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Article

Changes in Training-Clinic Patients: Evaluation of the Results and Processes[1]

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Abstract: This study investigated changes in patients cared for in a Training-Clinic and sought to understand the factors influencing the results of psychotherapeutic practices. The sample was composed of nine participants (eight women and one man) aged 33 years old or older, after they had completed psychotherapy treatment. Semi-structured interviews were conducted to evaluate adaptive efficacy, stage of change, and psychopathological symptoms. The Scale for Efficacy of Adaptation (EDAO-R), the Stage of Change Scales (EEM), and the Symptom Assessment Scale 40 (EAS-40) were used. Data suggest that easing symptoms is possible, as is progressing in stage changes; adaptive efficacy, however, is more resistant to change. Positive therapeutic bonds and the willingness of patients to act as agents of their own change may have been relevant in the psychotherapies outcomes, even though these were not directly evaluated. Longitudinal studies are needed to monitor processes from their beginnings.

Keywords: Psychotherapeutic Processes, Process Assessment (Health Care), Change (Psychology), Training-clinic.

Mudança em Pacientes de Clínica-escola: Avaliação de Resultados e Processos

Resumo: Este artigo objetivou avaliar mudanças em pacientes atendidos em clínica-escola e compreender possíveis fatores que influenciaram os resultados das psicoterapias. A amostra foi composta por nove participantes (oito mulheres e um homem), com idade igual ou superior a 33 anos, em fase de término de atendimento psicoterápico. Realizou-se entrevista individual semiestruturada para avaliar eficácia adaptativa, estágio de mudança e sintomas psicopatológicos. Utilizaram-se a Escala Diagnóstica Adaptativa Operacionalizada Redefinida (EDAO-R), a Escala de Estágios de Mudança (EEM) e a Escala de Avaliação de Sintomas (EAS-40). Os resultados sugerem ser possível esperar abrandamento dos sintomas psicopatológicos e progresso nos estágios de mudança. A qualidade da configuração adaptativa é mais resistente a melhoras. A aliança terapêutica positiva e a disposição do paciente como agente da própria mudança podem ter sido relevantes nos resultados das psicoterapias, ainda que não diretamente avaliados. São necessárias pesquisas longitudinais para o acompanhamento dos processos desde o início.

Palavras-chave: Processos Psicoterapêuticos, Avaliação de Processos (Cuidados de Saúde), Mudança (Psicologia), Clínica-escola.

Cambio en Pacientes de Clínica-escuela: Evaluación de Resultados y Procesos

Resumen: Se puso como objetivo evaluar los cambios en pacientes acogidos en clínica-escuela y comprender posibles factores que influenciaron en los resultados de las psicoterapias. La muestra abarcó a nueve participantes (ocho mujeres y un hombre), con edad igual o superior a 33 años, en fase final de atención psicoterápica. Fueron realizadas entrevistas individuales semi-estructuradas para evaluar la eficacia de adaptación, etapa de cambio y síntomas psicopatológicos. Fue utilizada la Escala Diagnóstica Adaptativa Operacionalizada Redefinida (EDAO-R), la Escala Etapas de Cambio (EEM) y la Escala de Evaluación de Síntomas (EAS-40). Los resultados sugieren que es posible aguardar ablandamiento de los síntomas psicopatológicos y progreso en las etapas de cambio. La calidad de la configuración de la adaptación es más resistente a mejoras. La alianza terapéutica positiva y la disposición del paciente como un agente de su proprio cambio quizá fueron relevantes en los resultados de las psicoterapias, aunque no directamente evaluados. Se hacen necesarias investigaciones longitudinales para monitorear los procesos desde su inicio.

Palabras clave: Procesos Psicoterapéuticos, Evaluación de Proceso (Cuidado de la Salud), Cambio (Psicología), Escuela-clínica.

This study aimed to evaluate changes in patients treated in a training-clinic and to identify factors that may have influenced the treatment results. The study is justified by the need to investigate the effectiveness of the psychotherapeutic interventions offered in this context, which for many patients constitutes the only opportunity to receive psychological counseling free or at a nominal cost.

There are few scientific studies that evaluate the effectiveness of psychotherapies conducted by students and that seek to comprehend and explain the psychological phenomena present in these treatments. Studies of this nature can guide the modalities of the practices developed in these institutions, encourage reflection and discussions, and serve as a parameter for other initiatives (Yoshida, 2005).

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However, there are still some challenges in clinical research to be overcome, since there are difficulties in its development within the reality of the Brazilian training-clinics (Santeiro, 2008).

