Counselling Psychology Doctoral Thesis:

THE EXPERIENCE OF EXISTENTIAL EXPERIMENTATION FROM THE SERVICE USERS' PERSPECTIVE IN PRIMARY CARE

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Statement of Authorship

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Abstract

Psychological therapies provided within primary care and of particular interest to this study, counselling psychology within primary care, are becoming increasingly homogensised. This is largely due to the need for therapies to demonstrate a robust evidence base, work alongside the medical model and meet the complex needs and restraints inherent in a primary care setting. Yet, the theoretical literature would suggest that existential-phenomenological therapy, a core modality of counselling psychology, could be aptly positioned to address the challenging requirements of primary care. The recognition of existential-phenomenological therapy as part of primary care's service provisions could have a three-fold impact; it could facilitate primary care's need to address clients' diverse needs, ensuring that there is flexibility and a choice of therapies within the National Health Service (NHS), it could also enable counselling psychology to work within an NHS setting, whilst maintaining its core attributes and values. Finally, to be recognised as an effective psychological intervention in the NHS, is a measure of success for existential-phenomenological therapy.

Existential Experimentation (EE) is an individualised short-term, goal-oriented psychological intervention, that was designed for primary care. The EE intervention is existentially-informed and was developed by EASE Wellbeing to promote wellbeing and recovery for individuals with anxiety and/or depression. Studies suggest that the EE intervention is effective at reducing symptomatology, perceived psychological distress and attaining client-determined goals (Rayner & Vitali, 2015). Similarly, the initial qualitative data on client-determined goals attained in EE, allows for positive optimism (Rayner & Sayers, 2016). However, the qualitative data is limited and the service users' experience of the EE intervention has not been explored. Therefore, qualitatively enquiring into the EE intervention from the service users' perspective seems key to inform current and future provisions of EE in primary care. Consequently, this study aims to gain an understanding of the service users' experiences of EE; to assess what were the more and less useful aspects and capture if, what and how change took place. The researcher held a placement with EASE Wellbeing and therefore acted as an 'insider researcher', with considerable experience implementing the EE protocol within primary care and a comprehensive understanding of the intervention.

Seven participants who had all completed EE in primary care were recruited. Two semi-structured interviews were conducted; the initial interview took place two weeks after the

completion of therapy and the follow-up interview was three months post-completion of therapy. Interpretative Phenomenological Analysis (Smith, 1996) was used to analyse the data, in order to highlight convergences, divergences and nuances in the participants' experiences of the therapy.

The participants described their experience of EE as a journey and thus the three superordinate themes that emerged from the research consisted of: the experience of beginning EE, the experience of the EE therapeutic work and the experience of leaving EE. The ten subordinate themes were comprised of: loss permeating existence, living behind the mask, in search of how to be, the value of a personalised approach, how the therapeutic relationship is key to change, stepping stones to awareness, key ingredients of client openness and active participation, reaching new awareness and personal meanings, towards acceptance and authentic living and short-changed by time. This research can inform the current and future service delivery of the EE intervention and existential psychotherapy and counselling psychology in primary care more generally. Moreover, it provides practice-based evidence that may aid a dialogue between existential-phenomenological therapies and the medical model.

This study will form part of the researcher's Doctorate in Counselling Psychology at New School of Psychotherapy and Counselling and Middlesex University.

Keywords: Existential Experimentation, Existential, Phenomenological, Counselling Psychology, Psychotherapy, Short-term, Time-limited, Brief Therapy, Primary care, Interpretative Phenomenological Analysis

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Research Question:

The experience of Existential Experimentation from the service users' perspective in a primary care setting.

Conventions

When referring to existential therapy or existential-phenomenological therapy, this encompasses a number of therapeutic schools and practices that are associated with the practice of existential and/or phenomenological therapy, so for the purpose of this study these terms will be used interchangeably. Additionally, like Spinelli (1994), I do not feel that it is possible to make a differentiation between counselling and psychotherapy that will be generally accepted and thus I have used the terms interchangeably, or substituted them with the broader term 'therapy' (p.39). Likewise, 'therapist', 'clinician' and 'practitioner' have been used interchangeably. Also, the terms 'service user', 'client' 'participant' and 'individual' are undifferentiated in this research study.

The research study has been written in the first person, as advocated in qualitative methodology literature (Forester, 2010).

Acronyms

BPS	British Psychological Society
CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CoP	Counselling Psychology
EASE Wellbeing	Engaging Activity Supporting Existence Wellbeing
EE	Existential Experimentation
EP	Existential-phenomenological
EPT	Existential-phenomenological Therapy
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence
NSPC	New School of Psychotherapy and Counselling
PCT	Personal Construct Theory
RGT	Repertory Grid Technique
UKCP	United Kingdom Council for Psychotherapy

Introduction

Primary care is the gateway to psychological interventions in the NHS and as such it plays an integral role in mental health care in the United Kingdom (UK). Due to the ever-increasing demand for psychological services and importance placed on accountability, there has been a drive to increase accessibility to empirically-validated psychological interventions at this level. A side effect of the current climate in primary care has been an increasing homogenisation of psychological interventions and yet client preferences in the decision-making processes of evidence-based treatment have been revealed as important to outcomes (Swift & Callahan, 2009). Accordingly, it has been acknowledged that there is a vital need for choice and flexibility to be integrated into all future service provisions in primary care (Cooper & McLeod, 2010; IAPT, 2012).

Research into existentially-based therapies is sparse, particularly within NHS settings, however theoretical literature would suggest that it could be a good fit for primary care, particularly due to its celebration of diversity (Koebbel, 2016). Moreover, counselling psychology's (CoP) status as a distinct profession is at risk in the NHS, due to its core values of pluralism being put into jeopardy as a result of it striving to meet the demands of the NHS (Woolfe & Strawbridge, 2010). But, existential therapy as a core modality in CoP, if recognised within primary care, could offer a way for CoP to maintain its core values, whilst working alongside the medical model.

Existential Experimentation (EE) is a short-term existentially-based intervention that was designed to meet the demands of primary care, whilst holding onto core existential values. There is a growing body of quantitative research revealing positive outcomes for EE (Rayner & Vitali, 2015), however there is no existing research into how the service users' actually experience it, thus the reason for this research. The aim of this study is to facilitate an understanding into the experience of the EE intervention from the service users' perspective in primary care. It hopes to detail what EE looks like in practice, how it is experienced and client-reported outcomes. But, more broadly it hopes to instigate a dialogue about how an existentially-based intervention could fit within primary care, what it could offer and the challenges to be grappled with.

The resulting research project has been divided into six chapters. In Chapter 1, I will introduce myself as the researcher. This will take place before Chapter 2 outlines how the literature review was conducted and situates the research topic. To situate the research topic, the contextualisation of primary care, counselling psychology and existential-phenomenological therapy will take place, as well as a review of the existing research and literature in the subject area. I will introduce Existential Experimentation (EE) as an intervention and review the existing literature and evidence for EE. This will be followed by an outline of the rationale for this study, and a presentation of the aims to be addressed by this research.

Chapter 3 relays the thought process behind the choice of research methodology. It will introduce Interpretative Phenomenological Analysis (IPA) and provide an account of how the research methodology aligns itself with the epistemological position underlying the research.

Chapter 4 describes the sample of participants and the procedural steps of the data collection and data analysis are clearly outlined.

Chapter 5 provides a detailed account of the IPA findings. This should enable the reader to feel immersed in the data and also ensure transparency in how participants' statements were developed into themes. The findings are ordered in accordance with the three emerging superordinate themes, that of 'the experience of beginning EE', 'the experience of the EE therapeutic work' and 'the experience of leaving EE'.

Chapter 6 honestly evaluates the quality of the findings and the limitations to the research design, before discussing the findings in light of existing research. The implications that the findings have for clinical practice are argued and ideas for further research are suggested.

Chapter 1: Introducing the Researcher

> *"As therapist and/or researcher we are part of those relationships, each partly influencing, informing and shaping the ways knowledge is co-created and stories are told" (Etherington, 2016, p.3).*

As, du Plock (2004) asserted, the notion of a neutral, objective researcher is as ludicrous as the notion of the neutral, objective therapist. As such, my identity as the researcher, my sense of who I am and my relationship to the research topic is a crucial factor in what can be illuminated, as with the practice of therapy. This subjectivity that is highlighted in the citation from Etherington (2016) above, is characteristic of practice-based research and is seen as a resource, not an obstacle in IPA (Parker, 1994). That said, in rejecting the possibility of a neutral researcher, it is necessary to start by describing 'where' I am in terms of the research angle from which I enter this topic. As du Plock (2016) suggests of researchers, I need to declare and describe clearly my values, assumptions and the trajectory of inquiry that I take in relation to the topic under investigation. This is so the reader can be alerted to possible alternative perspectives, as well as the perspective presented and possible biases being offered by the research. As such, I will be transparent about the position from which I commenced the research on a professional and personal level, as this will have inevitably impacted the research (Etherington, 2004) and I will relay the integral position that reflexivity takes in this research.

The starting point of this research was my own experience of therapy within the NHS. As an adolescent, I received treatment through CAMHS for psychological difficulties and I felt that my subjective experience was not attended to. I was not given a voice to describe the meaning and function of my symptoms, or to relay my experience and instead my symptomology alone was treated. Consequently, when I was old enough to make my own choice, I sought my own methods of recovery. This was a long journey which ultimately led me to discover EPT and to subsequently train as an existential counselling psychologist.

I was drawn both to the EP approach and CoP, due to the focus on the client's subjective experience and the fact that the therapeutic relationship is put at the centre of the therapeutic work. They both represented the experience that I had been wishing for during my own struggles and I hoped that I could offer an approach adhering to these core values and principles, to prevent others from having a similar experience to my own. I felt driven to treat clients as

experts in their own lives and offer a choice of therapies tailored to individual needs in NHS settings. This is what led me to acquiring a placement to deliver an EP intervention within primary care and also to be determined to research client experiences of therapeutic interventions.

I started to formulate the research question when I was working within primary care, in an EP way, which put the consideration and exploration of a client's personal meaning of their symptoms and situation at the forefront. I began to plan the research project as a way of articulating my experience of the EP intervention and how I felt it offered something unique to primary care. I began to record my process and curiosity about whether this belief was based on my own biases (for example, that I would have desired an EP-based intervention to be available when I received treatment through the NHS), or if in fact the clients also seemed to share this belief. I was taken aback when I discovered that an approach emphasising the subjective experience and autonomy of the client had a considerable quantitative evidence-base, but the clients' perspective of the intervention was missing and the qualitative research was minimal. It was from these reflections that I became acutely aware that as clinicians working across varying modalities, we too often make assumptions about what is working for clients. Therefore, I decided that I wanted to give a voice to the clients experiencing the therapy, to say what worked and what did not work for them. It was at this point that the exploration began to shift from, as du Plock (2004) discusses, a naïve quotidian acquiring of information, to a more systematic research enquiry. To elaborate, Barber (2006) distinguishes a naïve enquiry from a research enquiry as:

> *"To qualify as research, your inquiry must involve a careful searching, your method of collecting information must be located within a recognizable methodological tradition, and you must demonstrate systematic investigation and critical refection upon both what you are doing and how you are doing it. You need also to illuminate both your motivation and rationale and what influences you at the time" (p.89).*

Before continuing to how I collected information and began to systematically investigate the topic, I will describe the professional angle from which I entered the research further, to ensure that I am being transparent about the potential influences upon this research. On a professional level, I entered the research as a trainee counselling psychologist, with EPT as the core modality. As such, I was very aware of the drive for evidence-based interventions and the fact

that short-term existentially-based therapies have limited application within the NHS, partly as a result of this. It is essential that clients should have a choice of interventions and that therapy should be tailored to their individual needs, however this is currently not the case in the NHS, due to the demand for evidence-based practice. Therefore, my desire to generate an alternative or complimentary therapy to existing evidence-based interventions, in order to increase the choice of interventions available to meet individual needs, is considerable.

Moreover, I conducted this study as an 'insider researcher'. As Costley, Elliott and Gibbs (2010) convey, the 'insider researcher's' unique "organisational, professional and personal context will affect the way a piece of research is undertaken" (p.1) and therefore I will be very clear about my role within the organisation. When I started this research, I was working as a Voluntary Practitioner at EASE Wellbeing and one year on I was appointed as a Clinical Lead. At this point, I was responsible for the intervention's expansion to a new GP surgery in Oxfordshire, as well as being involved in discussions with commissioning groups, managing and supervising trainees. Though in the later stages of this research my involvement with EASE greatly reduced, I am aware that I entered the research with a comprehensive knowledge of the intervention under study and a strong vantage point.

I do not feel that I entered with a bias towards extracting positive over negative feedback on the approach, as first and foremost I wanted to hear the clients' perspective. I also take the view that all feedback is essential for a thorough examination of the intervention and its future development. Nonetheless, on the wider horizon, I hope that this piece of research will add to a larger evolving body of research, which may either aid the expansion of, or at least a dialogue about the potential expansion of the particular EP intervention under study, or EP therapies in primary care or the NHS more generally. With this in mind, it is clear that the findings impact me on both a personal and professional level and hence rigorous attention to researcher allegiance bias was essential (Luborsky et al., 1999).

Nevertheless, I feel this 'insider's research' is justified as there can be a real benefit to such an involvement with the research topic. As du Plock (2016) suggests, EP therapists should take seriously the possibility of grounding their research in subjective experience and naïve enquiry, stating the following:

> *"While it is not always the case that the researcher is prompted by direct, personal experience to embark on their enquiry, the resulting study in impoverished and, I would argue, less informed by phenomenology if the self of the researcher is not reflected upon. We might, in fact, speculate such reflection is even more important when the researcher's motivation for exploring a phenomena is unclear, or is 'hidden' behind the adoption of a 'phenomenological method'" (p.15).*

As such, I value my position as 'insider researcher' and my personal journey leading me to this research, but at the same time transparency and reflexivity has taken a prominent place in this research, in order to check my decision-making processes and my impact on the research, to ensure validity and credibility (Fox, Morton & Green, 2007).

Behar (2014) writes in a text about humanistic anthropology, that researchers who locate themselves in their own texts forfeit the defensive position of 'scientific observer' and this is exactly what this research aims to do. She states that this does not require a "full-length autobiography, but it does require a keen understanding of what aspects of self are the most important filters through which one perceives the world and, more particularly, the topic being studied" (p.13). I hope that this section has made appropriate movements towards this position.

Chapter 2: Literature Review

This chapter will start by describing the purpose of a literature review, as well as outlining the approach taken to searching for literature relevant to this study. This will be followed by the research being situated, with primary care, CoP, and EPT being contextualised. This will include a discussion of what is meant by evidence-based research, how this is used for determining the efficacy of therapies and has resulted in the promotion of specific orientations over others. The implications that evidence-based practice and research has for existentially-based therapies and thus also the EE intervention under examination will be highlighted and finally, the reader will be introduced to the EE intervention; its characteristics, conceptualisation and existing research-base.

Searching the Literature

A literature review was conducted, in order to sensitise myself to the topic of interest and survey the landscape of existing literature in the field. This was to establish if there was scope for me to explore something new in the area of interest and open up possible areas of enquiry (Bowen, 2006), that would be a valuable contribution to the knowledge-base of CoP and EPT. Boote and Beile, (2004) relay that "if the literature review is flawed the remainder of the dissertation may also be viewed as flawed because 'a researcher cannot perform significant research without first understanding the literature in the field'" (Randolph, 2009, p.3). Moreover, Zhu and Cheng (2008) describe how "The selection alone of a literature review is a sophisticated academic skill; the literature review must be current, comprehensive in its range, and demonstrate awareness of the chronological sweep of relevant fields" (p.134) and with this in mind diligent attention has been paid to the literature reviewing component of the research.

As such, initially I searched the literature using 'berry-picking' (Bates, 1989) and 'snowballing' (Ridley, 2012) techniques to get a scoping review of the range of existing literature on the main topic. I followed reference lists and focused on key authors in the field, following research and placement supervisors' recommendations to find further eligible studies. Additionally, I sourced journals and theses, via the British Library's online resources, such as EThOS and used conference materials. This iterative process was carried out for the duration of the research.

Following this, a more systematic review of the literature was conducted, with keyword searches in research databases, such as EBSCO, MEDLINE (Pubmed), EMBASE, PsychINFO, Web of Science, and the Cochrane Library Database. The last search was conducted on 11th December 2018, with the following combinations of keywords:

1. Time-limited, Short-term, Brief
2. Existential, Existential-phenomenological, Phenomenological, Existential Experimentation
3. Intervention, Therapy, Psychotherapy, Counselling Psychology
4. Primary Care, National Health Service, NHS, GP Practices, Public Sector

Table 1: Results of the Literature Search

Databases	Combination of Search Terms			
	1 + 2 + 3 + 4	2 + 3 + 4	2 + 3	1 + 2 + 3
PsychInfo	291	14,703	26,037	898
Medline (PubMed)	160	7329	10,042	243
Web of Science	203	185	183	200

Applying these keyword searches retrieved a plethora of literature, as you can see in Table 1, which I narrowed down by reading the studies' abstracts to identify their relevance to the current study. Literature was also searched for in relation to the design, methodology, reflexivity and ethical considerations of the study, however this was done in an exploratory 'berry-picking' and 'snowballing' format.

Situating the Research

I will outline the characteristics of psychological therapies in primary care within the NHS and follow this with an introduction to the characteristics of CoP. I will describe how CoP's values are closely aligned by EPT and therefore its position as a core modality within CoP, seems well placed. I will then relay the significance of EPT within a primary care setting and discuss the relevance of this to CoP and psychotherapy. This section aims to highlight the clinical significance of this study by situating it within its wider context, a key tenet to a study's validity (Yardley, 2008).

The Characteristics of Psychological Therapies in Primary Care

Mental health is the largest single source of disease in the UK, no other part of health care has the same prevalence, persistence, breadth and impact (Royal College of Psychiatrists, 2010). One in four adults in the UK are diagnosed with a mental illness, one in five adults report mental health issues, without being diagnosed and one in six experience anxiety and depression (Craig, Fuller & Mindell, 2016). The most common is depression (19%), panic attacks (8%) and general anxiety disorder (6%), however only three percent of all adults' report attending therapy, including those without an official diagnosis (Craig et al., 2016).

The NHS is the main public provider of mental health services in the UK and has implemented a stepped care model, with the main steps consisting of primary, secondary and tertiary care (Bower, 2000). Primary care is in a unique position within the public health system, because for individuals accessing mental health care, it is their first and main point of access, with approximately one in four General Practitioner (GP) consultations concerning mental health difficulties (Joint Commissioning Panel for Mental Health, 2012). Thirty percent of people with a long-term physical illness have a mental health issue, while forty six percent of people with a long-term mental health condition have a long-term physical illness (Naylor et al., 2012) and with costs of eleven billion pounds to treat mental and physical health separately, the clear links between the two indicate the need for a shift to a more integrated holistic approach to mental and physical health (Naylor, 2016). Thus, the central role of primary care is evident, as recognised by the World Health Organisation (1978) which defines it as "more than just the level of care or gate keeping: it is a key process in the health system. It is first-contact, accessible, continued, comprehensive and coordinated care".

Accordingly, the importance of primary care to the NHS has been recognised with the introduction of GP commissioning (Tait et al., 2013) and now a significant amount of mental health care is provided through psychological interventions in primary care (Department of Health, 2012). According to the stepped care model, there is a drive for individuals to be returned to primary care where possible, ensuring that the least intense intervention is applied to each individual's clinical needs. This is based on a number of social and economic advantages of delivering psychological therapies in primary care (Reilly et al., 2012), but also it has been revealed that physical health outcomes for individuals with mental health difficulties improve in primary care and outcomes for anxiety and depression are equivalent to specialist services (Lester, Tritter & Sorohan, 2005; Lester & Gask, 2006). Furthermore, Randomised Controlled Trials (RCTs) for outcomes of short-term counselling in primary care (up to six months) reveal that counselling is more useful than standard GP care for mild to moderate mental health concerns (NHS Centre for Reviews and Dissemination, 2001).

That said, RCTs reporting longer-term outcomes (eight to twelve months), reveal no significant difference between counselling and that of receiving usual GP care (Rowland, Bower & Mellor-Clark, 2001; Saxon et al., 2017). Likewise, a trial comparing non-directive counselling and cognitive behavioural therapy (CBT) revealed similar outcomes across the two modalities in their efficacy, but the important finding for the purpose of this discussion, is that both were advantageous to GP care in the short-term, but there was no significant difference longer-term (King et al., 2000). Furthermore, outcomes for those with more severe mental illnesses reveal a different picture (Bhavsar, 2017; Ramanuj et al., 2015).

Ramanuj et al. (2015) conducted a study to assess acute mental health service use by individuals with severe mental illness after discharge to primary care and this revealed that the majority of discharged clients were re-referred and the majority of those re-referred were in crisis. This is a retrospective study with a small sample size from of a local service provider and thus there may be factors specific to the particular setting that limit the scope of the findings. However, it could be deduced from this that given the better clinical status of the discharged group initially, further primary care provisions are required to better support and maintain stability of recovery of those discharged.

Therefore, it seems that while the delivery of psychological interventions in primary care is paramount and it appears beneficial in the short-term, the evidence supporting longer-term

outcomes seems less encouraging. Moreover, the findings from the study conducted by Ramanuj et al. (2015), suggest that there is a need to improve collaboration between primary and secondary care and offer a wider range of interventions in primary care that are more able to address the depth and breadth of presenting issues. While voluntary services and mental health outreach programmes have started to be explored in primary care to address these issues and encourage such a collaborative integration, there is still much need for improvement (Gask & Khanna, 2011).

Improving Access to Psychological Therapies (IAPT) was developed in 2004 by a Labour Economist, Richard Layard and Clinical Psychologist, David Clark. It is the largest provider of psychological interventions and is a government-funded initiative operating at primary care level. It aims to provide timely and equitable access to evidence-based psychological interventions, as defined by NICE guidance. A report one year after the rollout of IAPT, revealed that it had been beneficial in terms of improving access to therapy, but this was heavily weighted towards CBT (Clarke, 2018, 2019; Pilling, Whittington, Taylor & Kendrick, 2011). In 2008 at the time of IAPT's rollout, CBT was the sole approach able to demonstrate a robust evidence-base and despite repeated studies finding equal efficacy across therapies (Cuijpers et al., 2008; Stiles, Barkham, Twigg, Mellor-Clark & Cooper, 2006), IAPT's avocation of CBT as the frontline treatment, was thought to be a driving factor in the government funding for IAPT (Saxon et al., 2017).

