CORE Blimey! Existential Therapy Scores GOALS!

Attitudes and possible solutions for the problem of measurement in existential psychotherapy

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Abstract

This paper articulates an existential-phenomenological attitude to short-term work in public sector secondary care mental health services, and expresses how therapists and clients address the notion of measurable change through the setting of goals. We critically evaluate how to address the problem of measurement from an existential-phenomenological psychological therapy perspective. The philosophical informants of such approach to psychological therapy are elucidated and an analysis of client-directed goal-oriented change concludes the value of this approach.

Keywords

NHS, existential, phenomenology, outcome measurement, goals, change.

Introduction

> *Anthony (1993): [Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness…*
>
> (Shepherd, 2008)

The above citation is taken from the Policy Paper by Sheppard et al. (2008) in which is set out the government's changing attitudes and intentions with regards to the provision of services to help people engage with, understand and experience the benefits of addressing mental health concerns. The above statement and the emphasis in this paper resonate with our consideration of existential thinking, phenomenological inquiry and behavioural change and its application to clinical practice within the United Kingdom's National Health Service (NHS).

Change

From the perspective of the life-cycle of human existence, change is inevitable, living is an activity that is in a continual process of change (Sartre, 1943), whether change of circumstances, health or experience or understanding or activity. Thus, we extend this foundation to the therapeutic endeavour and assert that all clients come to therapy in order to change. However, this notion of change is not necessarily understood in a manner that is limited to symptom or harm reduction, but rather as the potential for clients to re-evaluate their currently held world views and their sense of self-construct in order that they may change their understanding of themselves, others and the world and their experiences.

We consider this as change in the same manner as historical notions of behavioural change were first articulated with the evolution of behavioural therapies that argued that 'if a behavior is learnt, it can also be unlearned' McLeod, S. A. (2010). With the advent of cognitive therapies, this notion of change was extended to encompass the notion of cognitions as actions and, therefore, susceptible to the same rules of being learnt and unlearned. Consequently, we would argue that if understanding or meaning or even acceptance changes, this is not only a valid form of change in a similar manner but can be similarly measured, albeit in a more sophisticated manner that is able to preserve the complex and subjective nature of human experience.

Intentionality and change

Furthermore, the premis for this argument emerges from the foundations of existential thinking in Brentano's (1874) concept of intentionality. This position adopts the stance in respect of our work that the client entering the therapeutic encounter does so with the intention to change. Moreover, the therapist also engages with the client with an intentional attitude that is expressed via the manner in which the therapy is practised. The manner of practising existential-phenomenological therapy that is relevant to us and which we would consider as the operation or 'doing' of therapy is the intentional attitude of the therapist that promotes with and for the client the dialogue with his or her own world. This dialogue as witnessed by the therapist is the action of descriptively clarifying living and lived experience that allows for an illuminating of values, attitudes, beliefs and assumptions that are central to how a client understands his or her experience. Further understanding or a change in understanding may be revealed and disclosed in the act of this inquiry and through the process of inquiry in and of itself (Spinelli, 2007).

Context

NHS, existential thinking and outcome measures

This paper articulates our experience of designing and implementing an

existential-phenomenological approach to psychological therapy within the NHS, and it expresses outcomes emerged from the analysis of real-world data, systematically collected during and after the application of a therapeutic system in a secondary care psychological therapies service in the NHS. This paper displays and discusses the practice-based evidence that emerged, articulating the themes of change that were wished for by clients and the degree to which these goals were achieved and by how many of the clients. In order to remain faithful to the epistemological and methodological foundations and principles of an existential-phenomenologically informed intervention, we chose to apply an outcome measurement form – part of the CORE-OM set (Mellor-Clark 2000), known as the CORE Goal Attainment Form. We used this method of measurement as it bridges the tension between rationalism and empiricism that was first proposed by Meno and rephrased by Socrates as '[A] man cannot search either for what he knows or for what he does not know[.] He cannot search for what he knows – since he knows it, there is no need to search – nor for what he does not know, for he does not know what to look for' (Plato, 1981). In this way, we are able to remain open to creativity, individuality and the breadth of human experience whilst considering that experience in terms of ontological givens, ontic responses and wishes, as well as remaining focused upon change as inevitable and recovery as desired – in client reported terms. These difficulties and the problems of measurement are dealt with below.