This is primarily due to many professionals feeling confused about the importance of research and its usefulness in the clinic and often believing that both are contrary and incompatible. This generally happens because psychotherapists are still formed in the belief that a good theoretical formation and supervision of colleagues is enough to acquire a formation as a psychotherapist. The need to transform the practice of psychotherapy, based on evidence from systematic research, requires an attempt to prevent the crystallization of some techniques (Araújo & Wiethaeuper, 2003; Serralta, 2010).

Secondly, most of the studies in the training-clinic seek to obtain data through documental research, with consultation of the patient records. However, as pointed out by Herzberg (2007), the records are often incomplete and lack systematization of the existing information. More accurate records of the services received are needed so that, from the accumulation and construction of knowledge necessary for the development of psychology in this context, undergraduates and professionals have the opportunity to keep themselves up to date and to extract data useful for the practice.

The majority of the work carried out in training-clinics respects the characterization of the population served. This type of study is important so that the treatment offered can meet the demand, taking into account the possibilities of the patients and, additionally giving rise to improved service to the community, as well as supporting the formation of the psychology students. Some studies investigate the abandonment of psychotherapy in this context. Others emphasize the importance of supervision as one of the major forms of learning and improvement and highlight the characteristics and personal skills that can influence the formation of a good psychotherapist (Aguirre et al., 2000; Chammas, 2010). Due to the conditions presented regarding the studies commonly performed in these institutions, the need is highlighted for studies that address the results and processes of psychotherapy conducted in training-clinics.

Evaluation of Change

The concept proposed by James O. Prochaska and his research group was adopted as the criterion for change (Prochaska, 1995; Prochaska, DiClemente, & Norcross, 1992), according to which, change must be comprehended following three dimensions: processes, stages and levels of change. This dimensional conception of change is also known as the Transtheoretical Model, developed empirically and applicable to any psychotherapeutic process, regardless of the theoretical approach.

The processes of change refer to mechanisms employed by the patient to modify their feelings, thoughts, behaviors or relationship patterns, over the course of the psychotherapy. They are categorized according to ten types: (1) consciousness raising (effort of the psychotherapist for the patient to obtain new information, insights and feedback regarding their problem); (2) dramatic relief (the patient experiences and expresses emotions and feelings related to the problem and possible solutions); (3) self-reevaluation (reorganization of the image people have of themselves and their values); (4) environmental reevaluation (recognition by the patients of how their behavior is causing problems for themselves and in the environment in which they live); (5) self-liberation (when a person chooses to take responsibility to change the problem, and to invest effort and energy to do so); (6) social liberation (the patients seek ways to live free of their problem and use environmental and social resources that encourage change); (7) counterconditioning (the individual seeks new ways to respond to stimuli associated with their problem); (8) stimulus control (the attempt to prevent and reduce stimuli that lead to problem-behavior); (9) reinforcement management (when there are rewards for the changes achieved); (10) helping relationship (the individual sees the opportunity to share their problems with someone they trust). These processes are present, with more or less emphasis, in all psychotherapy according to the theoretical approach of the psychotherapist (Prochaska, 1995; Yoshida, 2002).

The basic principle associated with stages of change is that the patients begin the treatment with different degrees of awareness and motivation to address their difficulties. There are six possible stages: precontemplation, contemplation, preparation, action, maintenance and termination. In the *precontemplation* stage, the individual is not aware of their problems and resists recognizing or modifying some attitude, even if friends or family members indicate that something is not right. In the *contemplation* stage, the person realizes and admits that he or she has a problem and thinks about overcoming it, but does not actually do this. In the *preparation* stage, the passage of the intention to act is solidified. In it some attempts are made to change, which are not completed or lack sufficient effort. The *action* stage involves a change that requires real effort for the individual to modify patterns of behavior or attitudes, aiming at overcoming his or her problems. In the maintenance stage, an effort is made not to return to the previous standards, with the aim of preventing relapse and consolidate the gains obtained in the action stage. When there is 100% confidence that the previous problems will not become part of a new pattern the person is said to be in the *termination* stage. In it, the changes are stable and there are no reasons for reversals.

The passage through the stages does not occur in a linear fashion. The change occurs, usually through a spiral motion, in which relapses and returns to the old patterns of behavior are expected. This means that with every reversal,

the patient can learn from their mistakes and try something different next time (Emmerling & Whelton, 2009; Prochaska, 1995). The third dimension is the levels of change, related to the extent and depth of the changes achieved or targeted in the psychotherapy. This can be related to changes in symptoms, situational problems, maladaptive cognitions, current interpersonal conflicts, family/systems conflicts and intrapersonal conflicts. Each one represents a hierarchical and dynamic order, according to which change in one level may give rise to changes in others, regardless of the level the person starts in (Prochaska, 1995).

