REBEL – Researching experience broadly experimentally and longitudinally

Mark Rayner
CEO EASE Wellbeing CIC
United Kingdom
Mark Rayner
mark@easewellbeing.co.uk
Psychological Therapist
MA

Existential Experimentation: from being and doing to an approach that addresses the theme of 'Insider and Outsider' (2017). *Existential Analysis*, 28.1 pp66-81

Lost for words (forthcoming) Rayner, M., Quinault, S. R., & Vitali, D., in *Case studies in existential psychotherapy and counselling*. Editor: S., Du Plock, second ed.
Existential Experimentation

Rayner, M., & Vitali, D. (2016). Existential Experimentation: Structure and principles for a short-term psychological therapy. *Journal of Humanistic Psychology*.

Sayers, L. & Rayner, M. (2016). What do clients want from therapy? *Hermeneutic circular - Newsletter of the Society for Existential Analysis*, April 2016.

Rayner, M., & Vitali, D. (2015). Short-Term Existential Psychotherapy in Primary Care: A Quantitative Report. *Journal of Humanistic Psychology*, 0022167815569884

Rayner, M., & Vitali, D. (2015). Psicoterapia Existencial de Corto Plazo en Atención Primaria: Un Reporte Cuantitativo. *ALPE Journal*, October 2015

Rayner, M., & Vitali, D. (2014). CORE Blimey! Existential Therapy Scores GOALS!. *Existential Analysis: Journal of the Society for Existential Analysis*, 25(2).

Rayner, M. & Vitali, D. (2013). Measuring a short term existential therapeutic intervention in the NHS. *Hermeneutic circular - Newsletter of the Society for Existential Analysis*, October 2013.

Abstract

In this paper, I underline the method of doing research in the public sector by discussing what and how clinical issues are approached via typical client presentations. As has been discussed in detail and is referenced above and below, EASE Wellbeing CIC promotes an intervention that is recovery focused, while redefining the notion of recovery and challenging the medicalisation of distress into a more human approach to what clients present as problematic. This approach shows students and clinicians how to elicit robust data while adhering to a systematic way of working that centres upon addressing client directed concerns. Central to this approach is both the collaborative nature of the work between GP, clinician and client and the idea that this focuses upon the two areas of clinical

work that may lead to a positive outcome for therapy: the client-attributable or context related factors ant the relational aspects of the endeavour.

Learning Outcomes

1. The primary endeavour and learning of this approach is one that centres upon those elements of therapy that have the greatest weight in leading to positive outcomes of therapy. Techniques have been shown only to represent approximately 15% of positive outcomes, while client-attributable and relational factors account for up to 70%. Thus, for therapy to have the greatest possibility of being successful, it is vital that attention is focused upon those areas rather than the expertise of the therapist in delivering a particular model or technique.
2. Integration of physical and mental healthcare – how to illuminate the expression of bodily expressed psychological difficulties. Particularly prominent in this field was the phenomenologist Marcel Merleau-Ponty (1966). However, this work does not belong to the sole remit of phenomenologists; Freud himself (Gottlieb, R. M. 2003) engaged deeply in this realm, exposing how the body 'speaks' and students and clinicians must be aware of verbal and non-verbal expression, in order to undertake a proper psychotherapy intervention.
3. Collaboration between healthcare professionals. Central to productive interventions is the co-constituted work of therapist and client but, moreover, the engagement of the GP in the early engagement of the client lies at the outset of this intervention and is crucial as engagement is the handmaiden to clients' motivation and willingness to be and stay in therapy, along with the development of hope. All therapy begins and ends but recent fragmentation of care into silos has inhibited the work and left both GPs and clients with long waiting times for therapy and a sense of disillusionment with the process of onward referral. Therefore, in order for this process to be effective, seamless pathways are essential.
4. Over the past 10-15 years, psychological therapy has become increasingly medicalised. Whilst we practice in routine medical settings, it is essential to recognise that not only do routine settings address the stigma associated with attending possible distant psychiatric or psychological facilities, but also the general public are more likely to attend places they are accustomed to attending and are almost inevitably close to where they live, thus enhancing ease of access.
5. One of the key principles to this service is the notion of early intervention as this often leads to better outcomes, as we know that in many areas of distress, waiting lengthy periods for help is associated with loss of hope and motivation. Early intervention is made possible by the above insistence on attendance in GP settings.

