Existential Experimentation: From being and doing to an approach that addresses the theme of 'Insider and Outsider'

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Abstract

This paper articulates how an existential-phenomenologically informed intervention fits within a primary care setting in the United Kingdom National Health Service (NHS). It focuses on how a measurable notion of change in the form of client-determined goals and Repertory Grid Technique (RGT) can be integrated in a way that does not compromise existential-phenomenological values and principles. A case study is cited to help demonstrate this way of working.

Key Words

NHS, existential experimentation, existential phenomenological psychotherapy, outcome measures, change, goals, Repertory Grid Technique.

Introduction

Existential Experimentation (EE) as an existential-phenomenological short-term approach in the public sector, is at the centre of the tension between being considered an 'insider' and 'outsider'. It was developed at the same time as the IAPT (Improving Access to Psychological Therapy) by the team at EASE Wellbeing. This paper aims to demonstrate a manner of integrating existential-phenomenological psychological therapy with NHS practices and consequently how it achieves a 'both/and' stance as discussed by Spinelli (2016) at the recent SEA conference.

The thinking behind this approach commenced a decade ago and was first published in this journal several years later entitled 'CORE Blimey! Existential Therapy Scores Goals' (Rayner & Vitali 2013). Since then, we have published several papers that embrace the integration of existential attitudes, phenomenological methods and humanistic principles, together with NHS standards of practice. These NHS standards of practice include: a rigorous risk assessment, risk management, as well as monitoring and measuring outcomes. Additionally, it adheres to a way of working that demonstrates a level of consistency in the intervention, allowing for the production of robust data required by the NHS.

Whilst it is very difficult to distinguish this as an existential approach, rather than simply a short-term one, it is underpinned by notions of openness and discovery of limitations, as well as potentials that are central to the ontological nature of the endeavour, thus rendering it existential in nature. Furthermore, the approach aligns itself with the existential notion of paradox, recognizing the tensions present in clients' difficulties, such as the cost of being 'depressed' as well as the possible 'gains' of adopting such a position. For example, it may be safer to stay indoors and depressed, rather than venture into the world when one has been traumatised by experiences within it.

EE additionally maintains its existential-phenomenological essence by challenging the medicalisation of distress. It does this by intervening early in the life cycle of distress and by applying a phenomenological methodology, in an attempt to explore and deconstruct the experience of the person in advance of them falling into the classificatory systems used to categorise psychological issues (Conrad, 2008; Rapley *et al.*, 2011; Rossler, 2013). Therefore, rather than homogenising distress, it is an individualised approach that explores how each individual relates to their world, helping them to re-evaluate their roles, beliefs, assumptions and attitudes. This in turn, empowers the individual to take responsibility for their life, which is not only based upon existential principles, but also on the government's recovery initiative, promoting individuals to live more fulfilling lives (Shepherd *et al*, 2008).

On the periphery

There are two key positions that relate to EE being involved in the theme of 'Insider Outsider'. First, existential-phenomenological psychotherapy and counselling psychology has sat on the periphery of services in the NHS. This is in part, a result of existential-phenomenological therapies failing to comply with statutory sector principles around risk assessment and management, rigorous maintenance of patient information, time limits to therapy contracts and aiming for 'recovery'. Having said that, EE's approach is appropriate to belong on the inside since it conforms to the required standards aforementioned.

Second and importantly, existential-phenomenological thinking occupies a position that enables EE to offer positive critical appraisal of that which is 'inside' such as the shortcomings of dominant models of current service delivery. For instance, primary care within the NHS is increasingly governed by NICE guidelines, which rely on evidence-based practice to inform therapeutic treatments, an aspect that existential psychotherapies tend not to adhere to. Randomized Control Trials (RCTs) are the main form of evidence relied upon, however they have numerous biases and flaws when applied to psychological research (House and Lowenthal, 2013). This is partly the consequence of attempting to generalise from something as diverse as human distress and because what clients deem to be effective

within therapy is subjective and differs across outcome measures (Margison *et al*, 2000). What is more, while some clients report positive outcomes from receiving an empirically validated treatment, one cannot infer from this that the effective aspect of the intervention was the specific technique, thus making RCTs less valuable in naturalistic settings than in laboratories (Assay and Lambert, 1999). Having said that, it is outside the scope of this paper to address RCT evidence in detail.

