Truth or Dare

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Existential Experimentation

Evidence from the application of a short-term existential therapy model in primary care

M. Rayner and D. Vitali
This presentation is our own particular view of the possibilities of measurement in the current world of psychotherapy that both demands statements of success as well as acknowledges the inherent difficulties and flaws in such attempts.

At the outset we will introduce some of what we have termed the phenomenological informants and existential attitudes as being the theoretical constructions upon which this approach was conceived.

There are some notions of truth at the end of this presentation in the form of results obtained from a study of our version of a short-term existential-phenomenological approach to psychotherapy in the public sector.

In terms of the dare in this endeavour – we will dare to describe in detail an operationalisation of this approach and apply it systematically in order to establish our ‘truth’ i.e. the evidence or rather the results obtained from the application of such an intervention.

M. Rayner and D. Vitali
Facing the challenge of integration

This presentation introduces an integration of existential attitudes with a measurable notion of change
Existential attitude to change and measurement

Symptoms do not adequately address the complex nature of human experience of distress

Change is inevitable in therapy

Change may be better understood as change in understanding of self, others, and world
Existential attitude to change and measurement

1. This approach to therapy assumes that therapies that aim solely at the eradication or amelioration of symptoms do not address the complex and broad nature of human experience.

2. However, this approach also believes that change is the inevitable characteristic of therapy.

3. Therefore, we re-construe our conceptualisation of change to encompass changes that may be about changes in understanding of 4. oneself or 5. others or 6. of the world.

   Thus we would argue that if understanding or meaning or even acceptance changes, this is a valid form of change that can be measured, while attempting to preserve the complex and subjective nature of human experience.
Intentionality and Intention to change
Intentionality and Intention to change

The premise for this emerges from the foundations of existential thinking in Brentano’s (1874) concept of intentionality.

This philosophical concept when applied to practice is understood as a person being inevitably given over to a process of living that involves change, thus, a person’s stance is inevitably one that is inclined towards...leaning towards.

Therefore, the environment of therapy is constituted by two people meeting in an intentional manner: a client intending to seek help, i.e. leaning towards that which proffers the possibility of recovery; and the therapist who has an intentional attitude of creating a space in which help may become possible. Thus therapy happens through this conduit of intentionality.
As mentioned, in order to measure a system or ‘doing’ of therapy, we need to articulate some key ideas in the practice of therapy so that we can contend that the ‘doing’ has an effect (or otherwise). In other words, that we can assert that we have adhered to some components of practice that are identifiable. The principles of this therapeutic practice are laid out as follows:

- Making sense of urgency
- Phenomenological attitude
- Setting goals and measurement
Making sense of urgency

What about now
What about this moment in time brings about the seeking of help on your part?

Time-limitations and recovery
How can we bring about or convene discussions about well-being and recovery in our limited time together? This reinforces the notion of this practice being rooted in understanding of reciprocal intentionality and, thus, urgency refers also to the co-constituted nature of the meeting.

Purposefulness
However, this is not a new idea – this has been expressed for many years regarding a proactive stance in short-term interventions. The difference lies in ‘how’ the above issue is addressed – the purposefulness of urgency in this therapy is explicitly addressed through the identification by the client of objectives articulated to the therapist as goals for therapy.

Principles of Practice
- Phenomenological attitude
- Setting goals and measurement
Phenomenological attitude

Resistance

Measurement

Phenomenological attitude and method

Discovery

gain access to breadth of experience $\rightarrow$ more adequate understanding

Principles of Practice

Urgency
Phenomenological attitude
Setting goals and measurement
1. Existential and phenomenological authors and practitioners have historically resisted for the most part systematisation of therapy - largely for two reasons: first, within this area there are a diverse range of practices.

Second, and more importantly, it is argued from a phenomenological viewpoint that any system of ‘doing’ therapy is in itself a reductionist practice that inevitably restricts itself to understanding human experience as a set of things i.e. symptoms. As such, existential-phenomenological so-called purists could reject any attempt at creating a system.

We overcome this resistance by basing our argument upon one simple premise: we have got to be able to assess what we do and whether it works: so we must say what we do. This approach is, therefore, a simple attempt to operationalise a measurable form of therapeutic practice.

