

WHAT DO CLIENTS WANT FROM TALKING THERAPY?

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What are the types of difficulties clients with mental health issues want support with? And what do clients want to achieve from talking therapies?

We have been looking at these questions recently in an ongoing pilot study

of existential phenomenological therapy, using a thematic method of qualitative analysis.

The existential phenomenological approach addresses human distress by retaining core issues around empowerment, choice and opportunity within clients. These core ideas are very effective when working with clients in primary care settings, as they are focused on triggering the active participation of the client.

Parallel to this is the idea that clients attend therapy to change. Our understanding of change is that it is a process of re-evaluating world views and self-constructs that have been embedded and practised throughout someone's life. With acts of re-evaluation and active participation by clients, comes change or acceptance of their understandings, beliefs and assumptions towards their experiences in the world.

We believe this process of change improves the mental health of clients, as they are able to inquire about and understand the position they have taken up in the world currently, the position they want to be in, and thus, what changes are needed in their lives in order to achieve this. The use of client-articulated goals that represent the clients' current attitudes and belief systems, but do not want, allow both clients and therapist to tailor therapy around understanding these systems.

Our pilot study

We conducted the pilot study in a primary care GP setting. It entailed an assessment, in which clients articulated their goals, and six sessions of psychological therapy that was client-directed and goal-focused, using Existential Experimentation. This short-term intervention is based upon existential attitudes, employing a phenomenological methodology and principles of humanistic psychology and human potential.

The intervention is integrated within an NHS GP surgery for the following reasons: it reduces waiting times through ease of access, as most people live close to their GPs, it reduces the stigma associated with mental health by attending non-specialized mental health sites, and deconstructs the medicalisation of clients' distress that has become the common discourse in recent times.

The clients are referred by GPs who, at the initial contact, use a screening questionnaire devised for the pilot. This is the first time clients are introduced to the notion of identifying goals, or in this instance a more general concept of 'problems'.

The screening questionnaire

This questionnaire serves several purposes. First, it creates an immediate sense of engagement on the part of the GP. Second, it provides the client with the sense that what they have to say is to form the basis for the work the therapist and themselves will embark on together.

Third, it creates valuable point-in-time set of information about the client from their perspective that emanates from this referral by the GP to the psychological therapist who will conduct a full assessment within three weeks.

Fourth, and importantly, it reduces the barriers between physical healthcare and psychological treatment by having the GP collaborating with the client and therapist. This last factor has been, and remains, largely missing from mental health services that are fragmented.

The form takes only a minute to complete and gives the therapist who assesses important baseline information about the client that directs the therapist towards questions that are not necessarily and predominantly driven by the realm of medicine. Instead, it initiates the process of understanding and engaging with human distress.

For example, in question 2, it is important that the client is asked to say how their concerns are affecting them, so that they are encouraged to move away from abstract terms like anxiety or depression, to a more specific and personal sense of their experience.

This is a descriptive, clarifying and collaborative process directed towards ameliorating the client's potential sense of being a victim of an illness

Furthermore, question 7 refers specifically to the notion that lasting change does require considerable self-motivation that is enduring.

Client-led strategy

We stress that this approach embraces a strategy of returning the notion of diagnosis to the person who is experiencing the distress or disorder. It is not something that is provided by the (expert) practitioner. It acknowledges the importance of the uniqueness of a personalised and client-led description of experience that may be initially expressed as a diagnosis.

This client-led strategy frees the therapist to attend to the client in a sound manner that addresses the breadth of experience in a phenomenological manner. In other words, the client identifies the focus for the experience that is considered in therapy, in order that the therapist is free to pursue the clarification of the meaning of experience and its impact and significance for the client.

This is a descriptive, clarifying and collaborative process directed towards ameliorating the client's potential sense of being

a victim of an illness. It also promotes options for intervening that are well attuned to the clients' concerns rather than more general therapeutic interactions and responses.

Identifying client goals

The psychological assessment is completed when they first meet the therapist. Part of this involves refining the 'identified problems' on the GP screening form to identify clear, specific and workable goals, using the CORE Goal Attainment Form. As a whole, the assessment further introduces the client to the notion that they will be at the centre of the therapeutic relationship to help and empower themselves towards recovery and resilience.

The clients in the pilot study were fourteen working-age female adults, referred by GPs who believed they would benefit from an Existential Experimentation intervention in primary care, as they disclosed symptoms of depression, anxiety and/or other psychological distresses.

They created their goals at the end of the assessment session. Each client was asked to develop three to four goals that they wished to work on throughout the six sessions of therapy, though some only developed one or two.