Overview

The approach that has been articulated in detail in the Journal of Humanistic Psychology (Rayner & Vitali 2015, 2016) is an approach that integrates existential attitudes, phenomenological methods, humanistic principles with the need to conform to currently dominant studies that are predicated upon evidence-based practice and RCTs.

Although these are explained in detail in these journal articles, existential attitudes represent, amongst other issues, the notion of world-views and approaching the situation with an openness that enhances a sense of agency and empowerment (Grealish 1 et al 2016). 'Empowerment includes

an enabling process through which individuals, organizations and communities exert control over their lives and is not only a psychological construct (Rappaport, 1987; Zimmerman, 2000). There is consensus that empowerment is key to recovery from mental health problems, enabling a person to take charge of their life and make informed choices and decisions about their life). Enabling processes 'represent a shift from a focus on ameliorating deficits and addressing risks to the development of capacity within individuals, organizations, and communities to promote wellness and effect change' (Freudenberg, 2004).
The phenomenological method is utilised to attempt to describe and clarify in detail the values, attitudes, assumption and beliefs of the individual and, further, to get closer to the person's relationship to the essential qualities of their experiences. Since this approach is driven by the goals (Judge 2005) that are elicited at the outset from clients, humanistic principles relate to the possibility of reaching for the fulfilment of the clients' potential to achieve their goals.

Research and clinical practice

The process of therapy and research has been designed in accordance with standards that uphold practice-based evidence (Barkham and Mellor-Clark 2003) and integrate clinical practice with the notion of producing robust and reliable data, in order to be accepted into the world of short-term therapies offered in the public sector. We have used pre- and post-therapy measures as well as monitoring scales on a session by session basis and have developed a digital way to record and securely store anonymised information that is accessible to GPs and to clinical leads and supervisors on a need-to-know-basis. Previous authors such as Lantz (2007) have informed this work but this intervention attempts to put their ideas into greater detail for the purposes of learning how to implement this type of approach in clinical practice.

The first comment to make is one that has been made most clearly by Mick Cooper (2008) that clinicians should not be afraid of doing research in a rigorous manner. I would add that academics and researchers should also not be afraid of doing clinical work that produces reliable and robust evidence. In this way, we combine the narratives articulated in therapy with the research aims. Correia (2017) discusses this in a recent paper finding that there is not a reason why an existential therapy cannot also elicit empirical evidence.

The second point to make is that this approach is not a manualised one but rather one that adheres to a manner of being operationalised that is clear but, nonetheless, illuminates a tension. This tension is one that has been discussed by Plato (Nehamas 1985) and by Merleau-Ponty (Dillon 1997). insofar as it is impossible to discover anything new if you know what you are looking for but it is also difficult to look for something unless you have an idea what you are searching for.

Research design

Therefore, existential experimentation is an intervention that overcomes this problem by focusing upon that which is important to the client (Black 2013) and the experiences of such clients in a relational manner rather than imposing either a technique or theory upon the experience. Thus, experience in this context means a whole range of concerns; cognitive, emotional, experiential, embodied and so on. The experience is measured in a longitudinal way as it follows each client through the whole process of referral to assessment to baseline scales to therapy to outcome measures to follow-ups. There is a further tension that is central to the approach that we use and that is the notion of being traumatised, having bad experiences and being able to embrace and survive them. This is central to one of the themes of the approach; the existential notion of paradox,

or two seemingly contradictory ideas happening simultaneously. In other words, the client both owns the problems and the possible solutions (Spinelli 2002).

