SEPI 2015

Where Practice and Research Converge

DREEM
Delivering Recovery-Enhancing and Enablement Measures

An approach to existential integrative therapy in Primary Care

M. Rayner and D.Vitali

Whilst the positions in the UK and the US healthcare systems may appear radically different in terms of service provision, nonetheless, both here as well as in the UK we have seen a huge rise in the demand for and diagnosis of mild to moderate (even enduring) mental health concerns that people present to their general practitioners within primary care settings.

In the UK, the government has attempted to address this for several reasons: first, the economic burden of people not working while suffering from such distress is greater than the cost to the government of poverty (See IAPT 2004 figures); second, healthcare has attempted through psychotherapy interventions, albeit unsuccessfully, to reduce the prescription of psychopharmacological medicine; third, in the NHS in the UK the public has become increasingly aware, although stigma still exists, of its entitlement to treatment and the accountability of state services to provide that treatment.

M. Rayner and D.Vitali

Whilst much of this may be different in the US, I suspect that many of the political, social and economic drivers are similar.

What we are describing is a therapy that we have called existential experimentation that centres upon the theme of this conference – where practice meets research. This approach to implementing therapy criticises dominant ideas emerging from RCT trials and theory driven models of successful treatment and provides an approach to distress in a human manner that promotes recovery, empowerment and enablement focusing upon solutions constructed and aimed for by clients, confronting stigma and challenging the allegiance to a medical model.

M. Rayner and D.Vitali

What Matters in Therapy?

