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A New Model to Treat Impostor Syndrome and Associated Conditions

Sebastian Salicru

Private Practice, PTS Psychology, Canberra, Australia

Email address:
sss@pts.net.au

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Abstract: *Background:* Impostor syndrome or impostor phenomenon relates to the difficulty in internalizing success due to feelings of being phony or inauthentic, despite having evidence of the contrary. It is an insidious and pervasive condition that is exacerbated in professional settings, and negatively impacts the mental health and psychological functioning of individuals and across populations. Multiple comorbidities include anxiety, depression, low self-esteem, burnout, somatic symptoms and social dysfunction, as well as decreased job satisfaction and performance. *Gap:* To date, no clear treatment guidelines or specific recommendations exist to treat impostor syndrome, and effective interventions are urgently needed. *Objective:* To address this treatment deficiency by integrating the Immunity to Change learning process and Schema Therapy into a unified framework. *Methodology:* This qualitative paper draws on the relevant extant literature, takes a scientist-practitioner stance, and uses a mini-case study that incorporates a client-therapist vignette to illustrate the model's protocol and operationalization. *Results:* A transdiagnostic, pragmatic model and protocol for short-term individual psychotherapy, to generate rapid change for clients to achieve their goals. *Conclusion:* This model will benefit psychologists practicing in organizational settings, and those working in career development or with student populations, busy professionals, and high-performing executives, who often experience impostor syndrome.

Keywords: Immunity to Change, Competing Commitment, Schema Therapy, Impostor Syndrome

1. Introduction

The impostor syndrome (IS) or impostor phenomenon (IP) relates to the experience of feeling like a fake despite having achieved some level of success or accomplishment [1]. Individuals experiencing IS have difficulty internalizing success due to feelings of being phony or inauthentic, despite having evidence of their competence [2]. Such individuals often report difficulty in managing their work-life balance [3], and may experience a wider range of mental health conditions and impaired psychological functioning [4]. This includes comorbidities such as depression, anxiety, low self-esteem, burnout, somatic symptoms and social dysfunction, and decreased job satisfaction and performance [5-7]. Recent meta-analytic research [8] has found that IS affects up to 80% of the population, is highly prevalent among both men and women, trans and nonbinary individuals, multiple ethnic groups, is exacerbated in professional settings, and lacks specific treatment recommendations. Given the insidiousness, pervasiveness, and far-reaching consequences of IS, and ambiguous treatment guidelines, effective interventions are urgently needed [9].

This paper addresses this deficiency by presenting a transdiagnostic, pragmatic model and protocol of short-term individual psychotherapy to generate rapid change. Taking a scientist-practitioner stance, I offer a model that integrates Immunity to Change (ITC) [10] and Schema Therapy (ST) [11]. To begin, I provide an overview of ITC, followed by an outline of its theoretical foundations and the techniques used. Next, operationalization of ITC is described using a real case example. Further, an overview of ST and the Young Schema Questionnaire 3 Short Form is provided. This is followed by a further description of the ITC operationalization, integrating ST constructs, using a clinical vignette of the case example. A discussion follows, including the unique contributions, benefits, and limitations of this new model. Finally, I provide a summary of concluding reflections.

2. Immunity to Change

2.1. Immunity to Change Process Overview

Immunity to Change (ITC) is a learning process developed by the Harvard University Graduate School of Education faculty's Robert Kegan and Lisa Lahey [10]. Informed by thirty years of research on adult development, ITC addresses the challenge of behavioral change being generally difficult to achieve. Using the psychological dynamic of "competing commitment" [12], the authors propose that failure to achieve personal goals is due to activation of the "emotional immune system", which is designed to protect individuals from negative consequences of personal change (e.g. shame, disappointment), rather than being due to lack of determination or will-power. Drawing from various psychological traditions, ITC operates as a meta-theory, and has been documented in the literature of education [13], and professional coaching and leadership development [14]. To date, however, it has not been contextualized for individual psychotherapy, or integrated with ST. Hence, the added originality of this article is in addressing this gap by presenting a protocol format that integrates ITC with ST. In doing so, the article also contributes additional nuances of ST and psychotherapy integration.