Yet, a lack of evidence does not equate to a lack of effectiveness and it is likely that the lack of evidence-base for some therapies is not a signal that they are less effective, but due to them being less conducive to measurement (House & Loewenthal, 2008). All therapies have to grapple with the current demand for evidence-based practice, as this idea came from the medical model, but as therapeutic relationships and therapy can never be identical, arguably they should not be measured in the same way. Nevertheless, CBT's manualised techniques, alignment with the medical model and thus focus on diagnosis and treatment of symptoms, allow it to be more readily measured by RCTs, the main outcome measure to develop evidence (House & Loewenthal, 2008).

Though, RCTs protect against allocation bias, they are vulnerable to a whole host of other biases (Alejandro, Jadad & Murray, 2008). It is clear that psychotherapeutic interventions have different rationales and outcome goals and so perhaps they should be assessed in accordance

with this. Consequently, the use of RCTs introduces bias because they are tailored to interventions and outcomes that are most readily assessed by them. Namely, these outcomes are in line with the design and goals adopted in CBT and directive therapies, as opposed to a non-directive approach like supportive therapies (House & Lowenthal, 2008) and thus RCTs are often just demonstrating which therapies are most readily measurable by them and thus are able to develop an increased evidence-base.

What is more, this target-driven practice and the underlying conceptual basis of IAPT has resulted in it relying on brief, symptom-focused outcome measures for evaluation, which could distort care and result in selection processes that favour clients judged as a good fit for the model (Steen, 2015). Steen (2015) highlighted the need to develop a wider scope and more holistic approach to care and acknowledge individuals who may not be helped by the IAPT model. Consequently, since 2012, IAPT has pledged its commitment to expanding the choice and flexibility of treatments (Department of Health, 2012).

This increased choice and flexibility of psychological treatments is essential, because due to primary care being the first point of contact for mental health interventions, client presentations are particularly diverse (Alexander, Arnkoff & Glass, 2010). The Centre for Academic Primary Care at the University of Bristol (2015) defines primary care as being based on "caring for people rather than specific diseases". This means that professionals working in primary care are generalists, dealing with a broad range of physical, psychological and social difficulties, rather than specialists in any particular area. This seems relevant to the approach that primary care takes towards mental health, where a paradigm that can meet such diverse needs and go beyond a unitary approach to distress is required (Alexander et al., 2010; Koebbel, 2016; O'Donohue, Byrd, Cummings & Henderson, 2005). Indeed, the NHS framework (NHS & Finance Directorate, 2014), the Department of Health (Department of Health, 2014), the IAPT program (Clarke, 2018) and NICE (2018) all recognise the limitations of the current service provisions and the importance of providing individuals with a range of treatment options to meet their individual needs.

Contextualising Counselling Psychology

Currently, a broad range of professionals are working within mental health in primary care, with diverse training backgrounds (medical, psychotherapy, psychology, counselling and nursing to name a few) and unique personal philosophies (Primary Care Workforce Commission, 2015). Amongst this, counselling psychologists are an increasingly prevalent group of practitioners working in NHS settings and specifically primary care and IAPT (Corney, 2003; James, 2013) and primary care is now the third largest placement setting for counselling psychologists in the UK (Ramsey-Wade, 2014).

CoP is an applied pluralistic specialty within psychology, which was given full divisional status by the British Psychological Society (BPS) in 1994 (Woolfe, 1996). CoP is a holistic, relational, culturally-sensitive approach, which embraces the individual's subjective experience, in order to focus on empowerment, wellbeing and potential (Cooper, 2009). It recognises the many varying therapeutic modalities and acknowledges the value of their co-existence, in order to adapt the therapy to individual client needs (Ramsey-Wade, 2014). It therefore can be said that CoP embraces diversity and pluralism (HCPC, 2019; Wilk, 2014) and with such values it emerges as a specialty aptly placed to meet the diversity agenda of primary care.

As Strawbridge and Woolfe (2010) state "Skills and competencies are essential but, just as good driving requires road sense, which is harder to define than the skills of vehicle control, good therapy requires a depth of theory and human response that is not reducible to formulaic prescriptions" (p.17). This is what CoP can offer, however the increasing demand for accountability, via evidence-based practice in the NHS tends to encourage short-term problem-focused work and standardised treatments for diagnosable issues (Strawbridge & Woolfe, 2010). This in turn draws health care towards the medical model and IAPT has been suggested as a mirror of how health care is moving towards 'McDonaldization', in which highly controlled, bureaucratic, dehumanised systems are becoming increasingly prevalent (Ritzer, 1993).

NICE states that the most robust evidence, based on RCTs, points to CBT. Thus, under IAPT policy it proposed to fund CBT training and a stepped care program. As mentioned earlier, this stepped care approach widens access to therapies, but it could be problematic for CoP, because it leans towards packages of problem-focused treatment and the 'low intensity' treatments are

frequently manualised or computer-based (Woolfe et al., 2010). Moreover, the underlying philosophy of this approach is based around the medical model, which aims to diagnose, treat and cure sickness, which is unquestionably a challenge for CoP, where the emphasis is on enhancing self-determination and an individual's potential, not cure sickness (James & Bellamy, 2010).

But, as James and Bellamy (2010) state in relation to what CoP can offer the NHS:

> *"Counselling Psychologists provide a continuing reminder that patients are people, and that people exist in relationship. It is all too easy when faced with long waiting lists, severe distress and disturbance, and the demands of a large bureaucratic organization to adopt a dehumanizing medical model of treatment" (p.413).*

Therefore, it is clear that CoP's existence in the NHS is essential, but arguably it seems that the future of CoP is dependent upon how it interrelates with the demands of the NHS, thus counselling psychologists desperately need to continue to grapple with finding a way to work alongside the medical model.

Existential Therapy – A Core model in Counselling Psychology

EPT is one of the orientations included in the practice of CoP (BPS, 2019) and is the core modality taught at two of the thirteen CoP training programs (Regent's University and NSPC) and is included as part of training elsewhere (Metanoia and Roehampton University). Consequently, many counselling psychologists are trained and informed by EPT (Ramsey-Wade, 2014) and many EP trained counselling psychologists are working within the NHS and specifically primary care, despite a lack of official recognition (Fairfax, 2013; Koebbel, 2016; Manafi, 2010).

It is important at this point to describe what I mean by EPT. Existential therapy or existential-phenomenological therapy, refer to many different therapeutic practices, so much so that a key feature is that there is no single way of working existentially (Cooper, 2003; Moja-Strasser, 1996). According to Vos, Craig and Cooper (2015b), there are four main schools of existential therapies. The first is 'Daseinanalysis', devised by Binswanger (1963) and then expanded by Boss (1963). This has influences from both Freudian theories and Heidegger's later teachings

and focuses on the client's expression of their being-in-the-world, in other words their relationship with self, others and the world and frequently includes dream work (Cohn, 2002). Second is 'Logo-therapies', or 'Meaning Therapies' developed by Frankl (1905-1997), which focus on establishing a client's meaning in life. These approaches use techniques such as socratic questioning (Frankl, 1985) and are frequently used in group settings. Third are 'Existential-humanistic Approaches' (Bugental, 1978; Schneider, 2003; Schneider, 2016; Schneider & Krug, 2010; Schneider & May, 1995; Yalom, 1980), which concentrate on the givens of life or 'ultimate concerns' such as mortality, isolation, meaninglessness and freedom and allow for interpretative techniques (Yalom, 1980).

The final school of EPT is the 'British School of Existential Therapy', predominantly pioneered by van Deurzen who established the first UK EPT training course in 1982 and British therapists like Spinelli (1994) and Cohn (1997) (Cooper, 2003). It has a strong focus on the phenomenological method of description, clarification and understanding and has a link to Laing's (1965) key work 'The Divided Self', in which meaning is believed to be found in madness and a view that opposes the medicalisation of distress is put forward. The current research takes place within the British school of existential therapy, this is because it is the school upon which the EE intervention is predominantly based upon, heavily drawing upon the work of Spinelli (1994), but also the researcher is most aligned to the British school of existential therapy, having studied at a university pioneered by Emmy van Deurzen.

Though there are varying views on the application and conceptualisation of EPT, there are certain principles and values that seem to be agreed upon across the various EPT approaches. For example, human difficulties in living are not seen as symptoms to be fixed, but as the tensions and paradoxes that are inherent aspects of being human, that we have to grapple with, elucidate and explore their meanings (van Deurzen & Adams, 2011).

EPT draws on the underlying principles of EP philosophy, so one aspect that is important to mention is that existence precedes essence (Sartre, 1943). Humans are seen to enter the world without an essence and then continuously create themselves. Therefore, we have a freedom to choose who we want to become and how we want to live, nothing is set, fixed or permanent. Therefore, concepts of choice, responsibility, freedom and limitations are significant within EPT (van Deurzen, 2010).

All phenomena are seen to emerge through relatedness and thus one can only make sense of another through an inter-relational context (Cohn, 1997). This implies a level of uncertainty is forever present, due to the incompleteness of our reflective capacity and reveals the vulnerability of constructs of self, others and the world and the fluidity of all meaning-based perspectives. This leads to an inherent anxiety in all reflective experiences and thus anxiety is seen as a given of human existence (May, 1961). Spinelli's (2015b) formulation of existential therapy encapsulates this, as he describes how EPT is based upon principles of relatedness, uncertainty and existential anxiety, which are thought to shape an individual's world, whilst the therapeutic relationship is seen as the essential vehicle to change.

In terms of existential practice, the therapist takes an exploratory, phenomenological, client-focused, relational and holistic outlook. Great importance is placed on exploring, understanding and clarifying the subjective experience, worldviews and meaning-making systems of each individual (van Deurzen & Adams, 2011). Interpretations are made on a hermeneutic level, ensuring that they are grounded within a client's description of the phenomena and are aimed at opening up and clarifying meanings and worldviews, rather than being reductive and thus assuming the position of 'expert' over the client (van Deurzen & Adams, 2011). EPT rests on the assumption of intrinsic flexibility, that while individuals are determined by their circumstances, which sometimes they cannot change, they always have a choice in how they respond and create something of these 'givens' (Cooper, 2003). Therefore, interventions focus on exploring such choices, responsibilities, possibilities and limitations, promoting the individual's sense of empowerment and autonomy (Cohn, 2002). Existential practice takes in the whole existence of the individual and those that wish to change a symptom or part of themselves, without exploring the rest will not be well suited to an existential approach (van Deurzen, 2012)

The British school of EPT and CoP both possess a phenomenological-humanistic value base and adopt a holistic perspective to human distress, considering context and focusing on subjective experiences (Moller, 2011). Consequently, both EPT and CoP are underpinned by a stance of openness to the prospect of many simultaneously occurring perspectives, realities, truths and possibilities (Kasket, 2012; Vos, 2013).

Cooper (2009) suggests that CoP is "ethics-in-action" and is therefore naturally aligned with the philosophically informed EPT (p.120), which addresses difficulties and concerns in a

relational, deobjectifying manner, rather than being medical in nature (Manafi, 2010). EPT thus can be seen as not only a standalone modality, as Spinelli (2003) states, but it is also beneficial for counselling psychologists working pluralistically, in order to provide an attitude and way to "think about the 'doing' of counselling psychology" (p.193).

I have provided a couple of examples of how CoP and EPT share epistemological and philosophical roots, because later I will go on to argue that EPT could offer CoP a way to maintain its core values and remain as a distinct profession within the NHS, whilst also adhering to the demands of such a setting.

Existential Therapy and Psychotherapy

EPT also has a significant role within psychotherapy in the UK. It is taught at six training institutions in the UK (Correia, Cooper & Berdondini, 2014), there is a professional organisation for existential practitioners known as The Society of Existential Analysis and the inauguration of the World Congress for Existential Therapy was in the UK.

While EPT is recognised within psychotherapy (Correia et al., 2014) and CoP (Spinelli, 2014), EPT does not have official recognition by NICE guidance, which strongly influences service provisions within primary care (Leng, Baillie & Raj, 2010). This lack of recognition might be in part a result of existential practitioners' anti-psychiatry attitude and reluctance to work alongside the medical model for fear of jeopardising the essence of EPT, that of depathologising difficulties in living (Cooper, 2003). But it might also partly be a consequence of EPT being challenging to operationally define and study (Cohn, 1997). Both of these factors may contribute to why there has been a lack of research into EPT, which in turn influences EPT's presence in the NHS, due to its limited evidence-base.

Existing Research into Outcomes for Existential-phenomenological Therapies

There appears to be a lack of systemic research into outcomes for EPT, resulting in a lack of empirical findings (Cooper, 2015; Koebbel, 2016; Schneider & Krug, 2010; Vos, Cooper & Craig, 2015a; Vos et al., 2015b). A review by Walsh and McElwain (2002) of the evidence for EPT did not cite a single experimental study that was in support of the existential approach. Though more recently research into existential outcomes has increased fractionally (Cooper,

2008; Craig, 2010; Langdridge, 2006; LeMay & Wilson, 2008; Stephenson, 2011; Vos et al., 2015b), Cooper (2015) describes how this is in part out of pragmatism, because existential authors have a concern for the future of EPT.

Vos et al. (2015b) innovatively attempt to systematically review fifteen RCTs which assessed EPT outcomes, with a total of 1,792 participants included. This meta-analysis revealed that EPT produces small effect sizes and from this study Vos et al. (2015b) reached the significant conclusion that "Existential therapy may have positive therapeutic outcomes at a magnitude similar to other humanistic, relational and positive-psychological therapies" (p.60). However, comparing the individual existential interventions included in this study, moderate to large effect sizes were found for meaning therapies, while supportive-expressive and experiential-existential interventions had small effect sizes. While this could suggest that meaning therapies are more effective, there are some alternative explanations worth highlighting. Firstly, meaning therapies were delivered in an individual format, whereas the other therapies were group-based and when the meaning-based group intervention devised by Fillion et al. (2009) was included in the analysis, the effect sizes decreased significantly. Such a finding would suggest that EPT may be most effective on an individual level. Another explanation concerns the fact that the differing therapies have different clinical characteristics, which may have been more or less readily measured by RCTs. Vos et al. (2015b) describe how the supportive-expressive and experiential-existential interventions were more exploratory, non-directive and emotion-based, compared to the direct, educational, exercise-based meaning therapies that discuss meaning in life. That said, CBT which has a similar format to the meaning therapies and reportedly involved the discussion of existential themes, did not exhibit significant effect sizes.

Finally, these findings need to be taken with caution due to the small number and poor quality of many of the studies included, particularly for supportive-expressive and experiential-existential therapies, with the presence of unclear, selective or incomplete reporting (Vos et al., 2015b), as well as large within-study variation. This could have been the result of a lack of specific inclusion criteria, with the severity of distress, format of therapy and client groups investigated varying. Nevertheless, this high level of variation across the studies highlights the difficulty in measuring outcomes for EPT, with the concerns addressed, client group and goals for therapy varying greatly. This emphasises the need for a new way of measuring outcomes for EPT to that of RCTs. Linked to this, as the study only included studies that applied quantitative methods (mostly RCTs), the subjective benefit for the clients may not have been

accounted for (Vos et al., 2015b). That said, the findings suggest that some existential therapies are effective for some client populations, namely structured meaning-based interventions seem to be effective at reducing anxiety and depression and increasing a sense of meaning for physically ill clients, particularly when they incorporate exercises, psychoeducation and the discussion of meaning in life.

However, the fact that the British school of EPT, which EE is considered to be a part of, was not included in the meta-analysis means that inferences and generalisations cannot be extended to include it. Furthermore, the inclusion of mostly group-based interventions for supportive-expressive and experiential-existential interventions and the client population being that of chronic or terminal physical illnesses, limits the inferences that can be made from the findings to EE and other forms of EPT or client groups.

A positive picture for outcomes is presented for the existential-humanistic approach in a review conducted by Elliott et al. (2013). This review assessed the outcomes for humanistic-experiential psychotherapies (HEP), with sub-approaches of existential therapy, person-centred therapy, gestalt therapy, emotion-focused therapy, psychodrama and body-orientated therapy. While the approaches included vary greatly, they were reviewed together because they share a common emphasis of empathy, valuing the therapeutic relationship and subjective experience, adopting a phenomenological approach and viewing individuals as meaning-making agents. The study involved a meta-analysis of nearly two hundred HEP outcome studies, as well including some qualitative studies on client experiences and helpful factors in therapy. HEP was associated with considerable pre-post client change, which was maintained over early (twelve months or before) and late (one year or more) follow-up interviews. In the controlled studies, clients in HEP showed large changes relative to clients experiencing no therapy and in comparative outcome studies HEP were found to be of clinical equivalence to other therapies. Additionally, HEP was valid for a diverse range of client presentations, including depression, anxiety, relationship and interpersonal difficulties, psychoses, substance use and coping with chronic medical conditions.

This study makes some headway in how it assesses outcomes by including some qualitative research, enabling the subjective experience of the client to be more readily accessed. However, it could be argued that the findings are positively biased due to the uncontrolled and unmanualised nature of the studies included. Moreover, in the same way that the British school

of EPT shares some similarities with the EP therapies included in the study conducted by Vos et al. (2015b), it also shares some similarities to HEP. But, the fact that studies from the British school of EPT were not included in this meta-analysis limits the generalisations that can be made to it.

Stephenson (2011) and Stephenson and Hale (2017) provide specific evidence for the effectiveness of the British school of EPT, by investigating EPT as routinely used to treat clients with an affective disorder in secondary care in the NHS, using a quantitative paradigm. Quantitative data was collected and analysed from the CORE-OM outcome measurement for clients receiving EPT (thirteen sessions on average) and CBT (twelve sessions on average) and a similar outcome was found for both EPT and CBT. Differences were revealed between waiting list and post-therapy and between pre and post-EPT, with reliable change occurring in ten participants, which was clinically significant for eight participants. Moreover, a quarter of the EPT participants moved from clinical to subclinical status from pre to post-therapy, which complements the findings of Rayner and Vitali (2015) on the impact of the EE intervention in primary care. As such, this study reveals how an EP intervention considered to be part of the British school of EPT can be valuable for some clients with an affective disorder. However, as this study involved a longer-term intervention to that of the EE intervention under investigation and was conducted in secondary care, inferences to primary care need to be made with caution. That said, it is significant that the supervisor overseeing the EPT intervention in Stephenson's (2011) study was Mark Rayner, the developer of the EE intervention and consequently there are many similarities across the two interventions.

Nevertheless, these findings do need to be read with caution, because the sample for EPT was significantly smaller (N=34), than the sample for CBT (N=109). Also, longitudinal data was not collected and therefore the long-term effects of the intervention are unknown. Moreover, a limitation raised in this study was the fact that the participants were not randomly assigned to the interventions and due to time restraints and service complications, recruitment for the second part of the study was not able to reach adequate participant numbers, meaning that it was not possible to investigate for whom the EPT intervention is most suited to (Stephenson, 2011). Finally, there was no manual for EPT, threatening the internal validity of the findings, due to uncertainty surrounding how individual practitioners' practice. However, is it ever possible to fully standardise a co-constructed relationship? As Stiles et al. (2006) deducted from their large practice-based research – even though it may not be manualised, the findings

do reflect the routinely delivered practice, with the typical client and thus, arguably the same can be said for this study.

Another study conducted within the British school of EPT was carried out by Craig (2010) and used a Hermeneutic Single Case Efficacy Design (Elliott, 2002) and abductive reasoning to assess the influence of three therapeutic modalities on client change. The study had the aim of examining whether the modalities work in everyday practice, as well as establishing the active ingredients within the interventions and how they are exerting their effects. Three participants from a psychological therapies service in secondary care were recruited; one experiencing CBT (12 sessions), one experiencing Personal Construct Therapy (PCP) (16 sessions) and one experiencing EPT (16 sessions). The therapists were in their first year of training for Clinical Psychology and the researcher was a trainee Counselling Psychologist, working within the placement on an honorary basis and therefore acted as an 'insider researcher'.

The findings reveal that for each case therapy causally contributed to client changes, but that changes in therapy were analogous to different forms of learning processes. There was an interaction of process factors and relational factors and client/therapist factors and expectancy effects were active contributors to client change. Interestingly, while factors common across the modalities such as 'feedback' had a significant impact on outcome, the execution of these common factors seemed specific to each modality, rather than the factor itself being unique to a modality.

The specific changes that took place within the EPT case, centred around a move to a position in which the individual had increased courage to be who one feels they are, increased motivation, spontaneity, independence, a decreased concern for what others think of their way of being and a shift in attitude around certain aspects of their self, with a sense of emotional control and liberation from burdens being reported (Craig, 2010). This change was seen to emerge through a process where "the discovery of choice and new ways of being in the presence of another causally contributed to changes in the client" (p.104).

This research study by Craig (2010) seems particularly important to report, because as with Stephenson's (2011) research, this investigation took place in a service in which the EPT aspect was supervised by Mark Rayner, the developer of EE, and therefore the EPT intervention investigated has similarities to that of the EE intervention. That said, the conclusions drawn in

this study are particular to the cases reported and cannot be used to infer wider claims about universal factors of change. Interestingly, in all three cases the permanence and strength of the client-reported changes were questioned and without the inclusion of post-therapy follow-up interviews, it is unclear whether the changes reported had long-term effects and the extent to which satisfaction bias and other factors including social desirability and the Hawthorne effect may have exaggerated the extent of change reported at the end of therapy. The changes might have been temporary, after all it was reported that the PCP participant was referred for further therapy and without follow-up interviews, details such as these are only available due to the insider position of the researcher.

Another important point to note is the fact that the therapists were trainee clinical psychologists, with CBT as their main modality and were only required to have delivered PCP or EPT for sixteen supervised hours before the research took place. Therefore, it is likely that their inclination towards CBT would have had an influence in all three cases, especially the EPT case where there is little evidence of in-session emotional experiencing or dialogue of the relational elements in the process, components expected and not found by the researcher. As Craig (2010) states, "The more cognitive stance of the therapist seems to have dominated, despite good faith efforts to work in an existential-phenomenological manner" (p.135).

Despite these limitations, the method developed in Craig's (2010) study holds tremendous merit in offering psychotherapy research a worthy complement to the methods of RCTs. While RCTs show pre-post change across a large sample as opposed to a single case and therefore the importance of such studies cannot be denied, this particular method offers insight into the process of therapy and how the active ingredients of an approach exert their effects to bring about the observed change in outcome, which not only complements the work of Stephenson (2011), but seems invaluable to EPT which is less readily measurable by RCTs. It enables nuanced individual differences to be revealed and gives space to a reasoning process that goes beyond the statement that therapy works, establishing what mediated the change and scrutinises the reliability of reported changes. As such, this study not only provides important information about the process of change relative to specific client outcomes, but highlights alternative means for measuring outcomes for EPT.