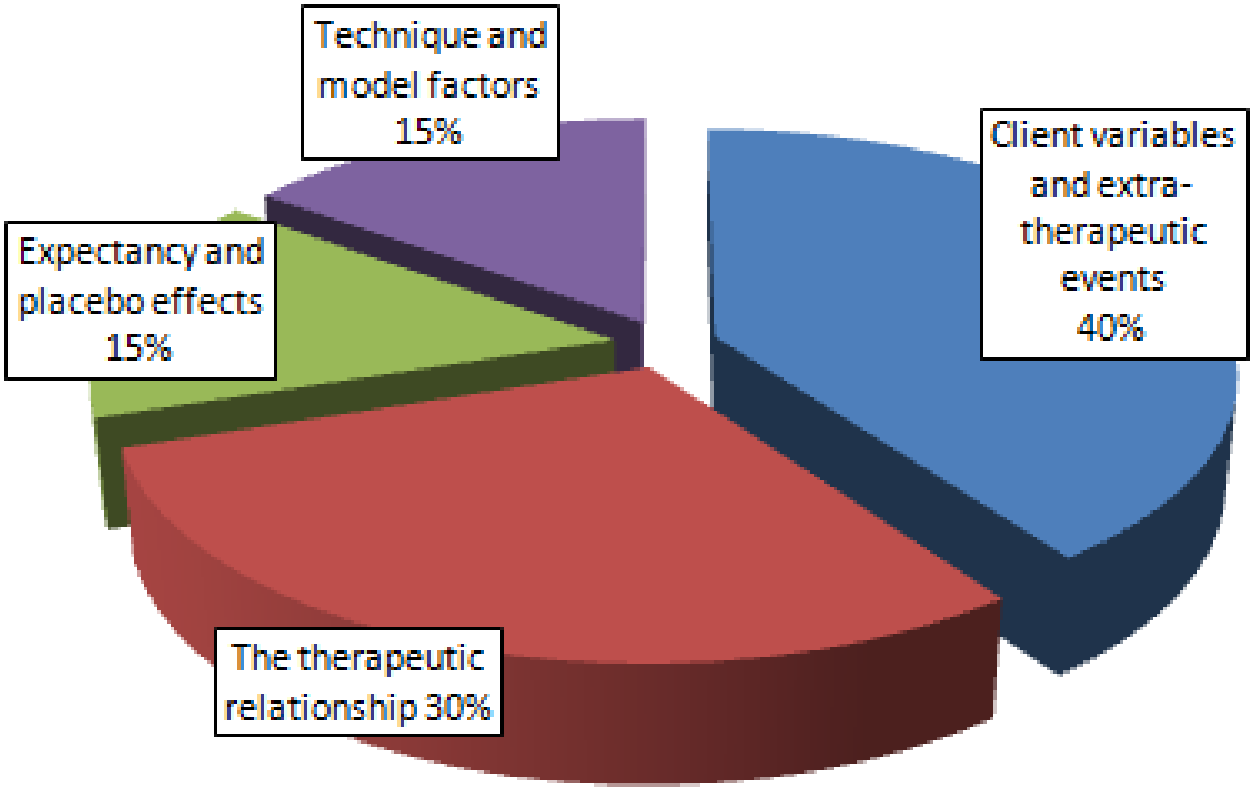
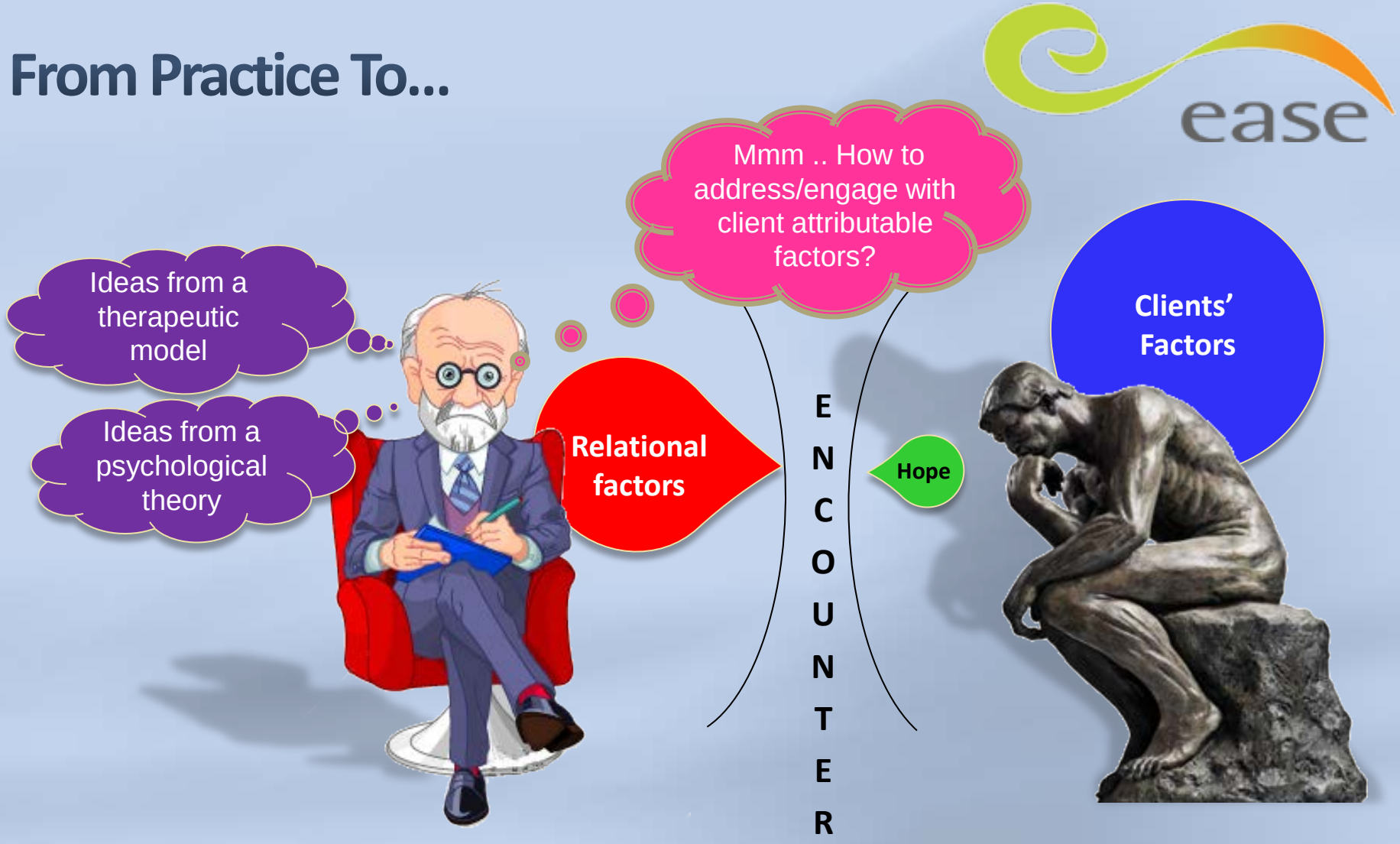


Figure 1. Percentage of improvement in therapy clients as a function of therapeutic factors (Asay and Lambert, 1999)

Therapy works! But what works about therapy?

