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Existential Experimentation: Structure and Principles for a Short-Term Psychological Therapy

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Abstract

This article follows and expands upon the description of an intervention that attained promising results with depressed and anxious patients in a feasibility study run in a U.K. primary care setting. This protocol for short-term existential therapy will also represent the primary reference for training and supervision of an ongoing pilot. The therapeutic approach described here aims to address in a constructive way the issues raised by the topical criticism around the application of the medical model in psychology. At the same time, this article will address the theoretical issues emerging, while trying to describe in a pragmatic way, how to apply an existential and phenomenological approach to low-intensity short-term psychological therapy. This short-term intervention aims to promote a proactive and creative engagement with clients with their personal difficulties and to attain recovery as a result of a greater sense of empowered resilience.

Keywords

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

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> *If One Is Truly to Succeed in Leading a Person to a Specific Place, One Must First and Foremost Take Care to Find Him Where **He** Is and Begin There.*
>
> [. . .] All true helping begins with a humbling. The helper must first humble himself under the person he wants to help and thereby understand that to help is not to dominate but to serve, that to help is a not to be the most dominating but the most patient, that to help is a willingness for the time being to put up with being in the wrong and not understanding what the other understands.
>
> —Kierkegaard, Hong, and Hong (1998, p. 45)

Aim

The aim of this article is to present Existential Experimentation (EE) as an intervention to support and empower clients in using their own living skills to understand and thus to face the inevitable struggles that life may present from day to day. We will present here a version of this model, which is based on an individualized assessment and six sessions of a goal-driven approach to therapy. This has been initiated as a compliment or challenge to the emergence within the public sector of the original implementation of the U.K. government initiative called IAPT, Improving Access to Psychological Therapies (Clark et al., 2009). EE was developed in the environment of the English National Health Service as an attempt to provide a framework in which counselors, psychotherapists, and psychological well-being practitioners utilize phenomenological principles in short-term interventions. This was conceived of and conducted in order to challenge the medical approach of contemporary dominant psychiatric and psychological practices, in which the experiences reported by the clients are validated and authenticated in terms of models of "illness."

Background

Seventeen years ago, Asay and Lambert (1999) analyzed decades of psychotherapy research and demonstrated that 40% of positive therapy outcomes are the result of what they termed *external factors* (now commonly known as "context-related" or "client-attributable" factors). This important research has shown that specialized treatment techniques are only responsible for some 15% of each positive therapy outcome, while the therapeutic relationship accounts for 30% of each outcome. More recently, a large meta-analytic study conducted by Cuijper et al. (2012), regarding the efficacy of nondirective supportive therapies for depression, attempted to partial out the contribution of factors common across various therapy models and confirmed both the crucial importance of the client-attributable factors and that of the

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therapeutic relationship in its multiple facets. It was reasonable to evince that what could make the difference in making therapy effective is for the most part dependent on two holistic factors: (a) the client-attributable and/or context-related factors; (b) the relationship with the therapist throughout treatment. Cooper (2008) has suggested that client-attributable factors are probably the most important determinants of therapeutic outcomes—accounting for the largest overall effectiveness of therapy, up to 70%. Particularly, the extent to which the client actively participates in therapy seems to be a strong predictor of such effectiveness (Orlinsky, Grawe, & Parks, 1994).

These findings connect with those of Norcross and Lambert (2011), which looked at investigating the evidence around the efficacy of the therapeutic relationship. This work compared more than 20 meta-analytic studies and investigated the most effective components characterizing therapeutic relationships. Their research showed that among the most effective predictors of a positive outcome of therapy are currently the following elements: (a) setting up and agreeing with the clients the goals for therapy and actively cooperating in attempting to achieve them (Orlinsky, Ronnestad, & Willutzki, 2004; Tryon & Winograd, 2011); (b) developing a good alliance that bridges the clients' needs and expectations (Norcross, 2002; Wampold, 2001); (c) being empathic, which is meant as the therapists' effort to understand their clients' experiences as they are perceived by the clients moment by moment (Elliott, Bohart, Watson, & Greenberg, 2011); (d) adapting the relationship to the different stages of change, and so being able to adapt to the different ways in which the client may relate to contemplating or engaging with change (Norcross, Krebs, & Prochaska, 2011; Norcross & Lambert, 2011; Rosen, 2000).

