, 52*, 443-447.

Feather, J. S., & Ronan, K. R. (2010). *Cognitive behavioural therapy for child trauma and abuse: A step-by-step approach*. London, England: Jessica Kingsley.

Feixas, G., & Botella, L. (2004). Psychotherapy integration: Reflections and contributions from a constructivist epistemology. *Journal of Psychotherapy Integration*, *14*(2), 192-222. doi:10.1037/1053-0479.14.2.192

Fernández-Álvarez, H. (2001). *Fundamentals of an integrated model of psychotherapy.* Northvale, NJ: Jason Aronson.

Ferrin, M., Moreno-Granados, J. M., Salcedo-Marin, M. D., Ruiz-Veguilla, M., Perez-Ayala, V., & Taylor, E. (2014). Evaluation of a psychoeducation programme for parents of children and adolescents with ADHD: Immediate and long-term effects using a blind randomized controlled trial. *European Child & Adolescent Psychiatry*, *23*(8), 637-647.

Flaskas, C., Stagoll, B., Larner, G., Hart, B., Doan, R., Weingarten, K., ... & Pocock, D. (2000). Dialogues of diversity in therapy: A virtual symposium. *Australian and New Zealand Journal of Family Therapy*, *21*(3), 121-143.

Flisher, A. J., Dawes, A., Kafaar, Z., Lund, C., Sorsdahl, K., Myers, B., ... & Seedat, S. (2012). Child and adolescent mental health in South Africa. *Journal of Child & Adolescent Mental Health, 24*(2), 149-161.

François, D., Powell, S., & Dautenhahn, K. (2009). A long-term study of children with autism playing with a robotic pet: Taking inspirations from non-directive play therapy to encourage children's proactivity and initiative-taking. *Interaction Studies*, *10*(3), 324-373. doi:10.1075/is.10.3.04fra

Freeman, J., Epston, D., & Lobovits, D. (1997). Playful approaches to serious problems. New York, NY: Norton.

Frew, J. E. (2013). Gestalt therapy training and research: Holding our place at academic institutions in the USA. *Gestalt Review*, *17*(3), 263-271.

Fuertes, J. N., Spokane, A., & Holloway, L. (2012). *Specialty competencies in counseling psychology*. New York, NY: Oxford University Press.

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic

analyses: A quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669-684. doi:10.1080/13645579.2015.1005453

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416.

Galicia-Connolly, E. Z., Shamseer, L., & Vohra, S. (2011). Complementary, holistic, and integrative medicine: Therapies for learning disabilities. *Pediatrics in Review/American Academy of Pediatrics*, *32*(2), 18-24.

Gates, B., Newell, R., & Wray, J. (2001). Behaviour modification and gentle teaching workshops: Management of children with learning disabilities exhibiting challenging behaviour and implications for learning disability nursing. *Journal of Advanced Nursing*, *34*(1), 86-95.

Gearing, R. E., & Charach, A. (2009). Medication adherence for children and adolescents with first-episode psychosis following hospitalization. *European Child & Adolescent Psychiatry 18*, 587-595.

Gearing, R. E., Schwalbe, C. S., Lee, R., & Hoagwood, K. E. (2013). The effectiveness of booster sessions in CBT treatment for child and adolescent mood and anxiety disorders. *Depression and Anxiety*, *30*(9), 800-808. doi:10.1002/da.22118

Geldard, K., & Geldard, D. (2009). *Relationship counselling for children, young people and families*. London, England: Sage.

Geldard, K., Geldard, D., & Foo, R. Y. (2013). *Counselling children: A practical introduction* (4th ed.). London, England: Sage.

Gelo, O. C., & Salvatore, S. (2016). A dynamic systems approach to psychotherapy: A meta-theoretical framework for explaining psychotherapy change processes. *Journal of Counseling Psychology*, *63*(4), 379-395.

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrated Psychiatric Behaviour, 42*, 266-290. doi:10.1007/s12124-008-9078-3

Gerring, J. (2004). What is a case study and what is it good for? *American Political Science Review*, *98*(2), 341-354.

Gil, E. (2009). *Trauma- focused integrative play therapy manual*. Fairfax, VA: Childhelp Children's Center of Virginia.

Glasser, W. (2000). *Reality therapy in action*. New York, NY: HarperCollins.

Glickman, N. S. (2009). Adapting best practices in CBT for deaf and hearing persons with language and learning challenges. *Journal of Psychotherapy Integration*, *19*(4), 354-

384. doi:10.1037/a0017969

Gold, E., & Zahm, S. (2008). The need for Gestalt therapy research. In P. Brownell (Eds.), *Handbook for theory, research, and practice in Gestalt therapy* (pp. 27-36). Newcastle, UK: Cambridge Scholars.

Gold, J. (2011). An attachment based integrative psychotherapy for anxiety disorders. *Journal of Psychotherapy Integration, 21*(4), 382-399. doi:10.1037/a0025459

Goldfried M. R., & Newman, C. (1986). Psychotherapy integration: An historical perspective. In J. C. Norcross (Eds.). *Handbook of eclectic psychotherapy*. New York, NY: Brunner/Mazel.

Goldfried, M. R., & Norcross, J. C. (1995). Integrative and eclectic therapies in historical perspective. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 254-273). New York. NY: Oxford University Press.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi:10.1016/j.nedt.2003.10.001

Greben, D. H. (2004). Integrative dimensions of psychotherapy training. *The Canadian Journal of Psychiatry, 49*(4), 238–248.

Greenberg, L. (2008). Quantitative research. In P. Brownell (Ed.), *Handbook for theory, research, and practice in Gestalt therapy* (pp. 64-89). Newcastle, UK: Cambridge Scholars.

Greene, S., & Hogan, D. (2005). *Researching children's experience.* London, England: Sage.

Grehan, P. M., & Freeman, A. (2009). Neither child nor adult: Applying integrative therapy to adolescents. *Journal of Psychotherapy Integration, 19*(3), 269-290.

Guba, E. G. (1990). *The paradigm dialog*. London, England: Sage.

Guerchenzon, Y. (2014). Integrative family therapy for child behavioural problems in a parenting support agency. *Australian and New Zealand Journal of Family Therapy, 35*(3), 295-309. doi:10.1002/anzf.1068

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of Narrative exposure therapy for the effects of trauma among refugee populations. *The Permanente Journal, 17*(1), 70-76.

Haahr, A., Norlyk, A., & Hall, E. O. (2014). Ethical challenges embedded in qualitative

research interviews with close relatives. *Nursing Ethics, 21*(1), 6-15.

Haarhoff, B. A., Flett, R. A., & Gibson, K. L. (2011). Evaluating the content and quality of cognitive-behavioural therapy case conceptualisations. *New Zealand Journal of Psychology, 40*(3), 104-114.

Hall, K., & Meintjies, H. (2014). *Demography – children in South Africa*. Retrieved from http://www.childrencount.org.za/indicator.php?id=1&indicator=1

Hamidpour, H., Dolatshai, B., & Dadkhah, A. (2011). The efficacy of schema therapy in treating women's generalized anxiety disorder. *Iranian Journal of Psychiatry and Clinical Psychology, 16*(4), 420-431.

Harris, J. E., Kelley, L. J., & Shepard, L. M. (2015). Multitheoretical psychotherapy for depression: Integrating strategies from evidence-based practices. *Journal of Psychotherapy Integration, 25*(4), 353-367.

Havenaar, J. M., Geerlings, M. I., Vivian, L., Collinson, M., & Robertson, B. (2008). Common mental health problems in historically disadvantaged urban and rural communities in South Africa: Prevalence and risk factors. *Social Psychiatry and Psychiatric Epidemiology, 43*(3), 209-215. doi:10.1007/s00127-007-0294-9

Hayes, A. M., Beevers, C. G., Feldman, G. C., Laurenceau, J. P., & Perlman, C. (2005). Avoidance and processing as predictors of symptom change and positive growth in an integrative therapy for depression. *International Journal of Behavioral Medicine, 12*(2), 111-122.

Hayward, M. (2003). Critiques of Narrative therapy: A personal response. *Australian and New Zealand Journal of Family Therapy, 24*(4), 183-189.

Heideman, S., & Hewitt, D. (1992). *Pathways to play*. Minnesota, MN: Redleaf.

Hendricks, P. S., & Thompson, J. K. (2005). An integration of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa: A case study using the case formulation method. *International Journal of Eating Disorders, 37*(2), 171-174.

Henry, L. A., & Williams, R. M. (1997). Problems in conceptualization within cognitive therapy: An illustrative case study. *Clinical Psychology & Psychotherapy, 4*(3), 201-213.

Herriott, R. E., & Firestone, W. A. (1983). Multisite qualitative policy research: Optimizing description and generalizability. *Educational Researcher, 12*(2), 14-19.

Hewitt, J. (2007). Ethical components of researcher - researched relationships in qualitative interviewing. *Qualitative Health Research, 17*(8), 1149-1159.