**Principles of Practice**
- Phenomenological attitude
- Setting goals and measurement

**Urgency**
Central to this approach is the method that is set out step by step below – this is the stance on the part the therapist of a deliberate 4. weakening of thought – this manifests as an ‘openness’ or ‘letting be’ that has a purpose. This takes place in conjunction with the setting aside, or the temporary 5. suspension of, assumptions about the meaning or explanation of experience known in phenomenology as the epoche – so we have used the classical terminology of ‘weak thought’ and ‘epoche’ to denote this attitude. The purpose of this active stance of openness/6. letting be and bracketing beliefs intends itself towards 7. discovery.

We are seeking to discover that which 8. presents itself from experience and to do so, the therapist must be available – availability emerges in this intentional attitude to see that which may emerge for reflection and understanding. If this is successful, we gain access to a 9. broader, more adequate understanding of experience than might be possible if we aim merely at symptom identification and amelioration.

<table>
<thead>
<tr>
<th>Principles of Practice</th>
<th>Urgency</th>
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<td>Phenomenological attitude</td>
<td>Setting goals and measurement</td>
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With our focus clearly on measure-ability, the above principles inform the setting of goals.

**Disability vs distress**

*Personal narrative*

*Identification of goals*

*Achieve-ability*

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**Principles of practice**

**Urgency**

Phenomenological attitude

Setting goals and measurement

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Since goals are the clients’ expressions of potential recovery rather criteria driven by service delivery requirements, this approach seeks to re-humanise notions of psychopathology, deconstructing the medicalisation of human difficulties and, therefore, challenging the idea of disability and illness.

- So we encourage a personal narrative of distress
- A narrative that can be encapsulated in the identification of goals for therapy
- Goals that the therapist and client can seek to achieve
Overview of the Intervention

Purpose: replicability of the results

Operational description of the intervention

Systematic application

EVIDENCE
This section describes an overview of the intervention, methodologically, trying to stay true to the spirit of enquiry, whilst recognising the need to address the questions of operationalization and systematisation, in order to provide a meaningful view of the efficacy and effectiveness of the treatment process. Therefore, at the heart of this presentation, we will describe:

- The process of sampling of clients for this treatment process
- A full description of the intervention procedure
- How we systematically applied the intervention to our client group
- The practice-based evidence that emerged from this study

...and how this intervention addresses questions of consistency, adherence to the procedure and notions of replicability
Operational description of the intervention

Session 1: Phenomenological horizons
Session 2: Phenomenological Reduction 1 – self-reflection
Session 3: Phenomenological Reduction 2 – self-construct
Session 4: Experimenting with change
Session 5: Embracing experience
Session 6: New horizons

Existential Experimentation (EE) has a precise Goal to promote recovery as a process of enablement of the client’s therapeutic discourse (Heidegger, 2001, Spinelli, 2007) and a journey rather than a place or point in time (Shepherd)
Horizons: From experience → Goal Setting

1st

Existential Experimentation

- Description and clarification of experience
- Proactive inquiry and identification of goals
- Promoting reflective stance and intentionality toward treatment
- Mobilisation of recovery and potential
- Writing of goals and refining of objectives

Description of the intervention

Session 1
Session 2
Session 3
Session 1: Phenomenological enquiry – the landscape and horizon of current experience

- Description and clarification of experience
- Proactive inquiry and identification of goals
- Assessment and promotion of a reflective stance toward experience and encouragement of intentional attitude toward treatment
- Mobilisation of recovery and potential
- Writing of goals and refining of objectives
Enablement through self-reflection

1st

2nd

Existential Experimentation

- Validation of the worldview and potential emerged in session 1
- Revisiting experience, problems and Goals
- Establishing client’s relationship to experience
- Establishing client’s relationship to self-having-experience
- Establishing the ‘meaningfulness’ potential of the experience as whole