NICE

In current service delivery in the NHS, both in medicine and psychological therapies, The National Institute for Health and Clinical Excellence (NICE, 2013) is responsible for providing 'independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation' (NICE, 2014). NICE guidance has historically relied upon Randomised Controlled Trials (RCTs) as the studies that produce the evidence-base upon which guidelines are created for treatment. Whilst it is not the place of this paper to explore this in detail, there are clear and well-articulated (Freire, 2006) difficulties with the use of this type of evidence when delivering psychological therapies. However, briefly but significantly, from a human perspective, it is much more difficult to assess homogeneity across a population experiencing psychological distress than it is for a population experiencing such illnesses as diabetes. Therefore, it follows that the 'one size fits all' approach raises questions when treating much more diverse experiences within categories of distress such as depression or anxiety. Furthermore, and this is where our contentions in this paper sit, what individuals experience as recovery and well-being often vary greatly with how many

of the routine outcome measures that are currently accepted define notions of recovery. NICE does acknowledge that, 'although these clinical guidelines are based on the best available evidence and they help health professionals in their work, they do not replace their knowledge and skills' (NICE 2013). This resonates with our thinking about the difficulty of evidence-based treatments struggling to adequately capture the breadth and diversity of human experience and difficulty. Finally, what the evidence discloses about what aspects of therapy impact upon outcomes has been reported by Lambert et al. (2001). In this, we see that 40% of therapeutic successes are due to client attributable factors, with the therapy relationship representing 30% and therapeutic technique representing only 15% (Lambert & Barley 2001). From this, it is reasonable to begin to contest the extent of relationship between the techniques utilised in a therapeutic intervention derived from an RCT and the outcomes. In other words, people may improve from having an empirically validated treatment but it does not clearly follow that the effective part of the treatment was the therapeutic technique.

Existential-phenomenology meeting the NHS

The approach that we are advocating here is one based upon a detailed exploration of the nature of a person's living and lived experience of themselves, others, the world and their difficulties, considered from the position of ontology and operationalised using a phenomenological methodology. This stands in better harmony with recent government statements that 'Shared decision-making will become the norm: no decision about me without me' (Millar et al. 2011). This goverment attitude has implications for both therapist and client, insofar as we are living and working in a social and political organising system that provides statutory sector NHS mental health interventions. This means that we live with constraints, limitations that are simultaneously possibilities. For the existential-phenomenological therapist in the NHS, this recognition necessitates that our practice is firmly rooted in the contextual landscape of current requirements for practice. This landscape is characterised by two key notions: entitlement and accountability. Entitlement means that a person is entitled to a treatment should they meet certain 'measurable' criteria; accountability means that services are responsible for being able to demonstrate that what they deliver is effective. Thus, from the position of existential thinking, the clients' freedom is 'situated' within this context and they must choose from a limited set of options and the therapist is bound by limitations around length of intervention, management of public safety and risk and further has to measure progress and outcomes of treatment. Therefore, an existential-phenomenological intervention within this framework is both a particular type of existential-phenomenological intervention but, more importantly, the existential attitudes and

phenomenological informants of this approach are well placed to be both flexible to these limitations and still retain the openness towards possibilities for treatment and recovery in these conditions. In other words, we will demonstrate in the section below that the rigorous application of the phenomenological method is able to operate within these boundaries and yet still be open enough to engage with the breadth of experience that is presented. Consequently, we are able to obtain replicable and reliable results as described and discussed in the results section.

The Department of Health publishes that existential therapy is among those therapies available within the NHS' range of interventions and the original mission statement of Aneurin Bevan for the formation of the NHS in 1948 proposes that people should have equity of access to services (NHS 1946). However, this is not been possible to maintain or develop for two clear reasons. First, in order to try and develop and promote equity and conformity, readily measurable and fundable (and effective) treatments such as CBT have proven to be the most attractive candidates for empirically-validated treatments. Second, existential-phenomenological therapies have not as yet submitted data that is of an acceptable standard to be considered by NICE for the development of a guideline for a treatment intervention. This paper hopes to commence such a process and lay a foundation whereby we can both improve the quality (and quantity) of our data, gain recognition from NICE as an approved method of treating psychological distress, and begin to articulate what constitutes an existential-phenomenological manner of practising psychological therapy in such a context

Principles of this therapeutic approach

In a world populated by evidence-based practice, NICE guidelines (2013) and a socio-economic and clinical organising system characterised by entitlement and accountability, a considerable challenge for this approach is to accept the givens of measurement and re-define the notion of change in recovery terms, whilst remaining faithful to the tenets of an existential attitude and a phenomenological method. We are also tasked with how we attempt to demonstrate an acceptably robust level of evidence, while remaining true to the experience of individuals. This section articulates the principles upon which we have attempted to operationalise this existential-phenomenological intervention in secondary care NHS mental health psychological therapy service delivery.