Hickson, H. (2016). Becoming a critical narrativist: Using critical reflection and narrative

inquiry as research methodology. *Qualitative Social Work, 15*(3), 380-391. doi:10.1177/1473325015617344

Hill, C. E. (2014). *Helping skills: Facilitating exploration, insight, and action* (4th ed.). Washington, DC: American Psychological Association.

Högberg, G., & Hällström, T. (2008). Active multimodal psychotherapy in children and adolescents with suicidality: Description, evaluation and clinical profile. *Clinical Child Psychology and Psychiatry, 13*(3), 435-448.

Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest, 3*, 39 –77.

Houghton, C., Hunter, A., Meskell, P. (2012). Linking aims, paradigm and method in nursing research. *Nurse Researcher, 20*(2), 34-39.

Howitt, D. (2010). *Introduction to qualitative methods in psychology*. Essex, UK: Pearson.

Huang, K. Y., Nakigudde, J., Calzada, E., Boivin, M. J., Ogedegbe, G., & Brotman, L. M. (2014). Implementing an early childhood school-based mental health promotion intervention in low-resource Ugandan schools: Study protocol for a cluster randomized controlled trial. *Trials, 15*(1), 1-18.

Hurley, J., Barrett, P. & Reet, P. (2006). Let a hundred flowers blossom, let a hundred schools of thought contend: A case for therapeutic pluralism in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 13*, 173–179.

Hutyrová, M. (2016). Utilization of Narrative approach in art therapy in children with behavioural problems. *Review of Artistic Education, 1*(12), 284-289. doi:10.1515/rae-2016-0034

Imes, S., Clance, P., Gailis, A., & Atkeson, E. (2002). Mind's response to the body's betrayal: Gestalt/existential therapy for clients with chronic or life-threatening illnesses. *Psychotherapy in Practice, 58*(11), 1361-1373. doi:10.1002/jcip.10084

Ingham-Broomfield, R. (2015). A nurses' guide to qualitative research. *The Australian Journal of Advanced Nursing, 32*(3), 34-40.

Ingram, B. L. (2006). *Clinical case formulations: Matching the integrative treatment plan to the client*. Hoboken, NJ: Wiley.

Insel, T. R., Collins, P. Y., & Hyman, S. E. (2015). Darkness invisible: The hidden global costs of mental illness. *Foreign Affairs, 94*, 127-135.

Institute for Integrative Psychotherapy. (2016). *What is integrative psychotherapy?* Retrieved from http://www.integrativetherapy.com/en/integrative-psychotherapy.php

James, S., & Prilleltensky, I. (2002). Cultural diversity and mental health: Towards

integrative practice. *Clinical Psychology Review*, *22*(8), 1133-1154.

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology, 46,* 3–11.

Jirojwong, S., Johnson, M., & Welch, A. (2011). *Research methods in nursing and midwifery*. Sydney, Australia: Oxford University Press.

Jongerden, L., & Bögels, S. M. (2015). Parenting, family functioning and anxiety-disordered children: Comparisons to controls, changes after family versus child CBT. *Journal of Child and Family Studies*, *24*(7), 2046-2059.

Josefi, O., & Ryan, V. (2004). Non-directive play therapy for young children with autism: A case study. *Clinical Child Psychology and Psychiatry*, *9*(4), 533-551. doi:10.1177/1359104504046158

Joska, J. A., & Flisher, A. J. (2005). An innovative inpatient psychotherapy unit in South Africa. *Psychiatric Services*, *56*(10), 1316-1317.

Joubish, M. F., Khurram, M. A., Ahmed, A., Fatima, S. T., & Haider, K. (2011). Paradigms and characteristics of a good qualitative research. *World Applied Science Journal, 12*(11), 2082-2087. Retrieved from http://www.idosi.org/wasj/wasj12%2811%29/23.pdf

Kane, R., Sandretto, S., & Heath, C. (2004). An investigation into excellent tertiary teaching: Emphasising reflective practice. *Higher Education*, *47*(3), 283-310.

Kellett, S. (2005). The treatment of dissociative identity disorder with cognitive analytic therapy: Experimental evidence of sudden gains. *Journal of Trauma & Dissociation*, *6*(3), 55-81. doi:10.1300/J229v06n03_03

Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology, 76*, 282–297.

Kenny, M. C., & Winick, C. B. (2000). An integrative approach to play therapy with an autistic girl. *International Journal of Play Therapy*, *9*(1), 11-33.

Khankeh, H., Ranjbar, M., Khorasani-Zavareh, D., Zargham-Boroujeni, A., & Johansson, E. (2015). Challenges in conducting qualitative research in health: A conceptual paper. *Iranian Journal of Nursing and Midwifery Research, 20*(6), 635-641. doi:10.4103/1735-9066.170010

Kieling, C., & Martin, A. (2013). Catalyzing the publication of international research in child

and adolescent mental health. *Child and Adolescent Psychiatry and Mental Health*, *7*(23), 1-2. doi:10.1186/1753-2000-7-23

Kirschenbaum, H. (2004). Carl Rogers's life and work: An assessment on the 100th anniversary of his birth. *Journal of Counseling and Development, 82,* 116-124.

Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, *42*(1), 37-51.

Kleintjies, S., Lund, C., & Flisher, A. J. (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry*, *13*(2), 132-139.

Knox, S., & Burkard, A. (2009). Qualitative research interviews. *Psychotherapy Research*, *19*(4-5), 566-575. doi:10.1080/10503300802702105

Komro, K. A., Flay, B. R., Biglan, A., & Promise Neighborhoods Research Consortium. (2011). Creating nurturing environments: A science-based framework for promoting child health and development within high-poverty neighborhoods. *Clinical Child and Family Psychology Review*, *14*(2), 111-134. doi:10.1007/s10567-011-0095-2

Krueger, S. J., & Glass, C. R. (2013). Integrative psychotherapy for children and adolescents: A practice-oriented literature review. *Journal of Psychotherapy Integration*, *23*(4), 331-334. doi:10.1037/a0034949

Krueger, S. J., Glass, C. R., & Arnkoff, D. B. (2011). Child and adolescent integrative treatments and the evidence base. *Psychotherapy Bulletin*, *46*, 7-12.

Kuyken, W., Padesky, C. A., & Dudley, R. (2008). The science and practice of case conceptualization. *Behavioural and Cognitive Psychotherapy*, *36*(6), 757-768.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Ed.), *Handbook of psychotherapy integration*. New York, NY: Basic Books.

Lambert, S. F., LeBlanc, M., Mullen, J. A., Ray, D., Baggerly, J., White, J., & Kaplan, D. (2007). Learning more about those who play in session: The national play therapy in counseling practices project (phase I). *Journal of Counseling & Development*, *85*(1), 42-46.

Lampropoulos, G. K. (2006). The next generation of SEPI: Integrationists from the "get-go." *Journal of Psychotherapy Integration, 16*(1), 1-4.

Lampropoulos, G. K., & Dixon, D. N. (2007). Psychotherapy integration in internships and counseling psychology doctoral programs. *Journal of Psychotherapy Integration*,

17(2), 185-208.

Lancet Global Mental Health Group. 2007. Scale up services for mental disorders: A call for action. *The Lancet, 370*(9594), 87-98.

Landreth, G. (2002) *Play therapy: The art of the relationship*. Hove, England: Brunner Routledge.

LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy, 8*(2), 19-34.

LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. *Counseling Psychology Quarterly, 14*, 149-163.

Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design* (8th ed.). New Jersey, US: Pearson.

Levant, R. F. (2004). The empirically validated treatments movement: A practitioner/educator perspective. *Clinical Psychology: Science and Practice*, *11*(2), 219-224.

Levenson, H., & Strupp, H. H. (1997). Cyclical maladaptive patterns: Case formulation in time-limited dynamic psychotherapy. In T. D. Eells (Eds.), *Handbook of psychotherapy case formulation* (pp. 84-115). New York, NY: Guilford.

Liebenberg, S. (2006). Needs, rights and transformation: Adjudicating social rights. *Stellenbosch Law Review*, *17*(1), 5-36.

Liese, B. S., & Esterline, K. M. (2015). Concept mapping: A supervision strategy for introducing case conceptualization skills to novice therapists. *Psychotherapy*, *52*(2), 190-194.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. (2006). Global and regional burden of disease and risk factors, 2001: Systematic analysis of population health data. *The Lancet*, *367*(9524), 1747-1757.

Luck, L., Jackson, D., & Usher K. (2006). Case study: A bridge across paradigms. *Nursing Inquiry, 13*, 103-109.

Lund, C., Boyce, G., Flisher, A. J., Kafaar, Z., & Dawes, A. (2009). Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. *Journal of Child Psychology and Psychiatry*, *50*(9), 1121-1130. doi:10.1111/j.1469-7610.2009.02078.x

Lyneham, H. J., & Rapee, R. M. (2005). Evaluation and treatment of anxiety disorders in the

general pediatric population: A clinician's guide. *Child and Adolescent Psychiatric Clinics of North America, 14*(4), 845-861.