So what happens in our everyday clinical practices?

From Practice To...



From Practice to...

From Practice To...

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.

However, there is evidence that:
goal consensus and collaboration; therapeutic alliance; empathy
are crucial.

From Practice To…

Hope, sometimes referred to as expectation and sometimes as placebo is always helpful

…and then the most significant slice of the pie which this approach addresses is the slice known as context related or client attributable factors.

From Practice 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 to...

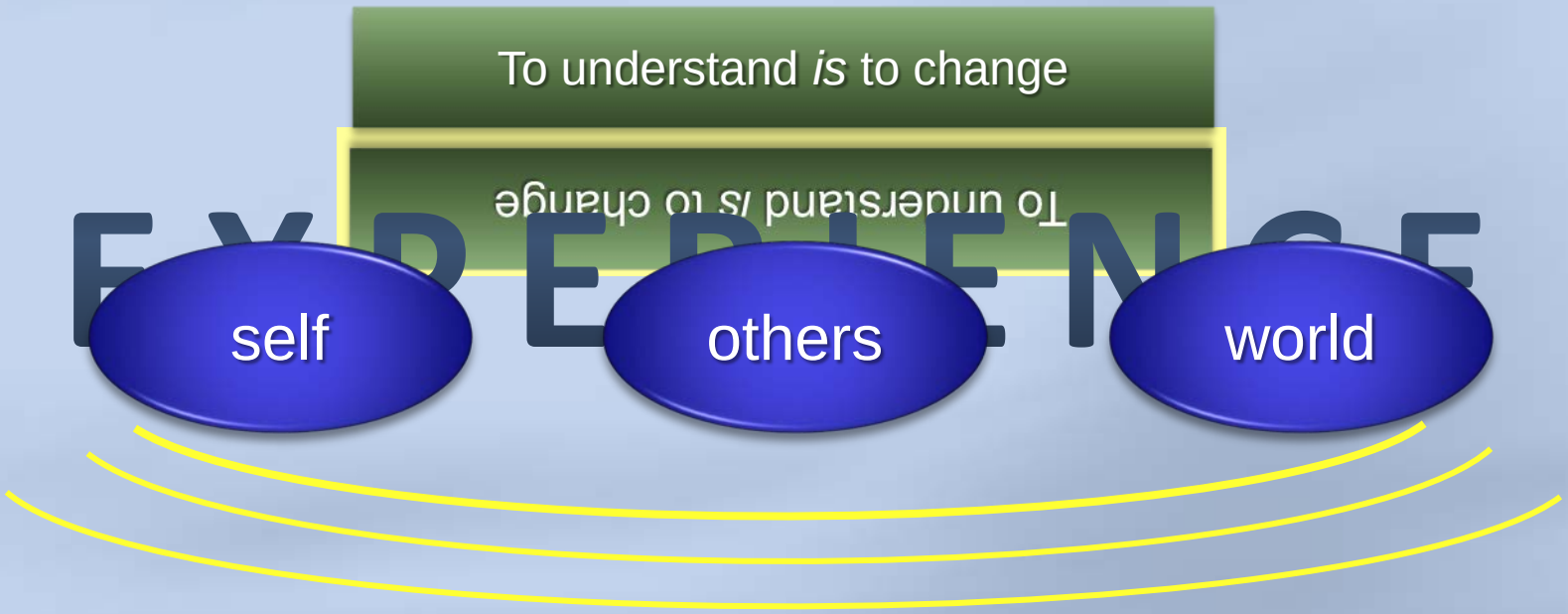
From Practice To...

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.

A client-centric attitude to change

A-symptomatic approach

Change is inevitable in therapy



Understanding is a process and interplay between discovery and inevitable change

Existential attitude to change and measurement

A client-centric attitude to change

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 that takes place in an environment that places continual emphasis upon self-reflection i.e. the reflection by the person of their experience of being in their worlds and the worlds of their values, attitudes, beliefs and assumptions.

