

Short-Term Existential Psychotherapy in Primary Care: A Quantitative Report

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Abstract

Existential Experimentation is a short-term integrative psychological therapy intervention. It is based on the recent government initiative focusing on recovery and thus integrates central ideas from existential theory, utilizes a phenomenological methodology, and applies considerations of human potential from humanistic psychology to support recovery and aim for well-being. This work explores the outcomes of a systematic application of this approach to working-age adults referred for a psychological intervention for depression and/or anxiety in terms of (a) reducing depression and/or anxiety symptomatology, (b) reducing the level of perceived psychological distress, and (c) reducing the need for psychological services. The sample consisted of working-age adults referred to primary care by their general practitioner. The patients' relevant symptomatology was assessed at every contact using Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7, and the level of psychological distress was monitored using CORE-OM. Pre-post effect sizes were evaluated using Cohen's *d*. Patients' access to psychological services was monitored at 6 and 12 months after discharge. The large effect sizes expressed show that this therapeutic approach operates effectively in reducing the symptomatology of depression and/or anxiety, while promoting significantly low relapse and dropout rates.

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short-term psychotherapy, integrative psychotherapy, existential therapy, phenomenological psychology, depression

Introduction

Background

In the United Kingdom, it is estimated that 15% of adults living in private households have a clinically significant level of depression and/or anxiety (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2003). Major depression is proven to significantly affect interpersonal, social, and work functioning (Sadock & Sadock, 2007) and is also associated with chronic psychological distress and escalation to suicidality and other disruptive psychopathological experiences (Gladstone & Beardslee, 2009). At the same time, anxiety, which is often associated with depression, is known to significantly affect the level of work productivity and to increase the frequency of access to medical services (Andrews, Issakidis, & Carter, 2001; Harvey et al., 2011; Wittchen, 2002). Therefore, there is an increasing recognition of the importance of early and prompt interventions that produce reliable effects in the long-term, preventing escalation to chronic or more severe distress and burdensome costs to services. According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (American Psychiatric Association [APA], 2013), depression is an affective disorder characterized by a loss of positive affect, which may manifest a range of symptoms, including difficulty to sleep, lack of self-care, poor concentration, or inability to maintain concentration, anxiety, and a generalized apathy toward everyday experiences (APA, 2013).

This short-term existential-integrative intervention takes a broader view of the person in order to gain a better understanding of the "human-ness" of the experience of the concepts of depression and/or anxiety rather than focusing only on the aforementioned psychopathological elements that are characteristic of the experience but are a reductionist perspective based on the medical model.

Patients' beliefs about depression are very different: Some understand their depression in terms of their life story and articulate coherent beliefs. For others depression cannot not be "explained" and appears as "not understood," which then may lead to less consistent beliefs (Burroughs et al., 2006; Karasz, Sacajiu, & Garcia, 2003). Patients also report that depression affects the inner texture of their everyday life and the understanding of the self in terms of social and individual identity (Brown et al., 2001; Karp, 1994). According to Antonovsky (1979), the challenge of coping with

depression is facilitated by promoting an integration of the experience of illness with a sense of personal meaningfulness.

It is clear that there is a need and an important place for brief interventions that can both challenge dominant manualized treatments and complement (as described below) existing evidenced-based practice in national programs. Therefore, the relevance of this approach is such that it expands the scope of current therapeutic approaches beyond symptomatology and advances present thinking around meaning-making processes and existential themes.

This short-term intervention challenges the dominant taxonomy and deconstructs notions of illness and psychopathology, with a view to approaching the breadth of human experience more adequately with respect to an existential and phenomenological perspective. This study utilized a six-session format to allow for comparison with and alongside “accepted” methodologies and dominant intervention strategies that were of similar duration, and addressed issues of complementarity.

Aim of the Study

This study explored the implementation and outcomes of Existential Experimentation (EE) within the United Kingdom National Health Service (NHS) primary care sector. Data collection procedures and consequent emerging practice-based evidence were attained using tools and methodologies similar to those applied by the Government’s IAPT (Improving Access to Psychological Therapies) program. This study explored the efficacy and reliability of this alternative approach to supplement and extend the potential of the IAPT program in its incredibly difficult and important task.

