



SEA 2015

Being & Doing

Existential-phenomenological therapy in the NHS

From theory to clinical practice to research

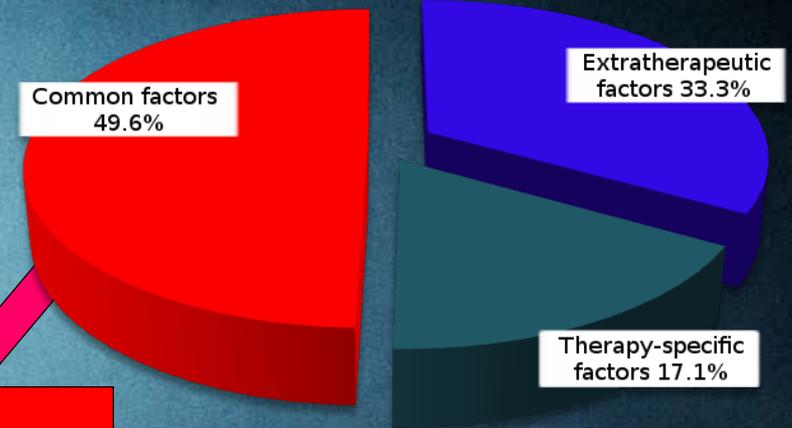
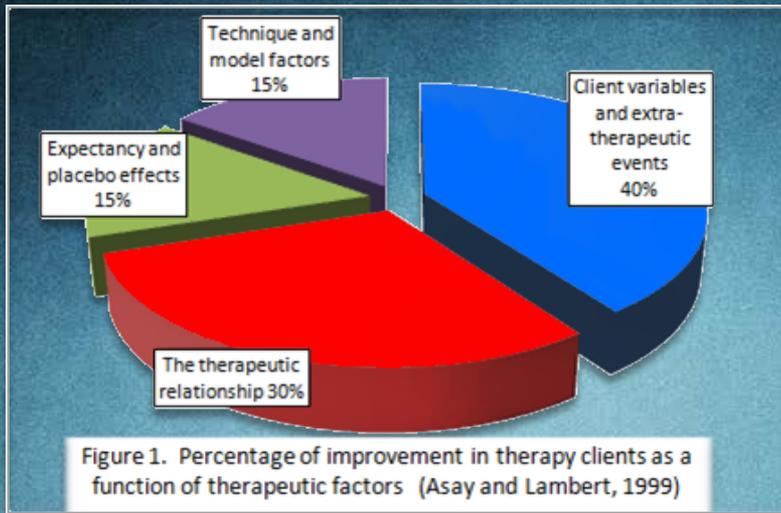
Jeans A., Smith S., Sayers L., Vitali D., Rayner M.



What we will describing is a therapy that we have called Existential Experimentation that centres upon the theme of this conference – being and doing – from the theory to practice to research and the development of robust practice-based evidence.

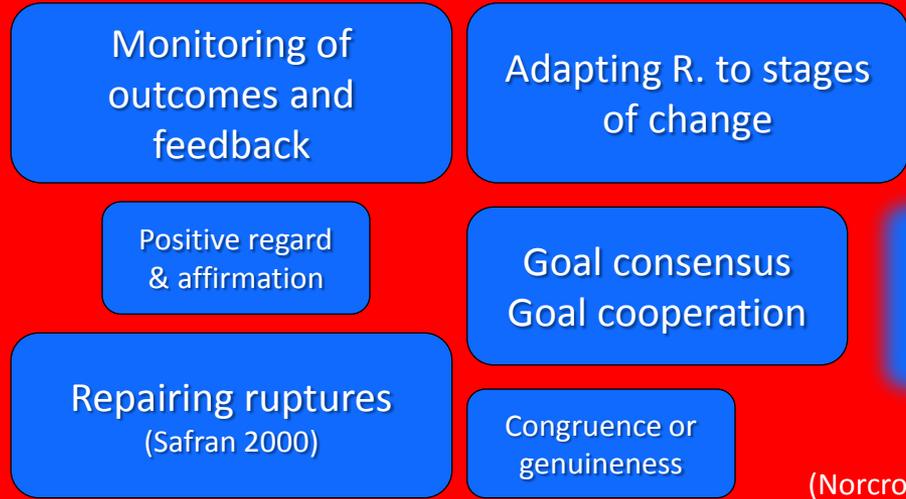
We present a model based upon an individualised assessment and six sessions of a goal-driven approach to therapy, since we initiated this as a compliment or challenge to the emergence within the public sector of the original implementation of the UK government initiative called Improving Access to Psychological Therapies (IAPT). This particular way of working with clients was developed as an attempt to challenge the medical approach of contemporary dominant psychiatric and psychological practices in primary care services (CBT). Existential Experimentation is oriented toward understanding human difficulty and suffering in the manner that these emerge in the lives of the clients, rather than being governed solely by the psychiatric or medical model.

What Matters in Therapy?



An attempt to partial out the contribution of factors common across psychotherapies, extratherapeutic events (including clients' contribution) and specific therapies in the treatment of depression. Cuijpers et al. (2012)

Therapeutic Relationship



(Norcross 2010)

Empathy

Extra therapeutic factors
(including client related factors)

What Matters in Therapy?



Therapy works!

But what works about therapy?

A section of the pie is informed by the philosophical underpinnings, theories and techniques adhered to by the therapists as well as the context or environment in which therapy is conducted.

The relational factors (AKA common factors) represent a large proportion of the pie but are not clearly understood, although some modalities that are strictly theory driven or manualised do state the nature of these factors as far as those models are concerned.

What Matters in Therapy?



