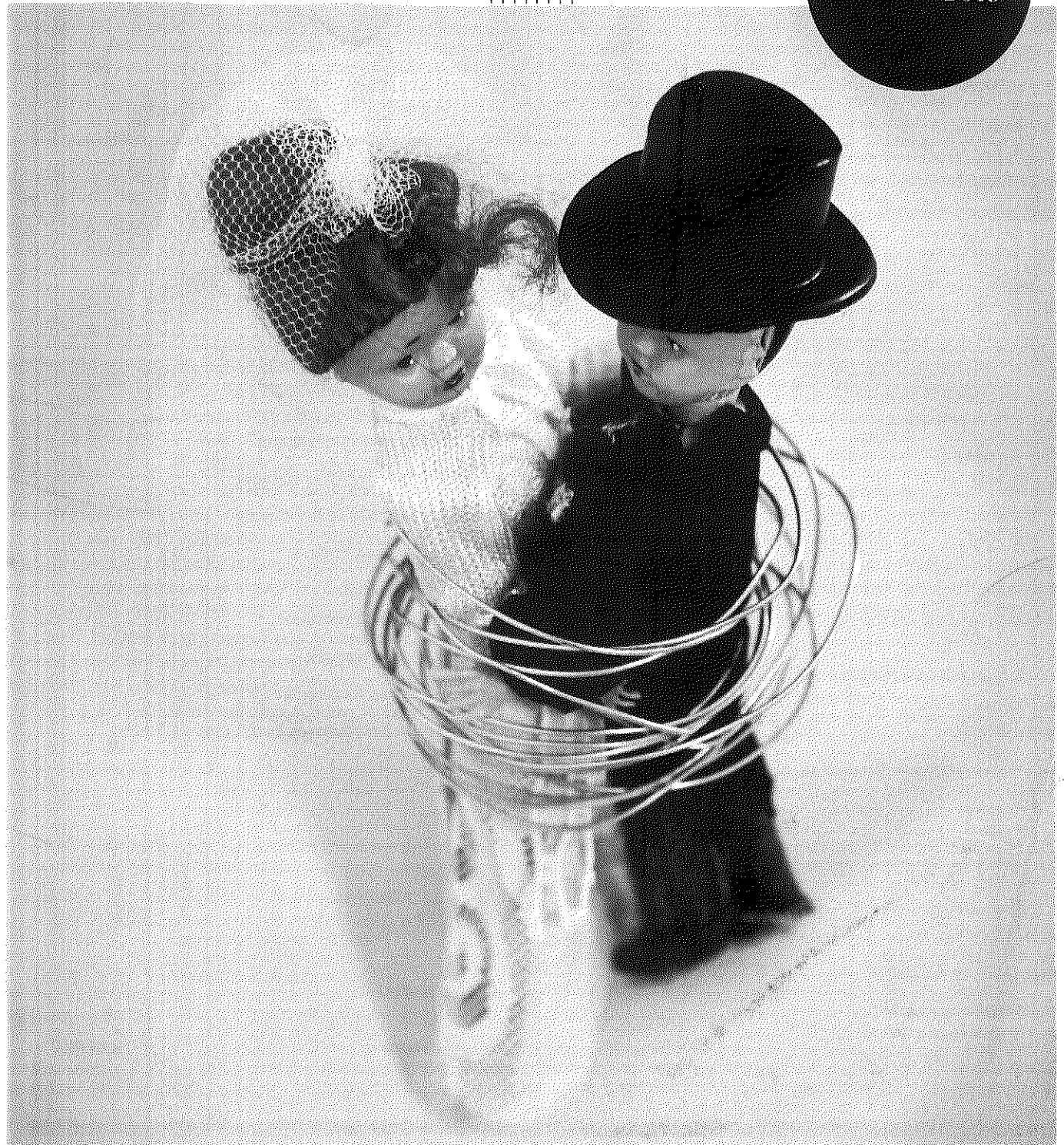


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MEASURING A SHORT-TERM EXISTENTIAL THERAPEUTIC INTERVENTION IN THE NHS

BY MARK RAYNER & DIEGO VITALI

I have been asked to write this in response to issues that were raised in the last issue of the *Hermeneutic Circular* and I hope that this describes and clarifies some of the questions raised.

As an integratively trained therapist who has worked in an existential-phenomenological manner in both the private and public sector for 17 years, I have seen many changes in practice and developments in how services are delivered and evaluated.

My basic stance is that existential-phenomenological therapies have sat on the margins of public sector service delivery and that this is a shame for those of us that believe passionately in addressing human concerns in a broad and inquisitive manner.

There has been much wrangling between types of therapies and types of therapists and we have seen the dawn of evidence-based practice and adherence to medical models of working.