Existential Experimentation

Existential and phenomenological philosophy are two areas of philosophy that are fundamental in informing psychotherapeutic approaches to human experience, as they form the cornerstones for inquiry into the subjective understanding (*hic et nunc*) of clients’ experiences of psychological distress, often categorized as “illness.” EE has strong epistemological roots in the phenomenological and existential philosophy of Kierkegaard, Nietzsche, Husserl, Sartre, and Heidegger. The EE therapeutic system is inspired by the work of Spinelli (2007), and its main operational structure is derived from the pragmatic work of Lantz and Walsh (2007) regarding short-term existential therapy. EE is designed to champion the integration of existential, behavioral, and meaning-related concerns to promote an understanding of recovery based on the client’s ownership and integration of the experiences of illness within

a subjective sense of meaningfulness (Shepherd, Boardman, & Slade, 2008). The application of a phenomenological method in the process of assessment, observation, and psychotherapy is crucial because, in agreement with Schneider (20011), it combines an approach inherently committed to promote a sympathetic immersion of the therapist in the experience expressed by the client. Furthermore, the phenomenological method maintains a scientific approach that relates to and systematically organizes empirical observations of the phenomena, with a view to sharing findings with a professional community (Schneider, 20011).

Method

EE was devised as a therapeutic intervention to sit alongside other short-term therapies applied within the United Kingdom in the NHS, such as those delivered by the IAPT program. With a view to facilitating access to therapy with as little resistance as possible, the therapeutic intervention was provided at the general practitioner (GP) point of contact, rather than at another (potentially more stigmatizing) specialized venue, such as a mental health hospital. This also aided in the reduction of facilities' costs by avoiding treatment in specialist hospitals, mental health, or psychology departments.

Referral Pathway and Timeline

The following describes the intervention in a procedural manner:

1. *Day 1*: Routine appointment with general practitioner—referral to Primary Care Mental Health Team (PCMHT) for psychological assessment/formulation and possible intervention.
2. *Day 7*: Triage and allocation.
 - a. Triage screening and signposting at PCMHT—assessment of eligibility/suitability for treatment (criteria for EE intervention indicated by primary diagnosis of depression and/or anxiety meeting the criteria expressed in the Sampling section).
 - b. Allocation to EE—Invitation letter to client for initial appointment (or exit or referral to IAPT or other appropriate service).
3. *Day 21*: Initial appointment with EE psychological therapist—psychological assessment and contracting for six-session continuous treatment (opt-in) or opt-out/unsuitable for treatment—exclusion criteria applied included level of risk or inappropriateness for intervention to mild-moderate anxiety or depression as defined by National Institute for Clinical Excellence (NICE; 2004, 2009).

4. *Day 42*: Six-session treatment intervention conducted on a weekly basis.
5. *Day 84*: Completion of treatment—discharge/watchful waiting/onward referral.

With a view to meeting clients' and service limitations, some flexibility on the duration of the process from commencement of treatment phase to discharge was considered in this study but without going beyond a maximum period for treatment of 12 weeks.

EE is not a sum of modular sessions that can stand by themselves: The very nature and the characteristics of the treatment itself brought us to consider the first contact to be as important as the discharge and therefore to consider the six-session treatment as a whole (Rayner & Vitali, 2013). For this specific reason, the NHS' IAPT standard amount of two contacts to consider the treatment as completed was not applicable. Even though the six sessions represent a short-term intervention, it is central to this endeavor that the process of EE therapy inextricably involves an engaging attitude on the part of both therapist and client that is motivated and committed from start to finish (Rayner & Vitali, 2014). Consequently, we considered as dropped out all those cases that did not complete the whole six-session intervention or that had no contact after the first assessment with the EE therapist.

Intervention

This section describes an overview of the intervention, methodologically, trying to stay true to the spirit of enquiry, while recognizing the need to address the questions of operationalization and systematization, in order to provide a meaningful view of the efficacy and effectiveness of the treatment process. It is important to recognize that, although these descriptions are listed chronologically, most may refer to elements that are repetitive, recurrent, overlapping, and dynamically intertwined throughout the intervention. Such is the nature of an intervention that is oriented toward change as expressed by the client, as opposed to defined according to certain criteria, and that recognizes that such change is an unfolding process rather than a point in time. This intervention is underpinned by a theoretical rationale that centers on existential and phenomenological informants and attitudes, namely, urgency, intentionality, and openness (Rayner & Vitali, 2014).

The outset of therapy is oriented toward a phenomenological description of difficulties, assesses the current "cost" of these experiences by contemplating, articulating, and defining what the client wishes or hopes for in respect of these experiences and for themselves as the outcome of therapy.