The other and intertwined idea central to this approach is the de-medicalisation of symptoms and the assessment of symptoms as expressed by clients not as pathogens to be removed but rather as reflections of the person's relationship to themselves, others and their world (Kathol 2010). It is crucial to understand this as it underpins much of what we do. Although the approach does systematically attempt to address the essential qualities of experience (Kern 1977), it does so in a manner that challenges the dominant discourses in psychological therapy that argue for the use of theory to encourage clients to comply with techniques aimed at reducing symptoms. What we know from the literature as mentioned is that over 70% of all positive outcomes of therapy are attributable to either client-related factors, relational factors and factors relating to hope and expectancy (Assay & Lambert 1999, Cuijper 2012, Cooper 2009, Elliott 2011).

This study will now illuminate the central aspects of the research while describing and discussing a case that presented to a GP for therapy. What is crucial to this endeavour is the manner in which the notion of research is introduced to clients and understood by clinicians. For some time now NHS services have audited and evaluated their of interventions but these have often been delivered to clients in a manner that has focused upon the service delivery targets as opposed to what we are proposing here. This method of research is designed in order that the client can see if and how they are benefitting or not from the service that they are getting, rather than the clinician simply being able to collect data that proves or disproves whether the service is effective. Clinicians have often been reluctant to impose forms or scales upon the clinical environment for precisely this reason but if they do so in a manner described above, the clinical and research components of the intervention both become more at one and also greatly encourage the clients to engage and embrace the idea of monitoring and measuring their own process and progress.

Method in Action

Mr. A is 43 years old and has recently split from his partner. He works as an engineer locally and is typical of clients that are referred to EASE Wellbeing by their GPs. They have two children and he has no previous experience of mental health concerns or services. He went to see his GP after several months as he was experiencing a sense of lethargy, apathy in a manner that he found unusual and was worried that he may have some sort of lingering medical illness. When he met his GP, they discussed his symptoms and what was going on in his life and the GP did tests for viral and influenza type problems including post-viral fatigue. At the same time the doctor was speaking to him about what was going on in his life, she commented on his slightly dishevelled appearance and 'flat' presentation that was not normal for her experience of him. He disclosed that he was having trouble motivating himself as his relationship had recently ended. At this point, the GP used the EASE GP screening questionnaire (see appendix 1) to elucidate these concerns and try to establish if there may be some psychological difficulties. He rose to this type of questioning and articulated that he seemed to lack energy, confidence and was struggling to concentrate at work and felt a sense of loneliness as he was living separately from his family. These descriptions (Lepper & Riding, 2006) asked him to state how this was currently impacting him and he said that he had missed some work, was not socialising as he was used to and had no sense of purpose. He said that he was motivated to try to understand how he had become this way and would be able to find the time to attend both for an assessment and, if appropriate, for sessions of therapy.

As a result of this preliminary discussion, the GP decided to refer him to EASE Wellbeing for a psychological assessment. The research process had already begun as in making the referral to EASE he started to think about what was going on in not a completely medical manner and reflect on his

current situation and had a sense of hope that he may discover what was causing the symptoms to impact upon his functioning. This idea has long been in the literature and is known as the Hawthorne effect of expectation (McCarney (2007).

Qualitative and quantitative measures

When he attended for the assessment the psychological therapist proceeded to refine the already expressed 'symptoms' in a manner that led to the development of goals for therapy. He said that he wanted to understand how he could regain, rediscover a sense of drive and will to carry on, recognising that, although he may not live with his partner and children, he could still participate in their parenting.