ITC aims to assist individuals to understand their difficulty in changing their behavior, using the metaphor of an immune system [10]. The process takes individuals through a progressive sequence of self-reflective exercises that: (1) map their immune system and assist them to understand it; (2) scrutinize the deepest underlying core beliefs or assumptions that maintain their unique immune system; (3) reframe their implicit theory of personal change and perspective; (4) consolidate and strengthen their learning; and (5) invigorate their readiness for behavior change. As a result, ITC work shifts individuals from their habitual and unreflective thinking patterns to far more self-reflective and deliberate patterns, by increasing their self-awareness. In a nutshell, ITC is a developmental framework that uncovers individuals' blind spots or competing commitments that work against their goals in subconscious ways. By making explicit these deep-seated contradictions, between individuals' intended goals and behaviors, ITC enhances clients' effectiveness to achieve and sustain personal change.

2.2. Theoretical Foundations

ITC operates as a meta-theory by drawing from various psychological traditions, and such an integration of approaches offers flexible and powerful ways for practitioners to assist their clients. More specifically, I identify the following five theoretical frameworks embedded within ITC.

2.2.1. Constructive Developmental Theory

The first theory underpinning ITC is Kegan's [15] constructive developmental theory (CDT). Inspired by Piaget's integration of "philosophy (constructivist theme) and biology (developmental), CDT combines constructivism and developmentalism. It relates to the progressive changes in how individuals make meaning or "know" epistemologically to become "active organizers of their experience" [16], by focusing on development of meaning and meaning-making processes across their lifespan.

2.2.2. Single-and Double-Loop Learning

ITC is also rooted in Argyris' [17] single- and double-loop learning work, and Argyris and Schon's [18] research, which epistemologically rests on Dewey's [19] theory of inquiry. Learning entails detecting and correcting errors, or producing matches between intentions and consequences for the first time. There are, at least, two ways to correct errors. Single-loop learning means detecting and correcting errors without questioning or changing the underlying rules, master or operating system of the corresponding systems. This means acting in one automatic mode only or a limited type of reaction, with no or very little learning or insight taking place [20]. Thus, the efforts made to change escalate, using the same repetitive actions, which keep yielding the same undesirable outcomes. A distressed client, for example, becomes frustrated or even angry when faced with her/his inability to achieve a desired goal or change a habit, without really exploring why s/he is unable to do so.

Double-loop learning, on the other hand, occurs when the governing variables of the system or master program are examined and altered first, and then alterative actions are taken to correct mismatches [21]. This entails assisting clients to recognise that the ways in which they define or frame their problem and resolution are the actual sources of being stuck with the problem. Double-loop learning enables clients to reflect on whether the rules or operating system they use to address their problem should be changed, and whether errors or deviations have occurred within their problem-solving process, and how to correct them. From this perspective, double-loop learning is an educational process through which clients learn to change their mindset by thinking deeper about their core beliefs, assumptions, and ultimately themselves.

2.2.3. Theory of Action

Argyris and Schon's [18] theory of action is based on Lewin's [22] action research formulation, which supports the developmental power of reflective thought, discussion, decision and action. Accordingly, individuals maintain implicit theories of action that they have developed about and for themselves over their lifetime. Typically, these include an espoused theory of action and a theory-in-use. While espoused theories are those that individuals claim to follow, theories-in-use can be inferred from observing the action taken. The theory-in-use actually governs a client's actions, rather than their espoused theory that they claim to hold or give allegiance to. Generally, clients are unaware of the incongruence between the two theories. Not surprisingly, they develop defensive routines or, as Argyris [23] puts it, "thoughts and actions used to protect individuals' usual way of dealing with reality", and – I will add – to avoid states of cognitive dissonance.

2.2.4. The Knowing–Doing Gap

Knowing, conceptual or declarative knowledge doesn't necessarily predict applied knowledge or doing [24]. This relates directly to the following distinction. Declarative knowledge relates to the acquisition of factual information, either abstract or autobiographical, and is concerned with 'knowing what to do'. Procedural knowledge, on the other hand, relates to 'how and when to do it' (e.g. plans, procedures, rules), and leads to the direct application of skills or abilities [25]. Declarative knowledge is usually learned didactically through listening to lectures, reading, observing, or conducting assignment. While these approaches may produce 'inert knowledge', they do not transfer to procedural or practical skills in the real world (e.g. coping strategies for emotional regulation). Procedural knowledge requires other strategies, such as action methods (e.g. role-plays, chairwork) and practice between sessions. Eventually, this real time application of skills or doing becomes part of the procedural memory. That is, skills are expressed without conscious awareness, and this could be disrupted if individuals try to perform them using conscious control [26]. The ITC process aims at closing the knowing–doing gap by promoting client self-reflection and procedural lifelong skills.