Lysaker, P. H., & Roe, D. (2012). The processes of recovery from schizophrenia: The emergent role of integrative psychotherapy, recent developments, and new directions. *Journal of Psychotherapy Integration*, *22*(4), 287-297. doi:10.1037/a0029581

Mairal, J. B. (2015). Integrative behavioral couple therapy (IBCT) as a third-wave therapy. *Psicothema, 27*(1), 13-18. doi:10.7334/ps¡cothema2014.101

Manickam, L. S. (2013). Integrative change model in psychotherapy: Perspectives from Indian thought. *Indian Journal of Psychiatry, 55*, 322-328. doi:10.4103/00195545.105558

Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review*, *29*(7), 647-657.

Maree, K. (2007). *First steps in research*. Pretoria, South Africa: Van Schaik.

Maree, K., & Van der Westhuizen, C. (2010). Planning a research proposal. In J. W. Creswell et al. (Eds.), *First steps in research* (Rev. ed., pp. 24-44). Pretoria, South Africa: Van Schaik.

Marketline. (2014). *Key facts and geographic location*. South Africa: PESTLE Country Analysis Report.

Markowitz, J. (1959). The nature of the child's initial resistances to psychotherapy. *Social Work*, 46-51.

Marriage, D., & Henderson, J. (2012). Cognitive behaviour therapy for anxiety in children with asthma. *Nursing Children and Young People*, *24*(9), 30-34.

Marshall, R. J. (1972). The treatment of resistances in psychotherapy of children and adolescents. *Psychotherapy: Theory, Research & Practice*, *9*(2), 143-148.

Masley, S. A., Gillanders, D. T., Simpson, S. G., & Taylor, M. A. (2012). A systematic review of the evidence base for schema therapy. *Cognitive Behaviour Therapy, 41*(3), 185-202. doi:10.1080/16506073.2011.614274

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3), 1-20. Retrieved from: http://nbn-resolving.de/urn:nbn:de:0114-fqs100387

Mathews, S., Abrahams, N., & Jewkes, R. (2013). Exploring mental health adjustment of children post sexual assault in South Africa. *Journal of Child Sexual Abuse*, *22*(6), 639-657. doi:10.1080/10538712.2013.811137

Mazanderani, F., & Paparini, S. (2015). The stories we tell: Qualitative research interviews, talking technologies and the 'normalisation' of life with HIV. *Social Science & Medicine, 131,* 66-73.

McDougall, T. (2011). Mental health problems in childhood and adolescence. *Nursing Standard, 26*(14), 48-56.

McLeod, B. D., Islam, N. Y., Chiu, A. W., Smith, M. M., Chu, B. C., & Wood, J. J. (2014). The relationship between alliance and client involvement in CBT for child anxiety disorders. *Journal of Clinical Child & Adolescent Psychology, 43*(5), 735-741.

McLeod, J. (2014). So many possibilities: Psychotherapy research and Narrative therapy. *International Journal of Narrative Therapy & Community Work, 1*(2), 31-35.

Membride, H., McFadyen, J., & Atkinson, J. (2015). The challenge of meeting children's mental health needs. *British Journal of School Nursing, 10*(1), 19-25.

Mental Health Care Act No. 17 of 2002 (South Africa).

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (3rd ed.). San Francisco, CA: Jossey-Bass.

Mertens, M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks, CA: Sage.

Miller, L. D., Short, C., Garland, E. J., & Clark, S. (2010). The ABCs of CBT (cognitive behavior therapy): Evidence-based approaches to child anxiety in public school settings. *Journal of Counseling & Development, 88*(4), 432-439.

Miller, W. R. (2010). Qualitative research findings as evidence: Utility in nursing practice. *Clinical Nurse Specialist, 24*(4), 191-193. doi:10.1097/NUR.0b013e3181e36087

Mills, C. (2014). Psychotropic childhoods: Global mental health and pharmaceutical children. *Children & Society, 28,* 194-204. doi:10.1111/chso.12062

Miniati, M., Callari, A., Calugi, S., Rucci, P., Savino, M., Mauri, M., & Dell'Osso, L. (2014). Interpersonal psychotherapy for postpartum depression: A systematic review. *Archives of Women's Mental Health, 17*(4), 257-268. doi:10.1007/s00737-014-0442-7

Mirnasab, M. M., & Bonab, B. G. (2011). Effects of self-monitoring technique on inattentive behaviors of students with attention deficit hyperactivity disorder. *Iranian Journal of Psychiatry, 6*(2), 84-86.

Mojta, C., Falconier, M. K., & Huebner, A. J. (2014). Fostering self-awareness in novice

therapists using internal family systems therapy. *The American Journal of Family Therapy*, *42*(1), 67-78.

Morley, C. (2011). Critical reflection as an educational process: A practice example. *Advances in Social Work and Welfare Education, 13*, 7-28.

Moss, P. (2010). English as a problem language. *Contemporary Issues in Early Childhood*, *11*(4), 432-434.

Murray, M. (2009). Narrative psychology. In Jonathan A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 111–132). London, England: Sage.

Muth, C., Bales, K. L., Hinde, K., Maninger, N., Mendoza, S. P., & Ferrer, E. (2016). Alternative models for small samples in psychological research applying linear mixed effects models and generalized estimating equations to repeated measures data. *Educational and Psychological Measurement*, *76*(1), 64-87.

Myer, L., Smit, J., Roux, L. L., Parker, S., Stein, D. J., & Seedat, S. (2008). Common mental disorders among HIV-infected individuals in South Africa: Prevalence, predictors, and validation of brief psychiatric rating scales. *AIDS Patient Care and STDs*, *22*(2), 147-158. doi:10.1089/apc.2007.0102

Neimeyer, R. A. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting & Clinical Psychology*, *61*(2), 221-234.

Newman, M. G., Castonguay, L. G., Borkovec, T. D., Fisher, A. J., & Nordberg, S. S. (2008). An open trial of integrative therapy for generalized anxiety disorder. *Psychotherapy: Theory, Research, Practice, Training*, *45*(2), 135-147. doi:10.1037/0033-3204.45.2.135

Ng, S. L., Kinsella, E. A., Friesen, F., & Hodges, B. (2015). Reclaiming a theoretical orientation to reflection in medical education research: A critical Narrative review. *Medical Education*, *49*(5), 461-475. doi:10.1111/medu.12680

Nguyen, Q. D., Fernandez, N., Karsenti, T., & Charlin, B. (2014). What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Medical Education*, *48*(12), 1176-1189. doi:10.1111/medu.12583

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Ed.), *Handbook of psychotherapy integration* (2nd ed., pp. 3-23). New York, NY: Oxford University Press.

Norcross, J. C., & Newman, C. F. (1992). Psychotherapy integration: Setting the context. In

J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration.* New York, NY: Basic Books.

Norcross, J. C., Karpiak, C. P., & Lister, K. M. (2005). What's an integrationist? A study of self-identified integrative and (occasionally) eclectic psychologists. *Journal of Clinical Psychology,* 61, 1587-1594.

Normann, N., Lønfeldt, N. N., Reinholdt-Dunne, M. L., & Esbjørn, B. H. (2016). Negative thoughts and metacognitions in anxious children following CBT. *Cognitive Therapy and Research*, *40*(2), 188-197. doi:10.1007/s10608-015-9740-2

O'Connor, K. J., & Ammen, S. (1997). *Play therapy: Treatment planning and intervention*. London, England: Academic Press.

Oaklander, V. (1992). The relationship of Gestalt therapy to children. *The Gestalt Journal, 5*, 64-74.

Oaklander, V. (2001) Gestalt play therapy. *International Journal of Play Therapy, 10*(2), 45-55.

Oh, E., & Bayer, J. K. (2015). Parents' help-seeking processes for early childhood mental health problems. *Child and Adolescent Mental Health*, *20*(3), 149-154. doi:10.1111/camh.12081

Oh, E., Mathers, M., Hiscock, H., Wake, M., & Bayer, J. (2014). Professional help seeking for young children with mental health problems. *Australian Journal of Psychology*, *67*(3), 187-195. doi:10.1111/ajpy.12072

Onwuegbuzie, A. J., & Leech, N. L. (2007). A call for qualitative power analyses. *Quality & Quantity*, *41*(1), 105-121. doi:10.1007/s11135-005-1098-1

Osborn, C. J., Dean, E. P., & Petruzzi, M. L. (2004). Use of simulated multidisciplinary treatment teams and client actors to teach case conceptualization and treatment planning skills. *Counselor Education and Supervision*, *44*(2), 12-134.

Owens, P. L., Hoagwood, K., Horwitz, S. M., Lea, F. P. J., Poduska, J. M.,Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(6), 731-738.