What has certainly been found by Rayner and Vitali (2013) for EE in primary care, which I will discuss in depth in relation to the existing evidence for EE shortly, but also by a number

of studies looking at outcomes from the varying schools of EPT, across a range of clients and in varying settings, is that clients who experienced EPT revealed positive outcomes on a range of indices that met levels commensurate with other approaches (Cooper & McLeod, 2015). Thus, it can be said that though the evidence for EPT is currently limited, it is at a "nascent but promising stage" (Schneider & Krug, 2010, p.94).

Existential practitioners have largely tended to approach the notion of research with a degree of suspicion (Lantz, 2004) and this can be understood in relation to the point mentioned above, regarding the difficulty in operationally defining and studying EPT. But debatably this suspicion of research is predominantly the result of the anti-reductionist, anti-medical model attitude that EP practitioners take, resulting in them being particularly critical of the form that research tends to take- when it focuses on observational, measurable behaviour and misses the rich detail regarding the client's subjective experience. In addition to this, du Plock (2016) speaks of the tendency for a concentration of dissemination through pedagogy, rather than on the accumulation of knowledge through research for EPT and with EP therapists frequently being located in private practice there is little pressure to produce research. Consequently, it would seem that it is the lack of research for EPT and therefore a lack of a robust evidence-base, that has resulted in EPT not being recognised by NICE guidelines as a possible therapeutic intervention in primary care.

That said, it seems that EPT could be well placed to meet the demands of primary care. The focus on givens of existence, temporality, limitations, finitude, uncertainty and motivation in EPT, would suggest that it could work well within the time-limitation for psychological therapies in primary care (Robinson, 2005) and such a setting could provide an opportunity to explore how clients relate to these components of human existence. In fact, finiteness and temporality are key concepts within EPT that are thought to aid motivation to change, the creation of meaning and taking responsibility for one's life (Shinebourne, 2006). Thus, for EP practitioners, the time-limitation on the therapeutic relationship and endeavour is always at the forefront and EP practitioners structure the therapy accordingly (Lamont, 2012; Marteau, 1986; Rennie, 2006; Strasser & Strasser, 1997). Therefore, as Schneider (2008) states, "to the extent that existential approaches are understood as attitudes, atmospheres and life encounters, they are not inconsistent with brief…engagements" (Ioannou, 2017, p.46-47) and as I will discuss in more depth in the following section, the literature would suggest that EPT can be very beneficial within a brief timeframe (Lamont, 2015; Rayner & Vitali, 2013; Strasser & Strasser,

1997) and yet EP practitioners have been critical of brief approaches to EPT (Cooper, 2003; van Deurzen, 2002).

Time-Limited Therapy

The current economic constraints and demand for increased access to psychological therapies has led to a surge in time-limited therapy, both in the public sector and work place schemes. There is a significant body of literature that delignates how time-limited therapy (therapy that has a pre-defined contract duration that is typically between six to twelve sessions) is distinct from open-ended therapy (Bor et al, 2004; De Shazer, 1985; Mann, 1993; Strasser and Strasser, 1997) and the following section will pinpoint some of these key differences.

Bor et al. (2004) describe how a key distinction of time-limited therapy is that it is acknowledged that not all issues can be addressed in therapy and therefore a clear objective, with an agreed amount of time to work upon it (between six and ten sessions), is vital. Linked to this, changes that emerge from the time-limited therapy are seen to be part of a wider process of change that the client is responsible for continuing themselves, both outside of the sessions and post-therapy. This idea of change within therapy acting as a springboard to the clients' own continued therapeutic journey, is a component echoed in both Bugental's (1995) and Strasser and Strasser's (1997) models and is seen to be vital in facilitating client empowerment. However, a vital aspect in this is that the therapist must make the time-limit and impending ending explicit from the outset, encouraging continuous reflections in each session about how time is being used.

Another key aspect described by Bor et al. (2004) is how in time-limited therapy the clinician is required to challenge the client from the outset, which can lead to a more urgent pace to that of open-ended therapy. An immediate concern that arises with the presence of an increase in challenges, is that this could risk the approach becoming too directive and the client might feel pressured into change or adopt the clinicians' perspective. Bor et al. (2004) recognise this potential limitation, highlighting that it as an aspect that the clinician needs to be mindful of, however they emphasise that the focus is upon finding solutions to problems in a collaborative way that draws upon the clients' own resources and possibility for autonomy. That said, it is unclear as to how such aspects are experienced in practice and as there is a risk of the approach being more directive no matter how well-intentioned, it is important that such aspects are

reflected upon and research into the clients' experience of this seems vital when implementing such a time-limited therapy.

Bor et al. (2004) argue that all therapeutic orientations can be effectively adapted to a time-limited setting, because the principle aim is to develop a "positive, strong, collaborative working alliance" as quickly as possible (p.8). Similarly, there has been an increase in literature and research to support the argument that time-limited therapy can be as effective as its longer-term equivalents and therefore should not be considered as an inferior replacement for long-term therapy (Duncan, 2013). To cite one such study, Davis, Corrin-Pendry and Savill (2008) investigated the long-term effects of time-limited integrative counselling in primary care. There were fifty-eight participants who underwent on average seven sessions of therapy, with their symptoms being measured using CORE-OM both before therapy, immediately after therapy and at thirty months post-therapy. It was revealed that the participants not only reported decreased levels of psychological distress both immediately and thirty months post-completion, indicating that changes had been effectively maintained, but that there was also a significant reduction in the number of GP visits in the twelve months post-therapy, compared to the twelve months before therapy.

Nevertheless, despite advocating the benefits of a time-limited approach, Hoyt (1995) argues that it is not universally suitable for all difficulties. In particular, early trauma and abuse is cited, because such issues often result in more time being required for the development of a trusting therapeutic relationship and changes take place at a slower pace. While this may not seem to be of relevance to a primary care setting and specifically the EE intervention under investigation, which addresses presenting issues such as anxiety and depression, it is not infrequent for aspects of trauma or abuse to emerge as the therapy unfolds. Furthermore, regardless of some of the potential benefits and positive experiences of time-limited settings, there is a clear discontent from individuals across modalities, regarding the overgeneralised reliance on time-limited therapies in the NHS. For example, a letter sent by the British Psychoanalytic Council to The Guardian (2016) argued that IAPT disregards the needs of many clients who require longer-term therapy and demanded change. That said, whilst striving for the delivery of treatments that can address each individual's needs, we have an ethical responsibility to provide our services as best we can in the current financial and political situation. This includes working to a time-limit and as Ioannou (2017) states, this should not be interpreted as a lack of ethical awareness for the approach and people in need. We need to

keep pushing for a more efficient, flexible and humane mental health system, but simultaneously we also need to do our best to provide an increased choice of interventions within the current circumstances of primary care. As EP-orientated therapists, this can be achieved by embracing such a setting and developing our understanding of how clients experience EP time-limited therapy, which would in turn facilitate the conceptualisation and understanding of how this can look in practice.

This section has looked at the broad features that distinguish a time-limited therapy from that of open-ended therapy. The literature for EP time-limited therapy will now be reviewed, in order to contextualise the EE intervention under investigation and further conceptualise the rationale for the research.

Existential-phenomenological therapy in a time-limited setting

EPT is often perceived as an open-ended or long-term approach, with therapists being "somewhat wary of the 'time-limited' or 'short-term' approaches" (Cooper, 2003, p.129). However, Spinelli (2015b) states with regards to the perception that long-term EP approaches are preferable, "it can be so, but the assumption that this is a necessary condition is a false one that is probably based upon caricature interpretations of existential therapy as an intellectually dominated enterprise centred upon the examination of abstract 'higher-order' ideas and concerns" (p.244). Although the literature and research into time-limited EPT is starting to increase, it is still very limited (Cooper, 2003), but this section will endeavour to discuss some of the key authors in the field.

From a pragmatic appraisal of service provisions, Bugental (1995), an existential-humanistic theorist and therapist, relayed that time-limited therapy is not an ideal reality and is less adequate to a longer-term option, but is a reality that is unavoidable. That said, he acknowledged that the time-limited frame could provide an opportunity for clients to embrace issues of temporality and finitude, which might serve to benefit the therapeutic process. As such, Bugental (1995) offered some preliminary reflections on what a short-term existential-humanistic approach would look like. He advocated a structured process, consisting of six phases and involving an assessment, the establishment of objectives, a teaching element, coaching on how to continue the process of exploration outside of therapy and how to address the ending. Crucially, Bugental (1995) posited that short-term therapy requires a specific

therapeutic goal or focal point to be effective, but that this requires particular skill from the therapist to ensure that working with a specific does not result in the therapy becoming too rigid.

The advocation of a specific focus or goal in time-limited work is echoed by Budman and Gurman (1988) in their 'time-sensitive' approach. They called this the Interpersonal-Developmental-Existential approach and it aimed to aid clients in understanding their interpersonal issues, by connecting them to developmental stages and existential concerns. Within their approach there is a striving for improvement over cure, and the presence of limitations to the work as a consequence of the time-limited nature, are the focal point to therapy. A distinguishing component of this approach, is that Budman and Gurman (1988) describe time-limited therapy as 'a state of mind' of both therapist and client and state that the effectiveness of time-limited EPT rests upon this (p.10). As such, I will discuss the core attributes considered to be 'a state of mind' that is conducive to effective time-limited EPT shortly.

However, it is Freddie and Alison Strasser 's (1997) model for existential time-limited therapy and core text, 'Existential Time-Limited Therapy: The Wheel of Existence', that is most well-established and closely aligned to the British school of EPT (Cooper, 2003). Both the approaches taken by Strasser and Strasser (1997) and Bugental (1995) are modular to some extent; Bugental (1995) states that towards the end of therapy a new series of sessions can be arranged and Strasser and Strasser (1997) offer modules involving twelve sessions in each module, plus two follow-up sessions which take place at six-week intervals post-therapy.

Strasser and Strasser's (1997) model takes a more positive view to time-limited therapy to that of Bugental's (1995), as the emphasis is on the unique possibilities afforded by the time-limited context, to engage with existential givens such as temporality and finitude, as opposed to seeing time-limited therapy as a lesser version to that of longer-term therapy. The time-limitation and overt presence of temporality is used as a tool in itself, where the awareness of time is seen to not only confront the client with an honest appreciation of their objectives in light of limitations, but also creates a sense of urgency and anxiety that is thought to be conducive to change, "knowing that there is an ending tends to evoke stronger emotions... so for instance emotions such as fear, anger, sadness and the recollection of previous losses and rejections help clients to identify their value and coping strategies" (Strasser & Strasser, 1997, p.15). However, within

Strasser and Strasser's (1997) book, the cited case studies do not explicitly convey how temporality is used in the existential therapeutic work and therefore how this looks in practice.

Also, in contrast to Bugental (1995) and Budman and Gurman (1988), Strasser and Strasser (1997) do not advise the use of goal setting, seeing difficulties as "inextricably linked" (p.15). Instead, the aim of the therapy is to explore each individuals' presenting difficulties in the context of their worldview, drawing on issues of temporality, choice, finitude, uncertainty, responsibility and relatedness. While such a stance is attuned with an existential understanding of difficulties in living and distinguishes it from other time-limited approaches, it simultaneously does not differentiate itself in its aims and process to that of open-ended EPT. It is the frequency that the therapist actively challenges the client through questions and reflections that is seen to set it apart from open-ended EPT, as well as the advantage seen to be afforded by using the time-limit itself as a tool to work on issues of temporality and finitude, to foster a sense of urgency and commitment to the work. That said, the modular approach where following two follow-up sessions, another module of twelve sessions with two follow-ups can be embarked upon, appears to contradict this core tenet. Clients are made aware of the option for further modules at the beginning of therapy and therefore while this level of flexibility to meet individual needs is commendable, it could be argued that this lack of finality in the time-limit, reduces the need for clients to face the immediacy of ending and therefore weakens the rationale that it is the opportunity that the certainty of a time-limit and ending offer, that distinguishes this approach from longer-term versions of EPT. Moreover, taking a modular approach limits the application of the model to certain settings, primarily to that of private practice, because within the public sector and particularly primary care, there is a requirement for a level of consistency across client treatment and a fixed time-limit.

Finally, as with Bugental's (1995) model, Strasser and Strasser (1997) advocate the need for structure within a time-limited context. Consequently, the 'wheel of existence', which is based on Yalom's (1980) four ultimate concerns (isolation, freedom, meaninglessness and death) and Binswanger's (1946) four worlds of existence that were expanded upon by van Deurzen (1997), form a framework for the practice of time-limited EPT. However, the emphasis on a strong therapeutic relationship is not overshadowed, with the authors relaying how the 'wheel of existence' can only be effectively applied within the context of a respectful relationship. But again, the inclusion of the 'wheel of existence' is based on approaches that are not unique to time-limited EPT and therefore it further highlights how it is difficult to establish what exactly

makes Strasser and Strasser's (1997) existential approach uniquely time-limited, other than taking a modular approach and like non-EP time-limited models (Bor et al., 2004), the increased sense of urgency and pace that is thought to be generated from the time-limit and frequency that the clinician challenges the client. Therefore, it could be argued that Strasser and Strasser's (1997) model incorporates only a minimal shift from what is considered open-ended EPT.

Langdridge (2006) recognised the limitations in Strasser and Strasser's (1997) model and expanded upon it by advocating the integration of principles of Solution Focused Therapy (SFT) (De Shazer, 1985) to existential time-limited therapy. Langdridge (2006) suggests that SFT has an "a-theoretical nature" and its focus on potential over problem lends itself well to an EP approach, whilst at the same time offering some techniques and structure (p.359). SFT is a social constructionist approach and with the emphasis being on a client's co-constituted nature, it can be said to correspond well with phenomenology (Langdridge, 2006). Furthermore, the appreciation that as humans the move through time to an uncertain future is something that causes experiential difficulty, but is a given that should be owned and not evaded, is a philosophical issue at the heart of both approaches. Consequently, contrary to open-ended EPT, in which the present is explored in light of how it is informed by past experiences and future possibilities, enabling a flexible approach to the exploration of the temporal stages, Langridge (2006) states that within a time-limit the focus needs to be shifted towards future possibilities. Therefore, Langridge (2006) describes an approach in which the past and present are discussed in order to understand each individuals' presenting concerns, but with the awareness of the limited nature of time, there is a strong striving towards goal attainment. As with other time-limited approaches, an increased sense of urgency and pace is thought to be evoked by taking this goal-orientated format, however the use of the 'here and now' relationship to facilitate an engagement with wished-for goals in the future, is in line with an EP approach.

The approach suggested by Langdridge (2006) seems to be more clearly differentiated from what is considered open-ended EPT and the incorporation of goals enables outcomes to be more readily measured for the application of the approach to medicalised settings. However, Langdridge (2006) highlights the challenge for a technique-focused approach to get accepted by existential therapists who are largely cautious of technique and skills-based practice, as well as the risk posed to the phenomenological component of therapy if the clinician becomes increasingly directive in the search for solutions. But regrettably, he does not outline how one

might manage such tensions to ensure a client-driven approach, or how goals or solutions might be conceptualised and measured, which are aspects that would be vital for the application of this approach in a primary care context.

It is evident that the time-limited models discussed have made a significant contribution to the essence of and possibilities afforded by working in an existential time-limited way. It seems that despite the limited literature for time-limited EPT, its engagement with existential givens such as temporality, finitude, limitation, responsibility, choice, and death, renders it well-placed to work within a time-limited setting. As Spinelli (2015b) conveys from his appraisal of the work of Strasser and Strasser (1997) and Rayner and Vitali (2014), "Whatever the approach taken, what has begun to emerge with regard to short-term existential therapy is that not only is it a feasible enterprise for therapists and clients to undertake; it is neither too diffuse nor too 'intellectual' in comparison to other approaches" (p.244). That said, while research into therapists' experiences of delivering time-limited EPT suggests that it is a possible, valuable and worthwhile endeavour, it is not without considerable challenges (Ioannou, 2017; Koebbel, 2016), which I will go onto discuss.

Despite the limited conceptualisations and research of time-limited EPT, the practice of it seems to be rising, with an increasing number of EP approaches (in and outside the UK) adhering to less than twenty-five therapeutic sessions with individuals, families or groups. These include logotherapy (Breitbart et al., 2010; Crumbaugh & Carr, 1979; Lantz & Walsh, 2007; Lee, Cohen, Edgar, Laizner & Gagnon, 2006; Zuehlke & Watkins, 1977), the American existential-humanistic approach (Fegg et al., 2013; Kissane et al., 2004; Spiegel et al., 199; van der Pompe et al., 2001) and the British school of EPT (Langdridge, 2006; Rayner & Vitali, 2015; Strasser & Strasser, 1997). Although what is considered EPT is loosely defined and the number of approaches that fall under 'existential therapy' is far ranging and pluralistic, what is clear is that there is an increasing movement to meet time-limitations as part of the approach.

A study using Grounded Theory conducted by Koebbel (2016) investigated the experience of therapists delivering time-limited EPT (six to ten sessions), in the hope to develop a theory of how EP clinicians negotiate their practice in primary care. This study is particularly relevant to the current research, because it took place in a primary care setting, with a number of the clinicians working with the EE intervention, although this is not explicitly stated. The study involved a sample of nine practitioners with varying degrees of experience, but mainly those

on a training placement with the service provider. Four key categories were generated: the medicalness of primary care, existential-phenomenological practice in primary care, negotiating practice in primary care and the impact of professional experience. What seemed to be of particular relevance was that the time-limit was a dilemma for most of the participants initially, however as they accepted the limits as 'givens' to the work and collaboratively inquired with their clients about the tensions posed by the time-limit and outcome measures, they were able to adapt their therapy to the time-limit. Such adaptations involved working in a more directive way, with the pace and proactiveness of the therapist (in terms of guidance, challenges, and formulation of concerns) increasing and the exploration becoming less phenomenological (the extent that client meanings were interpreted increased and certain issues were selected to be worked upon as opposed to ensuring horizontalisation). Importantly, while the therapists believed longer-term EPT to be more effective than time-limited EPT, the therapists saw six to twelve sessions of therapy as enough in primary care, viewing significant moments to have more relevance to outcomes than the number of sessions.

Goal setting played an integral role in the application of time-limited EPT in primary care, however this rigid structure imposed on the therapy was either viewed with frustration for being at odds with the clinicians' non-directive phenomenological attitude or as a useful component to the work. For the latter, these clinicians had found a way to navigate the tension by using goal setting and attainment as a phenomenological tool and focusing on the establishing and re-negotiating of goals, more than the attainment of such goals. As Koebbel's (2016) highlights, the practice of working towards goals, as well as the active way that the therapist shapes the therapeutic work, suggests an approach to time-limited EPT that is most aligned to the EE intervention, more so than Strasser and Strasser's (1997) model. However, the way in which the clinicians responded to the primary care context is most in line with Strasser and Strasser's (1997) way of working, being "flexible", ensuring EPT keeps its "organic spirit" and being open and idiosyncratic in nature, as opposed to following an operationalised protocol or involving psychoeducational or experimentational aspects (Koebbel, 2016, p.83).

Finally, the impact of professional experience and therefore confidence was found to be a vital aspect in the application of time-limited EPT (Koebbel, 2016). Therefore, in contrary to the point made above, Koebbel's (2016) research highlights that clinicians working in an EP time-limited way in medicalised contexts, desire more concrete formulations delignating how an EP time-limited therapy can look in practice. EPT involves so many practices and this can be

overwhelming when deciding where to start within a time-limit and the established approaches do not suggest how time-limited EPT could be specifically adapted to work within medicalised settings, where the need for consistency in treatment, a fixed time-limit and the measurement of outcomes is paramount. This is where the EE intervention distinguishes itself, because its operationalised protocol incorporates outcome measurements and guides the session structure, whilst also integrating existential attitudes. However, the fact that some of the participants included in this study worked with the EE intervention and yet desired a more concrete formulation of how time-limited EPT can look in practice, suggests that perhaps the application of the EE protocol somewhat differs to how it looks in theory.

Nevertheless, the study conducted by Koebbel (2016) provides strong support for the value of time-limited EPT in primary care, however there are evident limitations to the study. The sample size for a study applying Grounded Theory was small and the fact that the therapists involved are likely to have had similar perspectives, as they were trained at only two universities, Regents College and NSPC, which both have EPT as a core modality and share many lecturers, is certainly a limitation. Furthermore, the therapists were receiving training and supervision at their placements and being in the early stages of training may have been particularly impressionable to the perspective or protocol offered within the supervisory context of the service that they were working within. This means that inferences with regards to how clinicians can negotiate time-limited EPT in primary care should be applied with caution, however it provides significant insights on EP clinicians' experiences and ways of navigating both a time-limit and primary care setting.

Ioannou (2017) conducted an IPA study that explored the experiences of ten existential counselling psychologists and psychotherapists, all of whom were from the British school of EPT, and were providing therapy in time-limited contexts (six to twelve sessions). While this research did not take place in a primary care setting, the findings suggest that existential time-limited therapy is relevant for the increasingly widespread provision of time-limited therapies, thus revealing the possibility for CoP to remain pluralistic, by demonstrating the value of such a time-limited existential approach for meeting varying client needs. But also, the findings highlight how while it seems EPT can be of great value in time-limited contexts, as Koebbel (2016) emphasised, there are many tensions involved for therapists in implementing a time-limited existential intervention.

Time was experienced as insufficient by the therapists; there was a feeling of anxiety and powerlessness and some felt that the exploration of existential issues and ensuring horizontaisation was not possible within the time-limit. However, the deadline imposed by the time-limit was seen to have a facilitating effect, with each choice and area explored seeming particularly crucial as it would exclude other possibilities. Linked to this was the experience of urgency, in which the therapist was conscious to make the most of time, resulting in a faster pace. As such, dealing with one's own expectations as a therapist presented as significant, particularly as the therapists described the intensification of clients' expectations and their desire for a cure or solutions given their limited time in therapy, as well as the expectations of some employers to deliver significant outcome data. As Koebbel's (2016) research pinpointed, the tensions involved in implementing time-limited EPT, is thought to be exacerbated by the lack of support or the existence of a clear conceptual model, with the exception of Strasser and Strasser's (1997) book. This could shed light on the need for both research into and development of a clear conceptual model of how EPT might look in a time-limited setting, even if this is adhered to in a fluid way. The protocol for the EE intervention provides this and the current research study hopes to fill this gap, by revealing how EE, an EP-based intervention in a time-limited setting, is experienced in practice.