Much work has already been done in this field in the USA (Lantz & Walsh, 2007) and this paper both concurs with the 'elements' that are identified by these authors as well as the other factors that have historically been considered as part of a time-limited intervention (Balint & Balint, 1961, Malan, 1963, Molnos, 1984, Strasser & Strasser, 1997). Here, we articulate in finer detail some of the important considerations, both from

an existential-phenomenological perspective and one that subscribes to the notion of measurement and change.

Urgency: re-understanding the notion of change

Urgency refers to the intentional stance of both client and therapist. For the client arriving in therapy is arriving now, thus we immediately address the 'now' of this intention. The therapist is tasked with delivering a helpful intervention in a time-limited manner and therefore, this immediately implies there is an urgency to engage the client in a rigorous investigation of experience in order to disclose the contents, nature and meaning of said experience to gain a fuller, better or new understanding of the world positions that are therefore revealed by such experience.

As Shepherd (2008) comments 'a central tenet of recovery is that it does not necessarily mean cure ("clinical recovery"). Instead, it emphasises the unique journey of an individual living with mental health problems to build a life for themselves beyond illness ("social recovery"). Thus, a person can recover their life, without necessarily "recovering from" their illness' (Shepherd et al. 2008, 2). Thus, this therapeutic endeavour inquires about the 'now' that the client presents at the beginning of therapy and similtaneously articulates in the form of goals what would be the desired outcome for the end of therapy. Clients are thus enabled and encouraged to own the experience that they present, both in terms of it happening for and to them, as well as the meaning it has for them in order for them to be able to consider creating new meanings from experience or discovering more adequate understandings of experience so that they can claim the experience that they wish for. 'I am installed on a pyramid of time which has been me. I take up a field and I invent myself,[...] just as I move about in the world' (Merleau-Ponty, 1964: p 14).

Furthermore, when talking about urgency, according to van Deurzen (2002), 'freedom can only be assumed to the extent that one is aware of the necessary, the impossible and the desirable, [...] human beings can spend tremendous energy on trying to remedy what cannot be remedied' (van Deurzen, 2002: p 38). Moreover, she comments on the need and importance of exploring in therapy the notion of 'Being'; 'while most people are inclined to opt for passivity and comfort, once they get going on tackling life actively they often experience a surprising and gratifying sense of potency, adventure and excitement… (ivi, p 40)'.

Given this important conceptualisation of urgency, it is argued here that an existential-phenomenological therapeutic endeavour in the NHS that is time-limited proposes an urgency that emerges as a possibility, via the mechanism that we use for measurement: setting goals and measuring their attainment. This process that is a collaborative endeavour locates the therapy with a strong phenomenological grounding and bases its practice upon the

relational process as articulated by Spinelli (2007). Spinelli (2008) further addresses the initial phase of therapy as centring upon and staying with what and where the client is at present and we owe much to his attempt to create a way of practising existential therapy. We also recognise the potential contradiction here: that of staying with the client and that of seeking to elicit where the client wishes to aim for. This is the tension that we hold as therapists who are tasked with urgency of giving serious consideration to the end of therapy – the time-limitation – at the commencement of therapy.

'Weak thought' and Epoché

With a view to conducting a therapeutic intervention that subscribes to phenomenological enquiry (Husserl, 1913), the therapist actively practices an attitude of 'openness and letting be'. In other words, this attitude refers to that which Heidegger (1959) defined as Gelassenheit. This personal stance (or way to be toward the phenomenon) refers to the importance of a radical attitude of 'openness' to something beyond self, and centres on the idea of phenomenon as the very 'what' to which we are leaning in our observational disposition. According to Heidegger (1927), this idea of phenomenon *always* pertains to something manifest and, simultaneously, to something that lies hidden. Thus, also for the client, the attitude of Gelassenheit might be translated as a stance of 'abandonment' or 'releasement' towards things according to MacQuarrie (1972). This phenomenological stance is a non-manipulative, non-imposing way of letting things be what they are, an 'openness' to the Being of beings, a meditative 'letting oneself into the nearness of Being' (Heidegger, 1959).