Parkinson, G., & Drislane, R. (2011). Qualitative research. *Online Dictionary of the Social Sciences*. Retrieved from http://bitbucket.icaap.org/dict.pl

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*(9569), 1302-1313.

Pathak, A., & Intratat, C. (2012). Use of semi-structured interviews to investigate teacher perceptions of student collaboration. *Malaysian Journal of ELT Research*, *8*(1), 1-10.

Patton, M. Q. (1987). *How to use qualitative methods in evaluation*. Newbury Park, CA: Sage.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* (3rd ed.). London, UK: Sage.

Penn, J. V. (1978). A model for training foster parents in behavior modification techniques. *Child Welfare*, *57*(3), 175-180.

Persons, J. (1989). *Cognitive therapy in practice: A case formulation approach*. New York, NY: Norton.

Piaget, J. (1962). Play, dreams and imitation in children. New York, NY: Norton.

Pillay, A. L.,Wassenaar, D. R., & Kramers, A. L. (2004). Attendance at psychological consultations following non-fatal suicidal behaviour: An ethical dilemma. *South African Journal of Psychology, 34*(3), 350-363.

Pitney, W. A. (2004). Strategies for establishing trustworthiness in qualitative research. *Athletic Therapy Today*, *9*(1), 26-28.

Plagerson, S., Patel, V., Harpham, T., Kielmann, K., & Mathee, A. (2011). Does money matter for mental health? Evidence from the child support grants in Johannesburg, South Africa. *Global Public Health*, *6*(7), 760-776. doi:10.1080/17441692.2010.516267

Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and methods*. Philadelphia, PA: Lippincott.

Pollock, K. (2012). Procedure versus process: Ethical paradigms and the conduct of qualitative research. *BMC Medical Ethics*, *13*(25), 1-12.

Potgieter, R. (1996). *'n Model vir die assessering van die seksueel gemolesteerde kind onder die ouderdom van vyf jaar* (Unpublished master's thesis). Pretoria, South Africa: University of Pretoria.

Powers, S. W., Jones, J. S., & Jones, B. A. (2005). Behavioral and cognitive-behavioral interventions with pediatric populations. *Clinical Child Psychology and Psychiatry, 10*(1), 65-77.

Prochaska, J. O, & Norcross, J. C. (2010). *Systems of psychotherapy: A transtheoretical analysis* (7th ed.). Belmont, CA: Brooks/Cole.

Prochaska, J. O., Rossi, J. S., & Wilcox, N. S. (1991). Change processes and psychotherapy

outcome in integrative case research. *Journal of Psychotherapy Integration*, *1*(2), 103-119.

Rae, T. (2012). Child-centred play therapy, by Risê Van Fleet, Andrea E. Sywulak and Cynthia Caparosa Sniscak. *Emotional and Behavioural Difficulties*, *17*(2), 213-216, doi:10.1080/13632752.2012.683544

Raeburn, T., Schmied, V., Hungerford, C., & Cleary, M. (2015). The contribution of case study design to supporting research on clubhouse psychosocial rehabilitation. *BMC Research Notes*, *8*(521), 1-7. doi:10.1186/s13104-015-1521-1

Ramey, H. L., Tarulli, D., Frijters, J. C., & Fisher, L. (2009). A sequential analysis of externalizing in Narrative therapy with children. *Contemporary Family Therapy*, *31*(4), 262-279. doi:10.1007/s10591-009-9095-5

Ramsden, P. (2003). *Learning to teach in higher education*. London, England: Routledge.

Rankanen, M. (2014). Clients' positive and negative experiences of experiential art therapy group process. *The Arts in Psychotherapy*, *41*(2), 193-204.

Rao, R., Sagar, R., Kabra, S. K., & Lodha, R. (2007). Psychiatric morbidity in HIV-infected children. *AIDS Care*, *19*(6), 828-833.

Ravens-Sieberer, U., Otto, C., Kriston, L., Rothenberger, A., Döpfner, M., Herpertz-Dahlmann, B., ... & Klasen, F. (2015). The longitudinal BELLA study: Design, methods and first results on the course of mental health problems. *European Child & Adolescent Psychiatry*, *24*(6), 651-663. doi:10.1007/s00787-014-0638-4

Ray, D. C. (2008). Impact of play therapy on parent-child relationship stress at a mental health training setting. *British Journal of Guidance & Counselling*, *36*(2), 165-187.

Ray, D. C., Bratton, S., Rhine, T., & Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, *10*(1), 85-108.

Reay, R., Stuart, S., & Owen, C. (2003). Implementation and effectiveness of interpersonal psychotherapy in a community mental health service. *Australasian Psychiatry*, *11*(3), 284-289. doi:10.1046/j.1440-1665.2003.00574.x

Reilly, J., & Jacobus, V. (2009). Gestalt therapy: Student perceptions of Fritz Perls in three approaches to psychotherapy. *Australian Journal of Guidance and Counselling*, *19*(1), 14-24.

Richter, L. M., & Dawes, A. R. L. (2008). Child abuse in South Africa: Rights and wrongs. *Child Abuse Review*, *17,* 79-93. doi:10.1002/car.1004

Ricks, L., Kitchens, S., Goodrich, T., & Hancock, E. (2014). My story: The use of Narrative

therapy in individual and group counseling. *Journal of Creativity in Mental Health*, *9*(1), 99-110. doi:10.1080/15401383.2013.870947

Robinson, S. (2011). What play therapists do within the therapeutic relationship of humanistic/non-directive play therapy. *Pastoral Care in Education*, *29*(3), 207-220. doi:10.1080/02643944.2011.599858

Roediger, E., & Dieckmann, E. (2012). Schema therapy: An integrative approach for personality disorders. *Psychotherapy Psychosomatic Medicine Psychology*, *62*(3-4), 142–148. doi:10.1055/s-0032-1304615

Rogers, C. R. (1951). *Client-centered therapy*. London, England: Constable.

Romney, A. K., Weller, S. C., & Batchelder, W. H. (1986). Culture as consensus: A theory of culture and informant accuracy. *American Anthropologist, 88*(2), 313-338.

Ronnestad, M. H., & Skovholt, T. M. (2003). The journey of therapist and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*, 5-44.

Ross, A. L. (1974). Combining behavior modification and group work techniques in a day treatment center. *Child Welfare, 53*(7), 435-444.

Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.

Ryan, F., Coughlan, M., & Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: Qualitative research. *British Journal of Nursing*, *16*(12), 738-745.

Ryan, V., & Wilson, K. (1996). *Case-studies in non-directive play therapy*. London, England: Bailliere Tindall.

Salvatore, S., & Gennaro, A. (2015). Outlines of a general theory of the psychotherapy process. The clinical exchange as communicational field: Theoretical considerations and methodological implications. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (pp. 195–212). Vienna, Austria: Springer.

Sanchez, A., & Shallcross, R. (2012). Integrative psychodynamic treatment of ataque de nervios. *Clinical Case Studies*, *11*(1), 5-23. doi:10.1177/1534650111436210

Sawyer, M. C., & Nunez, D. E. (2014). Cognitive-behavioral therapy for anxious children: From evidence to practice. *Worldviews on Evidence-Based Nursing*, *11*(1), 65-71.

Sawyer, M. G., Erskine, H. E., Sawyer, A. C., Morrissey, M., & Lynch, J. W. (2015). Childhood mental disorders: A forgotten problem? *Australian and New Zealand Journal of Psychiatry, 49*(9), 774-775. doi:10.1177/0004867415592958

Scaletti, R., & Hocking, C. (2010). Healing through story telling: An integrated approach for children experiencing grief and loss. *New Zealand Journal of Occupational Therapy*, *57*(2), 66-71.

Schatzman, L., & Strauss, A. L. (1973). *Field research: Strategies for a natural sociology*. New Jersey, US: Prentice Hall.

Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry*, *52*(8), 853-860.

Schmidt, S. J., & Schimmelmann, B. G. (2013). Evidence-based psychotherapy in children and adolescents: Advances, methodological and conceptual limitations, and perspectives. *European Child & Adolescent Psychiatry*, *22*(5), 265-268. doi:10.1007/s00787-013-0415-9

Schmidt, S. J., & Schimmelmann, B. G. (2015). Mechanisms of change in psychotherapy for children and adolescents: Current state, clinical implications, and methodological and conceptual recommendations for mediation analysis. *European Child & Adolescent Psychiatry*, *24*(3), 249-253. doi:10.1007/s00787-015-0698-0

Schottenbauer, M. A., Glass, C. R., & Arnkoff, D. B. (2005). Outcome research on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (2nd ed., pp. 459-493). New York, NY: Oxford University Press.

Seidman, I. (2013). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College.

Seligman, L. D., & Ollendick, T. H. (2011). Cognitive-behavioral therapy for anxiety disorders in youth. *Child and Adolescent Psychiatric Clinics of North America*, *20*(2), 217-238.