Modern approaches to psychotherapy have had a great influence in the way Western society makes sense of living difficulties, aligning themselves often with medicine or rationalism that tends to objectify the quality of experience (Summerfield, 2004). Boyle (2011) clearly challenges this modern psychiatric discourse, stating that these taxonomies do not fully recognize that both form and content of all human emotional distress or "disordered behaviour are systematically, meaningfully and inseparably related to social context and life experience" (p. 35). This protocol attempts to address Boyle's position by acknowledging that these dominant classificatory systems have a strong influence on both the power dynamic in the therapeutic relationship and on the narratives of our clients. Furthermore, other important psychiatrists and psychologists such as Szasz (1974), Bentall (2009), Kirsch (2014), and Rapley, Moncrieff, and Dillon (2011) have considered from a critical perspective the limitations of conventional psychiatry and its psychological therapy corollaries. This is particularly poignant in the work with clients that are still at an early stage of their psychological difficulty. The relevance for

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the population we address centers on being an active agent, rather than a medical patient. In other words, this therapeutic endeavor pays particular attention to the way that the clients respond to, encounter, and are inhibited by the worlds they live in.

According to Vos, Craig, and Cooper (2015) there are currently four main schools of existential therapies. The first is *Daseinsanalysis*, which was first devised by Binswanger (1963) and then expanded by Boss (1963) and provides a therapeutic environment characterized by some influence from the classic Freudian theories and the existential philosophy of Heidegger (1027/1962). Approaches that are similar to Daseinsanalysis also provide a breadth of openness toward the experiences of the clients and toward how they express their relationship with others and with the world. The second is the *British School of Existential Therapy* (Spinelli, 2005; van Deurzen, 2002), which is characterized by more prominent reliance on the phenomenological method of description and clarification of experience and has clear reference to the work of Laing (1965). The third school is *meaning* or *logo-therapies* (Wong, 2009), which focus on helping clients to engage in the process of establishing meaning and purpose in their lives. These meaning-oriented approaches use techniques such as Socratic dialogue (Frankl, 1985) and are being developed for both group and individual settings. The fourth school includes the *existential–humanistic* approaches (Schneider, 2016; Schneider & Krug, 2010; Yalom, 1980), which instead allows for psychodynamics and interpretative techniques applied in a therapeutic context in which clients face unavoidable givens of life like mortality and freedom.

The epistemological background of the approach proposed and described here shares similarities with all the four schools of existential therapy and in particular with the phenomenological approach to therapy described by Spinelli (2005, 2015b) and the pragmatic approach to short-term existential therapy delineated by Lantz and Walsh (2007). The EE protocol was conceived as an organic integration of the most influential existential approaches to therapy into a model for short-term therapy, and the reader will find explicit and sometimes subtle similarities with the schools mentioned above. However, this protocol represents a unique attempt to formalize a way to conduct short-term existential therapy with primary care clients. This approach is oriented toward empowerment and resilience in that it can help people find their own creative ways of dealing with the struggles for which they are seeking help. In the development of this particular type of short-term therapy, we adopted a phenomenological architecture to provide a rigorous framework. This allowed for an enhanced degree of creativity on the part of the client, together with an openness to how the relationship may shift and change during the sessions. As we discuss in detail below, this approach invites clients to describe and clarify a breadth of experience that expresses in great detail their experiences and