Thus, clients are supported in elucidating their personal concerns through becoming self-conscious and reflective (Gallagher & Zahavi, 2012). Therapy proceeds with engaging clients in a manner that establishes the “I” in the experiences of each client in order to promote a sense of ownership regarding how experiences have been interpreted or understood (Spinelli, 2005). The focus of the intervention at this stage is about engagement with the therapist and the therapeutic task and assuming agency, as represented in the goals articulated as “mine.”

In the middle part of the intervention, emphasis is given to both reflection and interpretation in a psychoeducative manner and from a therapeutic stance. From this perspective of practicing therapy, it is this commitment to the understanding of experience that discloses the personal values, attitudes, beliefs, and assumptions that each person makes or holds about themselves, others and the world (Spinelli, 2007). Supporting the client’s self-examination of personal assumptions about self and the world is that which reveals how each person attributes meaning to experience. This allows for the central challenge of this therapy: to discover or reconstrue that which has been meaningful but is no longer desired (Spinelli, 2007). Thus, therapy examines and introduces the notions of change as reconsidering the impact and usefulness of (or no longer useful) “sedimented” views and reconfirms goals as representing wished-for, “transcendent” views and possible understandings of self. The experimental nature of this approach centers on nurturing the courage to reach for, lean toward potential and “enable a person to live more deliberately, more authentically and more purposefully” (van Deurzen, 2006, p. 389). The therapist supports the attempt to experiment with a “temporary” sense of self by focusing on the determined effort to reach toward an as-yet undiscovered sense of self that, although uncertain and unfamiliar, may be less impeded and has been expressed as desired (Woods & Hollis, 1999). Therefore, the shift in the sense of self is around the notion of self-understanding—emerging from the reflection of self as stuck in sedimented views of experience and self, and the challenge of becoming, yet being uncertain about the experience of becoming. Therapy recognizes the struggles this may involve in moving away from a familiarly experienced sense of self and embracing issues of uncertainty and the unknown as opportunity for growth, challenging possible fears with a sense of hope and potential.

Toward the final sessions of therapy, the focus remains consistently on maintaining a reflective attitude toward progress and obstacles (Mølbak, 2013) and identifies possibilities for generalizing, as with many therapies, the achieved as well as possibly unresolved aspects of those hopes, expressed as goals at the outset.

Sampling

The sample consisted of cases referred to the PCMHT of the Barnet Enfield & Haringey Mental Health NHS Trust. The potential participants were part of a larger set of cases referred by GPs for psychological interventions in primary care (see Referral Pathway section). All clients that agreed to participate in this study met eligibility criteria for an IAPT Step 2 intervention, according to the NICE Stepped Care Model for the treatment of depression and anxiety (NICE, 2004, 2009), and were then arbitrarily assigned by PCMHT either to IAPT or EE as an alternative. Therefore, the considered sample was homogeneous with the normal clinical population treated by IAPT. To sum up, the sample met the following criteria:

- Male or female working-age adults referred by GP for psychological treatment in primary care
- Male or female working-age adults that presented clinically significant levels of symptomatology for depression and/or anxiety; that is, participants who scored equal to or above the clinical cutoff of 10 on the Patient Health Questionnaire–9 (PHQ-9) scale (score range 0-27) and/or 10 or above in Generalized Anxiety Disorder–7 (GAD-7) scale (score range 0-21)
- Clients undertook outcome measurements at assessment, first and sixth sessions
- Clients began treatment within 28 days from referral (therefore a waiting time no longer than 4 weeks)
- Clients completed the six-session treatment within a maximum of 84 days (12 weeks)

Outcome Measures

Participants were assessed at the beginning and end of therapy, and then monitoring data were collected before every session during therapy using:

- *CORE-OM*: A pan-theoretical, pan-diagnostic, self-administered 34-item measure of psychological distress (Evans et al., 2000) was used pre- and posttherapy and CORE-5 OM was used as a session-by-session monitoring tool. CORE-OM scores of 10 or above have a sensitivity of 87% and a specificity of 88% for discriminating between members of the clinical and general populations.
- *PHQ-9*: A self-administered 9-item instrument for screening, diagnosing, monitoring, and measuring the severity of depression (Kroenke,

Spitzer, & Williams, 2001; Löwe, Kroenke, Herzog, & Gräfe, 2004). PHQ-9 scores equal or greater than 10 have a sensitivity of 88% and a specificity of 88% for major depression (Kroenke et al., 2001).