Shah, S. K., & Corley, K. G. (2006). Building better theory by bridging the quantitative–qualitative divide. *Journal of Management Studies*, *43*(8), 1821-1835.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22,* 63-75. Retrieved from http://www.crec.co.uk/docs/Trustworthypaper.pdf

Shiflett, C. L., & Remley JR, T. P. (2014). Incorporating case conceptualization drawing in counselor group supervision: A grounded theory study. *Journal of Creativity in Mental Health*, *9*(1), 33-52. doi:10.1080/15401383.2013.878680

Shisana, O., Rice, K., Zungu, N., & Zuma, K. (2010). Gender and poverty in South Africa in the era of HIV/AIDS: A quantitative study. *Journal of Women's Health*, *19*(1), 39-46.

Skovholt, T. M., & Ronnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development, 30*(1), 45-58.

Solomonov, N., Kuprian, N., Zilcha-Mano, S., Gorman, B. S., & Barber, J. P. (2016). What do psychotherapy experts actually do in their sessions? An analysis of psychotherapy integration in prototypical demonstrations. *Journal of Psychotherapy Integration*, *26*(2), 202-216.

Sorsdahl, K., Stein, D. J., Williams, D. R., Anthony, J., & Myers, B. (2015). Childhood punishment and risk for alcohol use disorders: Data from South Africa. *International Journal of Mental Health and Addiction, 13*(1), 103-114. doi:10.1007/s11469-014-9516-z

Sotskova, A., Carey, T., & Mak, B. (2016). Applying Goldfried's concept of assimilative psychotherapy integration: The process of synthesizing existential and cognitive behavioral therapy models. *Journal of Psychotherapy Integration, 26*(1), 36-45.

St. James-O'Connor, T., Meakes, E., Pickering, M., & Schuman, M. (1997). On the right track: Client experience of Narrative therapy. *Contemporary Family Therapy: An International Journal, 19*, 479-495.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage.

Stangier, U., Schramm, E., Heidenreich, T., Berger, M., & Clark, D. M. (2011). Cognitive therapy vs interpersonal psychotherapy in social anxiety disorder: A randomized controlled trial. A*rchives of General Psychiatry*, *68*(7), 692-700. doi:10.1001/archgenpsychiatry.2011.67

Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *The British Journal of Psychiatry*, *192*(2), 112-117. doi:10.1192/bjp.bp.106.029280

Stutey, D. M., Helm, H. M., LoSasso, H., & Kreider, H. D. (2015). Play therapy and photo-elicitation: A Narrative examination of children's grief. *International Journal of Play Therapy*, 1-12.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies

and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20,* 64-88.

Sukeri, K., Alonso-Betancourt, O., & Emsley, R. (2014). Staff and bed distribution in public sector mental health services in the Eastern Cape province, South Africa. *South African Journal of Psychiatry*, *20*(4), 160-165. doi:10.7196/SAJP.570

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63-75.

Tasca, G. A., Sylvestre, J., Balfour, L., Chyurlia, L., Evans, J., Fortin-Langelier, B., ... & Joyce, A. S. (2015). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy, 52*(1), 1-11. doi:10.1037/a0038252

Taylor, M. (2014). The role of the therapist. *Trauma therapy and clinical practice: Neuroscience, Gestalt and the body.* Berkshire, UK: Open University Press.

Taylor, M. A., & Callahan, J. L. (2005). Bringing creativity into being: Underlying assumptions that influence methods of studying organizational creativity. *Advances in Developing Human Resources*, *7*(2), 247-270.

Tewksbury, R. (2009). Qualitative versus quantitative methods: Understanding why qualitative methods are superior for criminology and criminal justice. *Journal of Theoretical and Philosophical Criminology, 1*(1), 38-58. Retrieved from http://jtpcrim.org/January_Articles/Qualitative_Vs_Quantitave_Richard_Tewksbury.pdf

Thériault, A., & Gazzola, N. (2006). What are the sources of feelings of incompetence in experienced therapists? *Counselling Psychology Quarterly, 19*(4), 313-330.

Thériault, A., & Gazzola, N. (2008). Feelings of incompetence in novice and experienced clinicians: Causes, consequences, and coping/correctives. In A. Reeves (Eds.), *Key issues for counselling in action* (2nd ed., pp. 228-243). Thousand Oaks, CA: Sage.

Thériault, A., & Gazzola, N. (2010). Therapist feelings of incompetence and suboptimal processes in psychotherapy. *Journal of Contemporary Psychotherapy, 40*(4), 233-243. doi:10.1007/s10879-010-9147-z

Tryssenaar, J., & Perkins, J. (2001). From student to therapist: Exploring the first year of practice. *American Journal of Occupational Therapy, 55,* 19-27.

Turns, B. A., & Kimmes, J. (2014). "I'm not the problem!" Externalizing children's "problems" using play therapy and developmental considerations. *Contemporary Family Therapy, 36*(1), 135-147. doi:10.1007/s10591-013-9285-z

Urao, Y., Yoshinaga, N., Asano, K., Ishikawa, R., Tano, A., Sato, Y., & Shimizu, E. (2016).

Effectiveness of a cognitive behavioural therapy-based anxiety prevention programme for children: A preliminary quasi-experimental study in Japan. *Child and Adolescent Psychiatry and Mental Health, 10*(4), 1-12. doi:10.1186/s13034-016-0091-x

Valero-Aguayo, L., Ferro-García, R., Kohlenberg, R. T., & Tsai, M. (2011). Therapeutic change processes in functional analytic psychotherapy. *Clínica y Salud, 22*(3), 209-221.

Van Baalen, D. (2010). Gestalt therapy and bipolar disorder. *Gestalt Review, 14*(1), 71-88.

Van Rijn, B., & Wild, C. (2013). Depression: Practise-based evaluation of transactional analysis, Gestalt, and integrative psychotherapies and person-centred counseling. *Transactional Analysis Journal, 43*(2), 150-163. doi:10.1177/0362153713499545

Van Steensel, F. J. A., & Bögels, S. M. (2015). CBT for anxiety disorders in children with and without autism spectrum disorders. *Journal of Consulting and Clinical Psychology, 83*(3), 512-523.

Vigerland, S., Thulin, U., Ljótsson, B., Svirsky, L., Öst, L. G., Lindefors, N., ... & Serlachius, E. (2013). Internet-delivered CBT for children with specific phobia: A pilot study. *Cognitive Behaviour Therapy*, *42*(4), 303-314.

Wachtel, E. F. (2004). *Treating troubled children and their families.* New York, NY: Guilford.

Wagner-Moore, L. E. (2004). Gestalt Therapy: Past, present, theory, and research. *Psychotherapy: Theory, Research, Practice, Training, 41*(2), 180-189. doi:10.1037/0033-3204.41.2.180

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work.* London, England: Routledge.

Ward, T., & Hogan, K. (2015). Using client-centered psychotherapy embedded within a pluralistic integrative approach to help a client with executive dysfunction: The case of "Judith". *Pragmatic Case Studies in Psychotherapy*, *11*(1), 1-20.

Waters, K. R. (2011). The hungry-for-attention metaphor: Integrating Narrative and behavioural therapy for families with attention seeking children. *Australian and New Zealand Journal of Family Therapy, 32*(03), 208-219.

Watkins, C. E. (2012). Psychotherapy supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. *Journal of Contemporary Psychotherapy, 42*, 193-203. doi:10.1007/s10879-011-9202-4

Weller, S. C., Romney, A. K., 1988. Systematic data collection: Qualitative research methodology. Newbury Park, CA: Sage.

Whitworth, A., & Wilkinson, K. (2013). Tackling child poverty in South Africa: Implications of ubuntu for the system of social grants. *Development Southern Africa*, *30*(1), 121-134.

Williams, C. D. (1959). The elimination of tantrum behavior by extinction procedures. *The Journal of Abnormal and Social Psychology*, *59*(2), 269.

Williams, E. N. (2008). A psychotherapy researcher's perspective on therapist self-awareness and self-focused attention after a decade of research. *Psychotherapy Research*, *18*(2), 139-146.

Williams, E. N., & Fauth, J. (2005). A psychotherapy process study of therapist in session self-awareness. *Psychotherapy Research, 15*, 374-381. doi:10.1080/10503300500091355

Williams, E. N., & Morrow, S. L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research, 19*(4-5), 576-582.

Williams, L. (2010). Making contact with the self-injurious adolescent: Borderline personality disorder, Gestalt therapy, and dialectical behavioral therapy interventions. *Gestalt Review, 14*(3), 250-274.

Williams-Orlando, C. (2013). Teaching meditation to children as part of psychotherapy. *Integrative Medicine*, *12*(4), 27-32.

Wilson, K., & Ryan, V. (2005). *Play therapy: A non-directive approach for children and adolescents*. Oxford, England: Elsevier Health Sciences.