Thus, for both client and therapist, this attitude is both an urgent call for what may be discovered and an openness to what may reveal 'itself-in-itself', otherwise thought about as one of availability to that which presents itself. This approach is committed to that which-shows-itself and that, to some extent still and always lies hidden (i.e. not-as-yet-reflected-upon but capable of such reflection). Thus, the manner adopted by the existential-phenomenological therapist promotes the changing illumination – the ebb and flow of elucidation – through which meaning and interpretations take place. In this perspective a phenomenological approach to psychotherapy might be considered as a light shining to elucidate experience, thereby giving access to the breadth of human experience.

Furthermore, as affirmed by Ratcliffe (2011), phenomenology aims to do that by attempting 'to cease presupposing a background sense of belonging to a shared world in which some things "are" and others "are not", and to instead recognise it as an ordinarily overlooked aspect of experience that can be made explicit and further characterised' (Ratclife, 2011: p 34). This Husserlian bracketing process, as also described by Spinelli (2005), aims to temporarily suspend our 'theories' about the clients and our skilful

assumptions. From a strictly hermeneutical point of view, bracketing is a renunciation of the 'ordering' and 'objectifying' power of the intellect and this bracketing belongs to the therapist and to him or her only. It is a difficult and courageous act; a 'weakening' of the thought, a loss and a renouncement of our clinical perspectives and interpretations that aim to open toward the client's narrative as this presents itself-from-itself (Heidegger, 1921). 'The epoché is the means through which Husserl discovered the blindspot of the natural attitude as well as the "method" for overcoming its limitations and rediscovering the world in the manner of an explorer encountering a vast new continent' (Morley, 2010: p 225). According to Cooper 'it is indeed a way to try and put to one side their theories about why clients may be the way that they are, and instead to engage with the actuality of their clients' narratives' (2007, p 8).

The observation of this specific rigorous attitude of weakening of the thought and Epoché is believed to allow for a more adequate understanding of the addressed experiences than some other dominant reductionist or explanatory approaches (Borgna, 1988; Cooper, 2007; Parnas, Sass & Zahavi, 2011; Ratcliffe, 2011; Stanghellini, 2011).

Setting goals

Finally, these principles inform the notion of setting goals as directed by the client in therapy which involves a detailed investigation into meanings and necessarily the language used to convey meaning. This brings into focus the medicalised language of current therapeutic traditions which we scrutinise using an existential-phenomenological lens. To this end, this approach seeks to deconstruct the medicalisation of human difficulties; challenging the idea of disability and illness and encouraging a personal narrative of distress.

Our attention turns in the therapeutic process away from the contents of distress towards the process by which certain meanings may have been sedimented and by which the therapeutic process may allow for a re-evaluation of those attitudes and belief systems by which the person may transcend their currently held world views.

Thus, we are concerned more with the 'how' than the 'what' of experience, as this discloses more of the person disclosing than of the subject or object being described. This is how we are able to direct our attention to the experiencer experiencing through this process. Husserl (1913) called the first noesis (e.g. perceiving something, imagining something, believing something etc.) and, therefore, the second as the obvious correlate of the first: the noema being the perceived, imagined, believed something. Therefore, this psychotherapeutic intervention enquires and applies itself to the very relationship between the noesis and its noematic correlate. In other words, on the process through which what is meant, experienced and wished-for by the clients and then how this emerges for and from the client themselves.

The 'problem' of measurement

In the current mental health service delivery system, 'we live in a world of testimonials, measurements, evaluations, audits, key performance indicators and competencies' (Rayner & Vitali, 2013: p 7), thus measurement cannot be avoided, should not be avoided if we are to be included in commissioned services, and should be embraced if we are to realise a position that permits us to develop what we might consider to be more relevant measurements of what it is that this type of intervention tries to achieve, such as purpose or meaning-based scales (Crumbaugh & Maholick, 1964; Steger et al., 2006).