Empirically validated interventions dominate the NHS, despite a lack of evidence for their superiority, while existentially based interventions remain sparse (Mcelaveney *et al*, 2013). Partly, this is because they are not readily measured by RCTs and therefore not endorsed by NICE guidelines (Leng *et al*, 2010). Yet, it is additionally because the application of an existential-phenomenological therapy makes it challenging to operationalise and practitioners are often reluctant to adapt to certain restraints (Cooper, 2008). Existential-phenomenological practices have not met the guidelines that allow therapies to be included on the 'inside', thus the intervention discussed here holds the tension between offering a consistent and measurable encounter with the notion of individualism, creativity and flexibility. Henceforth, it is a valid question whether being on the periphery represents a better description than being either on the inside or outside.

Therapy process

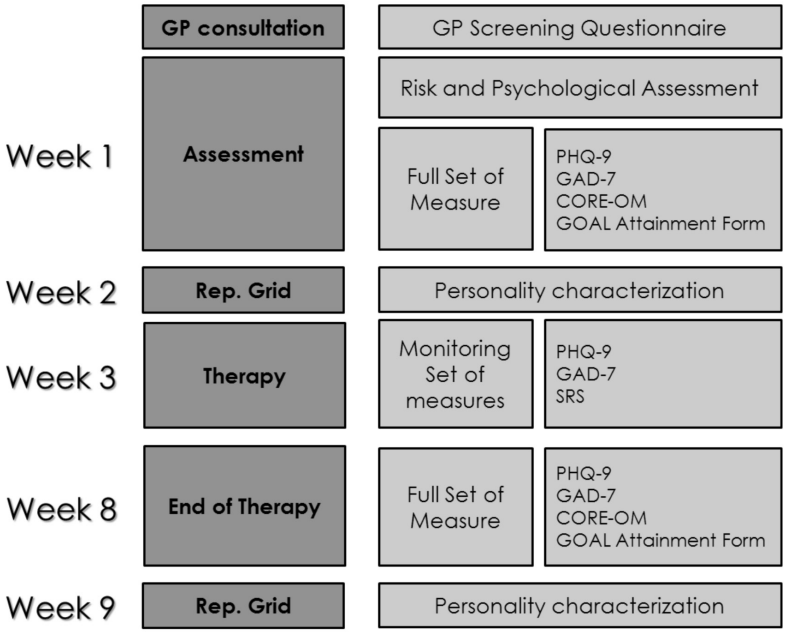
EE operates on a number of key principles:

1. Addressing psychological difficulty early in the life cycle of distress.
2. Challenging the medicalization of misery.
3. Providing a personalised yet measurable approach to psychological therapy.
4. Reducing waiting times by seeing clients at GP surgeries.
5. Challenging stigma by providing treatment in routine settings.
6. Reducing costs by avoiding psychiatric facilities and psychology offices.
7. Decreasing referral rates to secondary care by addressing concerns early.
8. Promoting recovery as defined by the ability to engage in life in a meaningful manner rather than one that is free of psychopathology or symptomatology.
9. The personalised approach is client directed through the elicitation of goals at the outset of therapy.

EE is currently being implemented within the NHS in Primary Care with the underpinnings of the principles above. The pathway is arranged chronologically from when clients complete a screening questionnaire

with their GP, to their follow up sessions. Referrals are made by GPs in Primary Care which is designed to get a sense of the client's difficulties, how they impact upon the client currently and to promote a tight sense of collaboration with the GP and EASE. Following this, an EASE clinician assesses each referral, to determine whether they meet the criteria for an approach that is short-term and sits within the NHS range for treatment of mild to moderate mental health concerns (see Rayner & Vitali, 2016). Following this, the semi-structured interview is carried out which forms the first part of the repertory grid, a form of measurement consistent with evaluation this form and other forms of therapy in terms of effectiveness at addressing notions of self-construct. Clients then receive six sessions of EE therapy, which is an operationalised approach in order to ensure that clinicians are adhering to the key principles and attitudes of the protocol, whilst also maintaining flexibility. For example, the protocol consists of de-objectifying distress, setting goals, attaining descriptions to promote reflection, improving clients' hermeneutic work, exploring their worldviews and attitudes around choice and responsibility and encouraging clients to