Wiser, S., & Goldfried, M. R. (1998). Therapist interventions and client emotional experiencing in expert psychodynamic–interpersonal and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, *66*(4), 634-640.

Witte, T. K., Gordon, K. H., & Joiner, T. E. (2009). The six-point dial of treatment: A useful framework for novice therapists. *Clinical Case Studies*, *8*(3), 226-240. doi:10.1177/1534650109334820

Wolfe, B. E. (2000). Toward an integrative theoretical basis for training psychotherapists. *Journal of Psychotherapy Integration, 10*(3), 233-245.

Wolfe, B. E., & Goldfried, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology*, *56*(3), 448-451.

Writer, S. (2015). *Shocking levels of poverty in South Africa revealed*. Retrieved from http://businesstech.co.za/news/general/94849/shocking-levels-of-poverty-in-south-africa-revealed/

Yanow, D., & Tsoukas, H. (2009). What is reflection-in-action? A phenomenological account. *Journal of Management Studies*, *46*(8), 1339-1364.

Yin, R. K. (2003). *Applications of case study research* (2nd ed.). Thousand Oaks, CA: Sage.

Yin, R. K. (2009). *Case study research: Design and methods*. Thousand Oaks, CA: Sage.

Yin, R. K. (2011). *Qualitative research from start to finish*. New York, NY: Guilford.

Yin, R. K. (2015). *Qualitative research from start to finish* (2nd ed.). New York, NY: Guilford.

Yontef, G. M. (1993). *Awareness, dialogue and process: Essays on Gestalt therapy*. New York, NY: Gestalt Journal Press.

Yontef, G. M. & Jacobs, L. (2007). Gestalt therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (8th ed., pp. 328–367). Belmont, CA: Brooks/Cole.

Zarbo, C., Tasca, G. A., Cattafi, F., & Compare, A. (2016). Integrative psychotherapy works. *Frontiers in Psychology*, *6*(2021), 1-3. doi:10.3389/fpsyg.2015.02021

Zayas, L. H., Torres, L. R., Malcolm, J., & DesRosiers, F. S. (1996). Clinicians' definitions of ethnically sensitive therapy. *Professional Psychology: Research and Practice*, *27*(1), 78-82.

Zinker, J. (1977). *Creative process in Gestalt therapy*. New York, NY: Brunner/Mazel.

Ziv-Beiman, S. (2015). Integrative psychotherapy and coping with psychopathological syndromes: Dilemmas around the treatment of a patient with resistant trichotillomania. *Journal of Psychotherapy Integration*, *25*(3), 175-182.

Ziv-Beiman, S., & Shahar, G. (2015). Psychotherapy integration. In R. L. Cautin & S. O. Lilienfeld (Eds.), *The encyclopedia of clinical psychology*. New York, NY: Wiley.

APPENDIX A

INTERVIEW PROTOCOL

- How would you describe the SPICC model?
- What are your experiences of applying the SPICC model in counselling children?
- What thoughts do you have on the outcomes of using the model?
- If any, what changes do you perceive in children who are being counselled by therapists using this model?
- Do you still use the SPICC model to council children?
    - **(Yes)** Could you elaborate on aspects about the SPICC model that attracts you to using it?
    - **(No)** If not, why?
    - How do you think can the model be adapted or modified to be used successfully in counselling children?
- Do you/have you adapted or modified the model in applying it to counselling children?
- What are the similarities between the SPICC model and other programs or interventions to counsel children?
- What are the major differences between the SPICC model and other programs or interventions to council children?
- Would you encourage other psychotherapists to use the model? Why/why not?
- What can other psychotherapists expect from using the model to council children?
- Can you describe specific cases or clients for which you would use the SPICC model?
- What makes the SPICC model suitable for specifically counselling children in South Africa?
- What do you regard most challenging of applying the SPICC model?
- What do you regard most rewarding of applying the SPICC model?

APPENDIX B

EXCERPT OF AN INDIVIDUAL INTERVIEW TRANSCRIPTION

INTERVIEWER: What other general thoughts do you have on the outcomes of using the model in individual therapy?

PARTICIPANT 1: You know I think … if I have to compare it to, for example, Norcross and Prochaska, I think, because the model speaks specifically about certain interventions and although it does say that you don't have to use all of them and you can use them different, for different periods of time, it does presuppose that in order to do it optimally you're gonna be really skilled in each of those areas. And I think that they're too, they they're very different. So I will be surprised to encounter a therapist who genuinely has that level of skill that I would want to have if I were implementing it regularly. Maybe that's just my perfectionism, but I'd want to really know each of those if I was gonna happily say that I use the SPICC model. I'd want to know that even if I didn't do narrative I had the capacity to do it if it was indicated. Or that I was you know a wizard, cognitive (unclear, laughing) therapy whatever so when I got to that phase I could use it if it was appropriate. And I think it's quite a big ask, whereas Norcross and Prochaska when they look at the integrated model; there's a lot more, because they look at so many different kinds of therapy, there's more leeway for the therapist to find their personality match with the therapy that they use and then be mindful of what they're trying to achieve to those particular strategies. So, for example, when they talk about you know consciousness raising; you could do that in a million different ways so I can do a psychodynamic intervention, somebody else could do something else, but we still achieve the same purpose. And I think for me that's probably a bit of a wobbly in the SPICC model I think that that it's presupposing in the level of expertise that maybe is quite difficult to attain.

INTERVIEWER: Okay, in all areas?

PARTICIPANT 1: In all areas, ja. And although I think you could probably work quite effectively without that, um if it's a model it should be achievable, you know? It should it should be actually attainable and I'm not totally convinced that it's attainable 'cause they are so very different, um even if you think about the personalities behind the guys who you know Pearls Gestalt versus you know kind of child centred like wow. It's a very different way of

being. But I mean it would be interesting to see, you know, as it is more researched, whether those things shift, or whether more flexibility is introduced um, I don't know.

INTERVIEWER: And if any, what changes do you perceive in children who are being counselled by therapists using this model?

PARTICIPANT 1: I suppose I mean … my group probably is the best and I mean, one of my Master's students is using the model beautifully um she's really, she's a very skilled lovely therapist and um and I think there's a … it's always difficult to tease out the person of the therapist though and the model that they're using, but I think that there's a lovely holding that happens with it. So um and for me holding, now being my psychodynamic self, the holding and containment are two different things. So the holding is kind of like that initial space of being able to feel safe and like you can actually start to express. And then containment for me is the moving forward so it's still with that sense of safety but the therapist provides, the therapist as a container kind of, is actually supposed to be moving the therapy forward not just holding it so it's all cosy and cotton-woolled. And um I think it does allow for that. So there's a feeling, like, because there's a sense of movement maybe in the way the therapist is thinking about how this, that's conveyed in some way to the child, like we're going somewhere together. There's a feeling of a journey and a process that's here. Because I think the therapist is very, needs to be very mindful of every step that they are doing. Whereas I know, from having supervised non-directive play therapy, for example, that it lends itself towards just going to the room and just being in there. If you don't know what you're doing, you can do no damage, which is great, but you can also do no therapy.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: Um because you're not holding this conceptualisation of this as a working moment and a working space. And um probably the more I've been in the field and the longer I've worked and the older I've got, the more adamant I am that every therapy, every encounter needs to involve work.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: Um so this for me I think introduces that on a almost um an unconscious level for the therapist and then it's communicated to the client. That we, you know, we we're here to we're here to move and to work, and we can do that slowly and gently if that's what's needed, or we can do it at a quick pace if that's where you're at, but nevertheless that's where we headed. And I really like that. And I can see, interestingly enough, in the students that I'm supervising, even though they're not using the model, when we kind of use it as a framework; so I'll say to them, you know "okay I know you're working differently but just for a moment think, where are you in the therapy process right now? What are you trying to achieve?" That it provides them with a holding, you know 'cause it brings them very solidly back to the sense of "okay, this is a process, there should be movement, what am I doing to contribute to that, where am I getting in the way?" Um and that I think the child then benefits from because there's a therapist who is much more proactive maybe in a way, you know.

INTERVIEWER: And this process that the child goes through, um is it a growth process?

PARTICIPANT 1: Mmm I would describe it as the process of change

INTERVIEWER: Okay,

PARTICIPANT 1: So ja, so depending on what it is that has brought them there um. So it could it could be change in the sense that nothing changes in the actual world but within themselves they are better able to manage it, cope with it or understand it. Um I'm just thinking I have I have … a new referral that I will go back to now when I go home who has just been diagnosed with type 1 diabetes and he immediately made me think that the SPICC model would be very useful because he's really struggling with that diagnoses and fighting it and doing all sorts of self-destructive things. And um it will be very interesting to see whether using that model; he can have his period kind of acting out and exploring all his anger and rage but eventually get to the point where he's able to implement skills that are going to be life preserving quite literally for him.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: And um ja so that that's quite nice to have that concept in my head 'cause I'm immediately thinking okay this is something where that process of change;

nothing's gonna change in terms of his diagnosis, but within himself we could get him to a space where his, his head his feelings, his actions are just in a very different place, ja.