In the second meeting the psychological therapist and the client discussed how his psychological concerns that were affecting his physical wellbeing. In the assessment following from the original brief overview completed by the GP in the screening questionnaire, we employ a range of scales to assess nomothetically the level of his difficulties. These scales are the dominant scales commonly used in therapies treating mild to moderate disorders like anxiety and depression, in addition to two of the CORE set of scales. We use the GAD-7 to assess anxiety as it is considered in the commonly used taxonomy of mental health problems and the PHQ-9 to assess depression. These measure of anxiety and depression showed the baseline scores for Mr. A were 18 and 14, which meant that, according to the way services arrange inclusion criteria, he met the levels for treatment in primary care. We also use the CORE-34 as it discloses 5 domains of distress and the Goal Attainment Form which refines the original GP questionnaire into four main difficulties. Mr. A disclosed that he felt worthless due to the split, unable to find the drive to socialise, a sense of loss of confidence to be a 'man' regarding parenting and work and the ability to shrug off the problems. The fourth 'goal' he articulated was around his view of himself as someone who had, upon scrutiny, had relationship difficulties for some time. He said his father had been somewhat absent due to over drinking and his mother had had to raise him and his siblings which had led to an unbalanced sense of growing up with a controlling mother.

During the assessment, we approach these problems in a manner that, rather than viewing them as symptoms of an illness, try to establish them as reflections of his relationship to himself, others and the world so as to approach the positions he currently adopts in relation to himself, others and the world. In this way, we inquire into the values, assumptions, attitudes and beliefs he holds that are impacting and inhibiting his ability to function and he desires. This then becomes a meeting where he is able to personally take up stances about how he would like to be and so we call these and they are known on this form as Goals for therapy. Therefore, the problems elicited at the GP screening stage known now as Goals for therapy are articulated by the client and the process of the EASE intervention is applied in a systematic manner to address these goals. In other words, the goals are wished for positions, so, we are in essence, starting therapy from the end – where would the client like to be having had therapy to address his goals.

Operationalisation not manualisation and NHS standards

As part of the assessment, we stay with NHS procedures and assess also issues such as medication, family history and, importantly current and historic risks, using the Grist (Vail, Adams, Gilbert, Nettleingham & Buckingham, C. D. 2012) form of assessment. This is a rigorous assessment that has been developed by researchers at Aston University and provides through a detailed algorithm a clear idea of what and to what degree risks may or may not be present and, like all of our forms, is created and stored digitally and securely. It is important to know both the difference between risk

and goals as EASE Wellbeing adheres to NHS standards and it is, therefore, vital to identify who and how to include and possibly exclude people from a primary care intervention.

To return to the assessment of Mr. A, there are a number of other issues that are discussed at this point to ascertain how we might collaborate in his recovery. I use the term collaborate as many therapies that are manualised use this term but in fact rely upon the person to articulate their problems, then tell them what is wrong with the manner they are managing them and if they address them according to the manual they will recover. This is what I would call compliance as opposed to collaboration, since we know of the importance of the client having agency in their distress and the relevance of the relational and client-related factors that inform us of the higher possibilities of recovery when the client is 'in charge' of how they address their concerns. Mr. A expressed his sense of loss in the splitting up of his relationship but also his determination to understand loss of something as the possibility of something else. In other words, he was able to see that he may have a relationship with his children that, whilst apart, may be viewed as still having value. This is part of the phenomenological process of looking clsely at the essential qualities of experience, not trying to change the experience but rather being able to take up a different stance in relationship to the same experience. Again, understanding is central to this as a change in his understanding of something represents a change but not an eradication of something and it is this change that we measure using idiographic scales such as client reported experience measures and repertory grids that I will describe later. Thus, we view changes in understanding as a valid and measurable form of change and we are able to do so because of the use of both qualitatitve and quantitative forms of measurement.

The psychological assessment focuses both on the descriptions of the client about his difficulties as well as the therapist's impressions about these concerns as well as the numeric values associated with the distress elucidated by the client. This approach to what we could call 'clinically integrated research' is what yields both nomothetic as well as idiographic information. In our most recent pilot we introduced a measure called Repertory Grids, which are conducted over two sessions. One takes place at the start of therapy and the other after the sixth session. A repertory grid is a tool used to assess a client's beliefs, values and assumptions about themselves and significant others in their worlds. We use it in a way so as to identify a sense of current self-construct and a sense of how the individual can contemplate an ideal sense of self-construct. The technique of the repertory grids is flexible and bridges the gap to create a mixed manner of measuring client change. In other words, it creates evidence for the effectiveness of the intervention using a mixed quantitative and qualitative method of assessment that is scientific and valid (Winter 2003).