Figure 1: Visual representation of the EE therapeutic process



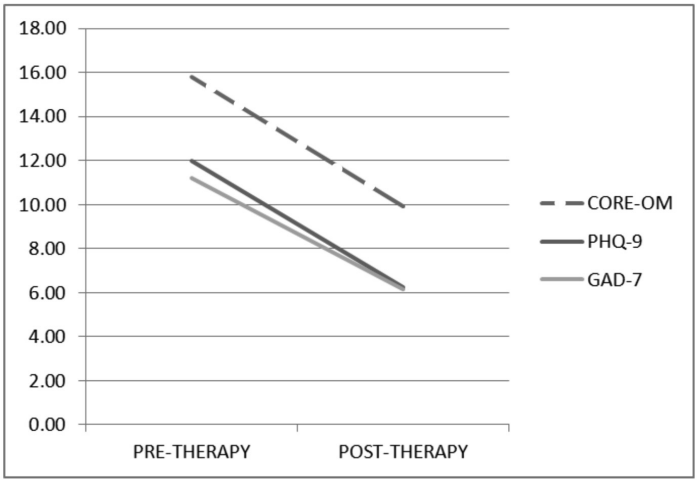
attempt open-ended experiments with new ways of being within both the therapeutic relationship and the world. The second part of the repertory grid interview is carried out after the six sessions of therapy and two follow-up sessions are conducted at three and six months.

Integrating a measurable notion of chance/ becoming an insider

To measure and monitor outcomes, EE uses a range of measurements, some that are commonly used within the statutory services and others that are not. EE has incorporated the current IAPT scales such as PHQ-9 (Kroenke *et al*, 2001) and GAD-7 (Spitzer *et al*, 2006), which are delivered on a session-by-session basis, and CORE-OM (Evans *et al*, 2000), which is administered pre and post therapy and at the follow-up sessions. These outcome measures are used to enable EE to be compared to psychological approaches of similar time lengths in primary care, in order to establish whether an existential-phenomenological approach was effective for treating distress in primary/secondary care. EE additionally measures and monitors outcomes not commonly used within the NHS such as the Session Rating Scale (Duncan *et al*, 2003) on a session-by-session basis and the RGT (Fransella, Bell & Bannister, 2004), which is administered pre- and post-therapy (discussed in further detail below).

A feasibility study for EE looking at symptomatology and perceived psychological distress outcomes for adults referred for depression and/or anxiety was conducted (Rayner and Vitali, 2015). On average EE reduces depression (measured with PHQ-9), anxiety (measured with GAD-7) and psychological distress (measured with CORE-OM) of individuals within a primary care setting. Similarly, data from an ongoing pilot study was recently analysed and found consistent results; a reduction in anxiety, depression, and psychological distress post therapy.

Figure 2: Data from an ongoing pilot study showing a reduction in all scales measuring symptomatology



N. Valid CORE forms	22
N. Valid PHQ-9 forms	20
N. Valid GAD-7 Forms	18
Total N. of clients	24

Thus, EE seems to produce promising psychotherapeutic outcomes in terms of reducing the symptomology of depression and anxiety. That said, we appreciate that these scales that are predominantly used within the NHS, do not adequately capture a client's experience, and the focus on symptomatology is not representative of the aims and values of an existential-phenomenological approach (Cooper, 2008). Rather, we take up the position that clients express their concerns using the language of illness, but when this is deconstructed we find that their difficulties more often are relational. In other words, we understand words like 'depression' or 'anxiety' as representing a person's relationship to themselves, others and the world. Therefore, EE takes the stance that rather than change referring to the eradication of symptomatology, change can be understood in terms of a change in understanding of oneself, others and the world, which we believe can be expressed and measured through goals.

Goals

Hopes are expressed by therapists nowadays as goals and by clients as wished-for positions in their life. In other words, what they would like

to achieve in therapy. Furthermore, our work is underpinned by the notion of intentionality, the idea that problems that clients express nowadays as symptoms, when deconstructed, are understood as expressions of their relationships to themselves, others and the world. Thus, we argue that symptoms are aspects of world experience and, as such are inevitably meaningful, purposeful and functional. While this approach does not directly address meaning, existential-phenomenological thinking and work considers all experience in the above terms.