Therapeutic relationship: The magnitude of this relation accounts for roughly 8% of the total variance in therapy outcomes. The alliance, along with therapist effects, is one of the strongest validated factors influencing therapy success (Wampold, 2001)

Empathy: Norcross (2010) meta-analysis resulted in an overall effect size of .30, a medium effect, but there was significant evidence that suggested that the effect of empathy is not consistent and may be affected by other factors

What Matters in Therapy?



Goal Consensus: The goal consensus-outcome meta-analysis Norcross (2010) — based on 15 studies with a total sample size of 1,302 — yielded an overall effect size of .34. This substantial result reflects the meaningful positive outcomes that are associated with improved agreement between therapists and clients about the aims of treatment and how to accomplish such aims

Goal-cooperation: The collaboration-outcome meta-analysis Norcross (2010) — based on 19 studies with a total sample of 2,260 patients — yielded an overall effect size of .33

What Matters in Therapy?



Positive regard and affirmation: meta-analysis of 18 studies (Norcorss 2010) that met our criteria for inclusion (e.g., the treatment was individual psychotherapy, clients were either adolescents or adults). The overall effect size among these studies was $r = .27$, indicating that positive regard has a moderate association with therapeutic outcomes.

Congruence or genuineness*: meta-analysis on 16 studies (Norcorss 2010) shows a small to moderate effect provides evidence for congruence as a noteworthy facet of the therapy relationship.

*refers to a relational quality of the psychotherapy relationship. There are two facets of congruence. The first reflects a mindful genuineness on the part of the therapist, underscoring present personal awareness as well as authenticity. The second facet of congruence refers to the therapist's capacity to conscientiously communicate his or her experience with the client to the client

What Matters in Therapy?



Monitoring of outcomes and feedback: Results of the meta-analysis (Norcorss 2010) showed that rates of patient deterioration in psychotherapy were cut in half, and rates of positive responding were several times those of clients who received treatment without formal feedback. The most dramatic effects were achieved for the clients at risk for negative outcomes early in psychotherapy and for psychotherapists providing information about the client's perception of the therapeutic relationship, motivation for treatment, social support system, and negative life events.

What Matters in Therapy?



Ruptures in the therapeutic alliance are episodes of tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2000). Exploring and repairing alliance ruptures when they occur can be an important element contributing to positive treatment outcome. Large effect.

Adapting the relationship to the stages of change. large effect:
A patient's stage of change reliably predicts the success of psychotherapy; precontemplation -> contemplation -> action. Patients enter psychotherapy with varying readiness to change or what researchers have called stages of change. Some minimize or deny their problems (precontemplation stage), some acknowledge their problems but are not yet ready to modify them (contemplation stage), while others are ready and eager to alter their problems immediately (action stage).

From practice-base evidence to...



Ideas from a therapeutic model

Mmm .. How to address & engage with those client's factors?

Ideas from a psychological theory



Relational factors

E
N
C
O
U
R
A
G
E

Hope

Clients' Factors



From practice-base evidence to...



We know that the client's active participation in therapy is a strong predictor of therapeutic success, we also know that the client's world is equally important (Extra-therapeutic factors aka context or client attributable factors). The life and environment of the client affect the notions of impediment and opportunity. The collaboration between client and therapist implicate the notion and manner of change. Therefore, this therapy takes up a position whereby the client holds the key to both the problem and the possible solution. We believe, according to the structure of the Pie, that as therapists we have limited impact upon the client's experience or interpretation of their world. This therapy, therefore, focuses upon the two most significant segments of the Pie, those being the relational factors and those that are the domain of the client's world. Thus, the task of therapy is to ascertain with the client how the client construes and expresses that which is meaningful to them in respect of their experience of themselves, others and the world. In that sense, the real *thinker* in the room is the client. From a theoretical standpoint, the predominant, at least initial, task of the therapist, is to assume and enact a rigorously phenomenological stance towards the experience as disclosed and in order to encourage a greater breadth of disclosure by the client.

From practice-base evidence to...



We therefore used some phenomenological ideas to describe and test a technique that moves the balance of the interaction from the position of the therapist to the one of the client or towards what we would identify as a truly collaborative or reciprocally intentional stance.

...to research



EE is a short-term therapy model infused with theoretical positions proposed by Spinelli, Schneider and others and published evidence from Lantz and others. Tested for efficacy in a feasibility study (Rayner & Vitali, 2015)

...to research



We are going to look at the therapeutic process with two clinicians presenting material that adheres to the process of this therapeutic approach and then we will address the evaluation of data collected for research that is information reported by clients and how levels of distress are measured.

...to research



The informants of this approach were conceived of in a time when evidence-based practice began to dominate ways of working that were driven by limitations that were time and resource limited. This inevitably led to the restrictions in practice where entitlement to treatment was high on the political agenda and accountability of services were highly visible.

Thus, articulating a way of approaching human distress that retained core issues around empowerment, choice and opportunity had to be aligned with a robust research basis, whereby the tensions I mentioned at the outset could be focused upon.

...to research



Therefore, we created a way of working that emanated from a sound philosophical and practical rationale.

This was reinforced by literature from authors such as Spinelli, Schneider and Lantz, amongst others.

Over recent years we put into practice this perspective, wherein these core ideas that are very effective when working with primary care clients and that are highly focused on triggering the active participation of the client, could be implemented, measured and analysed.

Lantz, J. E., & Walsh, J. F. (2007). *Short-term existential intervention in clinical practice*. Lyceum Books.

Spinelli, E. (2007). *Practising existential psychotherapy: The relational world*. Sage.