Existential attitude to change and measurement

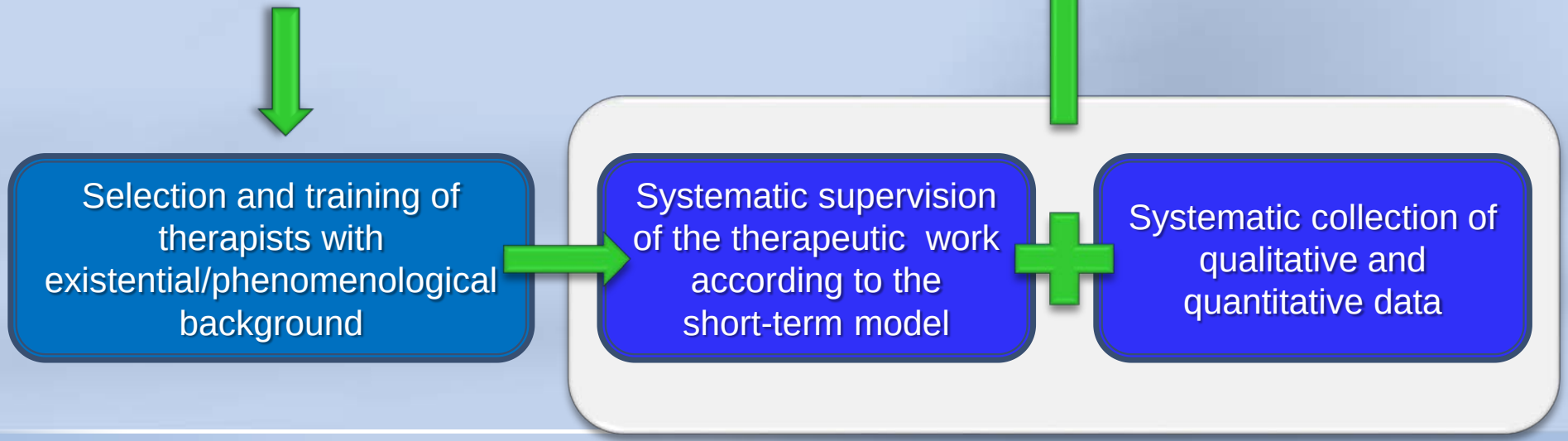
A client-centric attitude to change

3. Therefore, we re-construe our conceptualisation of change to encompass changes that may be about changes in understanding of oneself or others or of the world in the above mentioned and depicted environment of reflection.

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.

..to research

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

..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 in at the outset could be focused upon.