Thus, it is incumbent upon us to deconstruct these meanings, functions and purposes. This is not to say that these are desirable positions as the intention of coming to therapy is to address that which hinders us, but principally a phenomenological enquiry attempts to move the language of illness to one of human experience. In doing this, the endeavour between client and therapist becomes one where blame, shame, dysfunction and stigma can be addressed and also promotes a sense of agency. In other words, the client can quickly recognise the experience as 'mine'. This we believe contributes greatly to clients being engaged, interested and motivated (which is hard to measure) in how they can understand the positions they have taken up in relation to their experience, rather than try to simply get rid of unwanted thoughts, feelings and/or behaviours. These are some of the key principles of this approach, but further research is needed to explore what creates, reinforces and maintains notions such as engagement and motivation.

Clients rate, in their final session, the degree to which they feel that they attained their goals, thus allowing for an individualised and creative method for measuring change across therapy. Furthermore, client-determined goals seem to provide a valid outcome measurement that additionally compliments an existential-phenomenological approach (Rayner and Vitali, 2014). Below are results from an ongoing pilot study.

Table 1				
	1st Goal n=22	2nd Goal n=21	3rd Goal n=17	4th Goal n=11
Not at all	0.00%	0.00%	0.00%	0.00%
A little bit	4.55%	9.52%	0.00%	18.18%
Moderately	27.27%	4.76%	52.49%	45.45%
Quite a bit	40.91%	71.43%	25.29%	18.18%
Extremely	27.27%	14.29%	11.76%	18.18%

Table 1: Clients rated achievement of goals post therapy*

• This data is to be viewed as anecdotal at present as the sample size is small due to some clients not rating their goal achievements and some

only construing two or three goals out of four.

Additionally, in the on going pilot study, thematic analysis was utilised to assess the client's goals (Rayner and Sayer, 2015). The following were key themes found from analysing the goals; developing and understanding self, understanding relationships with self and others, understanding emotions, understanding the need for more or less control, dealing with givens and holding onto something versus letting go. As mentioned, EE challenges the way in which we understand change, so that rather than change referring to behaviour or symptoms, it can also include a change in understanding of oneself, others and the world. Therefore, the content of the goals seems to be in line with the type of change that EE works on achieving and encompasses existential-phenomenological themes.

Repertory Grid Technique

As part of the process of validating the ongoing pilot study, a tool to measure change of clients beliefs, assumptions and values of themselves, others and their world has been introduced as part of the therapeutic process. RGT is an idiographic and personalised quantitative outcome measure that allows an individual's beliefs and values to be explored phenomenologically, whilst enabling patterns to emerge and be represented in a quantitative way. We believe that the flexible nature of RGT bridges the gap between qualitative and quantitative research and could be a more beneficial way to create evidence for psychotherapy research and EE in particular (Winter, 1994).

RGT was designed in harmony with personal construct theory and it assesses how an individual construes and gives meaning to themselves, others and their world (Kelly, 1955). EE helps the client to explore and challenge their assumptions, rigid beliefs, contradictions and paradoxes in relation to themselves, others and their world and thus RGT seems to also be in line with an existential-phenomenological approach such as EE (Winter, 1994). Furthermore, in EE the client is encouraged to explore new ways of being, whilst acknowledging the benefits and costs that such changes may bring (Spinelli, 2015). RGT captures an individual's paradoxes in the form of implicative dilemmas, where a wished for change in one aspect may lead to an undesired change elsewhere. For instance, a client may wish to be able to say 'no' more easily to others, but this would risk others perceiving the client differently. Therefore, it can highlight what dilemmas are present which may be contributing to a client's feeling of 'stuckness' in their current way of being and as RGT is conducted pre and post therapy, it reveals whether the number and content of dilemmas change over therapy for each client. Consequently, the aims of EE seem similar to what RGT captures and therefore we believe that RGT is an outcome measure that detects the complexity of change that occurs across EE more

adequately than just using the standard psychological scales, common in the NHS (Fransella, Bell & Bannister, 2004).