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their relationship to those experiences. EE is a particular approach to therapy that explores and naturally challenges the sense of definite-ness or stuck-ness often presented by clients in their current narratives. It further aims to promote the clients' own resources (e.g., of self-reflection) for a purposeful engagement with and understanding of their difficulties. The experimental nature of this approach is neither meant as some procedure "done" to clients nor as an idea prescribed by the therapist, or as a combination of the two. Rather, experimentation springs from the client and expresses a particular type of responsible-own-choice (Frankl, 1985) to take action (in a Franklian sense), to engage with experience in ways that may be un-familiar and potentially unstable but contingent. We think that this openness on the part of the client is strongly mediated by the capacity for a therapy to address, from a phenomenological standpoint, the tension between the current familiarity of the client's everyday ways of being (which may include the reasons for the consultation) and other contingent possibilities that may be un-familiar, unstable, and yet to be contemplated. In other words, this therapy speaks to a manner of engaging that assumes that the greater the capacity for this sort of openness in this therapeutic stance, the greater the possible openness for and with the client to consider their contingent possibilities, those that may be potentials for transcendence. In agreement with Spinelli (2005, 2015a), this perspective recognizes and welcomes the inevitability of change in our lives, while also acknowledging that, for clients to overcome the difficulties that they describe, they may be called to explore, choose, and engage with the meaningful possibilities that may be on their horizons, in life, or in therapy.

While this therapeutic approach is oriented toward understanding human difficulty and suffering in the manner that these emerge in the lives of the clients, we also aim to address directly the need to tackle stigma on both the personal level and on the public level, in order to increase the likelihood of the clients participating actively in their recovery (Corrigan, 2004). Therefore, this intervention is designed to be delivered in full by psychologists, psychotherapists, or counselors in the routine practice settings of general practitioners. By delivering this intervention in these settings, we specifically aim to address the stigma associated with attending professional, psychological, or psychiatric facilities to facilitate ease of access and attendance locally.

Existential Experimentation Protocol

De-Objectifying Psychological Distress

In order to understand the problem or problems presented by clients and to establish meaningful goals for this short-term intervention, the texture of this therapy is constituted by the rigorous application of a phenomenological

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method of description and clarification of the experience presented. In agreement with Spinelli (2015a), “Therapy concerns itself with the undesired, unexpected and unwanted disruptive consequences arising either from the experience of change or the inability to bring it about” (p. 5). This approach offers clients an engagement in a dialogue regarding the personal and subjective meaning of their current difficulties in a way that is related to their personal experiences and to their social contexts. This dialogue can be described as client-centric, where the therapist works as a facilitator encouraging clients will and capacity, both to explore, reflect on, and utilize their own interpretations of experience and, furthermore, to consider what and how their personal situations led them to reach out for help in therapy. It is very important that, from the outset, the therapist consistently seeks for the clients’ perspectives and descriptions without inferring or assuming anything about such perspectives (Morley, 2010). In order to direct full attention to the content presented by the client, the therapist employs a phenomenological reduction that can be summarized in two movements: (a) *Suspension*: the therapist attempts to bracket their presuppositions and all past or theoretical knowledge about the phenomenon (the clients’ discourse) that is not based on direct intuition and that is appearing to his or her consciousness; (b) *Openness*: the therapist attempts to withhold his or her own natural tendency to acknowledge some general or specific determination or definition of the observed phenomenon (Giorgi, 2012). Using a Socratic questioning style, the therapist exercises the position of the one who does not know anything about the nature, meaning, and context of whatever is presented: everything needs to be shown and described by the client before the therapist can understand it, before the therapist can see it in a way similar to the manner the client intends it to be seen. This phenomenological reduction is a difficult task which requires empathy and emotional receptivity, and also humility, a reflective attitude, patience, and practice (Bettelheim & Rosenfeld, 1993). The therapist here aims to shift the initial relational stance from a (passive) position where the client is presenting the problem to the expertise of the doctor to an (active) position in which the clients are called to show the therapist the ways and meanings of their distressing experience. In order to facilitate this process, the therapist needs to be firmly aware of two important principles: first, that despite the apparent clarity or self-evidence of any expressions of distress on the part of the client and despite any degree of similarity with other past or current clients, at this initial stage the therapist should actively attempt to embody the Socratic stance of “I know that I know nothing.” In fact, the therapist assumes that he or she does not know or see how the issue at stake is felt by the clients, and consequently cannot explain, describe, or change it for them. Second, and as a corollary to the first, that the clients are the only

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people in the room who are in positions of knowing, describing, or changing their presenting issues.