Protocol Overview



Existential Experimentation

- Challenge current narratives and promote openness
- Promotes the Goals for therapy as something described by the clients
- Promotes clients' own resources in the a context of choice, purpose and responsibility
- Challenges current held worldviews through experimentation therapy

Protocol Overview



Existential Experimentation

This section describes an overview of this intervention which tries to stay true to a certain epistemological spirit of enquiry whilst recognising the need to address the questions of operationalization and systematisation. This in fact represents an attempt to provide an existentially and phenomenologically oriented approach that can be applied in clinical contexts in which measuring the efficacy and effectiveness of the treatment process is crucial.

Existential Experimentation (EE) was conceived as an intervention that aimed to support and empower clients in using their own living skills to understand and thus to face the inevitable struggles that life may present from day to day.

Protocol Overview



Existential Experimentation

Challenge current narrative and promote openness: EE is a particular approach to therapy which explores and naturally challenges the sense of definite-ness or stuck-ness often presented by clients in their current narratives.

“Goals for therapy” as described by the clients: The experimental nature of this approach centers upon the articulation of goals that are identified at the outset by the clients. (2005, 2015) while also acknowledging that for clients to make changes that they wish for, they must “experiment” with that which troubles them.

Protocol Overview



Existential Experimentation

Promotes clients' own resources in the a context of choice, purpose and responsibility: The therapist aims to promotes the clients' own resources in the context of their own life limitations for a purposeful engagement with and understanding of their difficulties.

Challenges current held worldviews through experimentation therapy: The name 'experimentation' is not meant as some procedure done to clients or prescribed by the therapist. Rather, experimentation is a process that welcomes the inevitability of change (Spinelli 2005, 2015) while also acknowledging that for clients to make changes that they wish for, they must "experiment" with that which troubles them.

6 Active Principles of EE



Existential Experimentation

1st Contact

- De-objectifying psychological distress
- Setting the goals for therapy
- Elicit descriptions, narratives and client's own hermeneutic work
- Working with worldviews
- “Experimentation”

End of 6th Session

6 Active Principles of EE



Existential Experimentation

De-objectifying psychological distress:

The use of psychological and medical models that tend to objectify (or even explain and rationalize) the quality of human experience has had a great influence in the way western society makes sense of living difficulties (Summerfield 2004). This influence is now the commonly accepted discourse for understanding what psychological difficulty or suffering is about. Instead of being embedded in such assumptions or theory-laden ways of working, this approach fosters a dialogue which encourages clients to explore their interpretations of experience and consider *what* and *how* their personal situation led them to reach out for help

6 Active Principles of EE



Existential Experimentation

Setting the goals for therapy:

The focus of this work centers upon a leaning towards understanding, meaning and the hope for change, with all that is possible as well as problematic about such change. The clients and therapist work together to understand the current 'cost' as well as the possible 'benefit' or 'gains' related to those living experiences. In other words, it is essential to recognise that all experience and the interpretation of experience are meaningful and purposeful, and that change is an inevitable challenge to the security and constancy of the presented situation. The therapist's work here is oriented to attain a solution-oriented description (GOAL) of the experience of the client so that the clients consider – in their own terms - the polarised positions of change and constancy, whilst acknowledging the existential risks of facing the unknown and the unfamiliar with a deliberate and purposeful attitude.

6 Active Principles of EE



Existential Experimentation

Elicit descriptions and narratives:

According to Spinelli (2007, 2015), the process of describing and understanding our way of being leads to inevitable shifts in the way the world presents itself, thus we speak of the inevitability of change as these shifts are in how the world is experienced. In this way, the EE therapist aims to establish a therapeutic context in which the clients explore the ways in which some *things* of their lives are the way they are.

6 Active Principles of EE



Existential Experimentation

Promoting the client's own hermeneutic work:

In the environment of psychotherapy, the relational encounter between the therapist and the client is directed towards a temporary suspension of presuppositions about experience, both on the part of the therapist as well as on the part of the client. This suspension promotes a potentially new way of 'seeing' that emerges by the clients engaging in a *continuous hermeneutic* (Giorgi 2007) in which they reflect, re-interpret and re-present the issues to themselves and to the therapist.

6 Active Principles of EE



Existential Experimentation

Working with worldviews:

From an existential perspective it can be said that individuals are responsible for themselves, their choices, their freedom and, consequently, their ways of being involved and engaged in the world. The EE therapist supports the clients in reflecting and contemplating the impact, the meaning and the usefulness of the current sedimented worldviews.

In this existential framework clients will engage in descriptions and reflections of experience while at same time the therapist will attempt to clarify and then understand those meanings in the same manner as present for the clients. This is a maieutic work in which the therapist is constantly aware of not-knowing the meaning of the object discussed: only the client can show the therapist how one particular meaning presents itself.

For the purpose of this short-term intervention it is crucial that the clients in a personal *discourse* in which the givens of their existence, their current worldviews and their goals for therapy as positions that are *wished-for*, are always present.