Although it has been suggested that there is a need for a theoretical model for brief EPT (Ioannou, 2017), it seems that the attitude of both therapist and client towards the time-limited setting is the most important factor. In EPT it is understood that it is through our attitudes that our experiences are coloured and given meaning (Frankl, 2004). Therefore, Budman and Gurman's (1988) argument that time-limited therapies, though they are often the result of restraints on service resources, are a "state of mind" of both client and therapist (p.10), seems relevant. Budman and Gurman (1992) compared the values of therapists practicing in a long-term and short-term format and from this they suggested that there are certain key values for time-limited therapists to hold:

1. Pragmatism and parsimony, the belief in improvement and not cure
2. Belief in psychological change as inevitable
3. Emphasis on clients' strengths and resources, as opposed to pathology
4. Acceptance that changes often happen after therapy has terminated and are not always visible to the therapist
5. Disbelief of the timelessness nature of some therapeutic models

6. Not engaging in fiscal issues that one might with long-term clients
7. Perception that therapy can sometimes be useful and sometimes harmful
8. Belief that the world is more important than being in therapy
9. Perception of treating a population rather than a given client
   (Budman & Gurman, 1992, p.113)

What is interesting about their findings is the focus on the therapist's attitude, values and beliefs towards the effectiveness of time-limited work, rather than techniques. There is also a sense of the need to be realistic in accepting what is possible within the limitations of time and managing expectations accordingly. Malan (1976) too, touches on this in his discussion of the therapists' attitude, focusing on "therapeutic perfectionism", in which the therapist strives to help a client with every problem the client expresses, rather than accepting the limitations of the setting and that change continues post-therapy, for which a therapist may not have the opportunity to observe (p.391). Consequently, belief and faith are necessary conditions for time-limited work, with Malan (1976) stating that time-limited therapists need to believe that changes to one area of concern may have a "ripple effect" on other areas (p.13). The importance of belief and faith for brief therapies is reiterated by Bor et al. (2004), stating that even small changes can initiate a process of change that can continue post-therapy and Hoyt's (2001) findings that therapists that hold the belief that clients can make beneficial change relatively quickly, are those most able to deliver brief therapy.

Similarly, Molnos (1995) states how confidence and faith in the effectiveness of time-limited therapy, as well as the belief that it is possible to use the time to maximum effect, leads to the optimal attitude for a time-limited therapist. This view that confidence and a positive attitude to the time-limit is an essential factor has been supported by a number of studies. For example, Gelso et al. (1983) found that therapists' confidence that the client will benefit from the treatment and their view of the extent that they will enjoy their work, as well as the client's willingness to change were the main contributors for effective time-limited therapy. Moreover, Levenson, Speed and Budman (1995) surveyed over 300 psychologists to discover that the therapists' attitude, experience and training in brief therapy predicts their self-rated skill in performing it.

Botler, Levenson and Alvarez's (1990) findings also supported this idea of attitudinal differences amongst therapists playing an important role in brief therapies. They found that

therapists working in brief timeframes, who held the belief that psychological change can occur outside of therapy and that the time-limited setting intensifies the work, worked more efficiently and with more satisfaction, regardless of their theoretical orientation. Likewise, Barrett-Kruse (1994) also provide a model of brief counselling that emphasises the therapists' attitudes and values as the main factors for therapeutic effectiveness, regardless of theoretical orientation. The fact that attitudinal factors may be the main aspects contributing to positive therapeutic outcomes in time-limited settings, is of considerable interest as it suggests that the focus should be on the quality of the therapeutic relationship and presence (Yalom, 1980), as opposed to the application of specific techniques or theoretical constructs, which is not only aligned with EPT, but it would also suggest that EP therapies should not let the lack of a time-limited existential-phenomenological model hinder their practice.

In fact, therapists' attitudes of optimism, confidence, acceptance and satisfaction seem to be facilitative factors in time-limited settings, so it could be that EP practitioners' attitudes are what is hindering the evolution of EPT into a time-limited approach, not the lack of a clear conceptual model for time-limited practice. With this in mind, an assertion made by Ioannou (2017) that existential therapists have an ethical responsibility to offer an alternative to technique and technological-based, medicalised treatments, which are becoming the norm in time-limited settings, seems fitting. EP therapists' need to hold the various tensions and paradoxes that such a setting presents and as the section above reveals, the therapists' attitude towards the time-limit is an important part of the experience. Therefore, training and supervision into how one might work existentially in a time-limited way, could provide clinicians with the confidence to work in such settings. But it is also clear that clinicians need to be mindful of how their attitudes are affecting their work. This is of great relevance to the current study, which aims to produce a detailed depiction of the experience of an EP time-limited approach, which might facilitate practitioners in working in such a way, but also could illuminate how the clients experience the therapists' attitudes, as well as the role that their own attitudes towards the time-limit might play.

Ioannou's (2017) study was not conducted in primary care and involved a combination of referrals; some were employee assistance programme referrals, some were from NHS secondary care services, university settings, low cost clinics and the voluntary sector. Moreover, the investigation did not focus on a particular presenting concern and the session lengths varied from between six and twelve sessions. However, this research revealed that an EP way of

working can be implemented in time-limited settings, in a manner in which therapists feel that they can maintain their philosophical, holistic and relational perspectives. EPT was perceived to be a possible treatment of choice in time-limited settings, which has relevance to the current study as the time-limit is arguably primary care's primary restriction on therapies. This adds to findings from research conducted by Koebbel's (2016), that therapists' perceived EPT as a viable and valuable approach within the time-limited setting of primary care. What is needed now, as Ioannou (2017) recognises, is for further attempts to be made in examining client experiences of EP time-limited therapies, to explore whether what therapists consider is useful or difficult in therapy, mirrors the experience of the clients, which this current study sets out to address.

Apart from Lamont (2012, 2015), limited attempts have been made to research the experience of clients in time-limited EPT. Lamont (2015) conducted an Interpretative Phenomenological Analysis into clients' experiences of a time-limited existential intervention. This was conducted with clients receiving a twelve-session intervention in a counselling service for individuals affected by HIV. The findings revealed that the service users felt the approach was both effective and viable, with participants reporting that it was an "actively relational, affirming and enabling approach…highly attuned to participants needs and objectives (Lamont, 2015, p.2). The time-limit was not seen to hinder the depth of exploration and the time-limit was seen as sufficient for addressing their concerns. However, it is worth noting that unlike the EE intervention, these clients were not addressing a specific issue, rather their unease in the world and the twelve-session format is at the upper end of what is considered time-limited therapy. That said, the clients highlighted how it was the establishment of an early alliance, a meaningful engagement with temporality and the ending process that were the vital components for the positive experience of the time-limit. They described how being made aware of the lime-limit from the outset and the end being referred to in each session was anxiety-inducing, yet it served to focus the sessions. In fact, it was reported that the overt presence of the time-limit instilled energy into the sessions, encouraged them to more assertively communicate their needs and to embrace their responsibility for continuing their therapeutic process. Although the study was not conducted in primary care, the intervention investigated involved a longer format and worked with a different client group to that of the EE intervention, it is relevant to the current study because it does give an insight into clients' experiences of a time-limited EP approach. Nevertheless, there is certainly a vital gap to be

filled in terms of exploring the clients' experience of time-limited therapies in primary care and particularly that of an EP intervention.

Existential-phenomenological Therapy for Addressing Diverse Needs

There is a large spectrum in the level of standardisation and manualisation amongst approaches that fall under the category of EPT (LeMay & Wilson, 2008). For example, many group therapies for physical health care such as Supportive Expressive Group Therapy (Spiegel & Spira, 1991), Experiential Existential Group Therapy (van der Pompe et al., 2001), Meaning-making Interventions (Lee et al., 2006; Vos, 2016a, 2016b) and Existential Behaviour Therapy (Fegg et al., 2013), have veered towards the manualisation of therapy. But, the majority of existential approaches remain unstructured, unmanualised and open-ended (van Deurzen & Adams, 2011). The more structured interventions reveal positive outcomes in relation to psychopathology, self-efficacy and meaning (Vos et al., 2015a; Vos et al., 2015b), but they did not make explicit how they identified a proposed focus, or how to incorporate and measure outcomes and thus this continues to be a perennial challenge for EPT (Westen, 2002; Wilson, 2007). This raises questions, as Koebbel (2016) highlights, that while such research on EPT from outside the UK is promising, questions about the implications for the actual practice of EPT in primary care remain.

That said, EPT's phenomenological mode of enquiry and emphasis on meaning-making, understanding and empowerment, would indicate that it is well placed to work with the diverse range of client presentations and needs in primary care (Alexander et al., 2010). While EPT is said to resist categories of disorder and pathology, such as those included in the DSM and ICD (Spinelli, 2007), an inconsistency emerges as it is clear that EPT is being applied to a diverse range of client presentations. For example, literature reveals that EP concepts can be applied to anxiety (Kirkland-Handley & Mitchell, 2005; Rayner & Vitali, 2014; Strasser & Strasser, 1997), depression (Arnold-Baker, 2005; Rayner & Vitali, 2014), addiction (du Plock & Fisher, 2005), sexuality (Barker, 2011; Pearce, 2011; Smith-Pickard, 2006; Smith-Pickard & Swynnerton, 2005; Spinelli, 1997), bereavement (Madison, 2005), death (Barnett, 2009; Cooper & Adams, 2005), human development (Adams, 2013; Kirby, 2005), children (Scalzo, 2010), families (Stadlen & Stadlen, 2005), relationships (van Deurzen & Tantam, 2005; van Deurzen & Iacavou, 2013), groups (Tantam, 2005), eating disorders (Schneider & Fitzgerald-Pool, 2005; Thomas, 2001), HIV (Lamont, 2015; Milton, 1994) and trauma (Corbett & Milton,

2011). While not all of these are relevant to a primary care setting, it is clear that EPT's breadth of applicability makes it well placed to address the diversity of client presentations in primary care.

Furthermore, the focus on meaning-making and change in understanding, over change of symptomatology in EPT, may promote long-term resilience. For example, encouraging clients to gain awareness into their stance in life, choices and responsibility, could enable them to feel empowered to take ownership of their difficulties and subsequent solutions to them (Hickes & Mirea, 2012; Perren, Godfrey & Rowland, 2009), rather than viewing themselves as ill and passive in their recovery, which is likely to result in a revolving door system to psychological services (Johnstone, 2000).

Tensions of Existential-phenomenological Therapy in Primary Care

Primary care, and therefore psychological therapies within primary care, are underpinned by the medical model, or at least have adapted to adopt a discourse with it (Koebbel, 2016). As aforementioned, it is certainly a challenge for EPT to work alongside the medical model and thus has been resisted by many practitioners and is partly a reason for the scarcity of EPT in primary care (Cooper, 2008). There is a tension in trying to preserve the essence of EPT, with its focus on subjectivity and depathologising distress, whilst simultaneously finding a way to create a discourse with the medical model, which centres around diagnosis to determine access to treatment and fuels the drive for psychological outcomes in primary care (Rayner, Kauntze & Sayers, 2017). That said, research has revealed that although EP practitioners initially felt 'Other' within the "medicalness of primary care", by addressing such tensions the EP practitioners found it possible to work alongside the medical discourse, whilst maintaining EPT's core values and principles (Koebbell, 2016, p.98).

Likewise, from my own experience as a trainee EP counselling psychologist working within primary care, it is my belief that it is possible to work within a medical setting, without the therapy itself becoming medicalised. I would concur with the experience of the EP practitioners in Koebbel's (2016) study, believing that EPT is a hugely worthwhile approach for those with mild to moderate mental health difficulties, because informal feedback that I have received from clients experiencing EE has been extremely positive. Consequently, although EPT is not espoused by NICE guidance, IAPT, or primary care and there is a minimal evidence-base, its

ability to address diverse client presentations and needs, its emphasis on temporality and its ability to fit within time-limitations, indicate that it could be a good fit for primary care. Furthermore, the fact that Koebbel (2016) revealed EP practitioners perceive working in this way within primary care, in which medical discourse is predominant, as valuable, is encouraging. However, research into the clients' experience of time-limited EPT in primary care is required, in order to understand the extent to which EP principles can be maintained in a medicalised setting, how effectively tensions are managed and if the approach can reach client-determined outcomes.

Summary of the Relevance of Research into Existentially-based Therapy in Primary Care

Psychological interventions provided in primary care are integral to mental health care in the UK. However as primary care is the first point of access, it has to have the capacity to address individuals with diverse needs and presentations within a short timeframe. It has been recognised that an increased choice and flexibility in the interventions provided in primary care is integral to most appropriately address such broad individual needs and this agenda needs to be acted upon in the current service provisions. CoP is a pluralistic approach that can match individual practitioners' skill sets to the needs of a client. Therefore, CoP is aptly positioned to fulfil this requirement of increased choice and flexibility. In particular, CoP's practice of EPT seems to be well matched to fulfil such an agenda, despite the lack of official recognition by NICE. That said, the tensions involved in EPT, an approach that fervently advocates the demedicalisation of distress, working within a setting where medical discourse is prevalent, is not to be understated. The research into EPT in primary care is limited and no existing research has explored into the clients' experience of EPT in primary care and thus this research study seems essential to begin to fill this gap. Additionally, this research study hopes to aid a discourse for existentially-based therapies to be recognised within primary care and potentially the NHS more generally. But also, to provide practice-based evidence, which is being increasingly encouraged (Barkham & Mellor-Clark, 2003), for practitioners working in an EP way within primary care or time-limited contexts.

Introducing Existential Experimentation

This chapter will introduce an EP intervention that is currently being implemented in primary care and is the focus of this research. It will describe the core tenets and principles of the intervention, its conceptualisation, how a measurable notion of change is integrated into service delivery and review the current evidence-base for this intervention. Finally, it will briefly revisit the literature for EPT within primary care, with the aim to further relay the value of this research.

Characteristics of Existential Experimentation

Existential Experimentation (EE) is an innovative short-term EP approach. Mark Rayner and Diego Vitali devised the intervention within the NHS, in order to provide a framework for therapists utilising existential principles in a time-limited setting and as a challenge to the medical model (Rayner & Vitali, 2015). It is a goal-driven approach, which adopts a phenomenological method of enquiry, in order to explore clients' difficulties with living, as described by Spinelli (2005, 2015b). It integrates principles of humanistic psychology, as the client seeks to fulfil their potential, as described by Schneider and Krug (2010), with existential attitudes and philosophy applied to clinical practice (Rayner & Vitali, 2015).

The aim of EE is to encourage clients to re-evaluate their values, sedimented assumptions and particular worldview and thus challenge the position that they take in relation to their difficulties. By applying existential philosophy, EE attempts to address the depth and breadth of human experience, in a way that explores notions of responsibility, agency and choice (Rayner & Quinault, 2018). This in turn hopes to inspire clients to embrace their current situation and difficulties with a sense of empowerment, agency, ownership and a willingness to face uncertainty (Cohn, 2002).

Phenomenological Method of Enquiry

The following section will unpack what is meant by the broad terms of 'phenomenological enquiry' and 'existential attitudes' in EE, to ensure clarity in the relaying the core tenets of EE. Firstly, to ensure a phenomenological method of enquiry, EE applies the three basic rules of phenomenology. These include description over explanation, with questions of 'how' and

'what' being asked, rather than 'why', in order to build up a picture and understanding of the clients' worldview and experience of their difficulties in living (van Deurzen, 2012). The second rule is the bracketing or suspension of assumptions, biases and presuppositions about the client and their difficulties, known as 'epoche' (Husserl, 1931). This ensures that the client is seen as the expert and the focus is on their lived experience, as opposed to knowledge, expertise, professional or personal views from the therapist being imposed upon the client (Morley, 2010). 'Horizontalization' is the third tenet, in which all aspects of the clients' experience are treated with equal importance. The therapist attempts to set aside their natural attitude to acknowledge a specific or general definition of the observed phenomena, by taking a position of openness (Giorgi, 2010).

Existential attitudes

In my practice with EE, I felt I took an EP approach, but I was confused by what exactly 'existential attitudes' looked like in practice. Rayner and Vitali (2015) state that EE is "underpinned by a theoretical rationale that centres on existential and phenomenological informants and attitudes, namely, urgency, intentionality, and openness" (p.5). Still struggling to grasp exactly what this meant and how this looked in practice, I entered discussions with Mark Rayner. He described existential attitudes as Heidegger's notion of 'Gelassenheit', which involves and 'openness' and 'releasement' to hidden meanings and mystery and has been explained as "what-Is which permits us simply to let things be in whatever they may be their uncertainty and their mystery" (Scott et al., 1969, p.xiii). This is an important attitude because, as described above, a phenomenological enquiry requires the therapist to bracket any pre-existing assumptions and one's natural attitude, in order to adopt a radical attitude of openness towards each individual's way of being, in order to attempt to enter the client's lived world and to try and see the world through the client's eyes. Translating 'Gelassenheit' into EE's clinical practice, rests on Spinelli's (2015) suggestion of taking a deliberate Socratic stance, with the therapist being "idiotic" or "un-knowing" (p.16-17). This position can be best described in the following way:

> *"The therapist remains as open as possible to that which presents itself in the current and on-going encounter; to treat the seemingly familiar, assumed to be understood or understandable, as novel, unfixed in meaning, and, hence, accessible to previously unexamined lived possibilities; to demonstrate our willingness to explore the world of*

the client in a fashion that not only seeks to remain respectful of the client's unique experience of relational being, but also to be receptive to the challenges that this unique way of being elicits upon our own narrational biases and assumptions – be they personal or professional or both" (Spinelli, 2015, p.16-17).

Hora (1960) described this openness towards a client as 'letting-be', but emphasised that this must not be misinterpreted for an attitude of passivity, but is a way to affirm the position that the client is taking up in their life and in relation to their difficulties (p.495).

A fundamental component of EE is also to encourage the client to adopt a stance of openness towards uncertainty and the fact that many simultaneous polarities and possibilities can co-exist (Rayner & Vitali, 2016). EE rests upon Sartre's (1943) philosophy that as humans we tend to 'thing-ify' ourselves, imposing structures and roles upon ourselves, in order to pretend that we are fixed with limited choice. While this limits our freedom, it provides a sense of existential security, predictability, constancy and meaning. Therefore, as Spinelli (2015a) recognises:

"All of us, to some extent, generate reflective sedimentations – fixed patterns of dispositions, feelings and behaviours – that persist over time and which shape and direct both our lived experience towards self, others and the world as well as our responses to what we perceive to be the lived stance of others and the world towards us" (p.10).

The consequences of change are unpredictable and change risks the death of security, continuity and all that we hold as meaningful, hence change is difficult (Spinelli, 2015a). Thus, it is not surprising that clients frequently present with a sense of definiteness in their current narratives and so a key part of EE is the exploration of the clients' tension of desiring change, and yet grappling with the risk of facing uncertainty that comes with giving up a familiar way of being and moving to an unknown position (Rayner et al., 2017).

There are a few things to draw your attention to here. Firstly, you will notice the reliance upon Spinelli (2015b) to articulate the specifics of what is meant by existential attitudes and this is because the EE intervention has been significantly influenced by his work. Secondly, I experienced difficulty in developing clarity when unpacking some of the terms used to describe EE, such as existential attitudes and deciphering what makes the EE approach unique from

other EP approaches. This perhaps indicates how the concepualisation of the protocol is fluid and this has implications for how the EE protocol may look in practice.

In fact, EE prides itself on having an operationalised, not a standardised protocol (Rayner & Vitali, 2014). This stance seems valuable to ensure that EP values are maintained despite implementing a protocol, yet this operationalised approach to a protocol also risks presenting as a hybrid of approaches and attitudes, without a clearly defined model of how it really looks in practise. Moreover, EE is a constantly evolving approach, which is laudable in the sense that it incorporates practice-based evidence, but it further raises questions regarding the extent to which it can actually demonstrate consistency and adherence to the protocol. Though many structured models of therapy are often not fully adhered to, there is a clear model of what it should look like in practice, so the extent to which it is being adhered to can be readily measured and evaluated.

The Development and Implementation of EE

In 2004, Lord Layard founded the IAPT programme in response to ever increasing presentations of anxiety and depression. As mentioned earlier, this led to the widespread implementation of CBT in IAPT, due to CBT being readily measurable and thus fundable. During this time, Mark Rayner was a psychotherapist working existentially in secondary care in the NHS and noticed the need for EPT to find a way to measure and monitor its outcomes, in order to be included within NICE guidance for the delivery of psychological therapies (Rayner & Quinault, 2018). Therefore, in 2008 at the same time that IAPT was being piloted, the EE intervention was conceived of by Mark Rayner and EASE Wellbeing was founded as a community interest organisation, which piloted the EE intervention.

Upon noticing the increasing divide between primary and secondary care, with lengthy waiting times for secondary care and rising costs, Mark Rayner and Diego Vitali developed the EE intervention, with the aim to promote wellbeing for individuals referred for anxiety and/or depression within primary care. From here a pilot study for EE was embarked upon within a number of GP surgeries in the London Borough of Barnet. As this expanded more surgeries signed up to have a pilot of the EE intervention and existentially-trained counselling psychologists and psychotherapists were recruited for clinical placements.

The pilot studies of EE demonstrated that EASE Wellbeing could considerably reduce waiting times, referral rates to secondary care and service provision costs (Rayner & Vitali, 2015). These reductions are partly linked to EE being delivered at GP surgeries, because this setting is thought to ensure early intervention, as most people live near to their registered GP surgery and thus this may increase accessibility to psychological therapies, allowing for the early identification of distress, which NICE has highlighted as vital for the treatment of anxiety and depression (Pilling, Wittington, Taylor & Kendrick, 2011). As well as reducing the stigma that can be present when attending specialist psychological services (Corrigan, 2004), thus increasing accessibility and facilitating attendance to psychological therapies (Rayner et al., 2017).

As aforementioned, mental health problems are frequently diagnosed in primary care and several studies have revealed that mood disorders account for 12-13% of mental health diagnoses and anxiety disorders at 8-10% (Ormel et al., 1994; Ansseau et al., 2004; King et al, 2008). Of those diagnosed with depression, 90% of cases are co-morbid with another mental or physical difficulty and as such diagnosing psychological co-morbidity is very complex (Pilling et al., 2011). Frequently clients will go from medical treatment to a psychological treatment and back again. EE takes up a prime position being situated in GP settings, by allowing it to take a holistic view to client difficulties, responding to multiple issues simultaneously and challenging the mind-body split, which is believed to reduce referrals to secondary care, as well as GP appointments (Rayner & Quinault, 2018).