The application of these two principles aims to validate the clients' experience as it is presented by them and in the way it makes sense in their subjectively meaningful contexts. This is what casts the foundation of the therapeutic work to come. This encouragement and consideration allows clients to position themselves and to start to appreciate that they are always at the phenomenological center of their experiences.

Setting the Goals for Therapy

The setting of goals is a process constructed on the ground that is being prepared by the previous two notions aimed at de-objectifying distress and opening the therapeutic space in which the clients are at the center of their experience. In order to set the goals for therapy, the therapist directly asks the clients to describe how therapy may help them and what this help therapy might emerge as for the clients. Again, the therapist is stepping aside and supports the clients expressing how change might look like for them with all that is possible as well as problematic about such change. Aiming to maintain the central role of the client in the crucial process of describing what a solution of their issues may look like, the therapist here will adopt a similar questioning stance to the one described previously, but this time attempting to let the clients express (or start to elaborate) the narratives and consequently the discourse about what would (or could) be a meaningful and useful change in their life. The therapist's aim here is to allow the clients to begin exploring the discourse about how certain things are difficult and to welcome the clients' perspectives on these. The therapist here will also work closely with the clients, trying to understand and to make explicit the current cost as well as the possible benefit or gains related to those living experiences that are contemplated by the client in the arena of change. Agreeing with Spinelli (2015a), we would describe change as an inherent phenomenon of our life, a process that is characterized as being somehow unfamiliar and sometimes even unwanted, difficult, or troubling. In this sense, change always conveys some degree of tension between the ways in which we deal with this process: we may peacefully welcome it, we may reflectively accept it, or perhaps we may spend a great amount of energy to find ways in which we can try to reject or resist it (Spinelli, 2015a). In order to set goals for therapy in a way that is consistent with this perspective, it is essential for the therapist to be aware that: first, all experiences and the interpretation of those experiences are meaningful and purposeful (Frankl, 1985; Wong, 2009); second, that for clients change is an inevitable challenge to the security and constancy of the

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presented situation (whatever that is). In this sense, change always results from and within the tension around opposing or accepting certain representations or interpretations about change.

At this crucial stage, the therapist is interested in the meaning of the experiences that the clients present in the prospective notion of change. This process begins with the therapist aiming to attain from the clients' in the clients' own words a preliminary solution-oriented description of their issues and, therefore, a subjective representation of how the clients would like change to appear. In order to do so, the therapist will primarily contemplate how the distressing experiences are articulated and described and, most important, how the clients think or see that any change might be beneficial to the currently adopted positions.

This inquiry is a continuation of the phenomenological approach, which we expressed as a rigorous method of observation and a suspension of beliefs on the part of the therapist. At this stage, the therapist focuses on the following:

1. The immediacy of experience, that is, understanding the issue at stake and its impact in the lived experience of the client avoiding abstract interpretation and/or causal explanations or generalizations
2. How certain facts, events, and consequent solutions are perceived by the client, that is, as above, understanding how the solution fits and feels from the clients' perspectives
3. Contemplating with a humble and empathic attitude how meaning unfolds from the narratives (Spiegelberg, 1972)

Through the application of the phenomenological method of observation, the therapist attempts to get attuned to the clients' unique ways of making sense of their problems and of the possible solutions. The therapist will ultimately let emerge the first representation of the goals of therapy as based on a client-centric and client-determined phenomenological understanding of what is the purpose of the work together. In this way, the goals appear as highly contextualized and narrative-rich descriptions of change that are elaborated by the clients and that provide the therapist with ideas, anchors, and clues for all the next phases of the work.

Elicit Descriptions and Narratives

The clients' narratives, and also our own narratives as human beings, are the forms and also the process through which we attempt to order the world and our experiences in a subjectively and meaningful way (Stanghellini, 2011).