Grouping goals into themes

We analysed the goals inductively to extract the main point from each, with relevance to the research question, to capture the semantic and conceptual aspect of the goal, which formed codes. For instance, the code 'facing the future' was extracted from the goal 'facing the future financially, without children, without a husband (he wants to go), without a job (not the same satisfaction)'.

We then examined these codes and grouped together into themes, in accordance with their coherence and similarity to one another. For instance, 'facing the future without children...' was grouped with 'dealing with menopause' as they both represented an idea that clients wanted to process and accept life circumstances or events that were inevitable and out of their control.

We continued

developing the themes until they began to describe a persuasive account of what people wanted to achieve from talking therapy. We constructed five main themes:

1) '**Understanding self**'. Clients commonly wanted to understand their views and feelings they felt towards their own self-concept. For instance, they set goals such as 'I want to increase my self-worth', 'understand my negative self-belief' and 're-define myself'.

2) '**Understanding relationships**'. The term 'relationship' in this instance denotes the relationship between self and world as well as self and others. Many clients' goals were directed at their relationship with their immediate partner or their whole family unit. Additionally, clients expressed a need to create 'better boundaries' when interacting so they are 'less affected by another's anger'.

3) '**Understanding emotions**'. Clients frequently constructed goals to understand emotions they felt towards themselves such as 'crying', the feeling of 'dread', 'stupidity', or their 'low mood' as a whole.

4) '**Dealing with givens**'. Many goals represented the idea that, through therapy, clients wanted to process events that have occurred or inevitably will occur. Specific goals included, 'coming to terms with menopause', 'facing the future' with dramatic changes such

as 'no children' and 'feeling responsible for others' behaviour'.

5) '**Letting go vs holding onto something**'. Clients wanted therapy to help them find a solution to situations that bring about internal conflict. For instance, they may want to move on with their life but cannot stop 'dwelling on the past' or they 'want to be more trusting', but in order to do that they have to 'give up a sense of control', or they have a 'fear of feeling trapped' but want to 'move forward' in their relationship.

Although clients were free to choose their goals, which as a consequence are subjective to those individuals, clients with both clinical and sub-clinical mental health issues disclosed common difficulties and wanted to address these common difficulties in therapy. Our findings also accord with previous qualitative analysis of therapeutic goals.

GP Screening Questionnaire



NAME _____ DOB: _____ DATE OF REFERRAL: _____

Please consider that all the information given below is confidential to the GP and the personnel involved in your care.

1. Please try to think about your daily life and try identify (in a few words) your problems and to rate their level of severity according to the following scale:

1. Normal/mild 2. Moderate 3. Severe 4. Extremely severe

Identified Problems	Severity
1.	
2.	
3.	
4.	

Were you able to identify the nature of your concerns?
YES ----- NO

2. How do these concerns affect you in your daily life?

3. Do you think that therapy could help you to understand your difficulties?

DEFINITELY ----- DEFINITELY NOT

4. Are you willing and able to commit to weekly sessions of therapy?

DEFINITELY ----- DEFINITELY NOT

5. Do you appreciate that therapy will be hard work psychologically and emotionally?

DEFINITELY ----- DEFINITELY NOT

6. Will you be able to also work on the process of change between therapy sessions?

DEFINITELY ----- DEFINITELY NOT

7. Can you think of being responsible for trying to change in a self-motivated and independent manner?

DEFINITELY ----- DEFINITELY NOT

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Using goals instead of illness

When people present their issues to GPs as depression or anxiety, it is hard to understand what that term means to the individual and it does not capture the specific issues they are struggling with. Thus, using goals enables health professionals to break down these broad labels, such as depression, in order to understand specifically what the client is struggling with.

From this, therapists can focus the dynamics of the intervention to better support and work with the client as an individual, rather than viewing the person in light of an illness. As a result, detailed and specific goals enable both the therapist and importantly the client to understand what their position is in life at present and where they desire to be by the end of and post therapy.

To give an example: during GP consultation someone may disclose they are 'depressed'. However, using goals as a tool to uncover what the client specifically struggles with may unearth that they want to understand their 'low self-esteem' and why they 'cry a lot'. For a health professional, it is clearer how to support the client with understanding their 'low self-esteem' rather than lowering the clients' depressive symptoms as a whole.

The themes we drew from client goals are limited to the small sample size and thus could not be statistically analysed. Having said that, it is still valuable to identify what is emerging at this early stage about what clients want from therapy. When our pilot progresses and we collate more client data, our themes denoting what people want from therapy may change.

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