Among the dimensions of change of the Transtheoretical Model, the stage of change is the one that is more applicable to clinical practice and research (Emmerling & Whelton, 2009). However, to comprehend the factors involved in the progress of the patient, or lack thereof, the other two dimensions, processes and levels of change, must also be considered (Prochaska, 1995). Another concept that has proven useful for the evaluation of progress regards the efficacy with which the patients address their problems.

The concept of adaptive efficacy, proposed by Simon (1989), includes ways to solve and address day to day events, and its quality involves the adequacy of the responses of the individual to the problems in the four areas of personality functioning: *emotional-relational* (E-R - emotional responses of individuals when relating with others and with themselves), *productivity* (Pr - includes answers related to work, study or the main occupation of the person), *sociocultural* (SC - responses related to social structure, values and customs of the environment in which they live), and *organic* (Or - involves the state and functioning of health and care of the body). If the problems are solved satisfactorily, without any conflict for the individual or others, the response is considered adequate. If the solution involves some kind of conflict (whether for the individual or for society), the response is considered inadequate. In inadequate responses, the solution encountered is unsatisfactory and there is still an internal and/or external conflict. The more adequate a set of responses is, the more the adaptation of the subject will be considered effective (Simon, 1989, 1997).

The combined use of the evaluation of the adaptive efficacy and the stage of change provides an overview regarding the chance of expected progress (Yoshida & Enéas, 2004). In addition, it is possible that there is a relationship with the levels of change, because when the quality of the adaptive efficacy of the subject is known, the conditions that the people have to face their difficulties are also known. Depending on the resources available, the change can be in one of the six levels mentioned. It should also be noted that the individual characteristics and the presence or absence of psychopathological symptoms, assessed as indicative of the general functioning of the patient, may influence the results and the improvement perceived by the patient (Corbella & Botella, 2004; Yoshida, 1999).

The focus of this study is the results of psychotherapy and processes of change in patients treated in a training-clinic. The aim was to evaluate some aspects of change in adult patients undergoing psychotherapy treatment. The processes were retrospectively evaluated using information provided by the patient during an interview for this study, and through consultation of the patient records. It was sought to relate and compare the stage of change, adaptive efficacy and psychopathological symptoms.

Method

Participants

The convenience sample was composed of nine participants (eight women and one man), aged 33 years or over, in the termination phase of individual psychotherapy, all from a psychology training-clinic, in a municipality of São Paulo state. Eight of the people were married and one was single. Their occupations ranged from retired, cook, student, cleaner, massage therapist and teacher. The participants presented diverse complaints, such as relationship problems, depression, health problems, worry and nervousness, difficulty in the work place, shyness and difficulty speaking in public.

Instruments

For the study, the instruments described below were used:

The *Stages of Change Scale* (EEM), adapted to Portuguese by Pace (1999), is a self-report measure, consisting of 32 items, subdivided into four groups that correspond to the stages precontemplation, contemplation, action and maintenance. Answers are through a five-point Likert scale, where 1 equals *strongly disagree* and 5, *totally agree*. The definition of the stage of change is given by the highest score in the items of a certain stage. For the individual to be classified in preparation, it is necessary to obtain maximum scores (score = 40) in both the contemplation and action stages. A study of the reliability and validity of the EEM (Yoshida, Primi, & Pace, 2003) indicated a lower internal consistency for the precontemplation ($\alpha = 0.56$) and contemplation ($\alpha = 0.57$) stages, when compared to the action ($\alpha = 0.82$) and maintenance ($\alpha = 0.77$) stages. The factorial structure obtained by varimax rotation with Kaiser normalization indicated four-factor solution, compatible with that of the original version.

The *Symptom Assessment Scale* (EAS-40) is a self-report measure, adapted and validated by Laloni (2001) from the *Symptom Check List - 90 - Revised* (SCL-90-R) (Derogatis, 1994). It evaluates the severity of the psychopathological symptoms, according to four dimensions: psychoticism (F1), obsessivity-compulsivity (F2), somatization (F3) and

anxiety (F4). Responses are given through a three-point Likert scale representing the intensity of the symptom: 0 (no symptom), 1 (slight symptom) and 2 (extreme symptom). The study with a clinical populations indicated good internal consistency for all factors (Cronbach's alphas between 0.77 and 0.86) and good test/retest precision, between seven and 15 days (*r* between 0.40 and 0.78) (Laloni).