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However, it is to be noted that world is neither meant as the mere totality of entities which can be said to be part of the physical and proximal surroundings, nor is intended to mean world like a particular realm, such as the world of primary school teachers, or the world of the bus drivers. Instead, world is meant here as that "wherein" someone can be said to live, the same "wherein" that the client inhabits and in turn co-creates. This same world is the one lived in with the therapist and the others (Cohn, 2002).

The work of the therapist has so far focused on setting out the possibilities of the therapeutic relationship as an encounter that centers on the description of the ways in which the clients' lives are problematic, and the ways in which their everyday lives can be reconstrued. Once the first two principles are applied, the therapist and the client would have achieved a clearer and goal-focused description of the issues emerging from the problem or difficulties presented. At this stage of therapy, the therapist is adopting a supportive role to encourage client to remain able and willing to maintain an active position at the center of the therapeutic endeavor. Moving forward from this stage, the therapist explores in more detail the experiences of the client by continuously moving his or her attention away from the content of the narratives to the texture of them (i.e., from the constituted content to the constituting process). Thus, this therapy works primarily by stimulating the process of description of the lived experiences, but then goes further and explores the meaningful relationships between clients and their experiences, and their relationship with the inescapable givens of their existence that cannot be changed and must be acknowledged and accepted. In the effort to fuel and motivate the descriptive and interpretative work of the client, it is important for the therapist to both let the narratives emerge, while also being curious about how different parts of the content relate to each other and to the emergent discourse.

In other words, the initial stages illuminate the landscape of the living experience of the clients. Then the work turns its attention to the relationship that the clients have with their experience, in an attempt to disclose first what is experienced then how it is experienced. This is what reveals the fundamental attitudes, values, beliefs, and assumptions about the person having the experience not just what the experience appears as. Because of the characteristics of this approach, some clients may start to express a lot of content, or perhaps attempt various rationalizations or speculations in order to explain or to impress on the therapist the validity of the content. The work of the therapist here is crucial, because at this stage the therapist needs to: (a) help the clients maintain their reflective attitude oriented toward the process rather than the objects of their experience, that is, more content is useful if it helps to cast light through reflection, but it is not useful if instead it contributes to

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burying the issue at stake; (b) help the client avoid engaging in explanations and rationalizations, instead maintaining reflections on and descriptions of how certain aspects of their lived experience make sense the way they do.

This particular way of approaching the clients' description of difficulties is coherent with a pivotal theoretical principle in existential therapies and that is often referred to as *relatedness* (Spinelli, 2015b). In this perspective, the key element of change is articulated as a co-constituted process aiming toward the client becoming reflective and self-conscious. This is a further manner in which this approach integrates organically ideas from the different schools of existential therapy, as it promotes an attitude whereby agency is co-constituted and ownership is "released" toward the clients' presentiment. In particular, it is recognized that this itself may be troubling, but is a key to the successful outcome of such an approach as has been shown. However, as also stated by Gallagher and Zahavi (2012), even though we are always prereflectively self-conscious, in reflection we are directing our attention in some way that we can distinguish the reflecting experience from the personal interpretation of the experience reflected on. This distinction is central to an intervention like the one proposed here because the application of a phenomenological method depends largely on this type of reflection (Gallagher & Zahavi, 2012). According to Spinelli (, 2015b), this circular process of describing and understanding undertaken by the client being with the therapist leads to inevitable shifts in the way the world presents itself. Thus, the therapist's enquiries and reflections aim to stimulate the clients to reflect, re-interpret, and describe again the issues to the therapist. This process is aimed at promoting a *continuous hermeneutic* (Giorgi, 2007) that may potentially uncover new ways of "seeing" that emerge from the clients' own perspective.