- *GAD-7*: A self-administered 7-item instrument for screening, diagnosing, monitoring, and measuring the severity of Generalized Anxiety Disorder (Spitzer, Kroenke, Williams, & Löwe, 2006). *GAD-7* scores equal or greater than 10 have a sensitivity of 89% and a specificity of 82% for Generalized Anxiety Disorder (Spitzer et al., 2006).

Data Analysis

All the participants were assessed at every contact, and therefore, at the end of therapy they had completed the measurements seven times (one pretherapy assessment, six therapy sessions). The clinical threshold for the given scales was considered according to the respective validation studies: 10 points for CORE-OM, PHQ-9, and GAD-7. Effect sizes of therapy were calculated using Cohen's *d* (Cohen, 2013). An estimate (1-tail) of the statistical power of the sample was calculated post hoc for an expected Cohen's *d* = .80 and given a Type I error rate of $\alpha = .05$.

To assess the outcome scores for each client we compared on average the scores expressed on the different scales at the first assessment (T0: before therapy) to the scores expressed at the end of therapy (T1: end of therapy). With a view to both adhering to NHS England standard parameters of recovery and to highlighting cases that moved from a clinical to a subclinical population, we adopted the same threshold parameters as those applied by Gyani, Shafraan, Layard, and Clark (2013) while describing IAPT's recovery rates. Thus, we marked as subclinical those cases that, at the time of discharge, displayed both the following:

1. A statistically reliable observed improvement
2. A score at discharge below the clinical threshold for the given scale

Our sample was composed of cases referred by an NHS PCMHT and was, therefore, homogeneous to the British clinical population observed in the study by Gyani et al. (2013). With a view to a better understanding of the results attained and to ensure better reliability in the application of criterion one, we adopted the statistically reliable change parameters estimated by Gyani et al. (2013) for a large U.K. primary and secondary care clinical population. Consequently, we considered as reliable a six-point change between pre- and posttreatment scores on the PHQ-9 and a 4-point change was adopted for GAD-7. For the CORE-OM global score, we considered the

reliable change index estimated by Connell et al. (2007), which indicates as significant any change in excess of 5.9 points between the pre- and post-therapy scores.

With regard to the second criterion, the threshold values adopted for each scale to discern clinical to nonclinical scores were taken from the validation study of each instruments and interpreted on the basis of their best sensitivity and specificity (see Outcomes Measures paragraph).

Results

Participants were recruited only from the London Borough of Barnet, Enfield & Haringey Mental Health NHS Trust and referred to EE between June 2011 and September 2012. The mean age of the participants ($N = 52$) was 37 years ($SD = 11.9$); 36% were men and 64% were women.

Dropout Rates

Considering the $N = 52$ cases agreed to undertake the six-session therapeutic process, the dropout rate as observed after Triage and Allocation (Point 2 of referral pathway) was 9.61% ($N = 5$). Observing the six-session treatment, the sample reduced to $N = 47$ cases that attended Session 1, four cases (8.5%) dropped out between Session 1 and Session 2, one case (2.12%) dropped out at Session 3, and one case agreed with the therapist to stop at Session 5. Therefore, the number of cases that completed therapy was 41, that is, 87.23% of the patients that began therapy ($N = 47$), and 78.84% of the initial sample ($N = 52$) of cases referred by primary care for this specific treatment.

Effect Sizes

A Kolmogorov–Smirnov test was executed using SPSS on the sample for goodness of fit and in order that the sample could be considered as normal ($p < .05$). At the end of therapy, we had 41 cases that completed treatment. With a view to measuring the pre–post effect on the clinical range, we used Cohen's d , and we considered only those cases that had a clinical score at the first assessment and submitted valid forms. As expressed by Table 1, comparing the average scores registered at first assessment [T0] to those that emerged at the end of therapy [T1], the effect sizes (Cohen, 2013) were large ($d > .80$) for all the given scales.

Of the 41 participants completing treatment, 24 (58.5%) submitted valid pre- and posttreatment PHQ-9 forms, 25 (60.97%) submitted valid GAD-7 forms, and 33 (80.48%) submitted CORE-OM forms. The differences in

Table 1. Effects of Therapy After Six Sessions: Summary of Average Scores Recorded by the Clinical^a Patients Who Started and Completed the Six-Session Intervention.