The *Operational Adaptive Diagnostic Scale Redefined* (EDAO-R), in which the evaluation is based on data obtained in the clinical interview, ranks the quality of adaptive responses such as: adequate, slightly adequate or very slightly adequate, depending on how they solve the problem, provide satisfaction and prevent internal or external conflict. The responses are assessed according to four areas of the functioning of the personality: emotional-relational (E-R), productivity (Pr), sociocultural (SC) and organic (Or). The evaluation is only carried out in a qualitative way in the SC and Or areas, without assigning scores, while the areas E-R and Pr the evaluation is performed quantitatively and qualitatively. There are five groups of possible adaptive diagnosis: effective adaptation (Group 1), ineffective light adaptation (Group 2), ineffective moderate adaptation (Group 3), ineffective severe adaptation (Group 4) and ineffective extreme adaptation (Group 5) (Simon, 1989, 1997). Studies focused on the psychometric qualities of reliability and validity have shown that the instrument has a high degree of concordance between judges (Yoshida, 1999).

Procedure

Data Collection

Information was obtained from the supervising professors regarding the patients who were in the termination phase of psychotherapy. They were contacted by telephone and invited to participate in the study. For those who agreed, individual interviews were scheduled to evaluate the EDAO-R and for the application of the self-report instruments (EEM and EAS-40). The interviews were recorded and transcribed.

Data Analysis

For the evaluation of the patient at the beginning of the psychotherapeutic process, the authors retrospectively and independently analyzed the screening interview and the report from the first psychotherapy session, based on the material encountered in the patient records. In each case, a clinical evaluation of the Stage of Change and the adaptive efficacy (EDAO-R) was performed. The beginning of the treatment of some patients had occurred many years before. Where there was disagreement, a discussion of the evaluations made it possible to reach a consensus.

In this step, the evaluator read the available material and proceeded first to the evaluation of the adaptive efficiency, based on the criteria of the EDAO-R (Simon, 1997). Then the material was re-examined, seeking evidence to indicate the stage of change based on the clinical judgment (Yoshida & Enéas, 2004). For this, the two criteria that define each stage were considered: degree of awareness that the patient demonstrates regarding the problem that led him or her to seek psychotherapy and to face it willingness. The statement "the patient reported having undergone previous psychotherapy for the same problem", was understood as evidence that the patient admitted having the problem and had been making efforts to address it, however, without success. In this case, the patient was classified as in the preparation stage. When there were indications that the patient had only sought care because of pressure from family members or due to referral by other professionals, the patient was considered to have been in precontemplation. The patient was classified as having been in the contemplation stage when there was evidence that the search for psychotherapy have been spontaneous, but without clear indicators of previous attempts to solve the problem. The option for the clinical evaluation, based on the data contained in the patient records of each participant, is justified by the fact that at the time of the study, all were in the termination phase of the psychotherapy. Where there was disagreement, a discussion of the evaluations made it possible to reach a consensus.

The post-intervention phase was evaluated through the self-report instrument (EEM). However, as will be seen in the discussion of the cases, the results of the EEM were analyzed clinically, considering the data obtained in the interview performed for this study. The mechanisms used by the patient to modify emotions, thoughts, behavior or relationship patterns throughout the psychotherapy were examined. This corresponds to the processes of change, and also the extent and depth of the changes achieved, which in turn correspond to levels of change.

The EAS-40 evaluates the index of psychopathological symptoms, at the end of the psychotherapy, and indicates the general functioning of the participants and how this would influence the treatment results. Regarding the overall EAS-40 and the four dimensions, the score = 1 was adopted as the cutoff point for the clinical population (Yoshida, 2008). It was sought to examine possible relationships between the reported improvements, changes in the adaptive configuration and the stage of change. Given the diversity of complaints, length of treatment and small sample size, the data analysis was performed case by case, grouped solely based on the evolution of the stages of change, defined as four groups: (1) evolution from preparation to action (P/A); (2) evolution from precontemplation to preparation (PC/P), (3) evolution from contemplation to preparation (C/P), (4) patient remained in preparation (P/P).

Ethical Considerations

The study was approved by the Human Research Ethics Committee of the Pontifícia Universidade Católica de Campinas (protocol No. 813/09). All the participants signed the Terms of Free Prior Informed Consent.