Promoting the Client's Own Hermeneutic Work

The kind of encounter described so far is one via which the therapist aims to avoid adopting a relational stance referred to *I-it* by Buber (1958; e.g., the typical attitude of observing a certain object). Rather, this approach promotes an attitude in which the therapist will acknowledge the presence of the other as the co-constituting counterpart of whatever is emerging in the encounter. In other words, the therapist aims to "become one" with the client and thus to explore the meaning of the presented experiences as it is being co-constituted in the here and now in therapy. The importance of this particular stance has its theoretical reference in the phenomenological distinction observed by Buber (1958) between the I-It and I-Thou relationship, and it also aims at describing the therapist's strenuous attempt to be open toward the unstable

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and co-created characteristics emerging in the engagement with the client (Spinelli, 2015b). This is another feature that distinguishes this type of therapy from other short-term interventions, where those aspects of "being a person" are commonly articulated as "things" in an I-It manner.

The core of therapy has been characterized by a relational environment in which the clients are engaged in a continuous hermeneutic work facilitated and supported by the therapist so far. From the therapist's perspective, the hermeneutic work carried out in this context of reciprocal intentionality aims to stimulate the emergence of the possibility for change as something being discovered and co-constituted in the context of therapy. In order to do so, the therapist proceeds in a circular manner by first letting the client describe their particular experiences and then by wondering in a genuine way about how these relate to the rest of the content and to the whole. In order to "wonder" in an effective way, the therapist needs to continuously maintain the effort to stay attuned to the current experiences of the clients by (a) welcoming and accepting the narratives of the clients as a whole without trying to rationalize or adjust them; (b) horizontalization (Langdridge, 2007), that is, giving equal importance to all the presented content including the sharp and fuzzy elements, including the gaps; (c) embracing the lived experience presented by the clients in the here and now. These three points represent the therapist being attuned to the mood or demeanor of the client. This kind of sensitivity and attunement to the current processes engaged by the client is also very important because it allows the EE therapist to shift the dialogue in a flexible way between narratives, reflections, and descriptions. This is important, as it facilitates and maintains the active nature of the hermeneutic work of the client. In other words, the therapist must not picture the six stages presented here in a sequential manner, but instead as overlapping and adaptive layers with which the clients is continuously engaged.

Worldviews and Givens Within the Context of Choice and Responsibility

In his existential philosophy, Heidegger (1927/1962) referred to the human being as *da-sein* and used this term to specify the dual nature of us as both being-there and being-concerned-with. Yalom (1980) refers to this specific idea by saying that any individual as a human being "[. . .] is 'there' (*da*-), but also he or she constitutes what is there." As Yalom continues, "The ego is two-in-one: it is an *empirical* ego (an objective ego, something that is 'there,' an object in the world) and a transcendental (constituting) ego which constitutes (that is, 'is responsible' for) itself and the world" (p. 220). From the perspective of practicing this intervention, how is this dual *being-there* and

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being-responsible addressed in therapy? Spinelli (2015b), but also other existential approaches inspired by the work of Frankl (1985), and more recently by Wong (2010), states that individuals are responsible for themselves, their choices, their freedom, and, consequently, their ways of being involved and engaged in the world. Thus, the EE therapist will consider and understand freedom and choice as part of the inescapable interrelationship that exists between the clients and their natural world as being-there (Spinelli, 2001).

In agreement with Spinelli (2005), the process of supporting clients' self-reflection and self-examination of personal assumptions about self and the world will unavoidably enable a process of change in how clients see and attribute meaning to experience (Spinelli, 2005). Thus, at the heart of this therapy, emphasis is given to both reflection and interpretation (used in a dynamic and interactive manner), that the therapist directs toward the clients in two ways: First, by considering the client as being primarily related-to and always involved-with the world and with the others; and second, by considering the client primarily bounded and limited by certain givens of existence that cannot be changed or rejected and must be accepted (Schneider & Krug, 2010; Yalom, 1980). In this way, the therapist supports the clients in assuming a position in which they are able to observe, describe, and reflect on the impact, the meaning, and the usefulness of certain ways of making sense of the world that have become "sedimented" aspects of the clients' experiences (Spinelli, 2015b; Wong, 2010). At the same time, the therapist helps the clients maintain contact with the unavoidable facts (existential givens) that inevitably impose certain limitations. In other words, there are limitations to the possibilities of experience and so there are limitations to the choices that can be made in order to respond to what life presents to any person. In order to achieve these two premises, the therapist should pay particular attention in helping the clients come to terms with their continuous and unavoidable engagement with their natural environments and, consequently, that the choices are not boundless like the common use of these words is often inclined to suggest. Instead, freedom and choice are meant here as both always and only possible if and when we as (human being) are able to see, recognizes, and accept our own determined-ness. Confronting these dynamics in the manner that is guided by this phenomenological approach can be a difficult process. This requires the therapist to both be able to observe and empathically detect subtle changes in the clients' ways of being-with the therapist, and further to be able to shift his or her role from a challenging to a supportive one.