Therefore, what are important in using these measurements are three simple, yet fundamental issues. First, this communication of measurements of effectiveness of our practice should be seen as a signal broadcasted towards other colleagues in the academic or clinical environment that simply demonstrates a willingness and an ability to communicate in the language of measurement and results and the recognition of the importance of doing so. Second, from the clients' perspective, we need to recognise that the statements that they make in respect of their distressing experiences are words that convey both a meaning and a relationship to their experience. In other words, when a person says they are depressed or experiencing anxiety, this approach understands these statements not as symptoms to be eradicated but rather responses to their 'thrownness' (Heidegger, 1921), as statements that potentially disclose their ontic relationship to their 'givens' or existential conditions. Third, whilst we recognise that the tools of measurement and questions contained therein do not purport to address experience (indeed may serve to conceal or bury it), the engagement with the questions and questionnaires is significant for two reasons. Clients who engage in the process of routinely monitoring their progress demonstrate a greater motivation towards their recovery and, as has been clearly documented in the literature around the Hawthorne Effect of Expectation or Pygmalion Effect (or even as Placebo), and from recent literature we know that there is a significant improvement attributable to the paying of attention to or monitoring act in and of itself (McCarney et al., 2007).

In the phenomenological literature, the idea of utilising standardised scales to measure change in psychotherapy and also to progress our knowledge and understanding of psychopathology is clearly problematic. Indeed Stanghellini (2011), warns that, by using rating scales 'that assume a priori systems of meanings we can overwrite personally structured meaning and narratives' (Stanghellini, 2011: p 25). Not only would we echo this, but would add that a standardised system of measurement proposes a potential risk to conceal or, to use a Heidegerrian expression, cause to be 'buried over' (Heidegger, 1921: p 60) those subjective meanings and narratives. That is to say, that any results that emerge from these systems of measurement

cannot be defined as phenomenological as such, and, therefore, cannot by themselves inform our actual clinical practice.

Nevertheless, as stated above, we cannot avoid the issue of measurement simply because it is problematic. Thus, in facing the paradox of the inquiry into knowledge proposed by Meno, we recognise that both the atomistic perspective of empiricism as well as the idea of an a priori knowledge in rationalism fail to overcome Meno's critical point. Therefore, we resolve this paradox using the ideas proposed by Merleau-Ponty (1945), where subject and object exist only because of their relationship as a continual dialogue. We believe this allows for holding the tension between knowing that one is looking for something while preserving the idea of not fully knowing what one is looking for and leaving open the possibility for the discovery of something not yet known. Any attempt to capture experience reduces experience in an atomistic way that does not when put back together reveal the fullness of experience. Yet, Merleau-Ponty recognises that human beings intend to and are inclined towards searching for some sort of truth or discovering and claiming to have discovered some'thing' of the nature of lived experience. Therefore, measurement of this therapeutic process remains and will always be a way to have reliable feedback and a representation of the work even if this is a diagram or derivative of the work. Hence, in our work, we stand by the results of the measurements as signposts to the world from which they emerge, whilst reminding ourselves to return to the lived landscape of experience that can never fully or adequately be described but rather discloses the dialogue between the experiencer and the experienced.

For these specific reasons, perhaps we cannot (yet) reject standardised measurement a priori, but rather we should consider them in a critical manner with a view to keeping very clear the extent of their value as indicated above and, hence the boundaries within which and for which our relationship with them can unfold as potentially meaningful to us and to our practice.

Methods

So we arrive at the interface between a way of practising psychotherapy – one that is informed by existential thinking and a phenomenological attitude and methodology – and a way of meeting clients in a manner that more adequately embraces their living experiences, whilst also engaging with other professionals in the field in a manner that is tangible.

Design

This study was part of a service evaluation that assessed the value of utilising The CORE Goal Attainment Form as well as assessing the

potential influence of short-term existential-phenomenological therapy in respect of client-directed change.

Sampling
Clients referred were all working age adults from the general population. Clients referred by primary care general practitioners and assessed by secondary care clinicians. Clients in the sample at assessment met the threshold criteria for a moderate to severe presentation with a clinical score >20 using CORE-34, for a 16 session psychological therapy intervention.