In order to facilitate the understanding of how RGT can aid the understanding of what and how clients may have changed across therapy, in addition to how clients goals are worked on within therapy and what this approach looks like in practice, a case study will be cited:

Case Study

Client Goals: 1. To be more confident, 2. Learn to accept myself, 3. Coming to terms with my face, 4. Being assertive

Why now?

The client is a 48-year-old female who on first appearances seemed very outgoing, confident and friendly. However, she immediately became tearful and reported feeling very depressed, overwhelmed by the world and consequently desiring to be alone, struggling to leave her house and feeling like a burden to those around her. When she was fifteen years old she had a severe car crash which she has no recollection of. Yet, she can recall the horrific moments upon awakening and not recognising herself in the mirror and times of wearing what she described as 'scaffolding' around her head, with people pointing and talking about her. She has been subject to thirty years of facial reconstruction surgery and her face is still disfigured and she wears a patch to hide her false eye. She described how everything is filtered through her appearance and eye and accordingly throughout therapy she was very conscious about what angle I was viewing her from, what I might be perceiving and thinking, and she described how she has never felt more self-conscious and lacking in confidence about her face in her whole life as she has done in the past few months.

For the past twenty years the client was happy working in the Ministry of Defence. However she felt she wanted to 'give back' for all of the surgery she received on the NHS and therefore retrained to become a nurse working in Accident and Emergencies. However, this turned out to be a huge challenge; the constantly changing setting meant that she would bump into machinery, due to her reduced vision and she would find herself apologising to it, thinking that it was a person, which she found immensely humiliating. Moreover, the high turnover of patients meant that they frequently asked about her patch in what she felt to be insensitive ways. Therefore, it became clear that this new environment had re-traumatised her and consequently she felt unable to return to work.

Exploring attitudes and opening up the narrative

It became apparent from opening up and exploring her narrative that

certain attitudes, assumptions and ways of being that once were adaptive, enabling her to stoically continue facing the endless surgeries, get a job, and make so many friendships, were no longer working for her. For example, she described how she felt the need to overcompensate for her facial disfigurement in order to feel equal to others. This was in the form of trying to please others, overworking, never saying no or putting her needs first, and caring for others while struggling to accept care in return. Also, she would take responsibility for everything and came across as extremely positive, friendly and outgoing, which exhausted her and she would have preferred to be alone. The client realised that her stoic attitude of getting on with anything without complaining, had contributed to her becoming overwhelmed with too much to do and not being able to do everything to her best ability. This constant pretence had become hard to uphold and meant that others took advantage of her generosity, knowing that she would step up to any challenge. Therapy worked on highlighting and empathetically challenging these assumptions and beliefs and introduced new perspectives into her narrative, by reflecting on these aspects when they occurred within the therapeutic relationship.

Challenging assumptions/experimenting with new ways of being.

A strong therapeutic relationship was developed immediately, which the client reported was influenced by genuineness and enabled her to develop confidence and experiment with new ways of being in and out of therapy. She was able to experiment with accepting care and not trying to please or care for me, being assertive in relation to telling her boss the conditions upon which she would return to work and perceiving herself and others in new ways. For example, at night she would hide her false eye from her boyfriend and she never left the house without her patch on. However, the client chose to spend the sessions speaking to me without her patch on. As her confidence grew in our sessions, this spread outside of therapy, with her arriving to the surgery without her patch on and going on a walk and speaking to two people without her patch on. She had never done this before and was astounded that others did not comment on her face or treat her differently. She decided not to wear her patch again and instead bought glasses. She could never have imagined the possibility of having the confidence to do this and hopefully therapy helped to empower her and allowed a safe space to explore others reactions and her own fears. However, amongst all this positivity, she also accepted that there would always be a spectrum of perceptions and responses; some people may not notice her face at all and may be concerned with their own inner worlds, while others will notice it, and some will be inquisitive for caring reasons and others may just be rude. She learnt that what mattered was maintaining her confidence, acceptance of herself and the ability to

withstand responses. She also became aware that no matter how much she tried to overcompensate, care for others or put on a pretence, she would not be able to predict others responses and would only exhaust herself attempting to do so. She started to accept what she had lost, but also came to an understanding that she would not be the ambitious, determined, loved and relatable person that she is, without all that she has been through.