Thus, we have created the following goals for therapy for Mr. A with him:

1. To have more energy and to be able to concentrate better
2. To regain his confidence
3. To be able to be better at socialising again
4. To challenge his loneliness

The EASE intervention at the outset of therapy focuses upon a phenomenological inquiry attempting to elucidate essential qualities of the client's experience. It transpired that his developmental experience with his biological family had come back to life in his current situation and he was presently scared of being like his father was. From an existential stance, we were not looking at causes but rather the complicated issue of time and how it is intertwined (Minkowski – Les Temps Vercu)– the present being part of the past and a concern for the future. Furthermore, the phenomenological enquiry attempts to not only describe but also to clarify the presenting concerns.

Thus, in this case, goal 2 and 4 were partly interrelated insofar as his confidence was closely associated with being part of a unit, the head of a family, a sense of belonging that came with that and a sense of purpose. So, as you can see, no goal stands totally alone or is a symptom of dis-ease in and of itself, but rather the clarificatory nature of phenomenology allows for a broader view of this person's experience. In research terms, phenomenological inquiry is always an on-going piece of research into lived experience, one piece of never ending research into the existence of man and his being-in-the-world.

An integral part of the process of therapy is the collection of weekly data, the GAD-7 and PHQ-9 scales, in a way that promotes from a clinical perspective a sense of the client staying attuned to how he feels and to enhance his self-reflective stance towards his experience (Husserl – phenomenological reduction). Whilst we acknowledge that the questions on the scales of themselves are not vital, what is vital is this element of the client being at the centre of his experience by reflecting upon how he is doing on in a continuous manner.

The experimental part of the EASE intervention also challenges the notion of an experiment as it is not an experiment with doing something different or thinking differently but rather it is about embracing a temporary, undiscovered, yet wished for sense of self as identified in the goals at the outset of therapy. Thus, we encourage Mr. A to think of how he would like to be and to temporarily try on this sense of self and report how it impacts upon his current sense of being. Bugental remarked 'why it is necessary that psychotherapists redirect their attention from gathering information about the client to attending to the client's actual experiencing in the living moment'. (Bugental, 1999)

As with many short-term therapies, the last sessions are centred around generalising what has been gained from therapy. Mr. A reported that he had tried to go out with friends and had joined the local gym and was really trying to engage with people who were similarly being alone but belonging to a common cause. He started to contemplate his role in the family and understand how he could still have a special, albeit different, relationship with his children by making the smaller amount of time spent with them more precious. This challenge the experience of loneliness and separation but he came to recognise that this was something that would take time and not be resolved in six sessions. Consequently, when he had his second repertory grid it illustrated that he had not achieved an ideal sense of self but the gap between his currently experienced sense of self and ideal had become smaller, which said to him that he was making progress.

At three and six months following therapy (Rollnick, 1995), he was invited for follow-up/review sessions. He reported that he had started to come to terms with the transient nature of some relationships and that many aspects of experience were not permanent. He had developed a better or calmer relationship with his ex-wife and was spending time with his children on a regular basis, not withdrawing for fear of not being a good enough parent.

His anxiety and his depression scales at the end of therapy had become sub-clinical, that is the GAD-7 (Spitzer, Robert L., et al. (2006). was now 9 and the PHQ-9 (Kroenke and Spitzer 2002) was 8 and these had continued to fall at follow up, suggesting that he may have become less anxious and depressed but also that he felt that he understood his position and was taking up a different stance in relation to his current situation. The second part of the goal attainment form that he started at the outset by eliciting goals asks for him to rate the degree to which he believed that he had achieved these goals. He rated the as 2, 2, 3, 4 respectively for goals 1, 2, 3 and four. He was also asked on this form to state what he found helpful about therapy and what was not helpful. He found that the relationship with the therapist was comforting and yet challenging, helping him to realise that there was not an answer but that therapy was a process that amounted to part of life's

journey and he was content to be more engaged in living on part of that journey rather than not being able to concentrate or have a sense of being part of something.