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

...to research

..to research

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

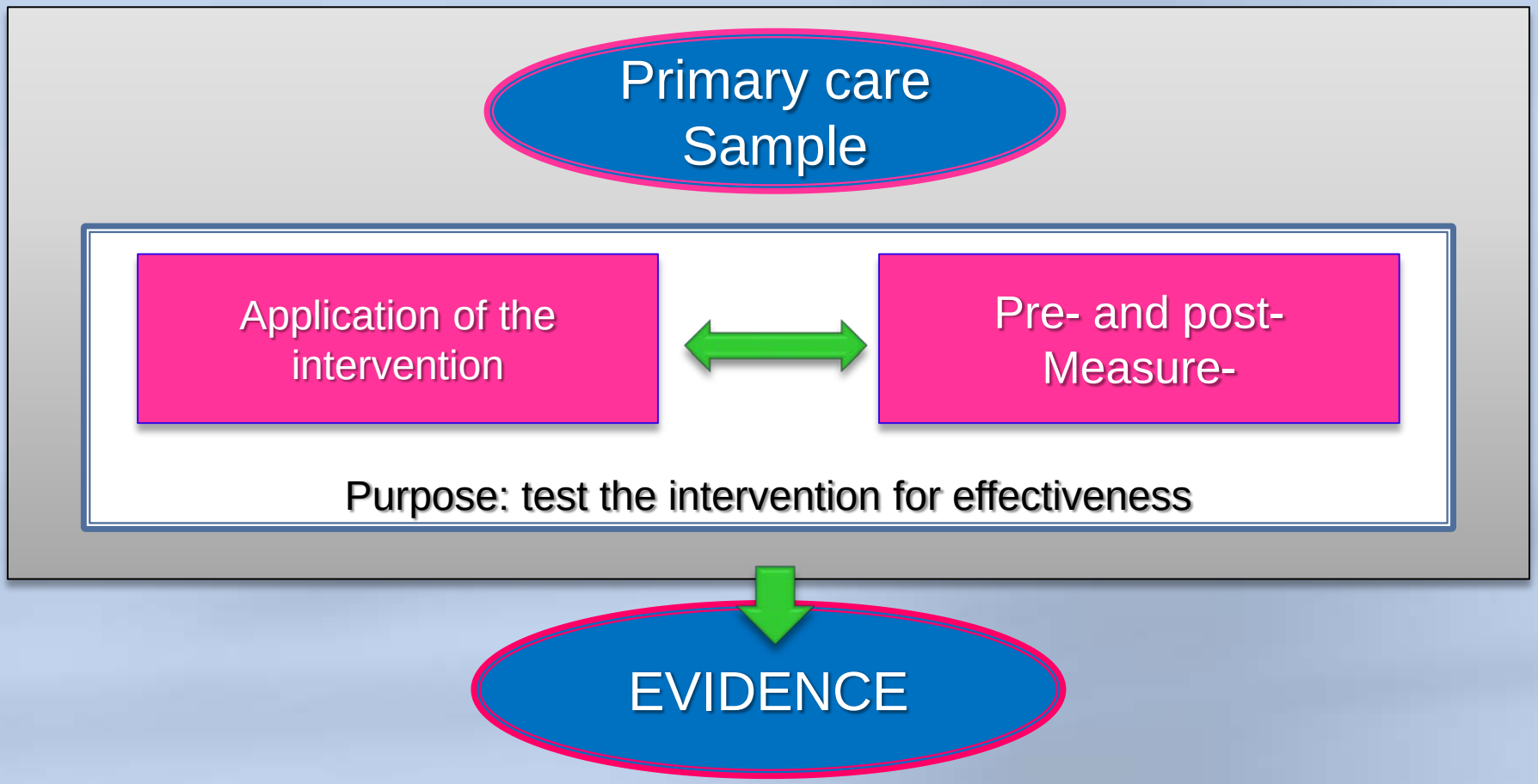
Over recent years we put into practice this perspective, wherein these core ideas that are very effective when working with primary care clients and that are highly focused on triggering the active participation of the client, could be implemented, measured and analysed.

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.

...to research

Feasibility study design



Feasibility study design

Feasibility study design

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 sample considered for this feasibility study

•

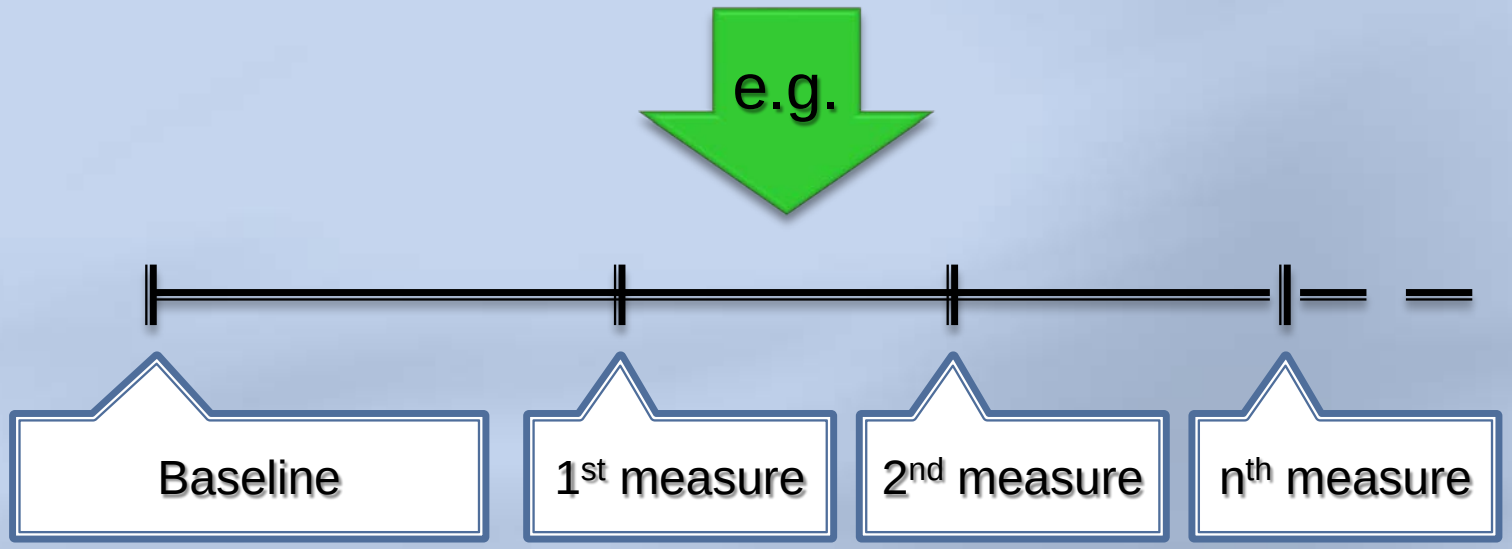
The intervention procedure and its application