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

Note. Report shows average scores at first assessment [T0], discharge assessment [T1], average difference between the scores, effect size, and statistical power. Statistical power was calculated post hoc according to effect size and sample size as one tail and considering a chosen significance of $\alpha = .05$.

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

scores observed between the first and last contact were converted in *z*-points, and considering a confidence interval of 95% we marked as outliers all the participants that expressed a *z* equal or greater than 1.96; expressed a *z* equal or smaller than -1.96. As shown in Table 1, we considered a sample of 23 participants for the PHQ-9 scores, and one participant was excluded as an outlier for showing a score difference between assessment and end of therapy that was off the 95% confidence interval ($z = -2.82$). For the GAD-7 scores, we considered 24 participants because, similarly, one participant was excluded as an outlier ($z = -2.21$). CORE-OM had the largest sample, and we recorded 32 participants submitting completed forms (one participant was excluded as an outlier with $z = 2.03$).

Figure 1 shows on average the pre-post effect of therapy on a clinical population as emerged from our data after a complete six-session intervention, and Table 2 shows the recovery rates according to the observed and monitored psychological distresses.

Relapse Rates

Given the 42 cases that completed treatment, at 1-year follow up, two cases (4.7%) have re-requested access to psychological services at the NHS.

Discussion

With the conception of the IAPT program in 2004 and its implementation in 2008, the profession of psychotherapy, counselling, and counselling

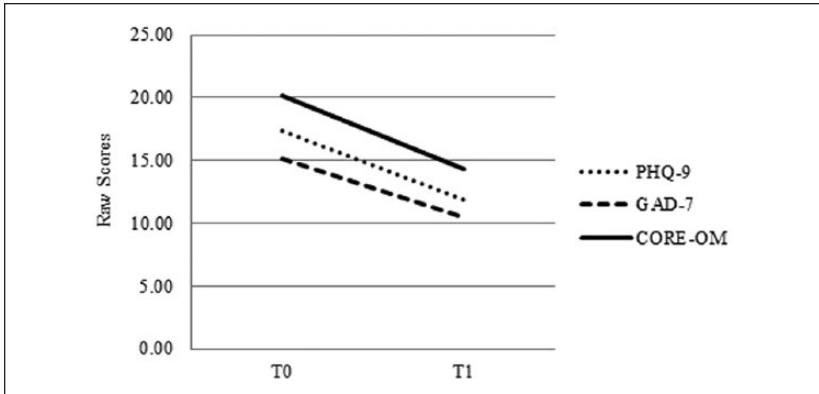


Figure 1. Effects of therapy after six sessions.

Table 2. Effects of Therapy After Six Sessions: Recovery Rates of Those Clinical Patients That Undertook a Whole Six-Session Treatment.

Scale	Subclinical	Cohen's <i>d</i>	<i>N</i>
PHQ-9	47.83%	1.38	23
GAD-7	58.33%	1.09	24
CORE-OM	31.25%	0.89	32

psychology has seen a rapid and demanding growth for evidence that therapy works, how it works and to what extent that work is measurable and lasting. While we have arrived at a place where most would acknowledge that therapy works, there continue to be great struggles between types or approaches or modalities. Research suggests from Rosenzweig (1936) to Luborsky, Singer, and Luborsky (1975), in addition to many contributors, to “common factors” ideas that most therapies produce similar amounts of success. However, from a researcher’s and commissioner’s point of view, CBT and other manualized behavioral approaches have been highly utilized since they offer a readily accessible form of measurement and implementation thanks to their highly structured techniques that also render them highly attractive. Nevertheless, commissioners, clinicians, and researchers themselves sometimes might not pay adequate attention to the very limited significance of therapeutic modality or technique in determining the outcomes of therapy compared with the major importance of client-attributable factors (Lambert, 2005; Lambert & Barley, 2001). The