In conclusion, while the therapy was as much of a success as he could have hoped for, the EASE intervention from a clinician and a researcher's perspective, demonstrated how both clinical work and robust evidence of that work could be combined, not only for the use of the clinician but importantly for the benefit of the client. The principles of early intervention, ease of access, addressing stigma by providing treatment in routine practice settings and aiming for the fulfilment of the client's potential all contributed to the work that was done. From an existential perspective, it demonstrated that the process of being in therapy and being a therapist is also a doing as it pertains to the existence of the person in their lived world.

Exercises and Discussion Questions

1. How might one approach experience expressed by a client that seeks clarification and so enables a broader sense of description?
2. How might one avoid the assumptions that one might have about the experience being expressed interfering with ascertaining an as clear as possible account?
3. Upon reaching for the notion of the sense of self expressed, how might one elicit positions that the client wishes to reach for?
4. How might one critique self-reflection as being a position that a person takes up in respect of their views?
5. If one acknowledges that life is ultimately limited, how might one explore a sense of living for and with the experience that one has or identifies as possible?
6. How does this approach challenge the medicalisation of distress and what more could this approach do to further this challenge?

Bibliography

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association.

Barkham, Michael, and John Mellor-Clark. "Bridging evidence-based practice and practice-based evidence: developing a rigorous and relevant knowledge for the psychological therapies." *Clinical Psychology & Psychotherapy* 10.6 (2003): 319-327.

Black, N. (2013). Patient reported outcome measures could help transform healthcare. *BMJ (Clinical research ed)*, 346, f167.

Bugental, J (1999). *Psychotherapy isn't what you think: Bringing the psychotherapeutic engagement into the living moment*. Zeig Tucker & Theisen Publishers.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly*. Sage.

Cooper, M (2009)."What do we know about the effectiveness of counselling and psychotherapy?" *Newport Centre for Counselling Research Conference (NCCR).*

Correia, E. (2017). *Existential Analysis* 28.1

Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: A meta-analysis. *Clinical Psychology Review*, 32(4), 280-291.

Day, J., & Liker, J. (2004). *Learning about lean systems at Freudenberg-NOK: where continuous improvement is a way of life*. Becoming lean: Inside stories of US manufacturers, 179-200.

Dillon, M. C. (1997). *Merleau-Ponty's ontology*. Northwestern University Press.

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., pp. 132-152). New York, NY: Oxford University Press.

Gottlieb, R. M. (2003). Psychosomatic medicine: The divergent legacies of Freud and Janet. Journal of the American Psychoanalytic Association, 51(3), 857-881.

Judge, T. A., Bono, J. E., Erez, A., & Locke, E. A. (2005). Core self-evaluations and job and life satisfaction: the role of self-concordance and goal attainment. *Journal of applied psychology*, 90(2), 257.

Kathol, R. G., Butler, M., McAlpine, D. D., & Kane, R. L. (2010). Barriers to physical and mental condition integrated service delivery. *Psychosomatic Medicine*, 72(6), 511-518.

Kern, I. (1977). The three ways to the transcendental phenomenological reduction in the philosophy of Edmund Husserl. Husserl: *Expositions and appraisals*, 126-149.

Kroenke, Kurt, and Robert L. Spitzer. (2002) "The PHQ-9: a new depression diagnostic and severity measure." Psychiatric annals 32.9: 509-515.

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

Lepper, G., & Riding, N. (2006). *Researching the psychotherapy process: A practical guide to transcript-based methods*. Palgrave Macmillan.

McCarney, Rob, et al. "The Hawthorne Effect: a randomised, controlled trial." *BMC medical research methodology* 7.1 (2007): 30.

Merleau-Ponty, M., & Smith, C. (1996). *Phenomenology of perception*. Motilal Banarsidass Publishe.

Minkowski, E. (1970). Lived time: Phenomenological and psychopathological studies. Northwestern University Press.

Nehamas, A. (1985*). Meno's Paradox and Socrates as a Teacher*.