Description of the intervention

Session 1
Session 2
Session 3
Session 2: Phenomenological Reduction

- Validation of experience as articulated in session 1 – acknowledging the experience as that which has been meaningfully interpreted by the person
- Revisiting experience, problems and Goals to confirm that what we have assessed upon reflection from the first session remains the agreed focus
- Establishing client’s relationship to experience – beginning to consider the ownership of experience by considering the inevitability of the relatedness between experience and experiencer
- Establishing client’s relationship to self-having-experience as articulated in session 1 – recognising that the self-having-experience is already a self full of assumptions, values and attitudes
Engagement with experience that both acknowledges and verifies the ‘meaningfulness’ potential of experience by:
- Confirming the value of lived and living experience.
- Recognising that experience is not passive but one actively informed by subjective meaning making structures and these mechanisms for making meaning containing both the problem of experience and contain possibilities for solutions.
- Reflecting upon the possible benefits as well as the potential difficulties in considering change

Thus session 2 is about establishing the ‘I’ in the experience in order to promote a sense of ownership in as far as how experience is experienced / interpreted / understood.

Therefore, from this perspective of practising therapy, it is this interpretation/understanding of experience that discloses the personal values, attitudes, beliefs and assumptions that the person makes or holds about him or herself, others and the world (experience).
Session 2: Phenomenological Reduction

Therapy proceeds with engaging clients in a manner that establishes the “I” in the experiences of each client in order to promote a sense of ownership regarding how experiences have been interpreted or understood (Spinelli, 2005).

The focus of the intervention at this stage is about engagement with the therapist and the therapeutic task and assuming agency, as represented in the goals articulated as “mine”.

Elucidate the person’s concerns through becoming self-conscious and reflective (Gallagher & Zahavi, 2012).

This process is common to many therapies and emanates from the phenomenological reductions and also articulated by Gallagher and Zahavi: “when we reflect....we step back from our ongoing mental activities and....this stepping back is a metaphor of distancing and separation, but also one of observation and confrontation” (Gallagher & Zahavi, 2012, p.72).
The self-construct explored

- Exploring the client’s relationship to the self-as-experienced in session 2.
- The challenge: Is this the most adequate manner self-evaluation?
- Cost/benefit of self-preservation
- Recognising that the current interpretation of self-as experienced discloses the present sense of psychological distress?
The self-construct explored

**Session 3: Phenomenological Reduction**

- Exploring the client’s relationship to the self-as-experienced in session 2.
- The challenge: Is this the most adequate manner of evaluating experience/experience of self i.e. The self-as....depressed, anxious etc.?
- Consideration of the world view(s) - engaging the client with the notion of the world view i.e. How could the client reflect upon and understand the usefulness/helpfulness of maintaining adherence to the values, attitudes, beliefs and assumptions that informed the self-as-currently-experienced?
- Recognising that the current interpretation of self-as-experienced discloses the present sense of psychological distress?

Thus....this session aims to reconstrue the position or the positions known as the world view or views as a process rather than being a passive and risk-free determined view of the self-construct. To enable the client to consider the possibility of movement from the current self-as-experienced to a transcendent sense of self that leans towards a sense-of-self-as-wished-for? In other words, an attempt to capture both the ontological notion of becoming as well as a specific ontic notion of change

- Therefore, undertaking the above challenges is considered as being key to the notion of possibility, opportunity and potential for growth and recovery but that this will be a challenge to sedimentation and structuring of experience.

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**Description of the intervention**

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<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
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Experimenting with change

1st
• Nurturing the courage to reach-for and engage in living more deliberately

2nd
• Re-establishing meaningful relations with potential by becoming open to possibilities

3rd
• Facing the difficulties and possible inclination of resorting to well-rehearsed and familiar “lenses” for interpreting experience

4th
• Observing the emerging self-as-wished-for as own by the client

• Enacting and so experimenting (at first with the therapist and then with outside world) that sense-of-self as “temporary” way to engage with the world and the others.

Description of the intervention

Session 4
Session 5
Session 6
Session 4: Experimental Process

- Nurturing the courage to reach for, lean towards and engage in living more deliberately
- Re-establishing meaningful relations with potential by becoming open to possibilities
- Facing the difficulties and possible inclination of resorting to well-rehearsed and familiar strategies and mechanisms for interpreting experience
- Considering the transcendental nature of self-as-wished-for and experimenting with a temporary sense of this self in relation to both the therapist as other, the therapeutic process as living experience and the outside world as validation or invalidation of self-construct.
Embracing experience

- Continuing reflection
- Challenges of sedimented versus self –as-wished-for.
- Living with, reflecting upon, understanding and embracing experience

Description of the intervention

- Session 4
- Session 5
- Session 6
**Session 5: Re-affirming and Practising**

- Continuing reflection in therapy regarding the value and difficulty of being a temporary-self or engaged in an experimental, experiential challenge to self-as-known vis-a-vis a sense of self-as-wished-for.