therapeutic approach adopted in this research was hence devised and applied considering as central the importance of those client-attributable factors along with that of the therapeutic relationship as a collaboration aimed toward the attainment and achievement of goals as delineated in therapy by clients themselves. However, as Mølbak (2013) pointed out in recent work, we are faced with the dilemma in modern therapeutic practices where clinicians are implored by clients to try to help them solve their immediate problems versus a situation where therapy may help to unravel and further disclose their life projects. Thus, this article argues similarly that therapy is better placed and more useful if it guides or helps a person to discover the “mystery” of their difficulties by elucidating the questions they need to ask and so attempt to understand themselves better (Mølbak, 2013). Furthermore, debates over types of evidence that are valid are still widespread but what we do know is that demand for therapeutic interventions continues to rise, perhaps because of greater awareness, perhaps because of greater senses of entitlement and perhaps in part because of the publicity of the IAPT program. Yet, we also know that one size does not fit all and that the therapeutic system described and evidenced above offers a flexible, timely, and cost effective process that produces good results and low relapse rates. Many therapies such as this have not been approved due to lack of robust evidence, and it is extremely costly to run large scale research projects to provide the type of evidence that has become known as the most “acceptable” with little chance of funding. It is also questionable whether randomized control trials in this field are necessarily the best or only type of trial that can elicit the evidence that therapy is helpful and effective. This report suggests that a broader approach to addressing difficulties in living, struggles with experience, and other psychological difficulties is effective and challenges the medicalization of misery. However, this study represents a “joining in” position, where we utilized tools of measurement that are still commonly accepted, but we would argue do not necessarily capture the breadth of human experience. Furthermore, although we did demonstrate a reduction in symptomatology, we would argue that there exist better scales for measuring broader issues such as those addressing more specifically other important areas of therapy such as self-esteem, meaning in life, relationships, and motivation that could be considered as client-related/attributable factors in change. We would also argue that when people present to their GPs stating that they experience anxiety and/or depression, these statements could be better understood as a person expressing that they are having difficulty in their relationship to themselves, to others, and within their worlds.

Therefore, while CBT may succeed some of the time, we would suggest that further research is needed to understand better the meaning and more detailed experience of anxiety and/or depression and that this type of approach is well situated to extend our knowledge.

However, there are clearly further limitations to the study presented here that go beyond simply the small sample size. We accepted that we are currently limited to evidencing our work in a manner that allows for comparison with other interventions by utilizing scales that center on symptom reduction. Thus, although we have demonstrated good effect sizes, we were limited by not utilizing scales of measurement that more closely resemble and assess the “wished for” outcomes or goals set by client, for example, having better relationships.

On average, the PHQ-9 and GAD-7 data shows a good and robust performance of the short-term therapeutic system in terms of effect on symptom reduction. With regard to CORE-OM as a pan-theoretic and pan-diagnostic scale, on average the effect observed on the score at the end of therapy was large but appeared of smaller magnitude if compared with the effects observed on the PHQ-9 and GAD-7 scores. This could be due to numerous factors, and it is definitely a sign that further enquiry is needed to clarify how good are these symptom evaluation scales in describing and evidencing the psychological difficulties of the clients. Recovering from a situation of general psychological distress is not the same or is not strictly related to a reduction in terms of generalized anxiety disorder or major depression disorder symptomatology (Shepherd et al., 2008). We believe change is a process of engagement with the distress that does not end with therapy but rather needs therapy to enable such a process to be delivered in a most effective and solid way.

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Author Biographies



Mark Rayner, MA, UKCP, qualified as an integrative psychotherapist and has practiced from an existential-phenomenological standpoint in the National Health Service and private sectors for 17 years. He is employed as a lecturer, course leader, and supervisor at Regent's University, London. He also supervises executive coaching organizations and provides advice to older persons' services and to a large children's charity. He has developed a deep interest in the application of existential-phenomenological approaches and what these epistemological positions have to

offer to the field of research and practice. He started a Community Interest Company EASE Wellbeing to further this work and to sit alongside large government and national programs for the delivery of psychological therapy interventions. He has an interest in research and demonstrating the opportunities for integrating existential-phenomenological approaches with humanistic principles to both supplement and challenge dominant ways of working in order to better address growing needs, entitlement of people suffering distress, and accountability of services to address demand in sectors with impoverished resources and inhibited service delivery models.



Diego Vitali, MSc, is a psychologist and passionate researcher. He qualified as a clinical psychologist at the University of Padua, Italy (BSc psychology 2006, 2 year + 1 year MSc clinical and dynamic psychology 2010). He has trained in Italy in the application of phenomenological and existential approaches to psychotherapy and clinical psychology in intensive care units. Having moved to England in 2012, he has worked for different charities in the field as a research consultant and data analyst. Currently employed by EASE Wellbeing as a consultant

and researcher, he is working on the evaluation of existential-integrative short-term interventions in the public sector that focus on young adults and adults experiencing psychological difficulties in the public sector. He is enrolled on the PhD program at Roehampton University testing and developing a novel approach to meaning-centered group therapy for chronic pain patients.