Rayner, M., & Vitali, D. (2015). Short-Term Existential Psychotherapy in Primary Care: A Quantitative Report. *Journal of Humanistic Psychology*, 56(4), 357-372

Rayner, M., & Vitali, D. (2016). Existential Experimentation Structure and Principles for a Short-Term Psychological Therapy. *Journal of Humanistic Psychology*, 0022167816655925.
Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and cognitive Psychotherapy*, 23(04), 325-334.
Spinelli, E. (2002) "The therapeutic relationship as viewed by existential psychotherapy: re-embracing the world." *Journal of Contemporary Psychotherapy* 32.1: 111-118.
The British Psychological Society www.wileyonlinelibrary.com (2016). Does empowerment mediate the effects of psychological factors on mental health, well-being, and recovery in young people? Annmarie Grealish1*, Sara Tai 2, Andrew Hunter3, Richard Emsley 4, Trevor Murrells 1and Anthony P. Morrison 2,51 Florence Nightingale Faculty of Nursing and Midwifery, King's College London, UK2 School of Psychological Sciences, University of Manchester, UK3 School of Nursing & Midwifery, National University of Ireland Galway, Ireland 4 Centre for Biostatistics, Institute of Population Health, University of Manchester, UK5Greater Manchester West Mental Health NHS Foundation Trust, UK Objectives.
Spitzer, Robert L., et al. (2006) "A brief measure for assessing generalized anxiety disorder: the GAD-7." *Archives of internal medicine* 166.10: 1092-1097.
Vail, L., Adams, A., Gilbert, E., Nettleingham, A., & Buckingham, C. D. (2012). Investigating mental health risk assessment in primary care and the potential role of a structured decision support tool, GRiST. *Mental health in family medicine*, 9(1), 57.
Winter, David A. "Repertory grid technique as a psychotherapy research measure." *Psychotherapy Research* 13.1 (2003): 25-42.
Zimmerman, Marc A.; Eisman, Andria B. Bond, Meg A. (Ed); Serrano-García, Irma (Ed); Keys, Christopher B. (Ed); Shinn, Marybeth (Ed). (2017). Empowering interventions: Strategies for addressing health inequities across levels of analysis. *APA handbook of community psychology: Methods for community research and action for diverse groups and issues*, Vol. 2, (pp. 173-191). Washington, DC, US: American Psychological Association, xiv, 680 pp. http://dx.doi.org/10.1037/14954-011)

Appendix 1.
GP Screening Questionnaire
NAME_____ DOB_____ REF
Date:_____
Mob. _____ Tel. _____
Email:_____
Please consider that all the information given below is confidential to the GP and the personnel involved in your care.
1. Please try to think about your daily life and try identify (in a few words) your problems and to rate their level of severity according to the following scale:
1. Normal/mild 2. Moderate 3. Severe 4. Extremely severe
Identified Problems Severity
1.

2.

3.

4.

Were you able to identify the nature of your concerns?
YES ---------- NO
2. How do these concerns affect you in your daily life?

3. Do you think that therapy could help you to understand your difficulties?
DEFINITELY ---------- DEFINITELY NOT
4. Are you willing and able to commit to weekly sessions of therapy?
DEFINITELY ---------- DEFINITELY NOT
5. Do you appreciate that therapy will be hard work psychologically and emotionally?
DEFINITELY ---------- DEFINITELY NOT
6. Will you be able to also work on the process of change between therapy sessions?
DEFINITELY ---------- DEFINITELY NOT
7. Can you think of being responsible for trying to change in a self-motivated and independent manner?
DEFINITELY ---------- DEFINITELY NOT
CLIENT I understand that in order for my EASE therapist to contact me and set an appointment with me I
consent to share the information in this form with the EASE Wellbeing staff Yes £
No £
Date and Signature
GP ONLY I _____ have acknowledged the difficulties expressed above and I am referring this client to EASE Wellbeing for a psychological assessment and for a therapy intervention as deemed appropriate.
Date and Signature