2.2.5. Paradoxical Theory of Change

According to the paradoxical theory of change within the Gestalt tradition [27], change occurs when individuals become who they are versus whom they persistently attempt to be (which they are not). Accordingly, change does not happen by trying harder, pushing, or similar means. Rather, it occurs when clients abandon, at least momentarily, who or what they want to become. Hence, the power of authenticity, which can be defined as the courage to be fully who or what one is in the present moment, is the only way to escape a past or future narrative or a socially constructed identity or reality.

2.3. Main Techniques

Fostering the relationship between a theoretical approach and techniques from other modalities is a hallmark of psychotherapy integration [28]. In this section, I outline the three main techniques integrated in the model presented in this paper: metaphor, sentence stem technique, and Socratic questioning.

2.3.1. Metaphor

The use of metaphor is implicit in actual name of the Immunity to Change (ITC) process. Metaphors are part of everyday language and useful linguistic mechanisms in psychotherapy [29]. They are a means to facilitate constructive behavior change [30], and effective conceptual and clinical strategies to strengthen the therapeutic communication and alliance [31]. A main advantage of using psychotherapeutic metaphors is that they enable explanation of abstract concepts easily in layperson terms [32], are memorable, and have clinical impact and motivational functions [33].

2.3.2. Sentence Stem Technique

Sentence stem technique (SST), or sentence completion technique, dates back to a projective testing technique aimed at accessing individuals' emotions and internal reactions when responding to ambiguous stimuli [34]. SST has also been used in personality studies [35], and as a creative free-writing way to quickly bypass superficial prose when evaluating client attitudes and clarifying attitudinal change during psychotherapy [36]. Sentence completion triggers clients' implicit knowledge of the necessity of the symptoms [37]. From this perspective, SST is a discovery learning technique.

2.3.3. Socratic Questioning

Socratic questioning (SC), or the Socratic method, is a well-established and important psychotherapeutic procedure [38] used in many modalities of psychotherapy, and is at the core of collaborative clinical communication [39]. Despite its iniquitousness in the literature, SC has been labelled and defined differently by various authors: Socratic teaching [40], Socratic dialogue [41]; Socratic reasoning [42]; Socratic education [43], and Socratic framework [44] to name a few.

SC can be used to change clients' minds or to guide discovery, as follows. The first option entails the therapist changing or correcting clients' distorted thinking or errors of judgment – a traditional CBT approach. In such cases, therapists take the credit for the clients' therapeutic outcomes. When using guided discovery, therapists teach clients to evaluate their emotions, physiological reactions, sensations, moods, thoughts, behaviors, life events, and to make more adaptive choices [45].

2.4. Operationalization of the Immunity to Change Process

ITC is operationalized using a four-column grid system that depicts the changing immune system. This four-stage process aims at making sense of a previously covert dynamic in a sequential way by uncovering individuals' blind spots, assumptions, cognitive biases, or deeply ingrained and hidden mindsets, which cause natural immunity to change. From this perspective, the goal of ITC is akin to that of ST, which aims at identifying individuals' variety of self-states, internal voices or implicit beliefs that describe their experience and shape their behavior [46].

Next, I illustrate the operationalization of ITC using a client whom I call Simon. The real client has been de-identified by using a pseudonym, applying a different age, and work title and setting. As brief background information, Simon is a 40-year-old married man working as a middle-level executive in a public sector organization, who presented to psychotherapy identifying himself as a workaholic and suffering from IS. Table 1 below illustrates Simon's first take of ITC during our third session. The previous two sessions were devoted to understanding his history, ascertaining and setting his goals for therapy, and building a therapeutic alliance.