Instruments
All clients were assessed using the CORE-34 measurement of global distress as a routine procedure, but for the purposes of this evaluation, we adopted one specific instrument from the CORE set of tools for measurement (Evans et al. 2000): The CORE Goal Attainment Form. This tool is a self-rating score which attempts to measure change with respect to outcome variables that are defined by the clients for themselves in collaboration with the therapists. At the ouset of therapy, the clients are presented with the form and asked to articulate four difficulties that are represented as 'goals'. Here we focus upon the goals that were identified and the degree to which the clients expressed that these goals were achieved. On the Goal Attainment Form at the completion of therapy, this degree of achievement is rated by the clients themselves on a scale of 0-4 as follows: 0 = not at all, 1 = a little bit, 2 = moderately, 3 = quite a bit and 4 = extremely. In addition to this information, the client at the end of therapy is asked to subjectively evaluate the experience of what are termed the 'Helpful Aspects of Therapy' as follows:

- To describe what it has been felt as positive about therapy. This might be an outcome, insight or experience. The client is also asked 'how helpful the experience, outcome or insight will be to you in the future and express this as slightly helpful, moderately helpful or extremely helpful;
- To describe (if present) anything which remains unresolved or that is still felt as uncomfortable.

Procedures
All goals as articulated by individual clients were first listed, then these statements were collated and clustered into themes. All statements were considered and the main themes that were evidenced were expressed in groupings as well as the supplementary (or less consistently expressed) sub-themes being represented in the depiction of the whole array of goals. This analysis was reviewed and considered and agreed with the clinical

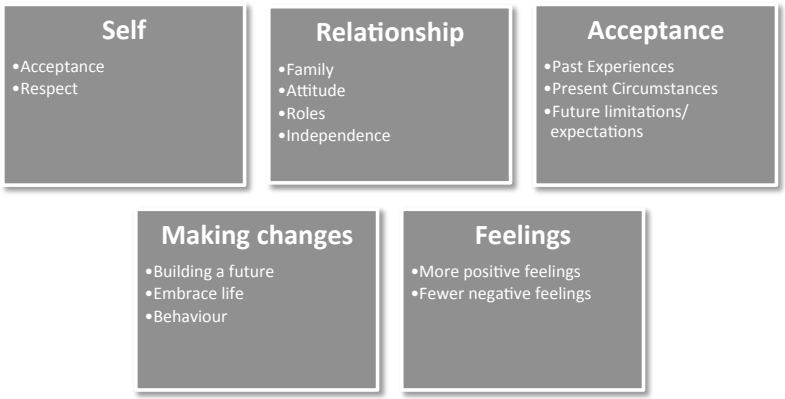
supervisor of the clinicians collecting and analysing the data.

At the end of therapy, clients were asked to provide a score for the degree to which they assessed that they had achieved each of the goals articulated. A frequency table (Table 1) and graphs (Figures 2 and 3) express the results of these outcomes.

Results

The considered sample included 30 clients from an NHS secondary care psychological therapies service. We observed that clients attended an average of 12 sessions that spanned an average of 4.5 months. 20 clients attended a full course of therapy, 8 ended early and there was insufficient data for 2. The Participants wrote down a total of 77 goals that were expressed as statements that spanned between 1 and 74 words ($\mu = 11$ words). The thematic analysis evidenced 5 main themes with relative subthemes (plus 1 'miscellaneous').

Figure 1: Themes emerging from client reported goals



All clients indicated and described at least one goal. Goals were set by the clients themselves on the basis of their own subjective experience, with 90% of the clients setting at least two goals, 70% setting three and 50% of the clients used all the four allotted spaces to describe goals.

Clients rated degree of achievement of goals post-therapy

Table 1				
	1st Goal n=30	2nd Goal n=27	3rd Goal n=21	4th Goal n= 15
Not at all	0.00%	7.41%	4.76%	0.00%
A little bit	13.33%	22.22%	14.29%	6.67%
Moderately	36.67%	18.52%	47.62%	33.33%
Quite a bit	33.33%	25.93%	19.05%	46.67%
Extremely	16.67%	25.93%	14.29%	13.33%