- Living with, reflecting upon, understanding and embracing experience – to maintain a stance that is a courageous attempt to stay with as well and lean for and towards those ideas about self that are hoped for in a purposeful manner that recognises and continues to reflect upon re-emergence of sedimentations that might impede the process and personal progress.
If and how experience may have started to appear different during therapy

What still remains concealed and unaddressed

Reviewing the value of what has been gained (and perhaps lost)

Considering on how the sense-of-self may face and embrace future existential obstacles and difficulties

Description of the intervention

Session 4
Session 5
Session 6
Session 6: Generalising

As with many therapies there is the need:

- To look at where therapy commenced, what was attempted, whether it has been possible or to what extent.
- By reflecting upon the experiences unfolded by experimenting that renewed sense-of-self: what remains undone or unconcealed?
- Reviewing the value of what has been gained (and perhaps lost) and considering how the sense-of-self may face future existential obstacles and difficulties.
- Reviewing to what extent the therapeutic endeavour has provided a platform for and reflective place in which to embrace life’s inevitable difficulties and resist the possible manner of interpreting experience in a self-defeating or harmful manner.
Repeated Measure Study

**Within subject Exploration** of the difference in scores measured before and after therapy with standardised instruments.
**Within subject Evaluation** of the effect sizes attained on the outcome scores the application of the module.
A repeated measure study is one that establishes a measure of experience that can be numerically assessed at the outset of the work – this is known as a baseline measurement i.e. where we start from. The measures are then repeated (in this study) on an on-going basis – this serves two purposes: first, that we are able at the end to see the simple difference; second, the frequency of repetition that we used i.e. each session mean that we are able to have some valid data to analyse even if the person leaves therapy before the completion.

A within subject exploration is one ........................................
and a within subject evaluation .............................................
For this specific reason, the default amount of contacts to considered by IAPT for treatment as completed was not applicable. Consequently, we **considered as dropped out all those cases that did not complete the whole 6-session intervention**
The sample consisted of:

- The cases were **referred to by the Primary Care** Mental Health Team (PCMHT) of the Barnet Enfield & Haringey Mental Health NHS Trust.

- The cases were all randomly chosen from those referred for psychological interventions in primary care and then proposed for this pilot project as opposed to receiving treatment within the IAPT programme.

In other words, all cases treated in this study were referred by the PCMHT to EE as an alternative to an IAPT intervention.
Male or Female working age adults referred by GP for psychological treatment in Primary Care that scored equal to or above the clinical cut-off of 10 on the PHQ-9 scale (score range 0-27) and/or, 10 or above in GAD-7 (score range 0-21)

Clients undertook outcome measurements at assessment, first and sixth session

Clients began treatment within 28 days from referral (therefore a waiting time no longer than 4 weeks)

Clients completed treatment within 84 days (12 weeks)
CORE-OM
Pan-theoretical, pan-diagnostic, self-administered 34-item measure of psychological distress (Evans et al. 2000)

PHQ-9
Self-administered 9 item scale for screening, diagnosing, monitoring and measuring the severity of depression (Kroenke, Spitzer, & Williams, 2001)

GAD-7
Self-administered 7 item scale for screening, diagnosing, monitoring and measuring the severity of Generalised Anxiety Disorder (Spitzer, Kroenke, Williams, & Löwe, 2006).
Chart Title

- Assessment time
- Between session 1 and 2
- After session 3
- Completers

N = 52

Results Discussion
### Results

#### Table 1. EFFECTS OF THERAPY AFTER 6 SESSIONS

Summary of average scores recorded by the clinical* patients who started and completed the six session intervention.