•

The design and methods applied to produce the evidence and results of this study

Design

Repeated Measure Study



Methods

Design
Sampling
Instruments and Procedures

Design

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.

Design

This therapeutic model is not "modular"

- 6-session treatment as a whole (Rayner & Vitali 2013)

Methods

Design
Sampling
Instruments and Procedures

Design

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**

Selection of cases

EE was proposed as an alternative treatment to IAPT

- Arbitrary selection of the cases
- Pool of IAPT-compatible, *Primary Care* cases

Selection of cases

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.

Sample

- **Male or Female working age adults**
- **Clinical:** PHQ-9>= 10 and/or GAD-7>=10
- **Complete set** of measures
- **Start treatment early** after referral
- **Completing treatment within** 12 weeks

Sample

- **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)

Instruments

CORE-OM (Evans et al. 2000)

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

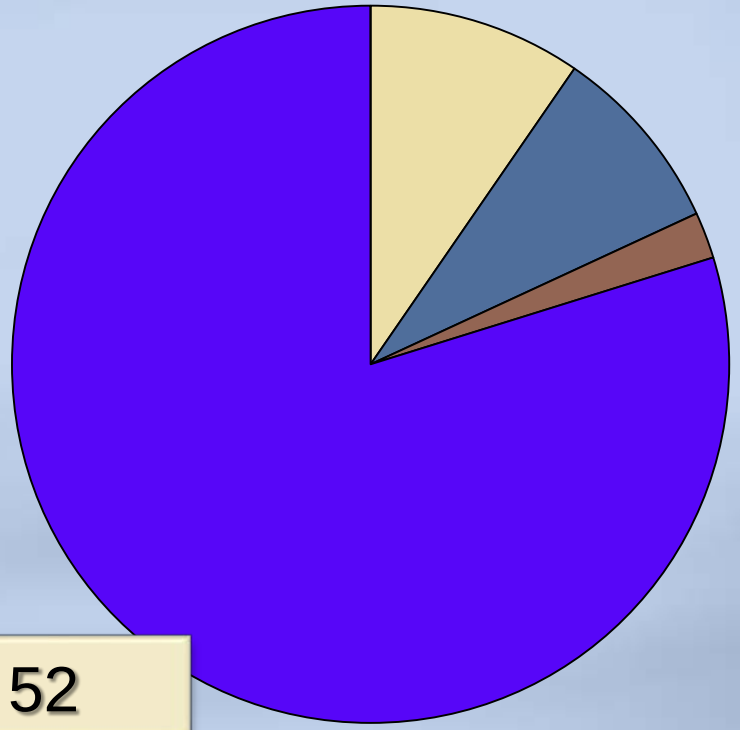
GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006)

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

Results

Drop-outs distribution over time



N= 52

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.*

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 α=.05.

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

Results

Table 2. EFFECTS OF THERAPY AFTER 6 SESSIONS

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

Scale	Recovery	Cohen's d	N
PHQ-9	47.83%	1.38	23
GAD-7	58.33%	1.09	24
CORE-OM	31.25%	0.89	32

Results

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.