The EE Intervention Pathway

Referrals for EE are made by GP's and following this a practitioner assesses the potential clients, to determine whether they are appropriate for the intervention. Clients have a goal setting session, followed by six sessions of EE that adhere to a protocol focusing on existential attitudes and principles, whist also maintaining flexibility and openness. As well as the phenomenological method of enquiry and existential attitudes already described, the protocol consists of de-objectifying distress, setting goals for therapy, eliciting descriptions to promote reflection, encouraging clients' own hermeneutic work, exploring and challenging the clients' worldviews within the context of choice and responsibility. In the last stages, clients are encouraged to conduct open-ended experiments with new ways of being, within the therapeutic relationship and the world, with the therapeutic space allowing for reflection on the impact of

such changes on self and others. I have cited just a few key tenets of EE, but this is certainly not an exhaustive list and the full protocol can be seen in a paper by Rayner and Vitali (2016). Finally, the clients have a three and a six month follow-up session. A visual diagram of the EE pathway can be viewed in Appendix I.

Conceptualisation of EE

From the inception of psychotherapy, the question of 'how and what works for whom?' has been asked and remains enigmatic (Roth & Fonagy, 2006). Therapy does seem to work with one third to three quarters of clients benefiting from a psychotherapeutic intervention, while one in ten deteriorate and one third recover without an intervention (Roth & Fonagy, 2006). Though much research has been dedicated to comparing outcomes across therapies, a vast amount of research has repeatedly found that no psychotherapy can claim superiority over another, in fact all therapies have equal outcomes hence the term the "Dodo bird" was coined (Weinberger, 1995, p.45).

A number of studies report CBT to have slightly higher outcomes, for example to cite just two studies, a meta-analysis on the comparative efficacy of psychological interventions for depression conducted by Barth et al. (2013) and a systematic review of controlled trials for the effectiveness of brief psychological treatments for depression conducted by Churchill et al. (2010) reveal slightly higher outcomes for CBT, but it could be argued that this is an overestimation, as the findings could be explained by publication, researcher or outcome methodology bias (Cuijpers et al., 2012, 2013; Munder, 2013).

Wampold (2001) relays the debate around what comprises positive therapeutic outcomes for evidence-based practice and suggests that there is a divide between those who believe positive outcomes in psychotherapy are due to techniques (as with CBT and Behavioural Therapy) and those believing it is related to non-specific effects (EPT, Person-centred, Psychodynamic) that are common factors across all therapies. The conceptualisation of EE was based upon such studies assessing the non-specific effects common across all therapies and factors attributing to positive psychotherapeutic outcomes (Assay & Lambert, 1999; Cuijpers et al., 2012, 2013; Orlinsky, Grawe & Parks, 1994; Orlinsky, Ronnestad & Willutzki, 2004).

Assay and Lambert's (1999) analysis of decades of positive psychotherapeutic outcomes in psychological research, revealed that on average 40% of the positive psychotherapeutic outcomes were a result of 'extra-therapeutic factors' (external, client and context-related factors), while the therapeutic relationship accounted for 30%, expectancy effects for 15% and specific modality techniques comprised only 15% of positive outcomes. These findings were further supported by a study examining the contribution of 'common non-specific factors' responsible for change across non-directive therapies for depression, carried out by Cuijpers et al. (2012). It was revealed that 'common factors' constituted just over 49% of positive outcomes, 'extra-therapeutic factors' amounted to just over 33%, whereas specific techniques accounted for just over 17%. Therefore, what is evident from these research findings is that 'extra-therapeutic factors', namely client-attributable factors, play a considerable role in outcomes. In fact, Cooper (2008) has suggested that client-attributable factors are likely the largest determinant of outcomes, accounting for up to 70% of therapeutic effectiveness, particularly the extent the client actively participates in therapy (Orlinsky et al., 1994). Rayner and Vitali (2015) incorporated these findings into the concepualisation of EE, by inferring what could make therapy effective on the most part is dependent on both the therapeutic relationship, the client-attributable and context-related factors.

However, many contend that the therapeutic relationship is the key vehicle accounting for change (Spinelli, 2007) and it is identified as the most consistent variable crucial to positive psychotherapeutic outcomes (Lambert & Bartley, 2001; Norcross, 2002; Norcross & Lambert, 2011). Norcross and Lambert (2011), investigated the evidence around the efficacy of the therapeutic relationship by comparing twenty meta-analysis studies investigating the most effective components of the therapeutic relationship. They established the most important relational components of an effective therapeutic relationship included; goal consensus (Bordin, 1976), therapeutic alliance (Bedi, Davis & Williams, 2005; Orlinsky et al., 2004; Winograd & Tyron, 2011), empathy (Elliot, Bohart, Watson & Greenberg, 2011), genuineness (Kolden, Klein, Wang & Austin, 2011; Norcross, 2010; Schnellbacher & Leijssen, 2009), repairing ruptures (Horvath & Bedi, 2002; Safran & Muran, 2000; Wampold, 2001) and adapting the therapeutic relationship to the varying stages of therapy (van Deurzen, 2010; Norcross, Krebs & Prochaska, 2011). Consequently, EE has been designed to not only activate client-related factors, but also to concentrate on the key relational factors established by Norcross and Lambert (2011) (Rayner & Vitali, 2016).

The EE approach shares similarities with all four schools of EPT, but it has been particularly influenced by the phenomenological approach described by Spinelli (2015b) from the British school of EPT. EE has been informed by the pragmatic approach and structural factors considered key by Lantz and Walsh (2007) for short-term existential therapy, but what seems to separate EE from other short-term existential interventions, is that EE was specifically devised to meet the requirements of the NHS. As such, in EE the adoption of a time-limited nature is seen as of equal importance to accepting the drive for evidence-based practice. Thus, EE faces a tension of subscribing to the notion of measurement, whilst also remaining dedicated to the subjective experience of the client and EP values (Rayner et al., 2017).

EE maintains its EP essence by challenging the medicalisation of distress, intervening early before an individual classifies their difficulties in terms of categories of disorder (Conrad, 2008; Frances, 2013). It deconstructs and de-objectifies distress by taking labels such as 'anxiety' and 'depression' and applying a phenomenological methodology to explore what such experiences are like for the individual and the personal meaning the individual gives to them (Bentall, 2010; Boyle, 2011; Szasz, 1974). This is believed to encourage clients to be "active agents" in their recovery, as opposed to a medical patient (Rayner & Vitali, 2016, p.4). Therefore, rather than homogenising distress, EE is an individualised intervention that explores how each client relates to their world, helping to bring into awareness and re-evaluate their decision-making processes, roles, values, beliefs, sedimented assumptions and attitudes, which in turn empowers the individual to take responsibility for their life, which van Deurzen and Adams (2011) relay are key attributes in an EP approach. Moreover, this focus on challenging a client's position in life is not only based upon existential principles, but also the government's recovery initiative, promoting individuals to live more fulfilling lives (Shepherd, Boardman & Slade, 2008).

At the same time, EE attempts to integrate existential principles with a measurable notion of change (Rayner & Vitali, 2015), something that tends to be seen as at odds with the values of EPT for reasons outlined earlier. Humans are continuously changing, regardless of whether this is in terms of circumstances, ageing, health, experience, behaviour or understanding (Adams, 2013) and it seems that embarking upon therapy, clients want to change and though the mechanisms for change are elusive (Cummings, Hallberg & Slemon, 1994), change is inevitable in therapy (Craig, 2010; Spinelli, 2015a). However, EE challenges what we mean by change, so that rather than it referring to the eradication of symptomatology, the assumption

is taken that change can be understood in terms of a change in understanding of oneself, others and the world (Rayner & Vitali, 2014). Rayner and Vitali (2014) argue that change in understanding is a "valid form of change that can be measured, while attempting to preserve the complex and subjective nature of human experience" (p.3), which is also in line with research by Levitt, Butler and Hill (2006), which revealed how change in symptomatology was not the primary focus for many clients. This suggests that determining the change desired by the client, which EE does through its client-determined goals, is essential.

Integrating a Measurable Notion of Change

Goal Attainment

In order to integrate existential attitudes with a client-determined measurable notion of change, the CORE-OM Goal Attainment form (Evans et al., 2000), is implemented as a psychotherapeutic outcome measurement. This consists of clients forming goals during their goal setting session, in a manner that is similar to that outlined by Cooper and Law (2018) and then rating the degree to which they believe they attained each goal on completion of therapy. The goals articulate how the individual wishes to transcend their current difficulties, allowing for a personalised approach to therapy, exploring the client's experience and deconstructing their narrative of illness (Rayner & Vitali, 2014). Therefore, client-determined goals seem to provide a valid outcome measurement, whilst also having an epistemological foundation that compliments an EP approach (Cooper & Law, 2018).

A retrospective study to assess client-determined goals as a form of outcome measurement for EPT, was conducted in secondary care (Rayner & Vitali, 2014). It was revealed that 87% of clients achieved their first goal, 70% achieved their second goal, 80% reached their third goal and 95% accomplished their fourth goal. This study included a small sample size (N=30) and was conducted with a sixteen-session EP intervention in secondary care, rather than a seven sessions model used by EE in primary care, thus meaning inferences to the latter must be made with caution. However, these results do suggest that EPT can help clients attain their self-determined goals, but the type of goal attained, for example whether they had discussed a problematic area, increased their understanding, level of acceptance, or experienced change in symptomatology, was unexplored. Furthermore, what was unresolved for the clients and the particulars of the intervention that were more or less helpful in attaining the goals, were not revealed.

Building on the research-base for using goals as an outcome measure for EPT, led to a qualitative inquiry into the type of client-determined goals developed in EE in primary care. This demonstrated that understanding self, understanding relationships, understanding emotions, dealing with givens and letting go versus holding onto something, were the key themes that clients wished to work upon (Rayner & Sayers, 2016). These findings suggest that the presenting concerns of clients' in primary care, seem to be in line with what EE and an EP approach can address. Additionally, they support a statement made by Corney (2003), that primary care clients are "distressed rather than mentally ill" (p.415), with difficulties being described in terms of existential anxieties as opposed to symptoms (Gallegos, 2005; Middleton & Shaw, 2000). Therefore, it could be argued that this outcome measure, as opposed to standard symptomatology scales normally used in the NHS, is more adequate for assessing the type of change that the EE approach, (and potentially EPT more generally) hopes to achieve (Cooper & Law, 2018; Newton, 2002).

That said, the sample for Rayner and Sayers's (2016) study was very small (N=14) and it is unclear how participants were selected for the study; what inclusion and exclusion criteria were applied. The developers of the intervention conducted this study and thus the lens from which they entered the thematic analysis was likely to be EP and EE-orientated, although this was not explicitly stated. There is no mention of how such an 'insider researcher' role was managed or the inclusion of reflexivity on how themes were reached, thus jeopardising the trustworthiness of the findings. Furthermore, client goals are co-constructed with the EE therapist, in order to elicit meanings beyond the initial presenting symptoms and therefore the type of goal created is influenced by the therapist. Consequently, it would have been valuable to look at the goals articulated by clients in their GP screening session, as well as the co-constructed goals from EE, in order to determine the clients' initial conceptualisations of their difficulties and objectives and how these might get reconstrued through therapy. Finally, the fact that this study relied upon the goals written on the CORE Goal Attainment form as opposed to utilising semi-structured interviews for example, risks limiting the depth of exploration. This is because meanings cannot be drawn out through dialogue and as the goals are often written by the therapist in their words, it moves the research into a more researcher-led arena. As such, further research is needed to establish client objectives upon referral, the extent to which the EE protocol or therapeutic relationship contributes to the conceptualisation of goals and therefore how client objectives may get reconstrued in therapy and what aspects of a goal the client felt was achieved or unresolved and the factors involved in these processes.

Symptomatology Scales

It could be argued that the form of change that clients' desire from EE, is a form of change that is not adequately addressed by the standard symptomatology scales and, may account for the fact that clients frequently report that the scales do not sufficiently represent their experience (Craig, 2010). Although EE acknowledges that the standard outcome measures implemented within the NHS are not in line with an EP approach, by implementing outcome measures used by IAPT, it allows the psychotherapeutic outcomes of EE, in terms of psychological distress, anxiety and depression symptom reduction, to be compared to other interventions, which is essential within the current climate demanding evidence-based interventions. Consequently, the Patient Health Qustionnaire-9 (PHQ-9) (Kroenke, Spitzer & Williams, 2001), Generalised Anxiety Disorder-7 (GAD-7) (Spitzer, Kroenke, Williams & Lowe, 2006) and Session Rating Scale (Duncan et al., 2003) are used each session. This is in addition to the CORE-34 (Evans et al., 2000), CORE-OM goal attainment form (Evans et al., 2000) and Repertory Grid Technique (Fransella, Bell & Bannister, 2004) that are used at the beginning and end of therapy.

A feasibility study to assess outcomes for adults referred to EE for depression and/or anxiety was conducted, in order to evaluate EE's effectiveness at reducing symptomatology and perceived psychological distress (Rayner & Vitali, 2015). It was revealed that on average EE reduces anxiety (measured with GAD-7), depression (measured with PHQ-9) and psychological distress (measured with CORE-34) for individuals seen within primary care (Rayner & Vitali, 2015). Thus, EE seems to produce promising psychotherapeutic outcomes in terms of reducing the symptomology of depression and anxiety, despite its focus not being on achieving such symptom reduction. However, this study is not without its limitations - the sample size was small (N=41) limiting the extent to which generalisations can be made and with satisfaction bias being a common occurrence in clients who have recently finished therapy, the fact that longitudinal data was not included in this study means that this bias was not protected against and the long-term effects for symptomatology reduction in EE is unknown.

Finally, despite the positive findings of Rayner and Vitali's (2015) feasibility study, the scales used for this study are designed to measure a change in symptomatology and as previously stated, this is not the type of change that EE aims to produce. Additionally, these scales do not reveal how and what clients are changing during therapy. Consequently, the developers of EE identified that an assessment tool that can measure the type of change occurring in EE is

required (Rayner et al., 2017) and have since employed Repertory Grid Technique (RGT) as a tool to detect the complexity of change across therapy, in the hope that it will provide valuable information about the type of change EE achieves.

Repertory Grid Technique

RGT was developed in alignment with Personal Construct Theory (PCT), which seems to converge with existential ideas in terms of worldviews and change (Burr, 1995; Kelly, 1955). Butt and Warren (2016) state, "The psychology of personal constructs can be seen as an existential phenomenological approach in that it has this real-world individual focus. Similarly, emotions are defined not in objective terms, but in terms of the person's action and experience" (p.16). Moreover, Kelly (1955) stated that we should never assume that others see the world in the same way as we do and encouraged individuals to stand back from their own construct system to view things afresh, which has clear resemblances with phenomenology (Butt & Warren, 2016). Also, PCT emphasises intersubjectivity, seeing an individual as rooted within the social world, which is similar to the existential view that "There is no inner man. Man is the world and only in the world does he know himself" (Merleau-Ponty, 1962, p.xi) and it is thought that constructivism can be said to be a synthesis of EP, hermeneutics and pragmatism (Chiari & Nuzzo, 2010). Consequently, the epistemological underpinnings of RGT seem more in line with that of an EP approach, than the symptomatology scales currently used in the NHS.

As a result, RGT's constructivist epistemology may capture how an individual's worldview and relationship to themselves, others and the world gets re-construed during the therapeutic process (Fransella & Bannister, 2004). RGT focuses on each individual's change process during therapy; the dilemmas and struggles that the individual holds and what may be leading to sedimented ways of being are exposed (Winter, 2005, 2007). Therefore, it is a personalised and sophisticated quantitative method, which may be in a better position to measure the individual differences of change occurring across EE, than the standard symptom scales. Moreover, the RGT statistical results paired with the scales could allow for strong results about whether clients are changing during EE and in what way this happens for each individual.

Accordingly, a feasibility study is being conducted by EASE Wellbeing, in order to examine the efficacy of RGT as an effective instrument to detect change across EE. At the XIVth Biennial Conference of the European Personal Construct Association (2018), the initial

findings for this research were reported to demonstrate a significant change in the prevalence of implicative dilemmas post-therapy and changes in the content of the discrepant constructs were found. This suggests that implicative dilemmas and EPT could be well-matched and RGT could reveal what and how change takes place (Santini, Sayers, Maspan, Vitali & Venturi, 2018). Nonetheless, these findings should be viewed with an ounce of caution, because as Santini et al. (2018) highlighted, RGT can be vulnerable to bias in a number of ways. Namely, biases can enter at the data collection level, as the RGT administers are involved in a semi-structured eliciting of constructs and thus the possibility of therapists (all EE and EPT trained) leading or influencing the construing of the constructs is likely. This could potentially bias the constructs to those in line with an EE or an EPT perspective. Munder (2013) describes how the validity of findings can be jeopordised when an alternative explanation, such as researcher bias can be given. Consequently, this is likely to be an aspect that would need addressing if RGT was to be used as a more mainstream outcome measure.

However, it is worth mentioning that integrating a measurable notion of change into any psychotherapeutic endeavour is challenging, due to the vast number of variables inherent in the process of therapy; the co-created relationship, the individual characteristics of both the practitioner and client, co-morbidity, medication and co-existing physical health conditions, to name just a few such variables (Stephenson & Hale, 2017). As Target (2008) states, it might be impossible to measure the influencing factor of effective therapy due to the nature of therapy, meaning the control of confounding variables is impossible. Crucially though, EE is making admirable advances in grappling with the tensions involved in trying to identify a focus and integrate measurement, in order to shine a light on what and how change takes place, as well as to find a way for EE to become more accessible in primary care.

Rationale for the Current Study

A number of quantitative studies (Craig, 2010; Stephenson, 2011) support Spinelli's (2007) argument that EPT is an effective psychological intervention in secondary care. However, other than Rayner and Vitali's (2015) continuing quantitative research, there are no other existing quantitative studies into EP approaches in primary care. That said, brief psychological interventions in primary care have revealed promising results (Gilbert, Barkham, Richards & Cameron., 2005; King et al., 2000; Shepherd et al., 2005) and it has been suggested that an EP way of working seems to be a good fit for a time-limited setting (Cohn, 2002; Hersch, 2011; Ioannou, 2017; Koebbel, 2016; Lamont, 2012; Langdridge, 2006; Rennie, 2006; Robinson, 2005). Moreover, the emphasis on phenomenological exploration, meaning-making, empowerment, choice and responsibility in EPT makes it suitable for the diverse range of client presentations in primary care and may promote long term resilience (Hickes & Mirea, 2012; Perren et al., 2009).

Finally, it is of great significance that qualitative research has revealed that therapists perceive working in an EP way in primary care as valuable, complex, but possible (Koebbel, 2016). This, alongside EE's initial positive quantitative outcomes, allows for cautious optimism that EE could be well placed to address client concerns in primary care. EE is currently the sole EPT within primary care that has a quantitative evidence-base. EE has shown that it can reduce symptomatology, perceived psychological distress and attain client-determined goals, consequently the initial quantitative findings for EE look very promising. What is clear is that there is a lack of evidence for EPT in primary care and Stephenson and Hale (2017) state that further research into EPT in the NHS, is urgently needed to allow for an evidence-base to emerge. An evidence-base is vital to encourage discussions amongst decision-makers, regarding the inclusion of EPT in service provisions, facilitating a move towards an increased choice of therapies in the NHS.

There is a particular sparsity of qualitative research into EPT in primary care, which as Finlay (2012) states is a 'sine qua non' for EPT (p.187) and as there is a growing interest more generally for qualitative research (du Plock, 2017), this seems like a gap needing to be filled. Likewise, Koebbel's (2016) advocates this view, but suggests that qualitative research into clients' perspectives of existentially-based therapies in primary care is needed for the development of EPT's evidence-base and approach in such contexts. What is missing from the

previous research into EE, is the clients' experience of therapy. What the clients' felt was particularly helpful or unhelpful, how their goals were worked upon within the therapy, what might have been left unresolved and what their experience of the therapeutic relationship was like, is currently unknown. It is unclear whether their view of their difficulties and their perception of the process of change, changed during therapy, or how change manifested itself in therapy and also in their life. These are just a few unexplored aspects that seem key to investigate in change and process qualitative research (Cooper & McLeod, 2015; Elliott, 2010).

Elliott (2008) states the "examination of client experiences is central to advancing theoretical understandings of meditational process in therapy (i.e., how therapeutic process gets translated into post-session and posttreatment change); this, in turn, has implications for predicting outcome" (p.239). Therefore, in light of these findings from the literature review, I have established that assessing EE from the clients' perspective is key for the development of EE and potentially existential therapies in primary care more generally. Thus, the main intention of this research is to provide information about the experience of EE from the perspective of clients in primary care.

Research Aims

As with any research project, this study intends to make something known that was previously uncertain (Weiss, 1994). I have identified that the client's experience of EE has not been explored and thus there is a gap in the literature and clinical field. du Plock (2004, 2016, 2017) in considering the value and relevance of research to EPT's specialism, has argued that EP therapists should make use of the philosophical attitude, which underpins their client work. He states that the inquiring mind is the 'sine qua non' of psychotherapy and thus there is no need for a radical break between this attitude and channelling it in rigorous ways when undertaking research. He argues that EP therapists are ideally placed to create case study exploratory research, which is grounded in naïve inquiry (du Plock, 2004). Consequently, this study aims to explore the overall experience and some specific aspects of the EE intervention, using qualitative methodology. To achieve this the following areas were addressed:

1. The general experience of EE

2. The experience of the therapeutic relationship – what, if anything, emerged in relation to the therapeutic relationship in EE

3. Presenting issues and objectives – the participants' concerns, hopes and expectations as they began EE

4. The experience of the therapeutic process and protocol – how, if at all, the participants concerns were worked upon in EE, what was more and less useful within the therapy

5. Outcomes – what, if anything the participants took away from EE, what changes might have occurred, how their life might have been impacted, and what was left unresolved

Clinical Significance

This study has acted on Cooper's (2008) assertion that research should start with questions emerging from the field that allows the researcher to contribute to an evolving body of knowledge and become more engaged with the wider psychotherapy and counselling community, with cited questions of 'what do clients find helpful and unhelpful in therapy?' (Etherington, 2004). This research study has worked off this premise, but also combined it with the researcher's personal interest in EP and CoP.