In my opinion there is probably no single type of therapy that can make real claims to be better, more effective, efficacious than another (Luborsky, 1975). But I do believe that utilising existential thinking and a phenomenological method (Husserl, 1913) offers the possibility of engaging with distress in a way that explores clients' meanings (Frankl, 1959) and encourages understanding and the hope for change and recovery (Sheppard et al, 2008) – which I believe to be central to the endeavour of any effective therapeutic model.

I know this is contentious but I think we live in a world of testimonials, measurements, evaluations, audits, key performance indicators and competencies, and, as Mick Cooper says in his book entitled *The Facts are Friendly* (2008), we should not be afraid of this. Therefore, I decided to *join in* and have developed a way of working in the NHS in primary care settings and have piloted a short-term existentially informed intervention that is based on several simple premises:

1. Early intervention in the life-cycle of human distress leads to better recovery and outcomes
2. Understanding human difficulties as distress rather than disability promotes the possibility of challenging the medicalisation of misery
3. Intervening at GP point of contact reduces stigma associated with mental illness and promotes better engagement
4. Change is the endeavor of all therapy, although change may be understood in many ways. In other words, from the perspective of this therapy, change may be understood in terms of change in understanding or viewpoint or experience of sense of self i.e. not just limited to behavioural but possibly behavioural change as well
5. This type of therapy challenges the notion of collaboration as used by manualised cognitive based therapies. This therapy believes collaboration to be the attempt to understand and work with the clients' identified concerns rather than suggesting what is, or may be termed as, maladaptive or faulty thinking and directing change, which this type of therapy would consider to be compliance rather than collaboration.

The following short précis attempts to describe an existential-phenomenological way of working that has been applied in primary care settings using an assessment and six sessions of therapy. This is not a standardised model but one that is operationalised (to be published) so that we can demonstrate what it is that we are doing on a session by session basis, and also so that we can evaluate whether this process has been effective for the clients and *what about* this process has been effective. Therefore, in the spirit of joining in we have used routine outcome measures so that we can compare and contrast our work with models like CBT and those used in national initiatives like Improving Access to Psychological Therapy (Layard, 2004). Whilst I fully recognise that CORE 5-OM (Evan et al., 2000), GAD-7 (Spitzer, 2006) and PHQ-9 (Lowe et al., 2004) measurements bear little or no relation to an existential attitude, nor do they elicit information that is necessarily a *real* measurement of recovery, unless we utilise these measures, we as existential therapists will continue to be side-lined and marginalised. The importance of using these measures lies first in the clients' willingness to complete them – see the Hawthorne Effect of Expectation (Landsberg, 1958) – and, second, it gives us data that ALL therapies in the public sector must gather to have any chance of commissioning. In addition, we have used another (somewhat under-utilised – in my opinion) tool known as the Core GOAL-attainment measure, which asks a client what they see as the concerns they would like to work on in therapy and then asks them to rate the degree to which they reached those goals at the end of therapy.

The most important assumption this therapy makes is that about the words that the clients use to express their presenting concerns. In order to help any person as a therapist, one must find where the person is already (Kierkegaard, 1844). Almost all clients have *learnt the language of illness* in today's world of psychological therapy delivery. This approach takes this language of depression, anxiety, etc. to be statements of *the persons' sense of relationship to themselves, others and the world* and, as such, is devoted to explicating what this means in the living experience of the person through a process of phenomenological inquiry as follows:

1. The assessment

This initial meeting centres around the stated concerns of the client and provides a form of psycho-education about the process of therapy and the measurement tools we will use. We also initiate the engagement with the client's goals for therapy. In statutory services we have to assess and manage risk and attempt to formulate the person's concerns. From a phenomenological stance we attempt to do the latter through a process of description, clarification and horizontalisation (Spinelli, 1989). It is in this session that the attitudes, assumptions, values and beliefs of the client are elicited, together with an assessment of how these may impact upon the way the person sees the world and their

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difficulties. The therapist is also engaged in the process of bracketing his or her own views in an attempt to see the world through the eyes of the other (Jaspers, 1913). It is worth noting that apart from the above statutory requirements that are mandatory in any type of therapy, there is nothing of this endeavour that sets it apart from other therapies other than the way in which the world views of the client are elicited in an existential manner that focuses upon the acts and contents of consciousness (Husserl, 1913).

2. First therapy session

In this session, the phenomenological process of therapy is also partly psycho-educative, inasmuch as we explain the limitations of our work together in terms of time (Minkowski, 1933) and outline how, in a collaborative fashion, we may aim towards the achievement of the goals indicated by the client. From the assessment session, we further explain that we are interested in the human breadth of experience not just the medical view of the person's concerns, thus challenging either implicitly or explicitly the notion of illness.

3. Second therapy session

In this session, we move the phenomenological enquiry onwards by eliciting the nature of the person's relationship to their concerns, and the relationship that they have with themselves as a person who has these concerns, and attempt to place the person at the centre of their world so that they are able to begin to take ownership of their difficulties and start to disentangle themselves from ideas of illness and the typical stances that the harsh world has caused them to adopt. This is not to say that they have not possibly had awful, difficult and disabling experiences but rather this proposes that, if they are to recover, they must not necessarily, but may profit from, giving up the stance that they continue to be a hostage to. In other words, we introduce the idea that their sense of self is not immutable or the fixed result of past experiences but rather that time in the here and now allows for the consideration of the self that they would want to become.