INTERVIEWER: Okay so even though you're not implementing the SPICC model purely, for example with this client, it does inform your treatment plan?

PARTICIPANT 1: Yes ja, I think it's, I mean I … think very visually so it appeals to me in terms of the circularity of the model as well, I really like that, and I also think that for me um if I were to, if I were to draw or paint, maybe, if I were to paint a therapy process it would be circular. And it would probably be, it would probably have, I don't know. So we'd start with the central point and it would open out, probably into like a rainbow colours so we'd eventually, so it might start with something fairly dark in the middle and then eventually it will become quite a spectrum of colour and become quite expansive. So I think that visually, this model, works for my personal sense of what we're trying to do in therapy. So by the end there's kind of a whole mirage of colours that belong to the client, not to us, but we've been part of that process or kind of opened it up …

INTERVIEWER: Creating a rainbow

PARTICIPANT 1: Ja ja, so I think that that for formulation purposes it does give me a sense of where we're trying to go, ja.

INTERVIEWER: I know you said that you don't feel very comfortable with the approaches like Narrative, but do you think that the model can as it is be adapted for you to still feel comfortable using it with counselling children individually?

PARTICIPANT 1: Ja, I mean I think I … if I were to do it right now, I would leave out the … you see it's always difficult because I mean things are very defined, I don't know that I don't do narrative I think I do do stuff that's got narrative edges to it I just don't say "well now I'm doing narrative and now I'm doing Gestalt". So that that the boundaries are a bit blurred. There would probably be aspects to it but there wouldn't be um what I would consider my strengths at the moment. But I would then just omit them. But I also know that … I mean if you work non-directively with children there's some children where you don't

need to do much at all and your presence is the there, and that's all they need and they do the most amazing therapeutic work.

And you have others where your involvement is much more intense and you will then need to interpret and reflect so … your role is much greater. So I think if the model is also like that, probably each of those phases, depending on who the child is and who the therapist is and the combination, will determine how much of each is really needed. I suppose because I don't feel confident in those I'm not going to be that open towards a narrative kind of thing. And that would worry me. So I would feel like if I'm going to um, I need to get my head around that, that I'm offering something that is actually the real deal, before I say I'm doing the SPICC model.

INTERVIEWER: Okay and what are the similarities between the SPICC model and other programs and interventions to counsel children?

PARTICIPANT 1: Mmm no I don't I don't know of um I don't have anything at the moment that has that um the basis of the therapy process incorporated into it, there are lots of there are lots of models that have um strategies that you implement one after the other or you know ABC models and all those kind of things, for various disorders and difficulties, but the combination of the therapeutic process being part of the conceptualisation – I don't know of any, I haven't come across any. Um and in fact for me, I think in our training they were actually quite distinct; process and strategy and technique were kept quite separate. And as well in my social work training too. So quite a new thing for me to have those two merged. And I intuitively do it but I've never formally been trained in doing that. And I certainly have not come across another model that does it um, ja, for child work, ja.

INTERVIEWER: Okay, and would you then say that that is the major differences? Is the structure of the SPICC?

PARTICIPANT 1: Ja, ja, and the fact that you are you're called on to think about your process aspects, not just your .. not *what* you do in the room but *why* you're doing it.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: Whereas if you, I mean if you take any other model um just the top off my head like if you take something like transactional analysis for example, you've got all the strategies around what you're looking for and how you would do to the room, but you're not necessarily saying okay this point of the therapy what aspect of change do I want to bring about? It's there, it's implicit, but it's not made explicit. Whereas I think the strength of the SPICC model is that it's made very explicit. Um and you're kind of challenged to think of it as much as you are about what you're doing and how you make sense of what actually happened in the room. So it adds a, there's almost a metacognitive capacity that's required the therapist to really reflect on that, and not just make it a content based. I don't know if that makes sense.

INTERVIEWER: (Acknowledge), thank you. Would you encourage other psychotherapists to use the model?

PARTICIPANT 1: (Yes)

INTERVIEWER: Could you explain a bit more please?

PARTICIPANT 1: I would, I think … there's always space for people who are specialised in approach. I mean I think that we draw the clients that we either need or we are able to help, so I think that there's a space for people who are totally Jungian and totally this and totally that, but my gut feel, because I still am a social worker at heart, and I like community work; is that in south Africa it's a model that's accessible. And for probably the majority of people. And I also do believe that um childhood needs to be short term; I think the days of long term, slow, non-directive child therapy are passed, for many reasons, resources being a big one of them, and there's certainly some cases where I've worked with that I just know that we could never have done it any other way, so it's not that I don't think there's no place for that either, but when I look at like the training, the master students who are training now; this is something that actually really equips them to work with the majority of the kind of cases that they come across. Whereas the other models tend to equip them for a portion of the cases they come across. So this is a much more holistic way of working. Um I can see them being able to use this if they're stuck in the middle of nowhere in a Comm.serve year um and really being able to do something for a client, if not everything, at least something. Whereas if they're trained in you know child-centred play therapy and they don't have a

room and they don't have privacy and they don't have you know, then they are stuck. So ja um I think I think that it's quite exciting and I would certainly I would like to see it I would like to see it implemented more. Um and for people to be more aware of it, I think it's very unknown.

INTERVIEWER: Ja, it's very new

PARTICIPANT 1: Ja

INTERVIEWER: I heard you say now that you believe that child therapy should be shorter; the creators of this model propose 6 – 10 sessions. Do you think that is possible?

PARTICIPANT 1: I think that's probably a little too short. Um, if I, again it depends on what your child is presenting with, but if I think about like really small people, you know like 4-year-olds, 5 year olds who are struggling to separate form Mom and Dad, they're not gonna benefit from an intervention that short 'cause it's gonna take them probably half of that to be totally comfortable with the play therapist.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: So I would say when I think short term, I probably think about 12 sessions. Um and maybe more. But I think I think as professionals we need to get our heads around shorter term therapy. And there are 2 reasons for that, I mean resources are one of them but the other is that I think you know children change so quickly developmentally, that there's a there's a change in health processes happening that we're not even part of. So there will be transitions that will happen independent of the therapy, just because they're growing up and so many other things are coming at them. But I think that if we want to be responsible about teaching robustness and resilience, we need to create a sense that you can come for a little bit of help and then kind of go out there and you try your wings, and if you still need help ja sure you can come back, but let's test that rather than we pop you in therapy and now you're here for the year. Um because there's implications and implicit messages that the child picks up as a result of that. You know 'I can't cope, I need to be here, I'm different', whereas a short-term intervention the child may not even recall it, it's such a tiny portion of their year. By the time that they get to the end of the year then they maybe remember that

nice lady you know who I met and saw, but it hasn't become a defining aspect. Uhm but they can always return so ja I do think, I do question the length of time that they suggest, um but I do think that they're on the right track about making a short term intervention.

INTERVIEWER: How many sessions would you suggest then for individual therapy using the SPICC model?

PARTICIPANT 1: I think a minimum of 12. Probably? I think I do that anyway when I work with children is that I tend to say let's we work for 6, then we have a parent feedback session, and then we work for another 6. So that there's a sense of like we've got enough rapport, I can really I can really speak from um genuine observation and experience of how this child is operating in therapy and what the state of the therapeutic relationship is at that stage. And then say okay we can start (unclear), or no, we're actually only halfway, or we only just started. Um so that's not, that's just what I know from experience, I don't have any evidence (unclear) but my sense is that 12 sessions for most children um and I'm not talking about severe trauma or, but divorce you know um family separations, family adjustments, those kind of issues, 12 sessions is quite a good number.

INTERVIEWER: Okay,

PARTICIPANT 1: 'Cause it's also never consistent, because it's always school holidays and something, so by the time you've worked with them you may actually worked for 4 months but you've seen them 12 times. So in, they've had the benefit of that therapeutic holding for a longer period than they've actually been in therapy sessions, which I think is also helpful. Um but ja that would be my idea of what's needed, ja.

INTERVIEWER: (Acknowledge), how many sessions did you employ with the group?

PARTICIPANT 1: We had 12 sessions.

INTERVIEWER: 12. Okay, and the psychoeducation case?

PARTICIPANT 1: Those, the psychoeducation groups are 8 sessions each, so they are shorter, and that's partly pragmatics 'cause it's fitting in with school terms and things, um but

also we've been able to work much more rapidly. So um whereas with the little traumatised girls it was slow in the beginning, very slow, ja. But also their process was also not over, it wasn't consistent, because there was school holidays, so they probably worked with me maybe about 5 months. Those 12 sessions were over 5 months. 'cause I also had to come here, so there was my absence and then there was their school holidays. So in all, and it's quite dear because they spoke about the fact that, they would say to me "we've had you for almost half a year", and it's like it's a big deal, so in their mind the experience of that group process was actually that it was as long as half a year. Despite the fact that the contacts weren't, and that's I think what I mean by but that holding space is still there, even if the sessions are not weekly within that space.