Figure 2: Degree of goal achievement for 1st and 2nd goals

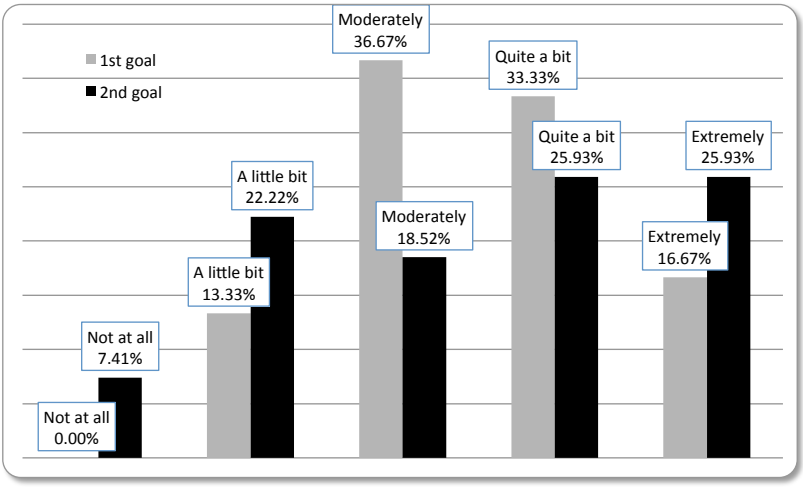
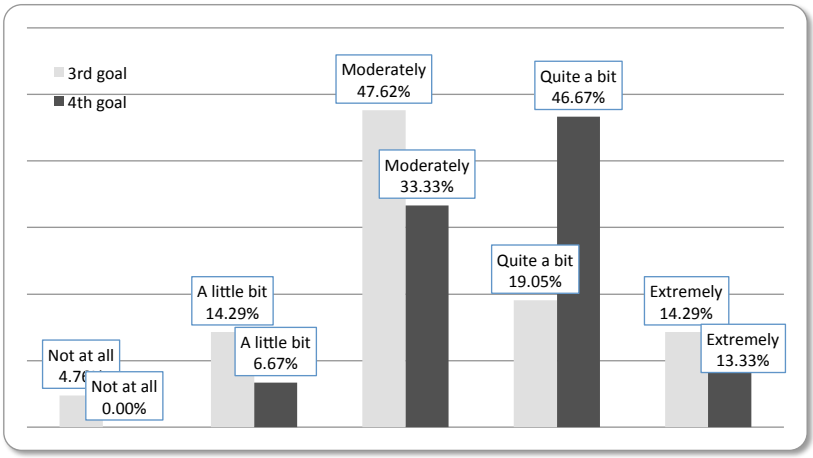


Figure 3: Degree of goal achievement for 3rd and 4th goals



Discussion

What this paper set out to express was that a manner of conducting psychotherapy informed by existential-phenomenological thinking as described above was able to be measured using a tool known as the CORE Goal Attainment Form. Even from a preliminary perspective, it is clear from the above tables that in excess of 86% of the sample reported that they achieved goal number one in a range between moderately (well achieved) to extremely (well achieved). Similarly, clients reported that 70% of the time they achieved goal number two between moderately and extremely (well achieved). For goal number three the figure is 80% and it is 93% for goal number four.

All the participants in the sample (n = 30) described at least one goal. 90% of the people described two goals, 70% described three goals and 50% of the total population described all four goals. Thus we are confident that people are interested in delineating their hopes for therapy and expressing these as goals. Furthermore, we would reinforce the notion discussed above that monitoring of goals is a form of paying attention to what is taking place as well as a commitment to the process of therapy and is also subject to the Hawthorne Effect of Expectation.

Limitations of this study

In attempting to develop a manner of practising existential-phenomenological therapy that is informed by the above rationale, this paper measures

whether goals, as disclosed by clients, were achieved and the degree to which this was accomplished. However, further data needs to be analysed that will indicate what remains to be resolved for clients, what clients are still hindered by and what about this type of therapy, that has been described above, was helpful. We need to recognise the possibility that (some of) this improvement/achievement of goals in therapy may be due to a Placebo effect. Furthermore, this study does not purport to address issues of adherence to a manualised form of therapy but rather an attitude to therapy that is informed by existential thinking and a phenomenological methodology. Nevertheless, we hope to have shown a framework in which utilising measures (either qualitative or quantitative) and eliciting positive reinforcement in existential therapy could be both worthwhile and achievable. We believe this input might help 'us' – as existential therapists – proceed from an anecdotal account of how therapy works to the emergence of a more operationalised account of the existential factors that inform practice and so can be tested.

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