Table 1. *Immunity to Change Process Example – Take 1.*

Column 1	Column 2	Column 3	Column 4
Stated Commitment (Improvement goal)	Undermining Behaviors (Things I do or not do instead)	Competing Commitments (Worry box or fears)	Big Assumptions (BA)
Stems		*Questions and stems*	
I am committed to ….	*What I'm doing, or not doing, that is preventing my commitment being fully realized is....*	*If you imagine yourself doing the opposite of your undermining behavior, what discomfort, worry or fear do you detect?* *I'm afraid of …. and I may also be committed to....*	*I assume that if my competing commitment is not met,...*
Simon's responses			
I am committed to having more family time and work-life balance.	*I work too many hours and don't take enough time off for leisure or recreation.*	*I'm afraid of being perceived as an incompetent or irresponsible manager.*	*I assume that if I don't work so many hours, and take time off, I will be seen as bad, irresponsible, and an incompetent manager that doesn't care about his job.*

The stages for each column of ITC are described as follows:

1. Improvement goal (Stated commitment). During this initial stage clients identify a goal or outcome that: is important to them in their life; they wish to achieve; are committed to; and have experienced significant difficulty in achieving to date. Clients are invited to complete the stem "I am committed to ….". Simon indicated that he was committed to having more family time and work-life balance.
2. Undermining behaviors (Things I do or not do instead). Next, considering that the identified goal or commitment has not yet been achieved despite significant effort and attempts, clients are invited to write down what behaviors they are engaging in (or not) that precludes them from achieving, or are working against, their identified derided goal. These behaviors are seen as irrational, and clients identify them by completing the stem: "What I'm doing, or not doing, that is preventing my commitment being fully realized is....". Simon recognized that his undermining behaviors were that he worked too many hours and didn't take enough time off for leisure or recreation.
3. Worry box or Fears (Competing commitments). The third stage entails clients identifying their worries, fears, and competing hidden commitments, which constitute the real reasons they are not achieving their stated goal. A competing commitment is "a subconscious, hidden goal that conflicts with their stated commitments" [10]. To identify these, clients are invited to reflect upon and identify their worries or fears, as well as stronger and more compelling goals or outcomes they may be committed to – beyond their conscious awareness – that are preventing them from achieving their goal. To this end, clients are invited to complete the stems "I'm afraid of …." and "I may also be committed to....".
4. Big Assumptions (BA). This last stage entails uncovering the assumption(s), underlying the stories or beliefs that clients accept as reality, or treat as truths and perpetuate their immune system. To uncover their BA, clients are invited to identify how they might feel if their competing commitment is not met, by completing the stem "I assume that if my competing commitment is not met...". According to Kegan and Lahey (2009), if clients come up with something that unnerves them a little, they are probably on track. Conversely, if they come up with something noble, they probably need to try again! Simon's BA was that if he didn't work so many hours, and took time off, he would be seen as a bad, irresponsible, and incompetent manager who didn't care about his job.

In summary, the dynamic equilibrium generated by the above stages stalls clients' effort in what can appear to be resistance to achieve the stated goal, when it in fact is their inherent and hidden personal ITC. Clients' inability to identify and close the gap between what they genuinely want, or even desperately desire, and what they are actually capable of, represents a metaphysical journey – a helpful component to facilitate childhood trauma [47]. Through this they develop a capacity to no longer be subject to their beliefs and assumptions – a "central learning problem of the twenty-first century" [10].

3. Schema Therapy

3.1. Model Overview

Schema Therapy (ST) or Schema-Focused Cognitive Therapy [11], is a relatively new form of integrative psychotherapy that has become increasingly popular among psychotherapists, as a preferred transdiagnostic treatment approach [48]. ST spawned from Beck's [49] cognitive therapy, and was initially developed by Young [50] to treat chronic conditions that were resistant to significant gains using CBT. Progressively, ST has culminated into a unique integrative treatment for a spectrum of emotional and relational problems, including personality disorders. ST is now recognised as an effective and pragmatic psychotherapy type that integrates previous therapies, such as CBT, attachment theory, psychoanalytic object relations, self-psychology, relational psychoanalysis, social constructivism, and Gestalt Therapy [51]. ST emphasizes the role of processing information that escapes mental consciousness, and bridges psychotherapeutic and cultural traditions [52]. Making extensive use of experiential and

action methods, ST emphasizes the therapeutic relationship as limited re-parenting, within which therapists act as healthy role models whose behavior can be internalized by clients [53].