At this point the therapist is committed to be with the clients while engaging with the meaning of their experience in an open and creative way. Exploring clients' relationships to their natural worlds is a well-accepted

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principle in the field of existential psychotherapy and it is argued as crucial to proceed toward a wider understanding of the clients' way of being in the world (Spinelli, 2005; van Deurzen, 2002). In this sense, the therapist promotes an attitude with clients to assist in their taking up a position or positions at the center of their experience by restating a sense of "responsibility" and "choice" with respect to those positions that encourage them to "be" in certain and particular ways, given the possibilities open to them. From a Franklian perspective, the current ways of being of the clients may be seen as a result of the way they are choosing to respond to whatever it is that their life is calling them to respond to. In this perspective, this approach recognizes that for any change that therapy may elicit or catalyze (e.g., via the clients re-construing meaning, understanding themselves, or even changing their behavior). These choices must be made in a context in which clients are able to both distinguish and accept the givens of their existence. In this sense, this model of existential therapy aligns itself with ideas proposed by Sartre and Barnes (1992), for whom "an existential therapy will bring into the light the subjective choice by which each living person makes himself a person" (p. 574).

"Experimentation" in the World

The experimental nature of this approach is about the person experimenting with possible aspects of the self-construct as contemplated in therapy. In this sense, the therapist encourages clients to experiment with those ideas and worldviews that emerge in the space and process of therapy to seek possibly more adequate stances toward their experiences and achieve their goals or wished-for positions and potentialities. This allows for the major challenge of this therapy: through the maieutic work, the therapist aims to acknowledge and validate the positions and concurrent views of the world (worldviews) which are meaningful but perhaps are no longer desired (Spinelli, 2005). It is crucial for the purpose of this short-term intervention that the clients engage with the help of the therapist in a personal discourse in which the givens of their existence, their current worldviews and their goals for therapy as positions that are wished-for are always present.

Thus, 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, 2012, p. 389). The *experimental* nature of therapy has, therefore, nothing to do with experimentation meant as an experiment conceived of by the therapist or by the therapeutic system, in general. Instead, the therapist supports clients in enabling the temporary suspension of their current way of being (self-construct), then challenges clients in experimenting with the therapist in vivo and, subsequently, in their

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own natural worlds. As soon as the clients acknowledge and connect with that which really matters in their lives together with that which on the other hand is holding them or preventing them to change, they then naturally start to engage in a purposeful process of adjustment of their life paths (Schneider, 2016). In other words, experimenting with that sense of self-construct as wished-for, expressed at the outset as goals. Therefore, this means to experiment with a "temporary" and not yet defined sense of self-construct. Clients are supported in focusing on the determined effort to reach toward an as-yet undiscovered sense of self-construct that, although uncertain and unfamiliar, may be less impeded and has been expressed as desired (Woods & Hollis, 1999). This shift in the sense of self-construct does not spring from the suggestions or direction of the therapist, but instead emerges from the phenomenological reflection of the clients regarding their sense-of-self-as-stuck in sedimented views of experience and then as leaning toward a sense-of-self-as-not-yet-clear. The therapist recognizes and acknowledges the struggles this may involve in moving away from a familiarly experienced sense of self and embracing issues of uncertainty. Consequently, the therapist supports and encourages clients to face this difficult task as an opportunity for growth, and for challenging possible fears with a sense of hope and potential.