Feedback

The client said that at the end of therapy her 'depression' had entirely gone, and the world seemed to have colour again. She could never have imagined being the person that she had become over therapy. She said that if she had a moment of feeling very self-conscious when she saw people without her patch on she would think of all the possible perspectives of how others might view her and would not immediately assume that people were thinking negatively (for example they may have been staring at her, but they could also have been focusing on driving or not had good enough eyesight to see her false eye, or looked at her for other reasons), which allowed her to face the world and others. Understanding that her stoic attitude meant that people at work had no idea about the strain she was under, helped her to put her needs first and be more open about her vulnerabilities. Consequently, she was able to return to work and in her three month follow-up she reported that as a result of being assertive, not overcompensating and allowing herself to be vulnerable, she was now able to cope with work, has more energy and her colleagues do not resent her for not doing more than her fair share. While she stated that accepting her face would be a lifelong goal, she felt that the possibility is now more attainable and she feels that she has agency in her situation.

The above case study hopes to reveal what EE therapy looks like in practise and how the client's goals are worked upon. In terms of the client's repertory grid, viewing it in an exploratory manner rather than merely combining it with other RGTs to generalise from it, highlighted that before EE therapy this client perceived herself as very far from how she would like to be. In the graphic representation of the statistical analysis (principal component analysis) it can be noticed that the distance between her 'ideal self' and 'self' appears closer from Figure 3 (pre-therapy grid) to Figure 4 (post-therapy grid). Furthermore, her 'future self' (realistic view of where she might be in five years) seems closer to both her 'ideal self' and to the 'therapist' post therapy. These nuances of the data represented graphically in the after therapy plot perhaps may be interpreted as an increased sense of hope that she may achieve these wished-for new ways of being. Following the methodology for analysis explained by Winter (1994), it appears from

the plot that the structure in which the personal constructs are related to each other is different: constructs that appeared as very tightly grouped together before therapy, now seem more differentiated (Winter, 1994). These wider inter-construct distances on the map can be interpreted as greater differences between the meaning attribution functions of each construct dyad. This perhaps suggests that the client has somehow re-construed the way in which these constructs relate to each other and we like to speculate that these differences represent a shift in her worldview and so in her view of herself, others and the world. This potential change in worldview was reflected in her feedback about therapy, her goal scores and the therapists' observations across therapy.

Figure 3: Visual representation of the client's pre therapy assumptions about herself, others and her world.