4. Third therapy session

In this session, through phenomenological reductions we continue to look further at the relationship that they have with the concerns they've expressed, and how they have become this person and identified with a sense of self that is limited by these views. Here we are at the middle stage of therapy and, whilst we have considered the brevity of our interaction from the outset, it is here that we plan how they would like to re-understand or re-discover a lost sense of self through the interaction with the therapist. Again, it is worth noting that, although this therapeutic intervention considers the existential given of the person being in relation to the world (Heidegger, 1927) and that at this stage we are discussing choice and responsibility for who they are and how they would like to proceed, there are many therapies that would be doing something similar but approaching this from positions of different theoretical modalities.

5. Fourth therapy session

In the fourth and fifth session, the recognition that the person will soon be living in the world after therapy has ended is considered, and the clients are encouraged to live with their newly forming understanding of themselves. This is done both in the therapeutic encounter but also in the world as the clients are encouraged to try this temporary sense of self in whatever ways they choose to in their worlds and to bring this back to the therapist for reconsideration of whether or not this has been, or is becoming, a beneficial process.

6. Fifth therapy session

Further consideration is given to the notion of the client 'being-in-the-world' (Heidegger, 1927) insofar as the therapeutic space is recognised as a special space, but that all clients are inevitably living in the world of others, and their existence is both within and emergent from their own worlds.

7. Sixth therapy session

In the final session, this therapy envisages the journey ending as also a beginning (Sartre, 1943) and one that has hopefully allowed the client to reconsider their place in the world through a detailed investigation of their values, attitudes and beliefs. The CORE Goal Attainment Form is completed, along with the other measures.

The final important note relating to the use of these standardised measures of anxiety and depression is that when a person experiences therapy as understanding, compassionate, challenging and supportive and they feel better about themselves and/or understand themselves better, we have found, as indicated in the results below, that they tend to report that their anxiety or depression has been alleviated – thus we can demonstrate statistically significant and reliable change using this process.

The strong and inherent research-oriented backbone of this clinical experimentation should be underlined, insofar as this pilot project was carried out along strict lines of methodological data collection and analysis of outcomes. A specific paper about this research work is being prepared for publication and a preview of our results is presented below.

According to our data, this short-term existential intervention demonstrates success as follows:

- producing reliable and significant clinical improvements to a clinical population in primary care;
- reporting very low drop-out rates (to be published);
- producing recovery or at least high effect sizes for the patients presenting mild to moderate depression and/or anxiety.

The research study aimed to assess the clinical reliability and the average size of change produced in the clinical population. Therefore we aimed to produce quantitative results that could be further compared with the literature and benchmarked against the National Standards required by the National Health Service. The sample consisted of clinical cases (i.e. patients assessed above the clinical threshold with respect to the adopted scales) referred

to our practice by a primary care multidisciplinary team. The population was assessed prior to intervention and during therapy on a session-by-session basis and then re-assessed at the end of the 6th and last session using PHQ-9 (Lowe et al, 2004), GAD-7 (Spitzer et al, 2001) and CORE-OM (Evans et al, 2000). The proportion of clinical cases that registered a statistically reliable improvement (Jacobson & Truax 1991) was 55% for PHQ-9 ($\alpha=0.9$), 52.2% for GAD-7 ($\alpha=0.9$) and 57.1% for CORE-OM global score ($\alpha=0.95$).

We also considered a theoretical target-population for a primary care service and therefore we measured only the clinical cases that were assessed below the highest severity bands of the used scales i.e. those deemed eligible for a primary care mild-moderate short-term intervention; for these clients, we observed a statistically reliable improvement in 72.7% of the cases for PHQ-9, 76.9% for GAD-7, 64.3% for CORE-OM.

Contact: raynerm@REGENTS.AC.UK; scriem@gmail.com

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EEYORE & TINKERBELL: AN AEP PERSPECTIVE ON COUPLES THERAPY

BY REED LINDBERG

Successful long-lasting relationships are a combination of freedom and commitment, a balance that is sometimes hard to achieve. Jean-Paul Sartre's concept of bad faith helps us understand why. For Sartre bad faith, or lying to oneself about the nature of reality, comes in two forms: overemphasis on facticity or overemphasis on freedom. We can neither be free in a world without facts nor a fact in a world without freedom. Freedom has meaning only in

situation, and every situation is a combination of what the world brings and what we make of what the world brings. What the world brings includes our personal past (which constrains us once we have created it), our socio-material circumstances, our physical limitations, our past relationship choices, and the various givens of our lives. Freedom is our way of living those circumstances. Freedom without commitment to someone or something has little