<table>
<thead>
<tr>
<th>Scale</th>
<th>T0 (SD)</th>
<th>T1 (SD)</th>
<th>Diff (SD)</th>
<th>Cohen's d</th>
<th>Power (1-β error prob)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>17.65 (5.71)</td>
<td>11.48 (7.96)</td>
<td>6.17 (4.49)</td>
<td>1.38</td>
<td>0.99</td>
<td>23</td>
</tr>
<tr>
<td>GAD-7</td>
<td>15.25 (3.88)</td>
<td>10.04 (6.67)</td>
<td>5.21 (4.78)</td>
<td>1.09</td>
<td>0.99</td>
<td>24</td>
</tr>
<tr>
<td>CORE-OM</td>
<td>19.94 (6.68)</td>
<td>14.47 (7.94)</td>
<td>5.47 (6.16)</td>
<td>0.89</td>
<td>0.99</td>
<td>32</td>
</tr>
</tbody>
</table>

**Note.** Report shows average scores at first assessment [T0], discharge assessment [T1], average difference between the scores, effect size and statistical power. Statistical power was calculated post hoc according to effect size and sample size as one tail and considering a chosen significance of $\alpha = 0.05$.

* Patients were considered as clinical if they registered a score equal or greater than the suggested clinical threshold score for the considered scale.
Table 2. EFFECTS OF THERAPY AFTER 6 SESSIONS

Recovery rates of those clinical patients that undertook a whole 6 session treatment.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Recovery</th>
<th>Cohen's d</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>47.83%</td>
<td>1.38</td>
<td>23</td>
</tr>
<tr>
<td>GAD-7</td>
<td>58.33%</td>
<td>1.09</td>
<td>24</td>
</tr>
<tr>
<td>CORE-OM</td>
<td>31.25%</td>
<td>0.89</td>
<td>32</td>
</tr>
</tbody>
</table>
On average, the PHQ-9 and GAD-7 data shows a good and robust performance of the short-term therapeutic system in terms of effect on symptom reduction.

With regards to CORE-OM as a pan-theoretic and pan-diagnostic scale, on average the effect observed on the score at the end of therapy was large but appeared of smaller magnitude if compared to the effects observed on the PHQ-9 and GAD-7 scores. This could be due to numerous factors and it is definitely a sign that further enquiry is needed to clarify how good are these symptom evaluation scales in describing and evidencing the psychological difficulties of the clients.

Recovering from a situation of general psychological distress is not the same or is not strictly related to a reduction in terms of generalised anxiety disorder or major depression disorder symptomatology (Shepherd, Boardman, & Slade, 2008). We believe change is a process of engagement with the distress that does not end with therapy but rather needs therapy to enable such a process to be delivered in a most effective and solid way.
Figure 1. EFFECTS OF THERAPY AFTER 6 SESSIONS
What we have found by utilising this measure is that change does take place and that it is sought around the themes that were expressed by clients and that when clients express what it is that they would like to achieve in therapy and are given the space to work towards their goals, they very often achieve them to a reasonably high degree. Of course, they may have done so anyway but what we have tried to demonstrate here is the relevance of collecting this data in this manner as proper evidence.
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Figure 1. Percentage of improvement in therapy clients as a function of therapeutic factors (Asay and Lambert, 1999)
This intervention commences by assessing with the client those difficulties that are initially expressed as symptoms or notions of illness. From this point, the approach directs the client to pay attention to those worldviews that emanate from the values, assumptions, beliefs and attitudes that inform the expression of difficulties in the form of illness or disability. This approach centres upon the meanings that clients attribute to their difficulties and thus extends to a focus upon the inevitable meaning-making mechanisms of the person presenting for therapy. In so doing, there is a movement away from the notion of being infected by something and towards a sense of agency in respect of those positions. From this standpoint, existential experimentation empowers the client to consider a sense of ‘mine-ness’ in respect of their expressed concerns, thus directing the therapeutic endeavour towards the context in which the client ‘has’ their living and lived experience, thereby attending to the potency of the client rather than impotency in respect of psychopathological entities such as depression etc. This therapy accesses what are known as client attributable factors or contextual factors rather than or as well as technique-based factors in its attempt to capture more adequately the breadth of human experience that is known to be limited in many therapies whose focus is upon the dis-enablement of the person rather than enablement.