Results

Table 1 shows that six participants were treated using the Humanistic approach and three with Psychodynamics. The length of treatment ranged from six years (each year the psychotherapy was conducted by a different intern) to six months (one intern). Six participants evolved in the stage of change, with two passing from preparation to the action stage; three from precontemplation to preparation; and one evolving from contemplation to the preparation stage. Three participants maintained the same stage of change (preparation). In addition, three participants evolved in their adaptive efficacy, four maintained their initial evaluation, and one participant regressed. It was not possible to make a comparison with the EDAO-R in one of the participants, since there was insufficient data in the patient records to evaluate the Pr area at the time of their admission for the psychotherapy. The evaluation through the EAS-40 demonstrated that, of the nine participants, one did not presented psychopathological symptoms at the end of the treatment. It was verified that, in relation to the Symptom General Index, one participant presented a score above the cutoff point for the clinical population.

Table 1

Distribution of the Participants according to the Stage of Change (Pre- and Post-treatment), Theoretical Approach of the Psychotherapy, Length of Treatment in the Training-clinic, Efficacy of the Adaptation (Pre- and Post-treatment) and Psychopathological Symptoms (Post-treatment)

EEM pre and post	Participants	Approach	Length (years)	EDAO-R pre and post	EAS-40
P/A	2	Humanist	5/6	3/2	0.33
	4	Psychodynamic	5/6	4/2	0.9
PC/P	5	Humanist	≤ 1	5/5	0.77
	6	Psychodynamic	≤ 1	4/4	0.75
	7	Humanist	2	4/4	0.77
P/P	1	Humanist	≤1	5/5	0.6
	3	Humanist	2	?/4	1.23
	8	Psychodynamic	≤ 1	3/1	0
C/P	9	Humanist	5/6	¾	0.18

Note. PC - precontemplation. C - contemplation. P - preparation. A - action. EDAO-R = Operational Adaptive Diagnostic Scale Redefined; EAS-40 = Symptom Assessment Scale.

Discussion

The data analysis was started with the participants who evolved from the stage of *preparation* to that of *action*. It is worth noting that participant 2 sought the clinic spontaneously due to a disagreement with her father. An important fact in her life story was the suicide of her mother, which occurred many years ago and would have caused a great impact on the family structure. One of the processes of change that marked her treatment refers to self-reevaluation, since she reported that she “never argued with anyone”, was always the “nice one” and suffered silently. Today, however, she verbalizes her desires and demands her rights. Furthermore, she obtained a *consciousness raising* and began to reflect on the motives and meanings of some of the feelings in her life. The participant also made an *environmental reevaluation* and started to present changes in this field, improving the relationship with her father. Regarding the adaptive efficacy she evolved from Group 3 (ineffective moderate adaptation) to Group 2 (ineffective light adaptation). There was considerable improvement in the Pr area, because, although initially she found no support from her family to return to study, she finished high school and now attends a university. The initial evaluation was maintained in the E-R area. Even though the relationship improved with her father, she faced difficulties with the family of his girlfriend, and ultimately responded in an ineffective way to the situations that involved them. The participant did not present a high level of psychopathological severity that could suggest the presence of disturbances in any dimension of the EAS-40.

Participant 4 spontaneously sought the psychology clinic, because her husband was being unfaithful. At the same time, she faced difficulties in relation to work. The psychotherapy provided improvements for the participant and the processes involved include: *consciousness raising, self-reevaluation* and *self-liberation*. The treatment helped her to reflect on

the reasons for her problems and to realize what it was that made her anxious. There was also a perception that it was she who had to change and not the other, therefore she started to position herself and pursue her rights, managing to overcome some difficulties with her husband and to constructively reverse the marital conflict. There were gains in the quality of the adaptive efficacy, which passed from Group 4 (ineffective severe adaptation) to Group 2 (ineffective light adaptation). The Pr area presented effective evaluation. The participant was retired and was actively involved in craft and cookery courses, which correspond to *social liberation*. For her, these courses were a source of interaction and social relationships. There was also an evolution in the E-R area, however, in this there were still some problems to be overcome, as she reported that relapses make her recall the past situations. Regarding the severity of the psychopathological symptoms, the somatization factor was the most compromised (F3 = 1.4). This can be explained in terms of the participant having physical disturbances influenced by her emotional state, such as hypertension and "emotional diabetes". The fact that she felt forgetful may ultimately be aggravating the anxiety factor (F4 = 1.1). It is noteworthy that despite having performed some examinations, the results of which were negative, the participant was worried and feared that one day she may develop Alzheimer's disease.