Primary care is increasingly governed by NICE guidelines, which rely on evidence-based practice to inform therapeutic treatment (Guy, Thomas, Stephenson & Loewenthal, 2011). RCTs are the main form of evidence relied upon, however they encounter many difficulties and biases when applied to psychological research (Bager-Charleson, 2014; Friere, 2006; House & Lowenthal, 2008). This is likely to be the consequence of attempting to generalise from human distress, which cannot be fitted into neat categories and because what clients deem to be effective within therapy is subjective and diverges greatly across the outcome measures applied (Luborsky et al., 2002; Margison et al., 2000; Summerfield, 2004). Furthermore, while some clients report positive outcomes from receiving empirically-validated treatments, one cannot assume that the effective component of therapy was the specific technique, thus making RCTs less valuable (Assay & Lambert, 1999). Furthermore, as Hemmings (2010) highlights, though RCTs can be valuable in evaluating interventions in highly controlled contexts, within naturalistic settings that are clinically representative of service delivery, RCTs have abundant shortcomings and yet they are still viewed as integral for the development of a robust evidence-base. Therefore, as Mollon (2009) suggests NICE guidelines can be "misleading, unscientific and potentially impede good psychological care" (p.9).

In the most recent NICE guidance review by stakeholders (2018), NICE is criticised for its reliance on evidence from RCTs and omission of evidence concerning a broader range of modalities, especially that which reflects the service-users' experience. UKCP (2018) relay how this leads to an unreliable guideline that seriously threatens client welfare. In recognition of not only the ethical imperative of including service users in treatment decision-making processes, but the findings of a number of meta-analyses that have revealed how clients matched to their preferred psychotherapeutic treatment are less likely to drop out prematurely, have higher satisfaction rates and achieve more positive outcomes (eg. DeRubeis et al., 2014;

Lindhiem, Bennett, Trentacosta & McLear, 2014; Swift et al., 2011), NICE (2018), as well as The Department of Health (2012) have stated that individuals should have equal access to services within the NHS (Shepherd, 2008). However, it is of extreme concern that NICE recommendations themselves do not reflect this and CBT is instead recommended as a first-line treatment. As UKCP (2018) relay, it seems fair to argue that unless the principle of choice is adopted, this monoculture of therapies will seriously compromise client mental health.

That said, the qualities of EPT make it hard to operationalise and with accountability being a core aspect of service delivery in the NHS, this is something that EP therapists perhaps should grapple with. EP practitioners are frequently reluctant to fit within the constraints of measurability and thus instead empirically-validated treatments dominate, despite little evidence for their superiority (Marks, 2002; Mcelvaney & Timulak, 2013). This is of grave concern to some EP practitioners (Cooper, 2011; Mollon, 2009) and Cooper (2008) stated that as we are in a climate of measurements and audits in the NHS, EPT needs to find a way to join in, because regardless of whether there is a shift in the research methodologies recognised, without an increase in EPT's evidence-base its demise is likely to continue.

EE meets the current requirements for practice within the NHS and has found a way to 'join in' by offering time-limited therapy, monitoring outcomes and managing risk. Also, it is well-equipped to respond to the diverse needs of clients in primary care, due to its phenomenological and individualised approach to distress (Rayner et al., 2016). Therefore, research into the clients' experience of EE seems key for its development and in order for EE to be included in future service provisions (Cooper, 2008). This study should capture rich details about how clients' experienced EE and what and how changes may have taken place across therapy. This is in line with what Lepper and Riding (2006) suggests, that researchers need to accept the consistent lack of difference in outcomes between techniques and instead look at *what* and *how* clients change across therapy.

To summarise, research into this area seems essential for the following reasons:

1. The findings from this research may aid a dialogue between EP practitioners that are sceptical of working alongside the medical model and how to work within the restraints (time-limitations, drive for evidence-based interventions, limited financial resources) that the NHS would put on practice, with those that advocate EPT in the NHS and particularly primary care.

This could encourage more EP practitioners to find a way to work alongside the medical model, which subsequently could lead to existential therapies being included in future service offerings in primary care.

2. CoP, is meant to be a pluralistic approach and yet it is becoming increasingly homogenised in the current climate of the NHS, with CBT being the treatment of choice (Clarke, 2018). EPT is an important aspect of CoP that could offer a way for CoP to keep its core values, whilst working alongside the medical model and ensure that therapeutic modalities are matched to individual client needs. This study might aid a dialogue about the expansion of primary care offerings to include existentially-based interventions which counselling psychologists would be in a prime position to deliver.

3. EASE Wellbeing, where EE is implemented, largely employs and offers placements to existentially-orientated counselling psychologists and psychotherapists. Such placements in NHS settings are reasonably sparse and are likely to be in increased demand. Should EASE Wellbeing get commissioned by the NHS, this would increase access to trainee and qualified existentially-orientated counselling psychologist and psychotherapy positions, thus aiding the prevalence of both these fields within primary care.

4. This research will contribute to the clinical work that counselling psychologists and psychotherapists undertake, providing them with practice-based evidence. This practice-based evidence will also aid the continually evolving development of EE, by highlighting areas for re-evaluation and further research. But also, practise-based evidence makes an important contribution to evidence-based practice, which is what NICE guidance bases its decisions upon when identifying the most effective interventions for psychological treatment.

5. In an appreciation that "one size does not fit all" (Whalley & Hyland, 2009, p.291) and it is likely that "different things are likely to help different people at different points in time" (Cooper & McLeod, 2011, p.6), IAPT has pledged to increase the choice and flexibility of psychological interventions as part of its agenda. The government has shown their commitment to this stating, "we will work towards ensuring PCTs (Primary Care Trusts) give all patients a choice of NICE-approved psychological interventions" (Tyson, 2008). Therefore, by conducting further research into EE and thus developing its evidence-base, this might facilitate

existentially-based therapies to find a way to work within the NHS and receive official recognition by NICE.

Reflections upon Concluding the Literature Review

This chapter set out to introduce the reader to the research topic and relay how the rationale for the study came about. It is worth reiterating that the angle from which I entered the research will have influenced what was both illuminated and cast into shadow. The literature discussed here is not exhaustive and many other possible perspectives could be equally valuable.

In line with this, upon reviewing the literature, I noticed that initially I had fully adopted the promotional presentation of EE, describing it in an uncannily similar way to that of the architects of the intervention, which I picked up through exposure to their presentations at conferences, commissioning group pitches and during the EE training days. Therefore, the switch from being a practitioner at EASE Wellbeing, where I absorbed the theory behind the intervention and implemented the protocol without question, to a more suspicious position as a researcher, took time, practice and mindful discipline. Regular discussions with my supervisors and my 'critical friend', highlighted areas requiring increased scepticism and critical evaluation and aided me in taking a critical stance of "creative indifference", both in the literature review by exploring the phenomenon from many different perspectives and considering all options (Bager-Charleson, 2014, p.15) and going forward into the data collection and analysis.

Chapter 3: Research Methodology and Design

As Willig (2008) suggests, "what matters is that we identify, clearly and correctly, what type of knowledge we aim to produce and that we select a research methodology that is designed to generate that type of knowledge" (p.13). It is crucial that the aims and questions of the study are clear and the method selected is best placed to address these aims. Therefore, this section will detail the reasoning for choosing qualitative research methodology, the epistemological position of the research and how this guided and informed the research methodology adopted. The decision-making process behind using Interpretative Phenomenological Analysis (IPA) and an account of the alternative methodology considered for this study, will also be relayed. The data collection and method of analysis will be described and finally an account of the ethical considerations involved in this study will be outlined.

Choice of Method

Qualitative methodology was chosen as the methodology for this study as its epistemological and ontological foundations are most aligned with the position of this research and my position as the researcher. Qualitative research aims to develop the richest and most holistic descriptions possible, establish understanding, explore and interpret individuals' experiences (Weiss, 1994). It is inductive and generates theories, as opposed to testing hypotheses and searching for causal explanations and has constructionist ontology, asserting that phenomena and meanings are continually shifting as a result of social interactions and individual creation (Smith & Osborn 2008, p.14-25). Furthermore, it integrates multiple perspectives, believing that no single individual could have observed a process in its totality (Willig, 2008).

That said, there have been questions regarding qualitative research's value as a contribution to knowledge, with some critics seeing the results as impressionistic, imprecise and a product of art rather than an objective scientific method (Piore, 1979). However, this study agrees with Weiss's (1994) view that "While it can be valuable for the results of qualitative interview studies to be verified by other methods, it can also be valuable for the results of studies done by other methods to be illuminated by qualitative interview studies" and that qualitative studies can provide descriptions of phenomena not learned about another way (p.12).

Nevertheless, despite solely using and favouring qualitative methodology for the study, I agree with Vos (2013) who asserts that:

> *"All scientific research methods are limited, be it quantitative or qualitative. Absolute truth cannot be reached. Our therapeutic practices are like a diamond with many facets, and shining a light from only one research direction will only reflect one facet of it. One light alone cannot do full justice to the diamond. We need to combine the different lights of different research methods if we want to see more facets of the diamond" (p.23).*

Thus, with an appreciation of the fragility of knowledge and that absolute truth is unattainable, I recognise that only one viewpoint is provided by the results of one method and looking from another angle as well, could enable the phenomena to be more accurately studied. Like Vos (2013), I believe that in order to assess a participant's experience, it is best to view it from many research angles, reference points and multiple sources to strengthen the credentials of interpretation and identify commonalities and differences in perspectives. From this position, I felt that the best way of understanding the service users' experience of EE was to use mixed methodology; applying both qualitative and quantitative methodology. Therefore, it is important that I briefly outline my consideration of mixed methodology and how the decision to in fact not apply it arose.

Quantitative methodology is not in line with the epistemological and ontological stance of this research. This is due to its positivist epistemology, nomothetic nature and aim to systematically empirically investigate observable phenomena via statistics, as well as its focus on hypothesis testing and generating causal explanations (Langdridge & Hagger-Johnson, 2009). Yet, quantitative research is desirable for interventions that require a robust evidence-base to contend in the current climate of the NHS. As Lamont (2015) asserts, for existential therapies to be included in service provisions, it is important to be pragmatic about the way in which its evidence-base is developed and while qualitative methodology is most in line with the knowledge desired by this study, including a quantitative method could have increased the dissemination of the findings.

RGT is a quantitative research method, which seems to begin to bridge the gap between qualitative and quantitative methodologies. Unlike most quantitative methods, it is an idiographic and personalised quantitative measure, which has a constructivist, interpretivist

epistemology, which explores phenomenologically individuals' constructs, whilst representing changes in how individuals' construe their self-constructs in a quantitative way (Winter, 1992). Moreover, phenomenology (upon which most qualitative research methods are based) and PCT (upon which RGT was designed in harmony), share similar epistemological assumptions and allow for a rigorous exploration of the participants' experience, concerns, social and mental world and meaning making (Smith, 1999a).

Therefore, the constructivist epistemological position taken by RGT, rendered it the quantitative methodology most in line with the stance of this study and could have been used to offer an alternative framework to make "manifest the multidimensional nature of experience" (Turpin, Dallos, Owen & Thomas, 2009, p.51). It offered the opportunity to triangulate and validate the research findings, by identifying areas of convergences and divergences in each method's findings (Langdridge, 2007). As a result, mixed methodology was initially selected for this study, with the particular combination of IPA and RGT, having been successfully integrated in a number of previous studies (Blagden et al., 2014; Gerrish et al., 2014; Odusanya, 2016; Smith, 1999a; Turpin et al., 2009; Yorke & Dallos, 2015).

Nonetheless, the word count limitation of a doctoral thesis for thoroughly detailing the findings of both methods and innovatively integrating the two data sets raised concerns. Therefore, after lengthy consideration and following consultations with David Winter, a specialist in RGT, qualitative methodology alone was decided upon for the purpose of this doctorate study. However, as RGT data is being collected as part of EASE Wellbeing's service, the intention is to explore how the RGT findings compare to the IPA findings as a continuation of this current study at post-doctorate level, which has been approved by the NHS ethical board. This piece of research could further illuminate *what* and *how* change takes place in EE. Furthermore, if the data from the IPA interviews map onto that of the RGT data, it may be revealed that RGT is the most adequate measure to provide quantitative evidence for an existentially-based therapy and thus potentially help EPT to increase its evidence-base.

Epistemological Position: Critical Realism

A researcher's understanding of ontology (what we know) and epistemology (how we know it) shapes how the research is conducted and the methodologies chosen (Matthews, 2009). The aim of this study is to explore the unique experiences of a small number of individuals experiencing EE, however I, as the researcher take the view that my lived experience will also shape the findings. Therefore, this study accepts an individual's reality as their truth, whilst also acknowledging that knowledge is not formed in isolation and that there are 'knowledges', as knowledge is subjective and though a reality exists it is "imperfectly and probabilistically apprehendable" (Guba & Lincoln, 1994, p.258). Thus, I adopt a critical realism stance, appreciating that subjectivity is inherent in the process of understanding and attributing meaning. In order to position the epistemology, I will outline what is meant by phenomenology and how this is relevant to the research and research methods.

Hermeneutic Phenomenology

Phenomenology is a philosophy that the German Philosopher Edmund Husserl (1900/1970) initiated. Husserl's phenomenology is best described within the context of modern European thought, as his approach can be viewed as being born out of the implications of the Enlightenment. During this period there was a drive to enlighten people by enabling them to arrive at rational answers to problems, rather than trusting unexamined beliefs and prejudices. Husserl wanted to develop understanding from rational principles and find a method that would "search for radical certitude" (McLeod, 2011, p.36). This method involved the examination of everyday experiences, because he believed that it was in our emotions, actions, relationships and perceptions, that ultimate understanding could be derived (Natanson, 1973). As such, phenomenology can be described as "the description of things as they appear to consciousness" (Moran, 2000, p.6).

Intentionality is at the heart of phenomenology and relates to how human consciousness is always directed towards something and is linked to the process of meaning-making (Husserl, 1970, p.554). Therefore, phenomenology "sets out to study subjectivity objectivity and objectivity subjectively, whilst addressing the whole human conscious experience in all its complexity" (van Deurzen, 2014b, p.70). Husserl (1970) came up with a detailed way to carry out the task of phenomenology, which is to reduce each aspect involved in this process to

become aware of the subject, object and predicament or phenomena, this is known as phenomenological reduction. To do this, the inquirer has to attend to one's personal experiences of the world and then bracket this bias or 'natural attitude' (assumptions we each apply to make sense of the everyday world), in order to return to the essence of the phenomena as they appear to us (Husserl, 1970). Therefore, as van Deurzen (2014b) describes, "phenomenology is not an emptying of the mind, but rather a polishing of its lens in order to let the light through and illuminate things more brightly" (p.73). Bias can never be fully eliminated, but it can be reflected upon, altered and kept separate as much as possible.

The aim of phenomenology is to get an exhaustive description of the phenomena of everyday experience, therefore building an understanding of the essential structures of the phenomena, the 'thing itself' (Willig, 2008). But phenomenology can never make truth claims, because as Sandberg (2005) describes "the researcher is intentionally related to the research object, (so) the truth claim does not refer to an objective reality as such but to the specific meaning of the research object as it appears to the researcher" (p.56). This is where hermeneutics comes in, because any interpretation of the phenomena is informed by the inquirer's context, and the cultural-historical context for example (Gadamer, 1975; Heidegger, 1927; Schleiermarcher, 1998). So in phenomenological research two individuals are co-creating a particular construction of reality, they are searching for truth, but due to both of their worldviews and biases, the lens through which they will view it and the way they describe it will be a particular version of reality, it is a mere shard of truth (van Deurzen, 2014b) and again this is where hermeneutics plays a role in phenomenology as the construction of knowledge and understanding is inevitably a dialogical and collective experience (McLeod, 2011). Consequently, phenomenological methodology is in accordance with a critical realist stance, because they both rest on a philosophy that appreciates an individual's reality as their truth, but one of many possible truths or interpretations.

I, as the researcher and the intervention under investigation, both have existential-phenomenological roots. Therefore, a qualitative method in which phenomenology underpins them to varying degrees, appears as the best suited option. Nevertheless, as van Deurzen (2014b) warns "Phenomenology is not just a technique to rival with statistical analysis. It is a way of life and you cannot practice it unless you understand its spirit and adopt its philosophy. Practising phenomenology teaches you to sharpen your capacity for observation and self-observation" (p.70). Fortunately, as an EP practitioner, phenomenology has become a way in

which I live my life. This involved not taking anything for granted, avoiding making assumptions, trying to be mindful, curious and taking a naïve inquirer stance to explore others' truths. As such, I feel well positioned to conduct phenomenological research.

Qualitative Methodology: Interpretative Phenomenological Analysis

IPA, as the main psychological method, provides a rigorous and systematic way to conduct phenomenologically-informed research, which compliments the angle wished to be taken towards the research topic (Flick, 2007). It draws on Husserlian phenomenology, in order to capture the quality and texture of the lived experience of a phenomenon, in the attempt to achieve an insider's perspective (Finlay, 2003). However, it also recognises the impossibility of gaining direct access to participants' experiences and hence IPA also draws on hermeneutic phenomenology (Smith & Osborn, 2008). It acknowledges that participants' narratives will reflect their attempts to make sense of their experience within a context (Smith, Jarman & Osborn, 1999b) and it accepts that knowledge and meaning is co-created, so subjectivity and interpretation are inherent in the process of attempting to make sense of an individual's experience (Spinelli, 2005). Therefore, IPA appreciates that such an exploration into how an individual makes sense of their experience, will be influenced by the nature of the encounter between the researcher and participant and the researcher's own worldview (Cresswell, 2007).

Moreover, IPA focuses on the particular and analyses the individual case before any generalisations are made to further cases (Langdridge & Hagger-Johnson, 2007). This idiographic element, alongside its iterative and inductive cycle of analysis, allows for rich detail about what the phenomenon of psychotherapy is like, from the point of view of the specific participant who experienced it (Willig, 2008). Participants converging and diverging beliefs, meanings and experiences can then be highlighted and the essence of the experience for all participants can be captured (Eatough & Smith, 2008).

Linking IPA to the Research Aims

IPA was selected as the most suitable method to explore phenomenologically the experience of EE, because the aim of the study was to explore the lived experience of a small group of service users of EE. The aim was not to universally generalise, but instead gather rich descriptions of participants' experiences and IPA's phenomenological, idiographic, intuitive and descriptive aspects (Willig, 2008), were thought to be aptly placed to enable this. However, the study also adopts a critical realist stance and accepts that the participants' accounts and any truth is subjective, interpretive, context-specific and understands that the researcher's own worldview and experience will shape the findings. Therefore, the fact that IPA has a

hermeneutic component, looking at how participants make sense of their experience and acknowledging that this is influenced by the nature of the encounter between researcher and participant and the researcher's own worldview, giving it a flexible and reflective aspect, also made it particularly appealing for this study. Additionally, IPA's epistemological eclecticism, its capacity to engage with other methods such as RGT and forms of knowledge (the real and constructed) (McLeod, 2011), made it particularly appropriate for this research.

However, IPA has been criticised for not meeting standards of scientific rigour and it has been suggested that it bears little resemblance to philosophical phenomenology (Giorgi, 2010). Van Manen (2017) has expressed his concerns in relation to the widespread misunderstanding of phenomenological research and has likened IPA to a psychological 'therapy oriented' research method, rather than a phenomenological approach (p.776). However, I take Smith's (2018) view that sense-making and self-reflection is a part of being human, a therapist or researcher is not required to engender it. Therefore, the main role of the researcher is to invite participants to share their sense-making, acting as a witness and to then in turn make sense of it. This is not 'therapy oriented' research, but is what IPA's hermeneutic endeavour consists of and is aligned to hermeneutic phenomenology, as espoused by Heidegger's conceptualisation.

As this study takes a critical realist stance, it appreciates that interpretation has an important role in the way that we perceive and experience the world and thus when doing phenomenological research, interpretation cannot be removed (Spinelli, 2005). However, it also takes Giorgi's (2010) view that it is possible to minimise this in order to be a truly present, naïve enquirer to the participants' accounts and see the phenomena from a fresh perspective, in order to discover new things. Therefore, as an 'insider researcher' with pre-knowledge of the phenomena studied, it was essential that I was aware of my assumptions and bracketed these as much as possible. This was in order to be open to see what else is out there and enter the 'attitude of phenomenological reduction' and phenomenological 'epoche', focusing on 'how' one gets close to the participants' experience (Giorgi, 2010). Afterall, as van Deurzen (2014b) states, "we cannot just undo our usual way of approaching the world, we cannot simply change our gaze. The best we can do is discipline our gaze, applying it to the process of thinking, the object of our thinking and our own thinking consciousness" (p.73) and this is what I strived to achieve throughout the study.

Moreover, one appeal of IPA is that it is not one static method, instead it is evolving with a spectrum of ways of operationalising it. This can arguably result in a lack of rigour, with the interpretational component overshadowing the phenomenological, particularly amongst inexperienced researchers. Thus, to ensure rigorous attention to the phenomenological component of IPA, this study paid diligent attention to reflexivity, ensured a phenomenological interview and the analysis stayed close to the data, being as descriptive as possible with the researcher's presence minimised. Interpretation only entered at a later stage in the analysis. This was to fully investigate the experience of the participant and not that of the researcher, as well as to safeguard the credibility and validity of the findings.

Alternative Qualitative Methodology

Upon deciding on qualitative methodology, I considered a number of methodologies, which were in accordance with the epistemological and ontological underpinnings of the study, but were deemed less adequate than IPA for addressing the aims of the study. I quickly dismissed Critical Narrative Approach (CNA) (Langdridge, 2007), Discourse Analysis (DA) (Foucault, 1972) and Grounded Theory (GT) (Charmaz, 2005, 2006). I thoroughly considered Template Analysis (King, 1998), Thematic Analysis (Boyatzis, 1998; Braun & Clarke, 2006), descriptive phenomenological approaches (Langdridge, 2007; Moustakas, 1994) and Structured Existential Analysis (van Deurzen, 2014b), as possible research methodologies. The following section will describe my reasoning for opting for IPA, rather than each of these methods.

Adopting a Critical Narrative Approach (Langdridge, 2007) was excluded at an early stage of consideration, because although it would enable an in-depth exploration of experience in the form of stories from service users and is underpinned by phenomenological philosophy (McLeod, 2011), I felt that CNA's focus on providing structure to a sequence of biographical events and uncovering the participants' life story (Sools & Murray, 2015), would not fit the aims of the study. IPA's generation of themes and commonalities seemed to be more appropriate to explore the service users' experiences of EE.