In brief, the ST model comprises five interactive components: (1) child modes – developed from unmet childhood needs; (2) maladaptive coping modes (MCM) – overcompensation, surrender, and avoidance; (3) dysfunctional parenting modes – internalized as a result of poor parenting; (4) healthy adult modes – represent adaptive functioning; and (5) 18 universal early maladaptive schemas (EMS) – grouped into five schema domains, each one representing unmet core emotional childhood needs [11].

Early maladaptive schemas (or schemas) are pervasive mental structures, patterns or themes (including emotions, cognitions, memories, and bodily sensations) formed during early development, and later consistently repeated and reinforced throughout life, and which become dysfunctional, self-defeating, no longer serving an adaptive function. When a particular situation triggers EMS, patterns of MCM become activated, which reinforce and maintain EMS; thus, preventing individuals from processing and resolving their underlying emotions [11]. ST proposes that adaptive schema content is achieved by bypassing MCM, which enables changing the meaning and processing of emotions related to childhood experiences [54]. The main focus of this discussion is on EMS, due to its relevance to the model at hand.

The concept of schema in ST corresponds to the BA concept in ITC. Hence, the term "lifetraps" – "a pattern that starts in childhood and reverberates throughout life", is also used when referring schemas [55]. Similarly, BA are deeply rooted beliefs that people have about themselves and the world, which "they've long held close, perhaps since childhood" [12].

3.2. The Young Schema Questionnaire 3 Short Form

The Young Schema Questionnaire (YSQ) is a measure of EMS, or schemas, to understand and treat enduring mental health issues [50]. The YSQ-Short Form, Version 3 (YSQ-S3) is the short version (third edition), of the 232-item long version [56]. The YSQ-S3 comprises 18 scales and 90 items (5 items per scale). Each item is rated on a 6-point scale (1 = completely untrue of me; 6 = describes me perfectly). Higher scores indicate higher levels of EMS. Multiple studies that investigated the psychometric properties of the YSQ-S3 found it to have good internal and test re-test reliability, as well as congruent and convergent validity, in older adults in both clinical and nonclinical samples [57]. The YSQ-S3 indices indicate an acceptable fit of the 18-factor model [58]; thus, making it a psychometrically valuable instrument for the assessment of schemas in both clinical and research settings [59].

4. Model Operationalization and Integration of ST Constructs

In this section, I illustrate the operationalization of the model again; this time integrating Simon's most relevant schemas. The crux of the integration takes place in column four (BA), when clients explore where their BA may have come from. Undoubtedly, this is the most difficult stage, as clients need to intuitively ascertain their BA.

4.1. YSQ-S3 Results

Figure 1 below depicts Simon's profile created upon completion of the YSQ-S3.