The next cases discussed are those of the participants who evolved from the *precontemplation* stage to the *preparation* stage. Participant 5 was referred to the Psychology clinic by a psychiatric physician. Seven years previously she suffered a work accident and since then she has undergone regular examinations. She felt maltreated, humiliated and could not trust anyone. She had undergone several surgical procedures and was unable to work at the time. One of the main processes of change present in her treatment concerned the *helping relationship*, because although she could not specify what had changed, she said that previously she had felt very sad and wanted to die, but that at that time this had improved. This indicates that she still had the same feeling, but she felt helped, as she had found support and felt understood. There was no change in the adaptive efficacy, which continued to be presented as ineffective extreme adaptation (Group 5). The E-R and Pr areas presented compromise, due to the relationship problems at home and the accident she suffered in her work. Regarding the severity of the psychopathological symptoms, the anxiety factor was the most affected (F4 = 1.8). It is believed that this dimension was higher because the patient was concerned about who would be treating her in the following year in place of the intern who had accompanied her during the process (the intern was in the final year of graduation).

Participant 6 spontaneously sought the psychology clinic. However, the motivation to seek psychotherapeutic help came from family demands. With the psychotherapy, the participant obtained an *consciousness raising* and made *self-reevaluation,* since previously he was the "owner of the truth" and, when questioned, had to have an answer for everything. Later, he began to reflect on whether it was time to listen to the people who were around him and realized that he did not have control of all the situations, recognizing his limits. He also made an *environmental reevaluation* and believed the he was more active and involved with the family activities. It is clear, however, that he still needed to improve his "anger", because there were times when he fought with more intensity than was necessary. There was no change in the adaptive efficacy, which remained in Group 4 (ineffective severe adaptation). Regarding the Pr area, the participant had a general attitude of extreme contentment, which is considered very slightly adequate. The E-R area remained as slightly adequate due to him failing to contain his anger at times, which affected the environment in which he lived. Regarding the presence of psychopathological symptoms, the somatization dimension was the most compromised (F3 = 1.5). One possible explanation is the fact that the participant had alterations in blood pressure, which became high when something happened that affected his emotional state.

Participant 7 came to the psychology clinic through referral by the tutelary council (the Brazilian child protective services). The reason she decided to continue the treatment was because of relationship difficulties with her adolescent daughter and problems with her husband, who was an alcoholic. The processes of change involved included *consciousness raising*, *environmental reevaluation*, *self-liberation* and *helping relationship* (she put herself in the place of her daughter, reflecting on the way she acted with her and managed to go to the Women's Police Station to report her husband, who had threatened her. The psychotherapy was seen as a form of support and a place to "empty herself of the problems", through which she obtained relief by sharing her situation). There was no change in adaptive efficacy, which remained in Group 4 (ineffective severe adaptation). The E-R area was the most compromised. Despite the improvements, she still faced serious problems in this field. The Pr area also showed compromise, because her professional development had been interrupted due to the demands of her husband. The overall severity of the psychopathological symptoms was 0.77. The factors most affected were psychoticism and obsessiveness-compulsiveness (F1 and F2 = 1.1 each), although she felt her health was good and that there was nothing to stop her performing her everyday tasks.

Next, the cases of participants who remained in the *preparation* stage are presented. Participant 1 spontaneously sought the psychology clinic at the time that she was unemployed. She felt that she had many responsibilities, was stressed and ended up taking it out on her children, damaging her relationship with them. Although there was no evolution in the stage of change, according to the evaluation with the EEM, some processes of change were visible, such as *environmental reevaluation*, *consciousness raising* and *self-liberation* (she realized that people do not change because others tell them to, but because they want to). Even though

she felt improvements in the relationship with her children, her adaptive responses in the E-R area were considered very slightly adequate, because there were still difficulties in this area. The Pr area continued to present compromise and, despite having found a job, she did not feel satisfied in her work. Therefore, at the end of the treatment, the participant presented ineffective extreme adaptation (Group 5), remaining below the cutoff point for the clinical population, with an SGI = 0.6.

Participant 3 spontaneously sought the Psychology clinic complaining of being excessively worried and nervous. Due to this she was indecisive, sometimes crying, which made her more nervous, entering into a vicious circle. Although she did not evolve in the stage of change, according to the evaluation of the EEM, the main process of change observed referred to the *helping relationship*, since she had found, in the psychotherapy, a place where she felt supported and was able to share her anguish. It was not possible to establish a comparison regarding the quality of the adaptive efficacy concerning the Pr area, as there were insufficient data for the initial evaluation. It was observed that after the treatment she presented *ineffective severe adaptation* (Group 4). The E-R and Pr areas were compromised because she did not feel satisfied and encountered difficulties in these areas. The severity of the overall psychopathological symptoms was 1.23. This drew attention to the compromise in the obsessiveness-compulsiveness dimension (F2 = 1.6). In fact, it was revealed, through the interview, that the participant presented rigid traits, characteristic of people with symptoms of this factor.