Similarly, Discourse Analysis was excluded at an early stage, because although it examines how meaning is created through language and language certainly plays an essential part in EE and therapy generally, the focus in DA is on the patterns of language of participants' and how this constructs a particular reality (McLeod, 2011). Thus, DA is not focused on reaching an understanding of the participants' lived experience of a particular phenomenon, in a particular context, which is the aim of the study.

Grounded Theory and particularly the social constructivist version (Charmaz, 2005, 2006), which seeks to reclaim Grounded Theory from its "positivist underpinnings" (Clarke, 2005, p.xxiii) and emphasises multiple realities and the complexities of views, actions and worldviews, more so than Straus and Corbin's (1998) approach, was considered as the research methodology. However, while it explores processes, accentuates the meaning of an experience for a number of individuals and generates theory that could help to explain practise (Creswell, 2007), this study wanted to focus on the experience of service users, without the need for an explanatory framework. Besides, the method is most effective when little is known about the

topic under study and EE already has a theoretical framework behind it. Moreover, the aim of the study was to look at the experience of a small number of participants, rather than generating a theory for a wider population and on a more practical level, the large sample size required in GT would not have been possible due to the nature of the psychotherapy service delivery, method of recruitment and NHS ethical time restraints.

Template Analysis was considered as it takes a similar analytical process to IPA; employing semi-structured interviews and thematic analysis. Yet, in Template Analysis before transcripts are read, preselected codes that are established from previous research are constructed and used as a template for analysing the data (King, 1998). While this would enable certain aspects to be explored that had been highlighted as important factors in previous research, allowing for comparison to other therapies, Template Analysis is more researcher-centric. This would not only cause difficulties in terms of me being an insider-researcher and potential bias, but also as Langdridge (2007) states, IPA is "always inductive and grounded in the data with themes emerging from the text" (p.125), enabling a more participant-led exploration of experience. The more researcher-led aspect of Template Analysis would take away from the richness and openness of descriptions and avenues that IPA allows participants to explore.

Thematic Analysis was also considered, because it identifies recurring themes, illustrating how they are linked to each other, whist being flexible, simple and having minimal theoretical baggage (McLeod, 2011). It particularly attracted my attention, because Willig (2008) draws attention to IPA's last step of analysis when themes are drawn together to suggest that thematic analysis has an advantage here, because arguably this step tends to receive less interpretative attention and themes across the entire data set are less robust as a result (Willig, 2008). However, this study is interested in the individual participant and less so in the larger patterns across service users in primary care and thus IPA's idiographic, case-based nature was deemed more aligned to the aims of the study. .

Descriptive Phenomenological Approaches (Langdridge, 2007; Moustakas, 1994) were considered, because the separation of description and interpretation of reality and the minimisation of interpretation by the researcher would be hugely valuable for this insider-researcher study. However, this study takes the stance that reality is constructed and while one can bracket and ensure diligent reflexivity, the research encounter and findings are co-constructed, because we are continuously interpreting reality. As Weiss (1994) states, "The

interviewer will be constantly communicating – by nods of agreement and understanding as well as by questions and comments – what is of value to the study and what is not. Even if few directive questions are asked, the interview will be an interactional product" (p.81).

Structural Existential Analysis (SEA) is a specific form of phenomenological research, developed by van Deurzen (2014b) to initially provide a basis for EPT, however some doctoral researchers have incorporated elements of it into their dissertations. It involves three phenomenological reductions, advocates hermeneutic interviewing and describes how to work with bias. It encourages the researcher to fully immerse themselves and be open when collecting data in the interview, however, it takes a more structured approach to processing the information, detailing frameworks for this. This is to ensure "observations we make are systematic rather than haphazard or impressionistic and subjective" (van Deurzen, 2014b, p.76). It was therefore very appealing for this study, but my decision not to use this method was partly linked to NHS ethics boards tending to be more sympathetic to the use of a well-known psychological research methodology, particularly if one is opting for qualitative, not quantitative research. But also, despite being an EP therapist and thus well placed to use these phenomenological frameworks for analysis, the time taken to learn how to use the instruments effectively and confidently (van Deurzen, 2014b), concerned me.

Data collection for Interpretative Phenomenological Analysis

Regardless of how in tune the epistemological and ontological underpinnings of a method are with the research, like other research methodologies, qualitative research can also be used to impose a view or can be written as fact. Therefore, this study takes the stance that it is not the methodology (whether quantitative or qualitative), but how the method is used that is particularly important (Vos, 2013). For this reason, the next section will comprehensively detail how the data was collected and the method of analysis.

Sampling Strategy

Having obtained NHS ethics approval and ethics approval from NSPC and Middlesex University, I obtained permission from EASE Wellbeing and Longrove Surgery, to commence the recruitment stage of the study, beginning with a pilot study. I informed the therapists at EASE Wellbeing about my research and asked for their consent for me to interview their clients and invited any questions. Two senior qualified practitioners and three trainee existential-phenomenological counselling psychologists agreed to participate.

The participants were clients recruited from three practitioners at EASE Wellbeing working in primary care. One was a senior qualified practitioner and two were in the advanced stages of their Doctorate in Counselling Psychology and Existential Psychotherapy. The participants were not my own clients and had no previous contact with myself. The participants had been referred for psychological therapies by their GP, using a screening questionnaire devised by EASE Wellbeing. Following this, the lead clinician assessed them, to ensure that they were suitable for the intervention. It was at the end of this psychological assessment that the lead clinician distributed my 'Introduction Letter' (Appendix F), briefly detailing the research study and containing my contact details, should they wish to receive further information about the study. This was given to all participants meeting the inclusion criteria at their initial psychological assessment with EASE Wellbeing.

The participants that were interested in the study contacted me, using the details on the 'Introduction Letter' (Appendix F). I then emailed the 'Participant Information Sheet' (Appendix C), to enable them to further consider the study. The potential participants had the full course of therapy (at least seven weeks) to consider their decision to participate in the study.

Upon completion of their therapy, the potential participants were contacted by email to enquire whether they were still interested in participating and to set up an interview if so. It is worth mentioning that it was also possible for participants to sign up to the study at any point during their therapy, or just after completion of therapy. The dates of the interviews were scheduled for one, or two weeks post-therapy, depending on the participants availability. It was continuously made clear that the participants could change their decision to participate at any stage in the research process and that their therapy and any future therapy would not be affected.

To ensure a homogenous sample in line with IPA principles, certain inclusion and exclusion criteria were applied (Smith, Flowers & Larkin, 2009, p.49-50), which the participants met. This was in addition to EASE Wellbeing's criteria for assessing that clients are at an appropriate level of risk to access EE. The inclusion criteria were that participants were at a clinical threshold for anxiety and/or depression, based on the GAD-7, PHQ-9 and CORE-34 scales, alongside clinical judgment when presenting at their psychological assessment. This was to ensure that participants were as homogenous as possible in terms of the severity of their presenting difficulties (Smith et al., 2009, p.50). Participants that were considered to have completed a course of EE and as close as possible to the suggested timeframe (Appendix I), were included. In terms of exclusion criteria, participants that were not over the age of eighteen were excluded, however participants were not excluded based on other socio-demographic characteristics. Any participants that dropped out of therapy and therefore did not complete EE were excluded. Participants that were discharged from EE were excluded, except in cases where the reason for discharge was because a client's scores on the PHQ-9, GAD-7 and CORE-34 had dropped to subclinical level and this combined with clinical judgment, meant that the client had been considered recovered. Participants receiving other psychological interventions whilst receiving EE, or that were under the influence of alcohol and non-prescription drugs, were excluded.

The first seven participants who self-selected through purposive sampling were invited for interviews, with no discriminatory practice in participant selection. Seven participants were recruited, in order to enable a large enough sample to explore the range of individual experiences of EE, whilst bearing in mind word count restrictions, particularly with data from two interviews per participant. But also due to the time required for an in-depth exploration using IPA (Smith et al., 2009, p.51-52), as well working within the allocated time for

recruitment stipulated by the NHS ethics conditions, being that of six months, that was later extended to one year, due to the significant amount of time required to recruit in such a setting.

Table 2: Demographic Profile of Participants

Participant Pseudonym Name	Gender	Age Bracket	Ethnicity	Therapy	Interviews
Cyprian	Male	56-65	White British	Completed all sessions Wait pre-assessment: 51 days Wait post-assessment: 35 days Took 7 weeks to complete 7 sessions	Initial & Follow-up
Freddie	Male	56-65	White South African	Completed 5 out of 7 sessions (sessions 3&4 missed) Wait pre-assessment: 49 days Wait post-assessment: 55 days Took 9 weeks to complete 5 sessions	Initial & Follow-up
Zilpah	Female	56-65	White British	Completed all sessions Wait pre-assessment: 49 days Wait post-assessment: 83 days Took 7 weeks to complete 7 sessions	Initial & Follow-up
Casper	Male	46-55	White British	Considered completed & discharged after session 5	Initial Only

				Wait pre-assessment: 68 days Wait post-assessment: 132 days Took 5 weeks to complete 5 sessions	
Wilhelmina	Female	56-65	White British	Completed all sessions Wait pre-assessment: 57 days Wait post-assessment: 63 days Took 8 weeks to complete 7 sessions	Initial & Follow-up
Doogie	Male	56-65	White British	Completed all sessions Wait pre-assessment: 79 days Wait post-assessment: 90 days Took 9 weeks to complete 7 sessions	Initial & Follow-up
Otto	Male	36-45	Eastern European	Completed 6 out of 7 sessions (session 7 missed) Wait pre-assessment: 116 days Wait post-assessment: 31 days Took 7 weeks to complete 6 sessions	Initial & Follow-up

As you can see in Table 2, there is some variation in waiting times, particularly post-assessment. The time taken to complete EE and the number of sessions completed also varies. Given that the participants' experiences were typical of the general EE service users' experience, this

variation aptly highlights the complex and imperfect nature of therapeutic service delivery and how the ideal model and timeframe is rarely met. My idealistic vision that all participants would have exactly the same process, did not account for variables that would impact how EE can be implemented, such as client absences due to external factors such as bereavements, therapist holidays, shortages of therapists, increased therapy demand at certain points in the year and difficulties in obtaining therapy rooms in GP practices.

Interview Design

As advocated by Smith's (1999b) version of IPA and tending to be the preferred form of data collection for IPA studies (Reid, Flowers & Larkin, 2005), one-to-one semi-structured interviews were selected to collect the data. This selection was also motivated by the opportunity it enables for an in-depth engagement with a small sample, which is required in IPA (Smith et al., 2009, p.57).

At the beginning of the initial interview, informed consent (Appendix D) was obtained from the participants and a debriefing (Appendix E) was included at the end of both of the participants' interviews. Further details about this are provided in the 'Ethical Considerations' section. An interview schedule was used, taking the perspective put forward by Smith et al. (2009) that:

> *"By constructing a schedule, the researcher is thinking of virtual maps for the interview, which can be drawn upon if during the interview itself, things become difficult or stuck. As a consequence of this preparation, the researcher is generally able to be a more engaged and attentive listener, and a more flexible and responsive interviewer" (p.59).*

The schedule consisted of open-ended questions, as Smith et al. (2009, p.57) suggest, to enable a rich, in-depth participant-led exploration on the experience of EE (Appendix A). Suitable prompts and probes were used to aid the participants in detailing their experiences and to extract the implicit meanings of their experience. This followed Smith and Osborn's (2008) guidance, that the participants should "speak about the topic with as little prompts from interviewer as possible. One might say that you are attempting to get as close as possible to what your respondent thinks about the topic, without them being led too much by your questions" (p.61). As such, I avoided directive or closed questions and refrained from making

any interpretational statements, or introducing new words into the interviews, which may have been my own interpretation and bias. I ensured that throughout the interview the content and meaning of the participants' accounts were clarified and frequently checked that my own understanding of the participants' experience was accurate, in order to stay as close as possible to their experiences and ensure the findings were transparent.

As aforementioned, the research aimed to capture the participants' subjective experiences of EE and this required me to be open to negative feedback. Therefore, reflexivity played an integral role as I needed to be aware of how my position as a practitioner at EASE Wellbeing may have influenced my ability to accurately reflect upon what the participants described. The team at EASE Wellbeing made it clear that the research provides invaluable data from the clients' perspective and thus would be beneficial to the development of EE regardless of the findings, thus I did not experience organisational pressures in that regard. If participants only described positive experiences, I ensured questions were included about less useful aspects of the therapy and the therapeutic relationship and strove to give equal time to explore this. The use of a reflexive journal was vital in the interview schedule construction, enabling the documentation of the decision-making processes involved in including certain questions and tracking how the wording of questions was meticulously considered, in the hope to reduce the risk of biasing the flow.

To develop the interview schedule, I took a 'funneling' approach (Smith & Osborne, 2008, p.62) and started with a very general question 'Please can you tell me about your experience of the therapy you received?', before addressing some more targeted areas. This was to give the participants space to go in whatever direction seemed most important to them and to reduce the extent that my own biases might influence the exploration. But also, by asking the participants to describe a fairly general, but also descriptive experience to start with, I felt encouraged the participants to quickly become accustomed to talking (Smith et al., 2009, p.59) and set the ground for us to begin to develop a working relationship.

Following this, some more specific questions were asked to deepen the exploration and consider some notions that have been highlighted as relevant for therapeutic outcome and process research in the literature. For example, this included literature on significant events in EPT (Cooper & McLeod, 2015; Oliveira, Sousa & Pires, 2012), the change interview (Cooper & McLeod, 2015), client experiences of therapy and helpful factors (Clarke, Rees & Hardy,

2004; Lamont, 2015; Timulak, 2007), qualitative research on process and outcomes (Elliott, 2010; Elliott, Slatick & Urman, 2001; Timulak & Creaner, 2010) and common factors (Duncan, 2013; Wampold, 2007, 2015). The thinking behind including some more specific areas derived from previous research, was that while some participants might naturally discuss these aspects just by being asked the first general question, other participants might be less forthcoming and need these more specific questions to help them focus on aspects of their experience and elicit more detail. To construct the more specific questions, I kept in mind that "The plan for IPA interviews is an attempt to come at the research question 'sideways'…to set the interview as an event which facilitates the discussion of relevant topics, which will allow the research question to be answered subsequently, via analysis" (Smith et al., 2009, p.58).

Following the pilot interview, I discovered the need to prioritise questions, to ensure that the interview fitted within the designated timeframe. Once I had written an extensive reflexive piece, as I did with all subsequent interviews, I chose to leave out a question regarding 'a significant moment in therapy' and how the participants' 'hopes and expectations for therapy, changed over the course of therapy'. This decision was based on my sense that these questions were more leading than others, which were more of a "gentle nudge" (Smith & Osborn, 2008, p.61) and if relevant, these areas seemed to be covered in the other questions. It is worth mentioning here that all interview questions were asked for all of the participants, even if they had already been covered previously, to ensure that they did not have anything further to say on the topic. This was to guarantee that equal opportunity for discussion was given to each question, with each individual.

Two interviews were conducted with six of the seven participants. The initial interview lasted sixty to ninety minutes and was held between one and two weeks following each participant's final session of therapy. This timeframe was chosen to help avoid the participants' memory erosion and increase the likelihood of participation (Langdridge & Hagger-Johnson, 2009). The participants also had an individual three-month follow-up interview and the interview schedule for this can be seen in Appendix B. These interviews lasted between forty-five and sixty minutes. A follow-up at three months was decided upon, due to the fact that clients of EASE Wellbeing have a three-month review, at which point they have the opportunity to begin a new contract of therapy. Therefore, the follow-up interviews were scheduled before any new contracts for therapy commenced, whilst also allowing enough time for participants to further

reflect upon their therapy and for therapeutic outcomes to be integrated into the participants' lives.

Smith et al. (2009) describe the inclusion of follow-up interviews as a "bolder" and "more adventurous" design, however they also appreciate that the subsequent analysis can be demanding for the analyst (p.52). Accordingly, from the pilot study I identified that the follow-up interview risks becoming increasingly researcher-led. I had an abundance of initial statements that I wanted to expand upon, some of which I reflected were more for my own interest and this alerted me to the fact that the follow-up interview schedule construction would need to be diligently managed to protect against this. I will discuss this further in the 'Stages of Analysis' section (Chapter 4).

Nonetheless, as Weiss (1994) states:

> *"It is almost always desirable, if time and costs permit, to interview respondents more than once. You have to keep your frame pretty narrow if you plan to cover it all in a single sitting. Furthermore, a first meeting is partly about establishing the research partnership. Interviewer and respondent get to know each other, get a sense of the rhythm of interchange…Also, in the intervening time the respondent may have begun thinking about the areas discussed, and memories may have surfaced. Or the respondent may have been made more sensitive to the issues of the interview and may therefore have newly noted incidents worth reporting…With increasing contact and increasing confidence in the research procedures respondents are likely to be more willing to report fully"* (p.57).

Therefore, the follow-up interview was seen to allow the participants to provide any further reflections on their therapy experience and to address any satisfaction bias in the initial interview, which may have arisen from recently finishing therapy (Rosenman, Tennekoon & Hill, 2014). Furthermore, as Flowers (2008) describes, the cognitive load in interviews of remembering what the participant has said, ensuring reflexivity and utilising probes and prompts, in order to funnel information is very taxing, resulting in many lost opportunities for a deeper exploration. As I was inexperienced at using IPA as a research method, I found the follow-up interview enabled me to highlight any comments from the initial interview, which may have deserved deeper exploration or clarification, but were missed at the time.

Accordingly, the schedule for the follow-up interview started with a general question for further reflections to be provided, followed by the outcome questions from the initial interview being repeated. Then time permitting, some more specific questions concerning areas for expansion or clarification based on the initial interview were asked. The follow-up interview schedule can be seen in Appendix B and an example follow-up transcript in Appendix O.

Interview Setting

The interviews took place in a private room at Longrove Surgery, the same location to where the participants received therapy. This was decided upon because the interviews were required to take place at NHS premises and as the participants were being recruited from Longrove Surgery and the practice had already agreed to aid the undertaking of the research, it seemed the most appropriate option. I also thought that the familiarity might help to reduce anxiety and aid context-dependent memory (Godden & Baddeley, 1975). Moreover, the interviews would be easily accessible to participants, because they all lived locally to their GP surgery, limiting the burden placed on them in terms of time and finances for travel.

That said, I noticed that interviewing at the same location that therapy had taken place, might have contributed to the participants seeing the interview as what felt like an opportunity for further therapy. Qualitative interviews can seem to resemble a therapeutic exploration at times and with delicate topics being discussed, drawing a clear distinction between the two roles may always be a challenge. However, I was aware that the pilot participant drew comparisons between myself and his therapist and though this is an assumption, I felt that the shared therapy-research location may have hindered the participant in seeing me as an independent researcher and separate to EASE Wellbeing. Therefore, to manage this potential limitation of a shared location in the following interviews, I believed it to be essential to give more time to clearly distinguish the boundaries between my role as a researcher and an EASE therapist and reiterate the purpose of the interviews.

Ethical Applications

The research is compliant with codes of ethics established by Middlesex University, the British Psychological Society and NHS ethics guidelines. Ethics approval has been obtained from NSPC and Middlesex University research ethics committee (Appendix M). Additionally, this study was reviewed and given favourable opinion by 'East of England – Cambridgeshire and Hertfordshire' Research Ethics Committee (Appendix L). Written consent was obtained from EASE Wellbeing (the sponsor) to conduct the study with clients from their service and to access their client data (Appendix J).

Ethical Considerations

It is not enough to simply follow guidelines laid down by ethics committees that rarely address the intricate and specific ethical dilemmas that arise during each research study, so I engaged in a relational ethic of care (Ellis, 2017; Gilligan, 1982), in the same way I would within my therapeutic relationships. This meant that I ensured that there was a collaborative exchange, where an open and not exploitative attitude was adopted, in order to put the participants' needs first (Finlay & Gough, 2003). It was ensured that no harm was incurred to the participants and critical reflexivity was maintained throughout (Etherington, 2004).

Informed consent was obtained from the participants at the beginning of the initial interview (Appendix D). They were provided with a 'Participant Information Sheet' upon contacting the researcher, to enable them to make an informed decision about partaking in the study (Appendix C). This detailed the purpose of the study, the process, confidentiality and made explicit any risks involved. They were informed about the risk of emotional distress that could be caused from reflecting upon their experience of therapy, where issues recently explored in therapy may be talked about. Additionally, the participants were asked from the first point of contact about any individual factors that might lead to a risk of harm, so that the appropriate precautions could be taken to minimise such risks. The participants were informed about the voluntary nature of the study, their right to withdraw at any point in the research and that should this happen any data which may be personally identifiable, including audio recordings, would be destroyed. Additionally, as Brinkmann and Kvale (2008) suggest, it was clearly stated that there were no repercussions for not partaking in the study and their current and any future therapy with EASE Wellbeing would not be affected.

The participants received a written 'Debriefing Letter' (Appendix E) and were also verbally debriefed at the end of both interviews, in order to encourage reflection upon any unsettling emotions that may have arisen during the interview. This was essential to ensure non-maleficence, by identifying any foreseen harm or misconceptions and to check that the participants were in a safe place to leave (Flick, 2007). Additionally, the contact details of the researcher, the research supervisor and NSPC were provided to the participants, as well as contact details for external support services, such as free helplines, should the participants have any concerns following the interview. Additionally, as clients of EASE Wellbeing, the participants were informed that they could receive further free support through the service (subject to EASE Wellbeing's standard assessment process). Complaints procedures, via both NSPC and the NHS, were also detailed.

With qualitative research, it is only possible to ensure anonymity, rather than confidentiality due to the fact that the research supervisors and examiners have access to some of the participants' data. That said, the participants' identities were protected throughout the research process. In keeping with the Data Protection Act, all recorded data was encrypted and kept in a secure cabinet and will be destroyed one year after the research is completed and any identifiable information was modified. Unique codes that are only identifiable to the researcher were used and personal information was stored separately to the transcripts. Additionally, in order to be transparent, the participants were asked if they would like to be sent a copy of the research findings on completion of the dissertation (Bager-Charleson, 2014).

The participants were informed that their confidentiality would need to be broken in circumstances where information they provided was legally required to be passed on (Bager-Charleson, 2014). Likewise, they were advised that if they were to reveal that their therapist acted unethically, this would need to be reported to the therapist's supervisor at EASE Wellbeing, in order to be looked into internally. However, depending on what comes out of this report and the nature of the complaint, the researcher may encourage the participant to file an official complaint to the therapist's professional accrediting organisation, which the researcher could help to identify. The participants were informed of these procedures prior to consenting to the interview (Cooper & Mcleod, 2015).