6 Active Principles of EE

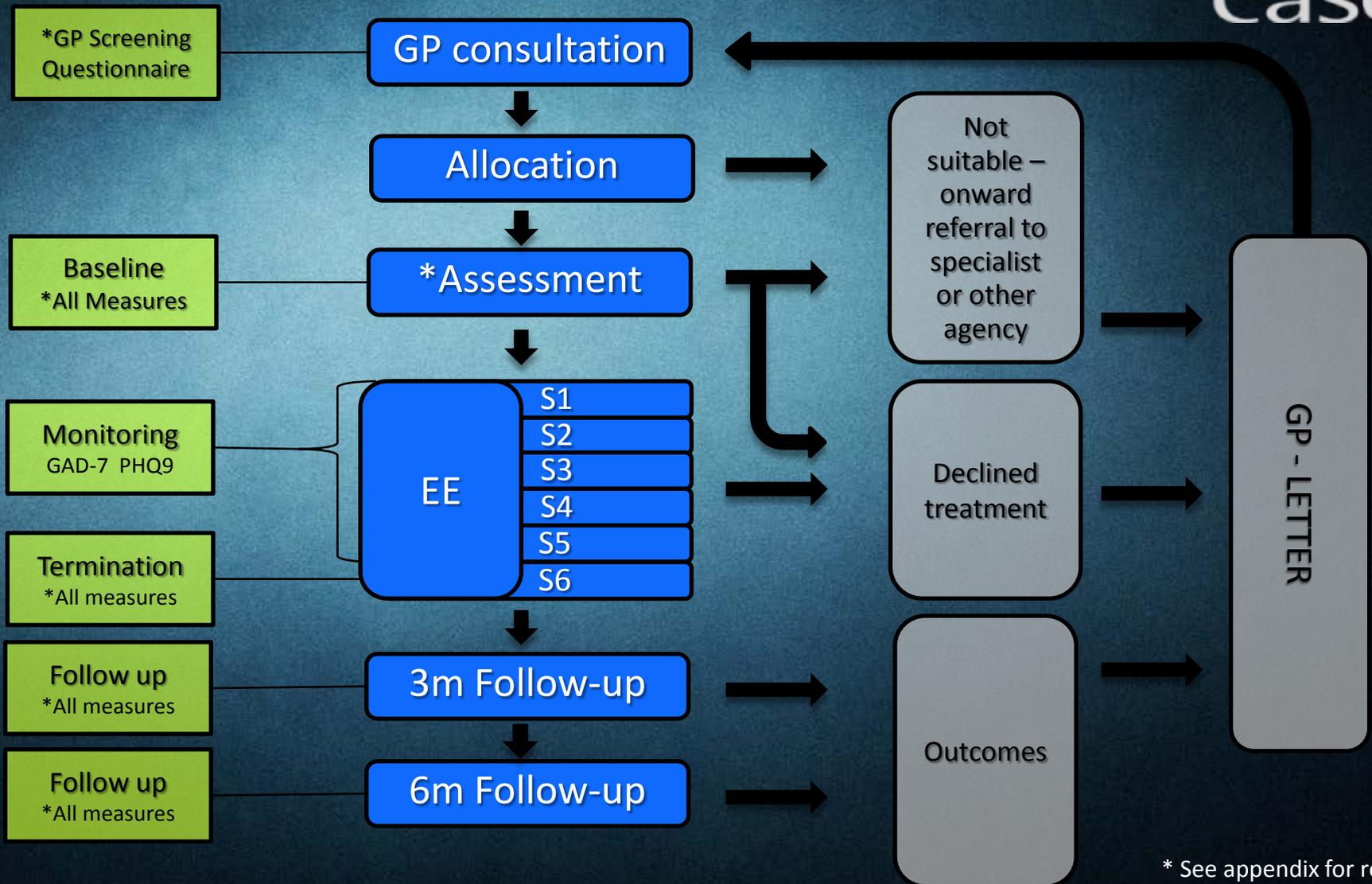


Existential Experimentation

“Experimentation”

The experimental nature of this approach is about the person experimenting with possible aspects of the self-construct as contemplated in therapy. In this sense, the therapist encourages clients to experiment with those ideas and worldviews that emerge in the space and process of therapy to seek possibly more adequate stances towards their experiences and achieve their goals or wished-for positions. The *experimental* nature of therapy has, therefore, nothing to do with experimentation meant as an experiment conceived of by the therapist or by the therapeutic system in general. Instead, the therapist supports clients in enabling the temporary suspension of their current way of being (self-construct), challenging clients in experimenting with the therapist in vivo and then subsequently in their own natural world.

Pilot Design





Amelia – Lead Clinician

- De-objectifying psychological distress
- Setting the goals for therapy
- Descriptions and narratives
- Working with worldviews
- “Experimentation”
- Discussion



Sarah – Ease Clinician

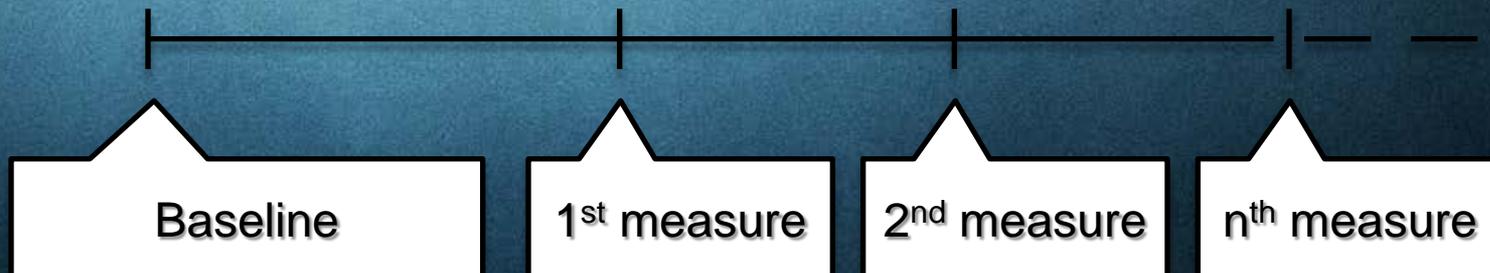
- Week 1: My abandonment in the worldview of the Jenny
- Week 2: Jenny's emotions took the centre of therapeutic encounter
- Week 3: Jenny reflects upon and contemplates her positions
- Week 4: new colours appear in Jenny – new ways of being
- Week 5: Jenny feels the tension between new colours and old colours (safer)
- Week 6: Jenny acknowledges the power and accepts the uncertainty of HER new positions

Background Evidence

Feasibility study (Rayner & Vitali 2015)



Repeated Measure Study



Background Evidence

Feasibility study (Rayner & Vitali 2015)



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:

1. When the same participants are used across conditions the unsystematic variance (often called the error variance) is reduced dramatically, making it easier to detect any systematic variance.
2. It is easier (no need for large sample) to detect effects attributable to therapy.