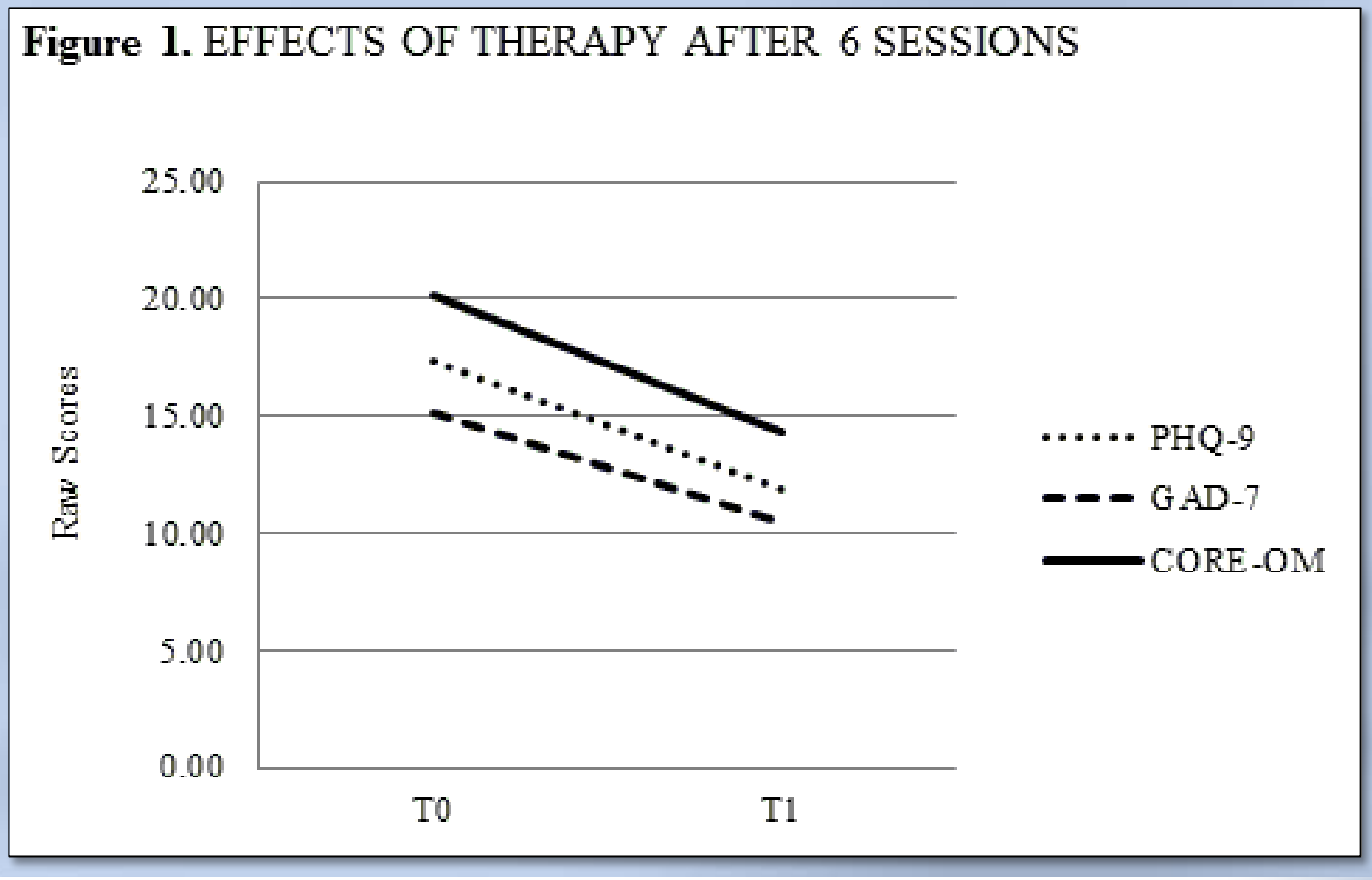
With regards to CORE-OM as a pan-theoretic and pan-diagnostic scale, on average the effect observed on the score at the end of therapy was large but appeared of smaller magnitude if compared to the effects observed on the PHQ-9 and GAD-7 scores. This could be due to numerous factors and it is definitely 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.

Results

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.

Results

Figure 1. EFFECTS OF THERAPY AFTER 6 SESSIONS



Results Discussion

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Results

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.

Results

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.

Results

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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