INTERVIEWER: And you think that benefitted the process?

PARTICIPANT 1: Ja, I do, I do. Um so I think if I were to do … I would terminate, in terms of the SPICC model the termination phase, I would start cutting down on the frequency of sessions within that space. So you might have, let's say 12 sessions, but the last two or three would be spaced with 2 weeks between, so you also get that benefit of partly assessing and consolidating, just to see how the child manages, and then also just to be able to extend it a little bit so that the holding is there but um they are also able to try their wings.

INTERVIEWER: Okay um I know you said that you backtracked a bit to resolve feelings, are there any other incidents where you felt that they went back to a certain phase, as the model lends itself?

PARTICIPANT 1: Um ja I just think … there was um, I'm not sure whether this, well I'll think aloud so …there was a moment in the group process where there was a hiccup, because one of the little girls, so we, one of the things that we did was we learned the song called 'the body song', which is a song about my body is nobody's body but mine, you run your own body you don't run mine, but actions are loud and whatever, it was really fun. And they liked to dance so they would dance to the body song. And one little person was obviously s fascinated by this song, that she went out into the playground and she taught it to several of her friends. And other girls in the group were furious with her, 'cause they felt that that was a breach of confidentiality.

INTERVIEWER: (Acknowledge)

PARTICIPANT 1: And in actual fact it wasn't, because the contract was that you didn't share other people's information, but you could share your own and you could share anything that I said in the group, because my information as obviously for public consumption. But nevertheless, it created quite a dynamic in the group. Now that was more of a group theory kind of process dynamic, but it did it did get it the way because it made, it got people's backs up, it made some people a little bit more resistant to sharing. Um so they each had their own little response to it, and there was a little bit of power play in that um I mean I knew about it because the school obviously gave me feedback in between sessions if anything happened, but also when I arrived with the group the first thing was that some little people wanted to come and tell me about it and report her, and she off course desperately needed to tell me her side of it. So there was a little bit of a backslide in the group in terms of the dynamics but also in terms of the therapy process. And I suppose you might you might be able to couch that from a SPICC model perspective in line with resistance. I don't think it was, it's a bit more complicated, because it was, there was definitely resistance to movement then, but it was as a product of a group process that made everybody a little bit less inclined to share um and to risk until we had resolved that. So once we had spoken about it and we'd kind of clarified the boundaries, and talked about the confidentiality, and the fact that nobody was actually really wrong here, because they were concerned about a breach here and they had every reason to be concerned about the breach, but the nature of the breach was actually a little bit more complicated. So we talked through it, then it got back on track. But I think if I think about my little group members, there were probably one or two who took that harder than others, um the little person who was um in trouble, interestingly enough actually came out of it with flying colours, because she felt very heard in that process. So instead of her being one of the ones who was then resistant it actually wasn't her, she felt quite vindicated you know (laughter) and in line with the whole victim-abuse kind of dynamic I think being heard was very healing for her. But there were others who were very cross. Um and (laughter) so I think that was a bit of a therapeutic moment, it was actually quite nice to work with it actually, it was quite challenging.

APPENDIX C

EXAMPLE OF DATA ANALYSIS

	Interview Transcription	Code(s)
INTERVIEWER	Okay I'm curious about what,	
PARTICIPANT 2	Curious (laugh)	
INTERVIEWER	(laughter) About what your take is on the Narrative therapy then in the SPICC model	
PARTICIPANT 2	It makes a lot more sense to me to have the Narrative therapy integrated into something else. So the Narrative therapy on its own is … I loved it, because it spoke to the power dynamic and the way in which you build a relationship with the children is very important, however it is lacking particularly when you work with children, so you need some of the Gestalt and the ag the initial	15
INTERVIEWER	Client-centred	
PARTICIPANT 2	Client centred approach. And the thing that I didn't like about the Narrative therapy; in the end you're not actually coming up with um something constructive that the child can then use, so then what is the point? So I feel better about myself, but now do I have any constructive strategies? And that unfortunately the strategies don't go with the philosophical underpinnings of Narrative therapy.	8
INTERVIEWER	Referring to that it should rather be integrated, do you think that's true for all the aspects of the SPICC model or specifically is it,	
PARTICIPANT 2	I'll be very honest with you and say that I'm an integrative person so I have always had anergic reaction against polarities	15
INTERVIEWER	(Acknowledge)	

PARTICIPANT 2	Don't talk to me about learning as either stage or continuous, it's not. It's both, so therefore just having one way of working does not make any sense to me whatsoever	15
INTERVIEWER	Okay, what do you think is the advantages of working integratively?	
PARTICIPANT 2	It's so much more flexible. I mean you can, depending on the child that comes to you, you might have a child who thrives in the person-centred so for example if you're working with a very gifted little one, they may not want to do play and where the SPICC model you can work around that so you could try you could start with Gestalt, do that but then you can you can maybe make it for an older, even though they're very young and, it's just so flexible, you know. And depending on the needs of the client. I mean I've got some teenagers particularly, they don't really have any emotional issues so ag it's not that you necessarily want to skip the steps but you go through some of them very fast and then you get to more a little bit more of the Narrative stuff and then developing the strategies and all that kind of stuff	15 16 15 14
INTERVIEWER	(Acknowledge)	
PARTICIPANT 2	So so I'm actually really tired so this is sounding so silly, but ja I think integrated is more flexible, it suits more clients, you can cater to more people's needs,	15 15 15, 16, 17
INTERVIEWER	(Acknowledge)	
PARTICIPANT 2	You really can	
INTERVIEWER	Do you think for children individually it is more advantageous to be treated with an integrative model?	

PARTICIPANT 2	I think everybody should be treated with an integrative model (laughter). We live in multiple systems, we have multiple systems within ourselves, we've got the emotional, we've got the cognition, we've got the we've got all of that going, the sensory stuff I mean it makes no sense if you're working with a kid with learning disorders you'd be referring to an OT, you'd be referring to a speech, you'd be referring to maybe remedial, even the doctor if there's a physical illness, why on earth would you want to do therapy in one modality? It doesn't make sense to me.	15 17 15, 17

APPENDIX D

EXAMPLE OF THE RESEARCHER'S REFLECTIVE JOURNAL

The initial data analysis is completed and I have produced, what I hope to be, the final draft of my research findings. Although the interview transcriptions were VERY time consuming, I am grateful that I did it myself as it resulted in me having gained more insights into the data.

Looking back on the interview processes, I have become aware of my lack of skill in conducting individual research interviews. Reading through the data, I now recognize many more opportunities for probing and clarifying so as to elicit more information. However, the data produced a lot of long, rich and complex descriptions – maybe because my participants are psychologists? (I am grateful).

I found it very tiring to have read and reread through all the data as many times. It has however benefitted my understanding of the research. I can now, in speaking to someone about my research, recite participants' quotations word-for-word and this makes me feel as if I am really involved with the data.

Although being very upset over having to redo the data analysis, and reproduce the research findings, I am now very thankful that I did. I gained a deep understanding of participants' experiences and I now realise that my first draft of research findings was lacking depth and order. The final draft is much more organised and concise, yet rich and complex.

It is a pity that I only had 3 participants (although I appreciate that I did not have even *more* data), as it would have been nice to support themes by quoting more than two or three participants. I found it somewhat difficult to organise the themes and sub-themes to each have at least two participants support the theme. Nonetheless I feel that 3 participants were sufficient for this qualitative research, especially considering the richness of the data.

APPENDIX E

TURNITIN REPORT

Kindly note that the full Turnitin report can be requested from the research supervisor.

PSYCHOTHERAPISTS' EXPERIENCES OF USING THE SEQUENTIALLY PLANNED INTEGRATIVE COUNSELLING FOR CHILDREN MODEL

Elsabé Nortje

DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

MAGISTER ARTIUM

in the

FACULTY OF THE HUMANITIES

DEPARTMENT OF PSYCHOLOGY

at the

UNIVERSITY OF THE FREE STATE

Supervisor: Dr. A. Botha

Co-supervisor: Dr. L. Nel

November 2016

i

M

ORIGINALITY REPORT

8%	6%	3%	2%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to North West University Student Paper	1%
2	uir.unisa.ac.za Internet Source	<1%
3	Submitted to University of the Free State Student Paper	<1%
4	Submitted to University of Wales Swansea Student Paper	<1%
5	dspace.nwu.ac.za Internet Source	<1%
6	media.proquest.com Internet Source	<1%
7	Botha, E., and M. Dunn. "A Board Game as Gestalt Assessment Tool for the Child in Middle Childhood Years", South African Journal of Psychology, 2009. Publication	<1%
8	mro.massey.ac.nz Internet Source	<1%
9	scholar.sun.ac.za	