Participant 8 spontaneously sought the psychology clinic because she was facing relationship problems with her daughter and she could not manage to leave the house because she feared leaving her sick husband alone. She could not impose herself nor say what she wanted. According to the EEM evaluation, there was no evolution in the stage of change, this being the *preparation* stage. Nevertheless, the processes of changes observed in this participant, referred to *self-reevaluation*, *consciousness raising* and *self-liberation*. As a consequence, she began to cope better with the problems at home, especially in relation to her husband. At that moment she could converse with him and felt well, also she did not worry about leaving him at home alone. The relationship with her daughter also improved, because after the treatment the fights were not as recurrent and there was improvement in the dialogue between them. The quality of the adaptive efficacy evolved from Group 3 (ineffective moderate adaptation) to Group 1 (effective adaptation). The adequate adaption in the Pr area was justified by the satisfaction in what she did and with the people with whom she worked. The E-R area also presented adequate adaptation (there was a noticeable improvement in the quality of her interpersonal relationships). The SGI was null, which indicated the absence of disturbances that might be affecting her life.

Finally, the cases are presented of the participants who progressed from the *precontemplation* stage to that of *preparation*. Participant 9 was referred by a speech therapist, however, said she had wanted treatment for some time. She said that she was very shy and had difficulty speaking in front of people, impacting negatively on her work as a teacher. *Consciousness raising* and *self-reevaluation* were the main processes of change present in the treatment of the participant, who acquired a new perception about herself (she realized that she needed attention from people). Regarding the evaluation of the adaptive efficacy, the patient passed from Group 3 (ineffective moderate adaptation) to Group 4 (ineffective severe adaptation). This regression may be explained by the fact that at the time of the interview the participant presented a problem in the E-R area that she did not have before. The index of overall severity of the psychopathological symptoms was low (SGI = 0.18), indicating that there were no symptoms that could be interfering with the progress of the psychotherapy.

The analysis of the interviews and of the evaluations of the self-report instruments allowed for the outline of a general framework for the changes and the comprehension of the improvements highlighted by the participants (*consciousness raising, self-reevaluation, environmental reevaluation, self-liberation, social liberation and helping relationship*). Regarding the levels of change, it was found that participants who evolved in the *adaptive efficacy* were those who achieved deeper changes (improvements in interpersonal and family conflicts). It is possible they had progressed, in relation to the adaptive configuration, due to changes in patterns of functioning, indicating that they acquired adaptive resources to respond more efficiently to the events.

The cases in which there was no evolution in adaptive efficacy, related to the participants with greater compromises in the E-R and Pr areas (Groups 4 and 5). In these patients the changes were more restricted and took place, in most cases, in relation to the symptoms. Prochaska (1995) indicates that improvement tends to occur more rapidly with respect to the symptoms, whereas for the individual to achieve the more profound changes, the duration of the psychotherapy may need to be longer. It is therefore likely that these participants required more time to resolve their conflicts, since Yoshida and Aeneas (2004) indicate that change in the more compromised patients usually occurs more slowly.

Some factors may have influenced the results of the psychotherapy, such as the willingness of the participants to be agents of their own change. Compared to those who were actively involved in the process, those who were passive achieved limited changes linked to improvement in the symptoms and relief in relation to the complaint. The severity of the disorder (physical or psychological) is also an influencing factor when it comes to change in psychotherapy (Corbella & Botella, 2004). It was found that, at the end of

the psychotherapy, four participants were below the cutoff point for the clinical population, regarding the symptoms general index (SGI), evaluated using the EAS-40. One participant with rigid traits, characteristic of people with obsessive-compulsive symptoms, was above this index. The four cases in which the SGI approached the cutoff point can be explained by the presence of physical disorders that interfered with the emotional state of the participant or because of anxiety generated by specific, not necessarily chronic problems.

Another factor seen as an essential part in the process of change is the motivation that drove the patient to seek psychotherapeutic help (Corbella & Botella, 2004; Santibáñez Fernández et al., 2008; Yoshida & Enéas, 2004). This motivation is closely linked to the degree of awareness of the patient. According to Prochaska (1995), people who are unaware of their problems, most often, have no motivation to engage in a process and are not likely to be willing to address their issues, if there are not interventions aimed at the recognition of their difficulties. This was seen in the participants who were initially in the precontemplation stage. They all sought psychological help due to external motives and they seemed unaware of the problems that were affecting their lives. However, over the course of the treatment they were able to comprehend this fact and wished to continue the psychotherapy. Additionally, it was observed that these participants were also involved in the process, probably because they felt understood when they shared their suffering.