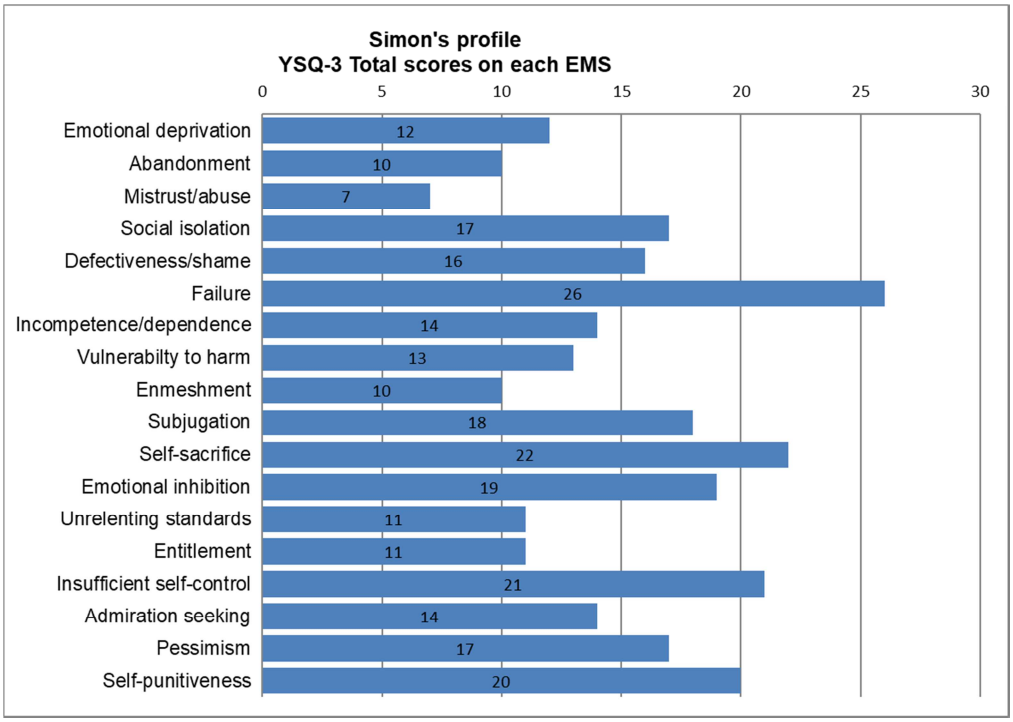

Figure 1. *Simon's YSQ-S3 profile.*

The results depicted in the above profile reveal the four most elevated schemas in descending order: failure; self-sacrifice; insufficient self-control; and self-punitiveness. The abridged clinical vignette below illustrates how, as the therapist, I was able to use this new information to engage in a deeper conversation with Simon by asking a new set of questions during our fifth session. Our fourth session was used to introduce Simon to the ST model and guide him through the YSQ-S3.

4.2. Clinical Vignette

S: It doesn't matter how hard I try; I don't seem to be able to make more family time and to achieve more work-life balance.

Th: I see! It must be exhausting, given that you have been trying for so hard and for so long.

S: That's right [with a deep sigh of resignation, and a profound sense hopelessness and discouragement].

Th: It must feel like all this is beyond your control.

S: Precisely! And I'm feeling deeply frustrated!

Th: I'm wondering whether you also – perhaps secretly – you're telling yourself that you're failing.

S: Yes, very much so! I guess, this must be related to my impostor syndrome.

Th: Good observation! It could also explain your most elevated schema in your profile: 'Failure to achieve'. (The belief that you have failed, will inevitably fail, or that you're fundamentally inadequate relative to others.) How long do you think you had this belief about yourself?

S: I guess it goes a long time ago … as far as I can remember.

Th: Sure! That's precisely what schemas are, and why we call them Early Maladaptive Schemas. Because they're formed early in life, and keep being reinforced later over time. And, eventually, they become self-fulfiling prophecies. Would it be useful if we explore this further?

S: Of course!

Th: In previous sessions, you spoke about the significant struggle you experienced at 9 years of age when mum and dad separated, and dad left home. I was wondering what beliefs "about yourself" [emphasis added] you could have possibly internalised back then?

S: Uhm… [long silence]... I'm not really sure.

Th: That's OK. If I recall properly, you also told me you were the older of three siblings. Let's consider this for a moment. What role could you have possibly led yourself to believe at the time, that you had to take within the family?

S: Uhm… Now that you say this, I will never forget my mother saying to me: "You're now the man of the house."

Th: That's interesting. What sense do you think you made about this at the time?

S: That I felt responsible for taking care of my mother, my brother and my sister?

Th: I see. How likely is this, do you think?

S: In think it is very likely. In fact, thinking about it now, I would say it's almost most certain.

Th: Tell me, what kind of job do you think you did in taking this new role?

S: I failed miserably!

Th: Wow! You didn't have to think too much about this one….

S: No. In fact, my mother's words have been engraved in my mind! But you know, I have never put these two together like this.

Th: So, what does this really mean for you now?

S: Well, I suppose it means that … [long silence] … I convinced myself back then that I was a failure!

Th: Well, that would certainly explain your most elevated schema (Failure). I'm wondering, what else you may have convinced yourself of about yourself back then?

S: That I had to help my family at all cost?

Th: Well, that would explain the onset of your second most elevated schema (Self-sacrifice) – excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification.

S: I guess, this would explain why I'm such a workaholic and I can't stop myself from always doing things for others, except for myself.

Th: Right! Your other two most elevated schemas are 'Insufficient self-control' and 'Self-punitiveness'. What thoughts do you have about these?

S: I guess the story would go something like this… I was unable to accomplish this monumental task (being the man of the house) … so I'm a failure, I lack self-control, and because of this I deserve to be punished! This would explain why I'm unable to reward myself by taking time off to take it easy and relax.