Constantly across these middle sessions and hence toward the final sessions of therapy, the focus remains consistently on maintaining a reflective attitude toward progress and obstacles (Mølbak, 2013). The therapist's disposition toward enabling the hermeneutic work of the client works in circular manner and aims for the clients to make sense of the new certainties and new discontinuities emerging through or because of the experimentation process. The final session of therapy aims at highlighting the strengths and the achievements of the clients in terms of existential skills that can be applied in similar or other situations of difficulty emerging in their daily life, therefore, therapy generalizes out what has been achieved during the therapeutic process.

Discussion

We have outlined above an overview of a particular version of this approach to treating clients with mild-moderate psychological difficulties in primary care (statutory) settings. Due to the context in which this approach takes place, it becomes possible to reduce waiting times as clients are seen in GP practices, normally close to their places of residence. This promotes a proactive and creative engagement by the clients with their personal difficulties and enables the process of recovery as a result of empowering a sense of resilience. Importantly, this approach challenges stigma by providing treatment in these premises, where they routinely visit for all manner of normal

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health concerns, as opposed to psychiatric environments, thus also reducing costs of these types of expensive facilities. This therapeutic approach challenges the dominant discourse around the medical model of illness that has been influencing the design and modeling of psychological interventions within the U.K. National Health Service care guidelines (NICE) for many years with great controversies (Conrad, 2008; Frances, 2013; Rapley et al., 2011; Timimi, 2014). In our view, diagnosis is driven by professionals and, while it may provide some comfort to the person to know that there is a name for the "thing" that they experience as troubling, this complicates the treatment of individuals in several ways. In fact, while it is incredibly difficult to be accurate in the diagnosis of psychological problems (Aboraya, Rankin, France, El-Missiry, & John, 2006), receiving a diagnosis creates a position both of entitlement and one of illness and stigma (Rössler, 2013), that can reduce a sense of personal responsibility and agency. We designed this integrative approach with the intention of deconstructing the objectification of human distress so that this process would enable therapists and clients to address the breadth of human experience and personalize the intervention as much as possible. We addressed the notion of accountability of services by promoting a more realistic sense of collaboration, rather than a diagnostically driven system that encourages compliance toward a specific goal of treatment identified by the clinician.

We have shown how the aims and objectives of this treatment are personalized and delineated during the first sessions by the client and how this is done in a context that promotes a sense of ownership and agency for clients. At the same time, we appreciate that it is important to delineate what it is that represents the architecture within which this work takes place. Thus, this article follows and expands the description of an intervention that attained promising results with depressed and anxious patients in a feasibility study run in a U.K. primary care setting (Rayner & Vitali, 2015). The present work represents a more detailed exploration of the procedures that are now being currently implemented in the training and supervision of therapists in an ongoing pilot. The process of operationalizing the practice to demonstrate adherence to certain procedures is a difficult task as it creates a tension that we address in a relational sense and thus via a truly collaborative endeavor with both the clients and the service providers and via recognizing the need to deliver robust evidence of efficacy and effectiveness.

Even though the development of the therapeutic approach described in this work is not definitive and will continue to evolve with this research, we can anticipate that the procedures will never achieve the algorithmic-type of precision present in other more label-driven approaches, as we think that

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every human being and their relationship to their therapist and their difficulties remains at some level individual.

All human beings experiencing or having experienced psychological difficulties do wish to change and recover, whether the change is one of understanding of self or other or the world or another form of change. Finally, we have argued that change in notions of self-understanding is a valid and measurable form of change, rather than limiting the measurement of change to reduction of symptomatic behavior or cognition. This notion of change allows for a sense of client-directed change that we argue is a more robust and lasting form of change, since it emerges from the explorations of the client with the therapist but more research is needed. However, this protocol represents one way to re-construe the notion of recovery as distinct from the medical notion of symptom cure. In our perspective it is the preparation with the person to face their psychological struggles and the ability to manage them independently that we define as recovery or good psychological health.

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