Background Evidence

Feasibility study (Rayner & Vitali 2015)



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.*

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

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 $\alpha=.05$.

* Patients were considered as clinical if they registered a score equal or greater than the suggested clinical threshold score for the considered scale.

Background Evidence

Feasibility study (Rayner & Vitali 2015)



Participants were recruited only from the London Borough of Barnet, Enfield & Haringey Mental Health NHS Trust and referred to EE between June 2011 and September 2012. The mean age of the participants ($N = 52$) was 37 years ($SD = 11.9$); 36% were men and 64% were women. Patients were considered clinical if they had an intake score higher than 10 points; this threshold was used as a parameter for statistical analysis as it has previously been used by validated studies. As expressed by Table 1, comparing the average scores registered at first assessment [T0] to those that emerged at the end of therapy [T1], the effect sizes (Cohen, 2013) were large ($d > .80$) for all the given scales.

Background Evidence

Feasibility study (Rayner & Vitali 2015)



Figure 1. EFFECTS OF THERAPY AFTER 6 SESSIONS

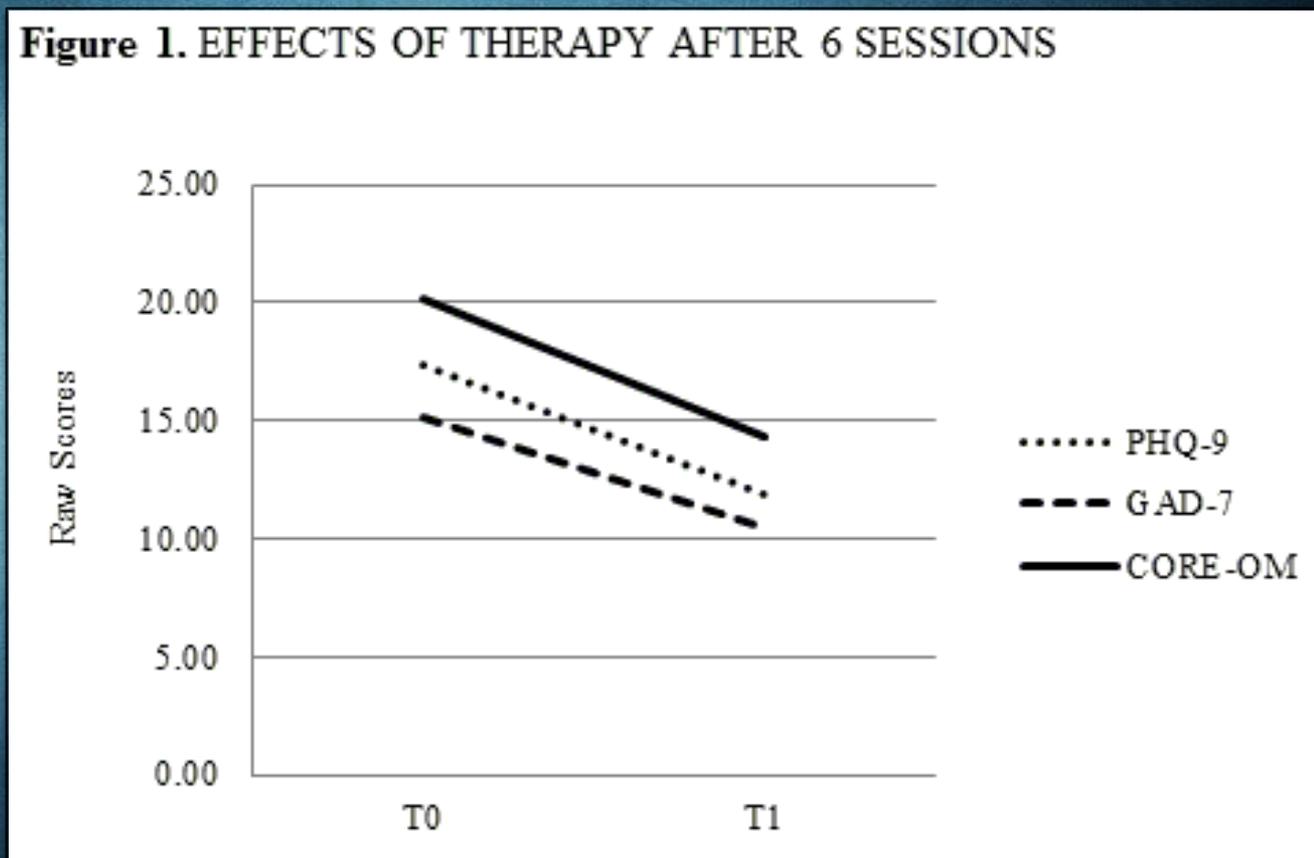
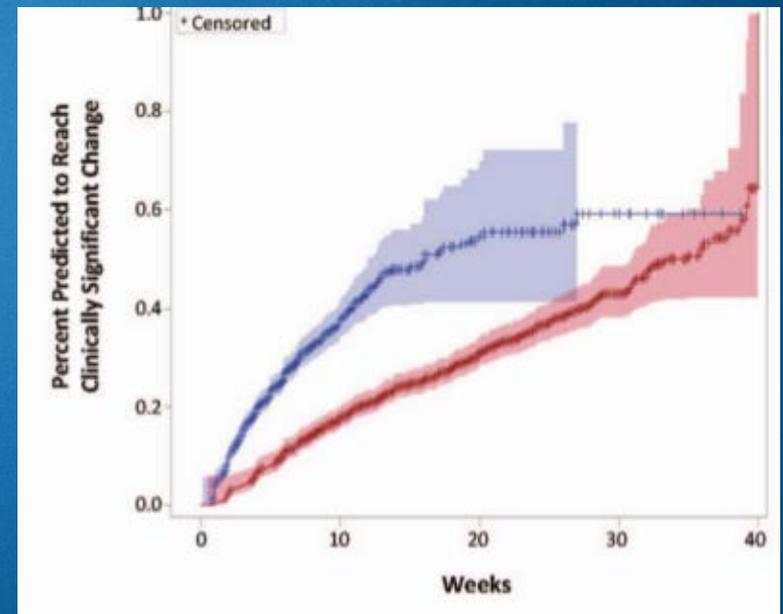
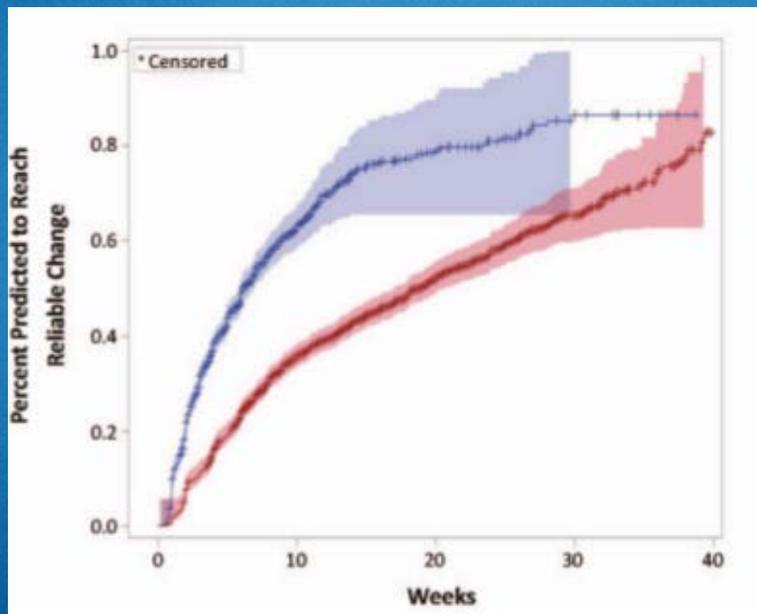