Th: You're doing a great job here! I'm wondering how would you piece all this together in your ICT process?

Table 2 below maps out Simon's second-take ICT using insights from the previous session, which he brought along to his sixth session.

Table 2. *Immunity to Change Process Integrating Schemas Example – Take 2.*

Column 1	**Column 2**	**Column 3**	**Column 4**
Stated Commitment (Improvement goal) *Stems* *I am committed to ….*	Undermining Behaviours (Things I do or not do instead) *What I'm doing, or not doing, that is preventing my commitment being fully realized is....*	Competing Commitments (Worry box or fears) *Questions and stems* *If you imagine yourself doing the opposite of your undermining behavior, what discomfort, worry or fear do you detect?* *I'm afraid of …. and* *I may also be committed to....*	Big Assumptions (BA) *I assume that if my competing commitment is not met,...*

Column 1	Column 2	Column 3	Column 4
Simon's responses			
I am committed to having more family time and work-life balance.	*I work too many hours and don't take enough time off for leisure or recreation.*	*I'm afraid of being perceived as an incompetent or irresponsible manager.* *I may also be committed to be a good, responsible, and competent manager that does a good job by working as much as I can. And there is always a lot of work to be done in the office.*	*I assume that if I don't work so many hours, and take time off, I will be seen as bad, irresponsible, and incompetent manager that doesn't care about his job.* *I assume that I will fail, as I have always failed throughout my life. Hence, I work as many hours as I can without taking time off. I also assume that it would be highly irresponsible of me not to do so.* *I further assume that working hard and responsibly means to always meet the needs of others at the expense of my own needs.* *Finally, I assume that if I don't do this, I should be critical of myself and I should punish myself because I have failed.*

As captured in Table 2 above, Simon more elaborately identified the root cause of his behavior by articulating his BA in greater detail for the second ICT. During that session, he presented as much less frustrated, and more accepting of himself and his situation. Simon reported feeling relieved, freer, and less preoccupied. "It is as if I finally got to know myself better. To my surprise, I also feel compassionate towards that 9-year-old that I once was and at peace within myself. I have never experienced this calmness and serenity ever before in my life", he said.

It is also worth noting that upon administration of the Depression Anxiety and Stress Scale 21 (DASS-21) during the sixth session, Simon's post-scores had decreased significantly. In moving forward, the client was encouraged to keep testing his BA by running real-life experiments, to continue re-evaluating his BA and replace it with new and more realistic interpretations that more accurately reflect his true abilities.

5. Discussion

The integration of schemas into ITC enabled an in-depth exploration of the IS by opening a collaborative and deep dialogue between client and therapist. This generated a new hypothesis and eventually reconceptualized the client's problem. Guided with the YSQ-S3 results, the therapist could probe the client using more focused and relevant discovery questions. This enabled the client to link specific critical landmark events of his childhood with the onset of his schemas. Equipped with these new insights, the client was able to better understand what had shaped his behavior, and re-interpret what had been driving it, further gaining new insights into his struggle. Hence, he could fully unpack his immune system, better understand his impostor syndrome, and then reformulate and reframe his long-standing predicament. The chief advantages of identifying the client's schemas using his YSQ-S3 results were twofold: (1) removed the ambiguity typically involved in ascertaining the BA; (2) facilitated the emergence of his unconscious long-held beliefs, which were contributing to his self-defeating behavior, into his conscious awareness. As result, the client was ready for re-evaluation and a reality check, and to very likely replace his BA; thus, able to make more conscious choices that better reflected his intentions and abilities.

This case example is in line with the literature in five main ways. First, the identification of the client's most dominant schemas or "pathogenic beliefs" [60] and the uncovering of deepest assumptions, is in line with the propositions that schemas are critical in the maintenance of chronic problems [61], and that family role expectations act as an antecedent to IS [62]. Similarly, learned family roles relating to the need to please other family members were highly correlated to impostor feelings [63]. In families for which the individual developmental needs of the child were inadequately meet, such children were required to develop a "false self" (p. 498), as way to receive validation [64]. This sense of false self, "is then likely to carry over into adulthood as insecurity about one's true identity, often felt as impostor feelings in those who are successful achievers" [65].