The opposite was noted in participants who presented a higher degree of recognition of their difficulties. Those who showed a willingness to address them, evolved to the action stage and were motivated to seek a change. In these cases, the motivation for change reflected as positive results in the process. These statements should, however, be viewed with caution, since the sample consisted of patients who were at the end of treatment. Therefore, by not including people who abandoned the psychotherapy at any point of the treatment, a bias could be introduced in the conclusions.

It was observed that the theoretical approach of the supervision, humanistic or psychodynamic, did not appear to be relevant regarding the occurrence of improvements. These data are consistent with the literature that has repeatedly pointed out that there are no significant differences in the results from the various types of psychotherapeutic approach (Araújo & Wiethaeuper, 2003; Diniz Neto & Féres-Carneiro, 2005; Kazdin, 2009; among others). It is believed that the factors of the relationship between the participants and the Psychology interns may have been more relevant than the specific elements of the technique and approach, as indicated by Serralta (2010). In a study performed by Binder, Holgersen and Nielsen (2009), the patients themselves considered the relationship with the psychotherapist as one of the most important factors for the change achieved in the treatment. Other authors also emphasize the importance of the therapeutic alliance and its influence on the results of the psychotherapy (Araújo & Wiethaeuper, 2003; Corbella & Botella, 2004). When the patient and psychotherapist construct a relationship based on trust and compromise, in which one becomes the collaborator of the other, a positive working alliance is established, which increases the possibility of promising results concerning the change in the patients (Santibáñez Fernández et al., 2008).

The design of this study followed as closely as possible the route taken by professionals who need to evaluate the progress of their patients. More specifically, the route taken by internship supervisors of the majority of the training-clinics that addresses all sorts of shortcomings, such as incomplete reports, some students being personally unprepared for the care of very compromised patients, among others (Chammas, 2010; Herzberg, 2007). In this sense, to judge whether or not the patient had evolved, they resorted to clinical experience and the results, independent of scales, where the results are eventually translated into scores.

In terms of studies partly or totally based on data from patient records, these deficiencies also end up contaminating the results, as is the case with the current study. Although the methodological rigor of the design used here might be questioned, it covers one of the current demands on the researchers in psychotherapy, which is to seek to establish bridges between practice and research, while respecting the context and the conditions under which psychotherapies are usually performed (Castonguay, 2011). It must be recognized, however, that this investigation is merely a small and modest step in this direction, which needs to be replicated with larger, heterogeneous samples. Moreover, whenever possible, the same pre- and post-treatment evaluation procedures should be respected.

Conclusions

The study in the Psychology training-clinic made it possible to know that the care given by students promoted improvements in the patients and that different factors may have contributed to the results of the psychotherapy. This study focused on the stage of change in which the patient was at the time of the intervention, the quality of the adaptive efficacy of the index of psychopathological symptoms. The analyzes performed, based on the material from the interviews suggested that the quality of the relationship between the psychology intern and the patient and the willingness of the patient to be their own agent of change may have been relevant in the outcome of the processes.

Another aspect that needs to be highlighted is that, from the interviews, the participants were able to review and reflect on the psychotherapeutic process of which they were part, in order to comprehend the improvements in their current lives. Regarding the results of the study, it was possible to combine

the three dimensions of change - progress, stage and level – in the comprehension of the progress of the patient or lack there of. In addition, the self-report evaluation instruments provided subsidies to complement, from a certain perspective, the improvements or relapses noted by the evaluators.

Concerning the population treated in the training-clinic, some participants had difficulty comprehending some of the statements of the EEM, which reinforces the need to use clinical criteria to more adequately evaluate the stage of change (Yoshida & Enéas, 2004). The incomprehension of these items should be understood as one of the limitation to this study.

As the sample of participants was treated according to only two theoretical approaches (Humanistic and Psychodynamic, with a predominance of the former), new studies should include participants treated according to other approaches and equitably distributed, in an attempt to reduce biases that may affect the results. Furthermore, because this research is of a retrospective nature, the improvements reported by the participants were limited to the information from their memories, losing data that could be considered important. In view of this, the need is emphasized for longitudinal studies, in which the processes can be followed from the beginning, in order to obtain more reliable data of the phenomena involved in the psychotherapy.

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