Figure 1 shows on average the pre–post effect of therapy on a clinical population as emerged from our data after a complete six-session intervention

Interesting and recent findings



The relationship between Session Frequency and Psychotherapy Outcome in a Naturalist setting



More frequent therapy is associated with:
steeper recovery rates curves + faster achievement of clinically significant change.

Erekson DM, Lambert MJ, Eggett DL. (2015)

Interesting and recent findings



Just a brief but v interesting update from recent and important findings (October 2015) from Erekson, Lambert and Egget that using an archival database of session-by-session Outcome Questionnaire 45 (OQ-45) measures over 17 years, 21,488 university counseling center clients (54.9% female, 85.0% White, mean age = 22.5) were examined using multilevel modeling, including session frequency. 303 therapist at the counselling center were psychologists or supervised psychologists in training (doctoral students in counseling or clinical psychology) who **provide treatment according to their theoretical preference, including cognitive– behavioral, psychodynamic, client-centered, existential, systems, and integrative modalities.**

On the basis of the results attained from our feasibility study we expect to find:

1. Large reduction (Cohen's $d > 0.8$) of the level of
 - Anxiety (as expressed by GAD-7 scores)
 - Depression (as expressed by PHQ-9 scores)
 - Psychological distress (as expressed by CORE-OM scores)
2. Feedback from our clients that have participated in the previous study suggested that this intervention can facilitate change as a result of the use of clients' personal resources. Therefore we implemented the use of Friborg's (2005) Resilience Adult Scale to explore these possible findings.

Hypotheses



Resilience.

Why use this particular resilience scale and not others. Because according to Wiley(2011) meta-analytic review on the most used resilience instruments, RSA-33 (friborg 2005) is a good instrument to examine intrapersonal and interpersonal protective factors presumed to facilitate adaptation to psychosocial adversities (personal strength, social competence, structured style, family cohesion, social resources).

CORE-OM (Evans et al. 2000)

PHQ-9 (Kroenke, Spitzer, & Williams, 2001)

GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006)

RAS (Friborg et al. 2005)