Second, this case illustrates how psychotherapy entails addressing the specific type of learning that individuals are exposed to through their past experiences – of early life in particular – which may have created distortions in meaning-making perspectives or mindsets [66]. Such mindsets become lenses through which future experiences are filtered, and templates through which these same experiences are interpreted, evaluated, and distorted; thereby, precluding individuals to learn from new experiences. Psychotherapy offers a safe environment to explore and work through such distortive mindsets, with the aim and potential benefit to enable clients' return to learning from experience. From a neuropsychotherapy perspective, this deconstruction process constitutes emotional and transformational learning, through which generalized schematic knowledge, or implicit semantic memories learned from original experiences [67], are retrieved and reprocessed through autonoetic awareness to produce "extreme therapeutic effectiveness" [68]. This process is also in line with the literature alluded to earlier; namely, double-loop learning concepts of espoused theory and theory-in-use [18], generation of new meanings, and generalization of results, and knowing versus doing gap [24]. Given that the client ceased trying harder to change when engaged in therapy, but rather trusted and followed the process, this case is also in line with paradoxical theory of change [27].

Third, this case illustrates how, informed by ST, the

extensive and ubiquitous use of the Socratic method, guided discovery or collaborative empiricism [69], systematic questioning or inductive reasoning [70], can be used in psychotherapy to lead clients to discover highly valuable information, and ultimately produce lasting change [71].

Fourth, taking a truly integrative stance, the presented case illustrates the advantages of blending top-down and bottom-up approaches for case formulation and treatment. While the model follows a manualized protocol by adhering to a conceptual model (top-down approach), it is also driven by detailed case formulation of the client's agenda – problems, needs and goals (bottom-up approach). Taking this stance enhances the identification and clarification of clients' goals in a very pragmatic fashion. Its benefit is that it enables clients to formulate and articulate their goals in plain language right from the beginning of the process, and subsequently uncovers their real barriers in achieving these goals. Paying careful attention to the case formulation ensures the intervention is tailored to clients' unique needs, which is the cornerstone of effective psychotherapy regardless of adopted theoretical orientation [60]. In psychotherapy it is more useful to focus on transtheoretical principles of change, rather than on the specific efficacy of therapeutic schools [72].

Fifth, while perhaps appearing less conspicuous, the therapeutic alliance between client and therapist, which constitutes the "most important transtheoretical principle of change" [73], is also intrinsically embedded in this model. This includes: the therapist's positive qualities (e.g. empathy, attention, and positive regard) to establish a strong bond with the client; their common expectation for positive change; and an agreement between the two on the goals to be achieved and methods to achieve them.

The originality and value of this paper is that it integrates the two seemingly independent approaches to arguably address the extinction of IS in a novel and meaningful way, by addressing its antecedents and consequences. From an applied psychology perspective, this paper offers an evidence-based informed model that can be used in a variety of contexts – industries, institutions, and other organizations – while contributing to advancement in applications in the field of psychotherapy.

6. Limitations and Recommendations

Despite the above-mentioned benefits and contributions, this paper is not free of limitations. The first limitation is that despite having presented a mini-case study, this is a conceptual paper. Hence, it did not involve comprehensive collection and analysis of empirical data or a control group. Hence, this model's generalizability and future viability await to be seen. To this end, further testing is recommended. The second limitation is that despite being a transdiagnostic approach, this model is likely to be more suitable for individuals experiencing mild to moderate levels of psychological distress and functioning. Hence, this model as a standalone treatment with certain clinical populations will probably be unsuitable; namely, individuals presenting to therapy highly dysregulated, with suicidal tendencies, or diagnosed with conduct disorders and related conditions (ADHD, substance dependence, bipolar), severe distress disorders (e.g. PTSD), thought disorders (e.g. schizophrenia, psychosis), personality disorders, and other psychiatric conditions.

7. Conclusion

This paper has presented a brief, transdiagnostic, pragmatic, and integrated model of individual psychotherapy to treat individuals experiencing impostor syndrome and other comorbid conditions, by integrating ITC and ST. This included an illustration of how, as a methodology for growth and change, ITC allows practitioners to integrate principles from various psychological theories and techniques, from different modalities, into a unified model and protocol. In doing so, this model offers new treatment guidelines for IS or which effective interventions are greatly needed. Notwithstanding its limitations, this model offers a relevant and pragmatic framework for psychotherapists to use ubiquitously in their practice.

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