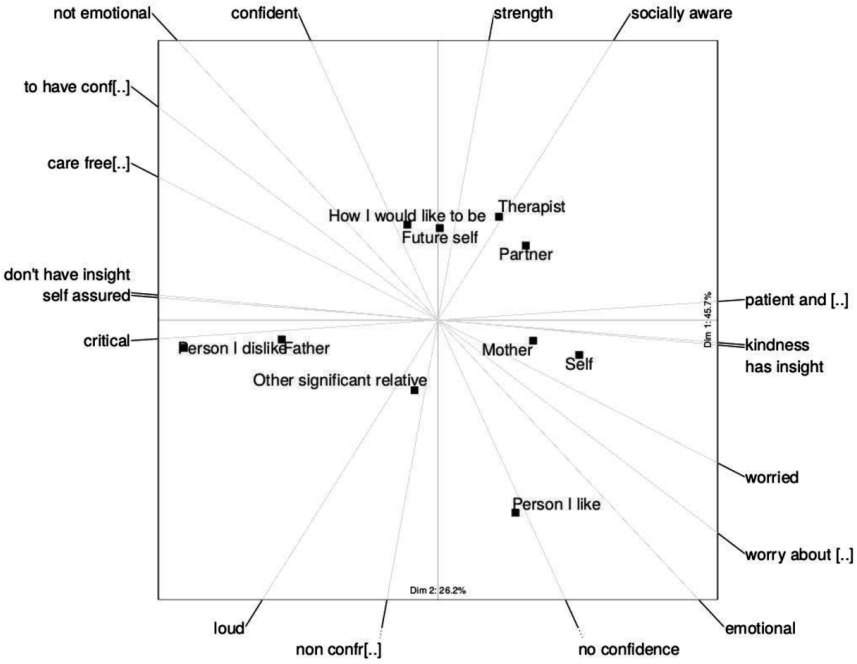
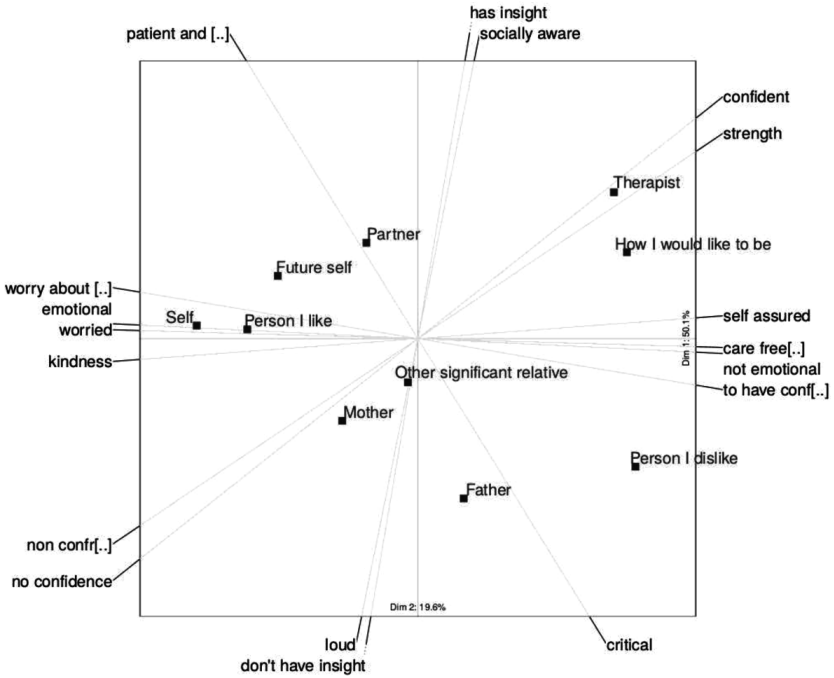


Figure 4: Visual representation of the client's post therapy assumptions about herself, others and her world.



We would like to thank Francesca Venturi for collecting the Repertory Grid data for the client discussed above.

Discussion

There are limitations to this study and the results presented above are just preliminary. The aim of the study was not to bring evidence about outcomes or produce evidence at this stage, rather to demonstrate a way of integrating different methodologies. The aim of the paper was to express the ways in which EE, as an existential-phenomenologically informed psychotherapy service, positions itself in the realm of Mental Health services. In order to be a flexible and adaptive service EE needs, and hopefully has, a sense of flexibility in its position and principles, although it recognises that the ambiguity of its position makes it a difficult place to be as criticism comes more easily from both 'insiders' and 'outsiders'. Nonetheless, EE tries to maintain a

stance of embodied choice, rather than responding to and acting upon the requirements of others' conditions. Essentially, EE is on the periphery of being an 'insider' and an 'outsider', which allows it to maintain the required responsibility of keeping up to date with insiders' concerns and fears and also of outsiders' concerns, motivations and fears of insiders' development and critique. We aim to be committed to both sides, without joining either.

Current research projects

A pilot study is being conducted in order to establish whether RGT is an appropriate assessment tool for identifying if and how clients change across EE therapy and the initial results allow for cautious optimism. We hope that RGT may be a more adequate measure to provide quantitative evidence for an existentially based therapy and thus potentially increase the evidence base, as well as enabling the comparison of what changes occur across modalities.

Moreover, while EE has shown positive outcomes at reducing symptomatology, psychological distress and helping clients achieve their goals, the clients' experience of EE therapy has not been explored systematically. Therefore, an assessment of EE therapy from the clients' perspective using Interpretative Phenomenological Analysis and RGT is about to be embarked upon as part of a Doctoral Thesis. The combination of IPA and RGT hopes to shine a light on the various facets of the client's experience. Additionally, using the RGT data will enable comparisons to be made with the qualitative data in an exploratory format, to see if this quantitative method for detecting change compliments the qualitative data, where it converges and diverges and it may help to highlight what happened during therapy.

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