Instruments



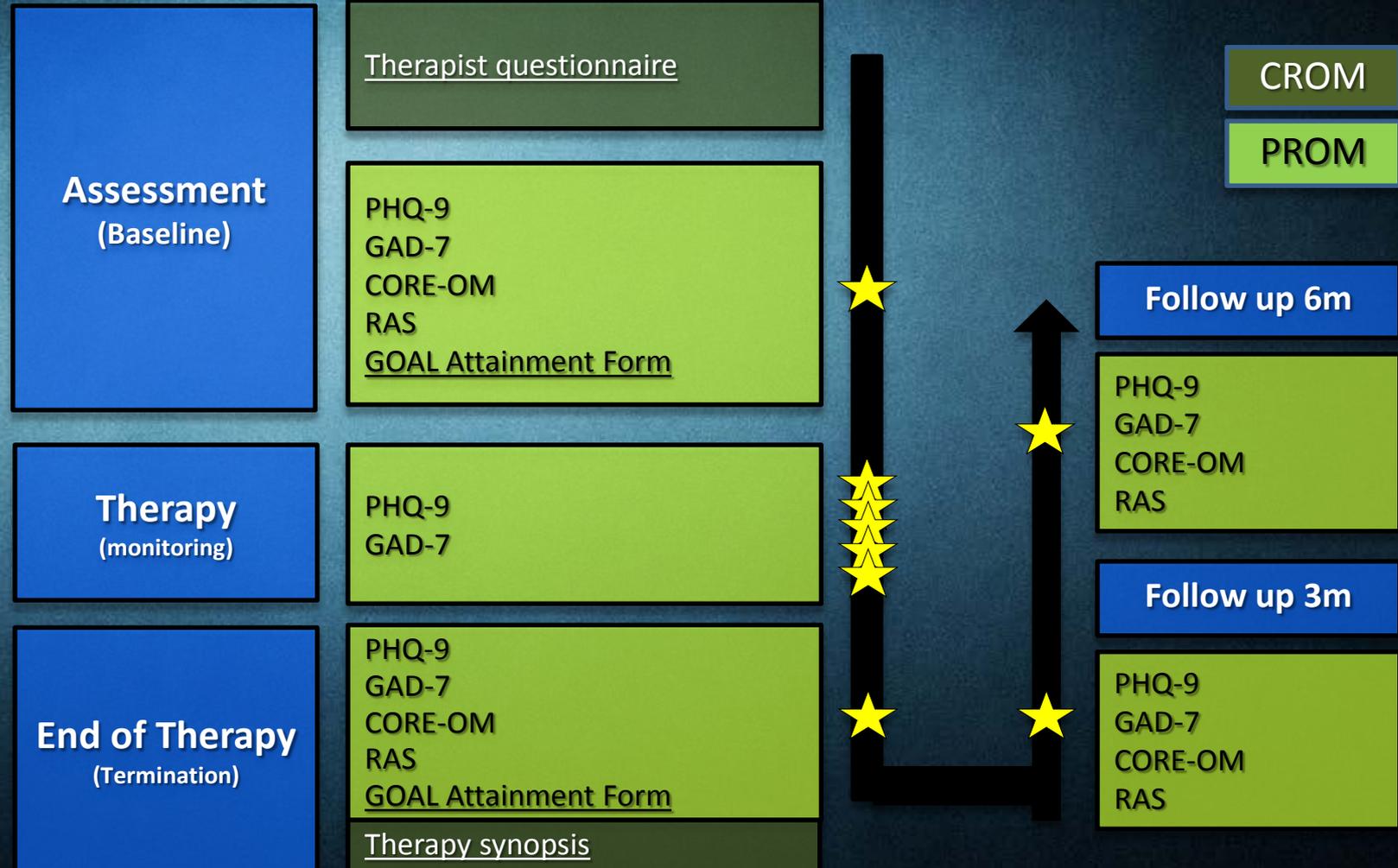
- Pan-theoretical, pan-diagnostic, self-administered 34-item measure of psychological distress
- Self-administered 9 item scale for screening, diagnosing, monitoring and measuring the severity of depression
- Self-administered 7 item scale for screening, diagnosing, monitoring and measuring the severity of Generalised Anxiety Disorder
- Self-administered 33 item scale for a multidimensional assessment of the capability for resilience –

Resilience construct to examine intrapersonal and interpersonal protective factors presumed to facilitate adaptation to psychosocial adversities (personal strength, social competence, structured style, family cohesion, social resources).

Methods 1/2



Repeated Measure Study



Methods 1/2



Baseline quantitative from the applied scales will be compared to the data collected at termination and at 3 and 6 months follow-up.

The analysis will produce an estimate of the effect that we therapy has had on the observed scales.



Collection of P.R.O.M, P.R.E.M and C.R.O.M:

- Pre-post measures (PROM – qualitative and quantitative)
- Pre-post measures (PREM – qualitative and quantitative)
- Each session monitoring (PROM – quantitative)
- Session notes recorded at each contact (CROM)
- 3m and 6m Follow-up measures (PROM & PREM)

Monitoring of therapist's adherence (two stages):

1. On the fly: qualitatively, via feedback during supervision
2. Post-hoc: qualitatively, via analysis and independent evaluation of the supervision notes recorded at each contact

Sampling & Inclusion Criteria



- **Male or Female Working age adults**
- **Self-referred or referred via GP**
- **Client's level of risk and psychological distress meets NHS' criteria for stepped care 1-2 (NICE)**
- **Agreement to undertake an assessment and 6 weekly sessions of therapy**

Sampling & Inclusion Criteria



All cases treated in this study were referred by the PCMHT to EE as an alternative to IAPT

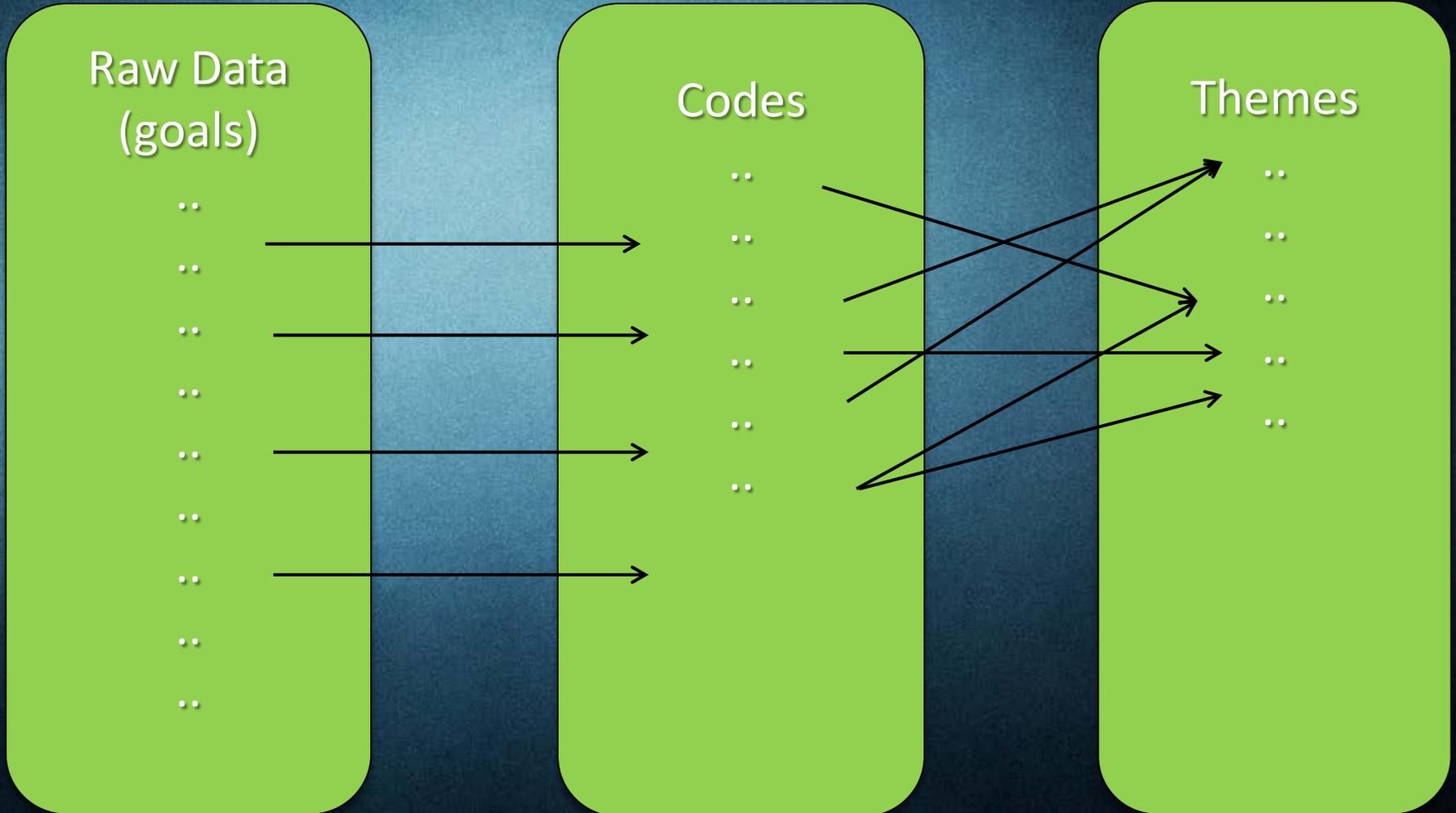
Therefore

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

Preliminary Qualitative Data

Thematic Analysis

(Braun & Clarke 2006)



Preliminary Qualitative Data



Thematic analysis of goals

Each participant, along with the therapist, creates 3-4 goals which embody what they want to achieve from therapy. These goals are studied, and the main points are extracted to form simple codes.

This is a simplistic visual representation of the processes undertaken to derive the themes and is not a linear process. The steps taken were in accordance with the 6 phases of thematic analysis described by Braun and Clarke (2006). So the raw data was coded, themes were thought of to identify similarity in what people want out of therapy, the themes were reviewed to make sure they best represent the codes and those that did not were removed from the theme and grouped with another theme or individual themes were split up into two themes or two separate themes were grouped together and finally themes were renamed to best describe them.

Preliminary Qualitative Data



Understanding
self

Understanding
emotions

Dealing with
givens

Understanding
relationships
Self-world & self-others

Letting-go
vs
holding-onto
something

Preliminary Qualitative Data



Thematic analysis of goals

Using Braun & Clarkes' (2006) 6 phase guideline of thematic analysis, the goal attainment forms (PREM) were coded and themes constructed. Of course this is only the beginnings of the qualitative analysis, but it is a demonstration as to what is emerging from the data thus far.

Understanding Self

- Understand being fat and ugly
- Need to blame self for everything
- Want to increase my self- worth
- Redefining myself
- Understand my negative self- belief
- Understand murky aspects of self
- Acknowledging positive aspects of self

Preliminary Qualitative Data



Dealing with givens

- Coming to terms with menopause
- practical needs/sides of life vs own dream world
- Feeling responsible for others behaviour

Preliminary Qualitative Data



Understanding Relationships Self-world & self-others

- Holding back in relationships
- Increase feeling of appreciation
- Understand relationship with partners (past/present)
- Understand my irritability with partner
- Understand attitude towards partner
- More balanced family relationship
- taking the 'victim role'
- Better boundaries/protection from others
- Socialize with others despite challenges to do it
- Understanding trust of others/control
- Understand my being detached

Preliminary Qualitative Data



Letting-go vs Holding-onto something

- Understand things are out of my control
- Fear of not coping
- Need for control
- Fear of being trapped
- Facing the future/uncertainty
- Understanding fear of being alone
- Understanding enjoyment of being alone
- Stop dwelling on the past

Preliminary Qualitative Data



Understanding Emotions

- Manage difficult emotions
- Reduce anxiety
- Explore feeling defeated /stupid
- Not to fear own thoughts or dread of living
- Manage low moods
- Ill health and related flood of emotions
- Understand crying
- Can't express anger



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.

Discussion



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.

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Appendix



GP – Point of Contact	GP Screening Questionnaire	
Assessment	Therapist questionnaire	
	Full Set of Measure	PHQ-9 GAD-7 CORE-OM RAS GOAL Attainment Form
Therapy	Monitoring Set of measures	PHQ-9 GAD-7
End of Therapy	Full Set of Measure	PHQ-9 GAD-7 CORE-OM RAS GOAL Attainment Form
		Therapy synopsis

For full information visit:
easewellbeing.co.uk