There were further ethical considerations in terms of my role as both researcher for this study and practitioner (Costley et al, 2010) at EASE Wellbeing. To ensure transparency and avoid

any deception, it was important to be honest about my role at EASE Wellbeing from the outset and the consent form detailed EASE Wellbeing's role as sponsor. However, it was emphasised that the research was not connected to EASE Wellbeing and it was essential to be clear to EASE Wellbeing (to avoid organisational pressures and role conflict) and the participants (to assure confidentiality), that EASE Wellbeing would only have access to the overall findings that have been published in this dissertation. EASE Wellbeing did not see the transcripts, hear the recordings or have any identifiable participant data.

Similarly, the participants' therapists did not know whether their client had chosen to take part in the study or not and did not have access to any of the participant data. This was particularly important to reiterate to the participants, because as a colleague, I knew the therapists that the participants had seen and this may have influenced what the participants felt they were able to say in the interview. The overall feedback provided by the participants within the interviews was fairly balanced, suggesting that the influence of my insider-researcher role at EASE in terms of biasing the feedback, was limited. That said, I noticed that the participants were exclusively positive about their therapists and negative feedback was directed at the therapeutic process. This raises questions as to whether there was a clear distinction between the therapeutic relationship and aspects of the therapeutic process. Or perhaps it felt safer to give negative/constructive feedback about the therapeutic process, rather than a therapist. If this is the case, the question then raised is whether this would have been the case generally, or whether my insider role influenced this.

Accordingly, it was essential to ensure continuous reflexivity about how my role as both researcher and practitioner at EASE Wellbeing may influence the interview and interaction with the participants and to repeatedly emphasise that the research was separate to the participants' current and future therapy and that their therapy would not be affected by what they told me during the interviews, or if they decided not to partake or withdraw (Finlay, 2003). As Costley (2010) advises, an ethic of care towards the participant was at the forefront when managing this practitioner researcher dual relationship.

In terms of myself as the researcher, research supervision, external consultation, placement training and therapy allowed me to feel supported.

Reflexivity

Qualitative research cannot take up a position of objectivity as the researcher, the researched and the research topic cannot be independent of each other (Coyle, 2007). However, it is the epistemological assumptions of a methodology that determine the position that it adopts with regards to the role that the researcher is seen to take in constructing meanings and producing the findings, and consequently the emphasis placed on researcher reflexivity. IPA, as a method rooted in hermeneutic phenomenology, recognises that the nature of the encounter between the participant and researcher, as well as the researcher's own worldview and context will impact the findings. As such, the researcher is given an active role in making sense of the participants' sense-making and therefore the researcher is inherently implicated in the findings. While the research reflects the participants' accounts of their experience of therapy, the researcher's involvement inevitably impacts what is cast into shadow or illuminated throughout the research. The literature included, questions and probes asked, non-verbal communications, the strength of each relational encounter, the follow-up questions selected and the researcher's interpretation of the participants' experience in the analysis are just a few examples (Smith et al., 2009) and as such, reflexivity plays a crucial role for IPA researchers.

Reflexivity can be understood as "the capacity of any system of signification to turn back upon itself, to make itself its own object by referring to itself" (Myerhoff & Ruby, 1982, p.2). It requires a continuous internal dialogue and critical self-evaluation of how one's position as researcher and the pre-understandings, beliefs, interests and assumptions that one brings to the research, might impact the research process and outcome (Berger, 2015). As Finlay (2011) relays, it is paramount that this takes place continuously throughout the research project and is vital in ensuring aspects of trustworthiness, transparency and accountability that aid the quality of research.

Guillemin and Gillam (2004) describe how "reflexivity requires that we make transparent the ethical decision-making processes that we engage in so that others can learn from these 'ethically important moments'" (Etherington, 2016, p.2). Therefore, throughout the project, the reasoning behind how certain decisions were made has been clearly outlined, in order to make the reader aware that the project was underpinned by theoretical, epistemological and ontological assumptions, as well as personal, interpersonal and organisational influences (Mauthner & Doucet, 2003). The consideration given to constructing an open

phenomenological interview schedule, how to manage my role as both therapist and researcher at EASE with regards to conducting interviews and storing data, the thought process behind deciding to include just one interview for Casper are just a few examples. Furthermore, as recommended by key writers on reflexivity (Bager-Charleson, 2014; du Plock, 2014; Etherington, 2004; Mann, 2016), a research journal was diligently used from the outset of the research enquiry. I explored my personal interest in the topic and what had led me to this particular research project, I made explicit my experience of the phenomenon studied and therefore what I expected to find. This was to enable assumptions to be explored and bracketed and also to capture how my ideas developed in light of the participants' accounts. It was used to note my reflections of each interview, including my experience of each encounter with each participant, initial questions, themes and concerns. It encouraged me to reflect on my role as researcher, the impact of the research upon my professional and personal life and my own continuously evolving experience of the research process (Janesick, 2000) and of EE, as well as how I might have been impacting the research process and findings. Furthermore, the research journal was particularly essential within the interview design, data collection and analysis stages, in order to guarantee that an accurate representation of the participants' experiences was captured and to safeguard against researcher allegiance bias (Etherington, 2004).

Another tool to aid reflexivity was the use of a 'critical friend'. This was a doctoral student on my course who I involved in a number of ways that I will now describe. Before conducting the pilot interview, the critical friend interviewed me using the interview schedule. This was important to check the openness of questions and experience which questions I struggled to provide rich detail for and therefore where probes and prompts might be particularly valuable for drawing out my implicit meanings. This experience was important to sensitise me to the experience of being a participant, as well as to reveal my own experiences as a client of existential therapy, albeit I was drawing on experiences from private open-ended existential therapy.

Following this, using my perspective as an EE therapist, I was then asked the questions regarding outcomes on the interview schedule. This was to identify what I expected to find, with the help of the critical friend probing me to develop richer meanings and understandings that had not unravelled from written reflections alone. For example, I strongly believed that the time-limit would be experienced as sufficient and perhaps serve to focus the work and meet

expectations, which I realised was largely based on what I had been taught in the training for EE. Moreover, based on informal feedback that I received from clients experiencing EE, and based on their CORE Goal-attainment scores, I expected the goal-orientated and fast-paced nature of the intervention to be welcomed. I expected the outcome measures to be seen as unhelpful based on feedback received when implementing the scales and also from my own experience of the RGT, having asked an RGT clinician to administer one to me. Lastly, from discussions with other therapists about how they practiced and understood the EE protocol, as well as from supervising trainees, I expected that while an EP approach would be experienced by clients, the EE protocol would not be clearly adhered to and therefore I doubted that elements of it would be described in the question regarding process.

Finally, an additional key task that the critical friend performed to aid my reflexivity, was challenging my choice of questions for the follow-up interviews. This was to ensure that the questions included were to clarify and expand upon the participants' accounts, striving to get an insiders perspective of EE and not born out of my own interests.

This section has strived to relay the pivotal role that reflexivity has played in this research, however sections of reflexive process have been included throughout this dissertation, starting with 'Introducing the Researcher' (Chapter 1), to then relaying certain decision-making processes involved in 'Searching the literature' (Chapter 2), 'Choice of Method', 'Interview Design' (Chapter 3), and 'Ethical Considerations', to name just a few examples. The following section will expand upon this by including an extract from my research journal in terms of the reflections that emerged from the pilot study.

Reflections on the Pilot Study Data Collection

As mentioned, I started a reflexive diary at the beginning of my research journey and immediately after each interview I noted my feelings, thoughts and initial impressions. This was how I came to a number of learning points from the data collection stage of the pilot study, which I will relay here.

The first point was that I was very anxious when the interview started to take a more therapeutic route. I was concerned that the participant's knowledge that I am a therapist, as well as a researcher, might lead the participant into a position where they might feel over exposed and vulnerable. With this realisation, I then felt restricted and robotic in my responses, being overly conscious not to let it become therapy. I noticed that the question 'Please can you tell me a bit about what brought you to therapy?' took the exploration into a more therapy-like arena and at times the link to the research question became increasingly tenuous. It was difficult to strike the balance between ensuring 'horizontalisation' (Husserl, 1970) and a participant-led interview, while determining when the narrative had lost its relevance to the research question and I was required to direct the participant back in an empathic and non-rejecting way.

Weiss's (1994) description that "The techniques of qualitative interviewing may seem uncomfortably close to constituting psychotherapy unsought by the respondent" (p.134) resonated with my fear of going into the realm of therapy and his definition of the differences between therapeutic and research interviewing acted as my guide. I was able to identify the many similarities in the method of interviewing and therapy, which the participant was himself highlighting- listening closely, encouraging detail, thoughts and feelings, but the key was to remember that the differences lie in the aims and practices of research interviewing and therapeutic interviewing.

What helped me to navigate this balance, was remembering that the aim of research interviewing is to elicit information for the study, in which the interviewee is a partner in developing research information. I considered changing the wording on the 'Introduction Letter' (Appendix F), thinking that this could help avoid further interviews becoming too therapeutic, however due to NHS ethics this would have required submitting an amendment and I did not feel the benefits warranted the inherent time delays for this. Instead, becoming more disciplined in bringing the participants back to the research question if they went on a tangent, seemed the

best option for future interviews. As part of this, I allowed my responses to be guided by the question "Does this material help illuminate experience in the area of study?" (Weiss, 1994, p.79).

An additional learning point was time management- having the ability to allow the participant the space to open up in response to each question, whilst ensuring that each question got equal time and consideration (if the participant felt it was relevant to their experience). I noticed that I allowed more time and space at the beginning of the interview and the participant's energy and time started to run out in the final questions. This was linked to the above point, that sometimes emotionally charged topics were being discussed and having the confidence to bring the participant back to the research question in an empathic way was challenging, but was a skill that I developed in subsequent interviews, to ensure all questions were treated with equal importance.

I noticed that the participant naturally covered much of what I was going to ask, but conscious to ensure that all participants were asked the same questions, I asked them regardless. This did not lead to smooth transitions, however as my confidence in the follow-up interview developed, I endeavoured to make my questions seem like "continuations of the respondents own associations", encouraging the participant to say more about what was already his focus where possible (Weiss, 1994, p.80).

On the subject of the follow-up interview, the pilot study revealed the importance of the inclusion of a follow-up for exploring client reported outcomes, as I immediately sensed a far less positive light was cast on physical and mental wellbeing at this point. The need for ongoing support was immediately apparent and a sense of helplessness and disempowerment was present. Therefore, the follow-up interview seemed essential to aid the understanding of the process of change and motivational factors, but mostly it alerted me to the need to be prepared to stay with difficult feelings of demotivation and helplessness without further therapy and the discomfort in refraining from stepping into a therapeutic role. As well as the need to provide the relevant signposting to further support and containment in the debriefing.

Most importantly though, I felt immensely privileged to have been admitted into another's private experience and the participant's therapy experience completely came to life in those

moments. Consequently, the daunting process of interviewing became the most treasured part of the research.

Concluding the Research Methodology and Data Collection

This chapter has outlined important method, procedural, ethical and reflexive decisions and considerations, that were made and integrated based on the epistemology outlined, in order to form the research methodology for this study. The next chapter will detail the method of analysis.

Chapter 4: Method of Data Analysis

Giorgi's (2010, p.3-22) critique that IPA's flexibility and non-prescriptive approach results in the interpretative element of analysis not being methodical, thus jeopardising the validity of the research, is not to be disregarded. Therefore, interview transcripts were phenomenologically analysed according to the structured procedure put forward by Smith et al. (2009) and this section will clearly outline the steps I took during the analysis stage, in the hope to make Giorgi's (2010) apprehensions inapplicable to this study and to ensure a key tenet of IPA is incorporated- that of transparency.

Data Protection and Storage

Participants were each assigned a pseudonym after their initial interview and all participant information was only identifiable by this pseudonym. The spreadsheet matching the participants to their pseudonyms, was stored on an encrypted USB. The audio recordings of the interviews were transferred onto an encrypted USB and deleted from the audio recorder immediately. The following files were compressed and encrypted using a symmetric AES-256 key:

- Data files containing the original audio recordings of the interviews
- The spreadsheet containing the information needed to connect the pseudonyms to the participants' real identities

This procedure guaranteed a high level of protection during the storage time and guarantees the destruction of the files at the appropriate time, via disposal of the encryption key. These data files have been stored in a locked cabinet, in a secure room at Longrove Surgery (NHS premises), and will continue to be stored here until the storage time has ended (one-year post-completion of thesis). Only I, as the researcher, have access to the research data during and after the study. The key to decrypt the AES-256 secure compressed archive files was generated by me and stored securely under my responsibility. The destruction of the randomly generated key will automatically destroy the files by making their decryption impossible.

Stages of Analysis

Transcription

The first analytic step prior to transcription, consisted of listening to the initial interview audio recording several times and noting any memories and reflections. This was to become familiar with the data (Frost, 2011), but also to acknowledge and bracket any initial thoughts and assumptions (Smith et al., 2009). Following this, the interview recording was transcribed into anonymised verbatim on a Microsoft Word document. Any personally identifiable information was anonymised (removed or edited from the transcript) and pseudonyms were applied. Within the transcript the researcher was identified as 'R' and the participant as 'P', followed by the intervention number. The transcription process took place in a private room at Longrove Surgery, to ensure that no personally identifiable information left NHS premises. Only anonymised and redacted versions of the transcript were accessed outside of Longrove Surgery.

After listening to the recording twice to check for the accuracy of transcription, I then began to read the transcript to actively engage with the data and once again I recorded initial notes and first impressions in my reflexive journal. This helped to further gather and organise my thoughts and bracket any initial assumptions. The initial interview was transcribed and read twice before the follow-up interview was constructed and conducted.

Constructing the Follow-up Interviews

Flowers (2008) describes how in a two-interview design, "the interaction may become more broadly 'interpretative…as social dynamics and 'response bias' potentially amplify or reify analysis interpretations" (p.26). Therefore, as an inevitably more researcher-led stage, it was crucial to diligently manage the follow-up interviews. Interestingly, as I started to immerse myself in the data from the transcript, it was evident that my emerging conclusions from fully analysing the initial interview first, before conducting the follow-up interview, would influence the direction of the follow-up interviews questions and analysis. Therefore, to reduce the risk of the follow-up interview becoming researcher-led, the initial interview was not fully analysed before the follow-up interview was completed. Having finished the transcription process, the transcript from the initial interview was only read twice, with areas to be clarified or expanded upon in the follow-up interview highlighted. After the completion of the follow-up and transcription process, the two interviews for each participant were then analysed together as a

single “mega-interview” (Lamont, 2015, p.89). Though, the individual transcripts were initially analysed separately, in order to preserve their uniqueness and any extracts of quotations included in the dissertation specify which interview they are taken from.

Consequently, the next step of the analysis process was identifying and highlighting areas that could be beneficial for further clarification or expansion in the follow-up interview. My inevitable interest in the participants’ accounts and eagerness for more detail meant that an abundance of potential further questions emerged. As such, continuously reminding myself of the research question was essential for refining this. Also, I realised that in ensuring that the interviews were as participant-led as possible, this would most likely limit the available time for specific questions and thus there was an essential need to prioritise.

Initial Noting

Having transcribed the follow-up interview, I started the initial noting stage of analysis. I coded the data from the two interviews in three ways: descriptively (staying as phenomenological as possible), linguistically (para-verbal and verbal expressions, repetitions, laughter) and conceptually (interpretations, what might be implicitly revealed, drawing upon my own perceptions and understandings to open up a variety of provisional meanings, as well as queries) (Smith et al., 2009, p.83-91). I meticulously worked through each line of data and these codes were noted in a column on the right of the Word document, using normal, italic and underlined script to delineate between the three categories. I started with the descriptive, then linguistics and finally when I was very familiar with the data moved to the conceptual comments (see Appendix P for a sample excerpt). This was a very lengthy iterative and inductive process, but one where I felt very immersed in the data.

I continuously doubted my ability during this stage, particularly developing the conceptual comments, where I found the interpretative leap from a purely phenomenological and descriptive portrayal of the participant’s experience, uncomfortable. Reassuringly, Smith et al. (2009) describe this stage as the most complex one, as it demands that the researcher “uses themselves and their own thoughts, feelings and experience as a touch-stone”, whilst also keeping the participant’s experience at the forefront (p.90). The critique of IPA often being too interpretative, alongside my acute awareness of my role as insider-researcher and tendency to be as phenomenological as possible, cautiously and tentatively introducing hermeneutic

interpretations in therapy, I believe contributed to my anxiety at this stage and striving to do IPA in the 'perfect' way. To guide me through this stage and particularly with the conceptual comments, I kept in mind the essentiality of the analytical focus of IPA being directed towards extracting the participant's point of view and attempts to make sense of what they have experienced (Smith et al., 2009, p.82) and remembering that what is important is that the interpretation was inspired by and arose from attending to the participant's words, rather than being imported from outside (p.90). As an 'insider researcher', it felt particularly important to diligently check the robustness of this stage and therefore I joined an IPA research group and involved a 'critical friend' who checked portions of the analysis, in order to achieve this.

Development of Emergent Themes

Next, I began the more interpretative component of the phenomenological analysis, developing emergent themes in phrase form (Smith et al., 2009). Emergent themes were developed to reduce the vast volume of data, while also striving to maintain the richness and complexity of the data (Smith et al., 2009, p.91). For this stage, I found it best to print a hard copy of the annotated transcript and working mainly with the initial noting (which corresponded closely to the original transcript), I started to develop emergent themes, written in pen in the left-hand margin, which I then recorded on the Microsoft Word document.

The emergent themes stayed close to the participant's words and were grounded within and captured the essence of a specific section of text. But, at the same time they were influenced by the whole text and what it may mean for the particular participant to have such an experience in the context and also taking a more abstract nature by drawing upon psychological ideas (Smith et al., 2009, p.92). This constituted part of the hermeneutic circle in which the emergent themes were developed in relation to the whole and the whole was interpreted in relation to the emergent themes (or parts).

I was overwhelmed by the richness of data, as the participants spoke at great length about their therapy experiences. While this was beneficial in the sense that rich reflections were provided and my limited input reduced the risk of biasing the flow, it led to an incredibly lengthy process of extracting emergent themes from the data and becoming comfortable immersing myself in the hermeneutic cycle was a considerable challenge. Due to my fear of moving away from the participants' precise words, I initially created an abundance of emergent themes. Many of these

were similar and I allowed for many replicates to get an idea of the frequency of emergent themes. To do this, I wrote each emergent theme onto a separate coloured piece of card, as recommended by Smith et al. (2009). Image 1, reveals the overwhelming number of emergent themes extracted from the pilot interview:

Image 1: Extraction of Emergent Themes

I moved the cards around to search for connections and group the emergent themes (Smith et al., 2009, p.92-100). I grouped emergent themes that were duplicates or conceptually similar and applied a polarisation process, in which themes that were polar opposites to each other were grouped together. There were some themes that clearly converged or were almost replicas and thus were absorbed into stronger themes, while others felt like outliers, though important. The frequency that themes appeared was taken into account, as a potential indicator of significance to the participant. Once I had grouped the pieces of paper, these clusters of emergent themes were given labels that I felt best represented their conceptual nature (Frost, 2011). From this, a master table was created, which consisted of cluster themes. The above steps were repeated for all participants and their transcripts were read using the previous master-list as a reference point for emerging themes and any additional themes were added to the master list.

At first, I grappled with a need to incorporate structure to organise the themes. This may have been part of what Smith et al. (2009) warn about, that the fragmentation of the participant's experience and re-organisation of data can feel uncomfortable. Yet this process in the analysis is key to the hermeneutic circle, with the whole interview being broken into parts, before becoming a new whole at the end of the analysis. However, I noticed that once the analysis

moved beyond the first participant, entering the hermeneutic circle and analysing the data in a less fragmented way became easier to reach.

An additional stage to the IPA process described by Smith et al. (2009) was included at this point. In cases where I had asked the participant to clarify a point made in the initial interview, I cross-referred between the two transcripts, in order to establish if there was more detail offered to what had been said initially and if there were any distinct divergences in perspective conveyed between the interviews. As Lamont (2015) suggests, "this within-participant step of analysis (was conducted) subsequent to the individual process for all transcripts in order to further manage the increased analyst-led nature of follow-up interviews" (p.91). The next key stage, as described below, was to identify patterns and commonalities between the participants.

Cross Participant Analysis

This step involved a cross participant analysis, to move from the particular to the shared by looking at emerging patterns, convergences and divergences, commonalities and nuances across the transcripts (Eatough & Smith, 2008). Themes were collated again using the polarisation process, in which themes denoting opposites were grouped together and the frequency at which certain themes emerged was also taken into account. This iterative process of refining, regrouping and the absorption of similar themes into stronger themes was repeated until all the transcripts had been analysed and superordinate themes developed. When analysing the later participants' transcripts, it was vital to bracket off themes from the previous interview to ensure new ones emerged. Fortunately, there was at least a month in between the analysis of each participant's interviews, which should have helped to bracket my conclusions as much as possible, in order to apply a truly phenomenological curiosity to the data.

The participants were given the option to be sent their anonymised transcripts via email, in order to check them for any discrepancies in interpretation. This was to ensure that the participants' experiences were represented as accurately as possible and to ensure the validity of interpretation (Finlay & Gough, 2003). Though, none of the participants opted for this stage, my research supervisors who are experienced in IPA coding and analysis, strove to safeguard the credibility of this process and check portions of the transcripts, in the hope to protect against researcher allegiance bias.

Development of Superordinate Themes

Superordinate themes were then developed, which represented a few clusters of themes that all shared a common connection, which will be discussed in more detail in the 'Findings of Analysis' section (Chapter 5). Again, in establishing the superordinate themes, the frequency of occurrences across the participants accounts were noted as potential identifiers. I found the creation of superordinate themes with just one participant in the pilot study difficult, struggling to zoom out from the specific and move to the general. Yet, with further interviews the zooming out process to search for recurrences happened more naturally and three distinct stages became apparent, that were aligned to the participants temporal experience of EE. These stages included; that of entering EE, time spent on the therapeutic work and experiences of the relationship and leaving EE. In fact, these contexts quickly became apparent during the interviews themselves and it is worth mentioning that the chronological structure to my interview schedule is likely to have facilitated this abstraction process. The prevalence and clarity of these three superordinate themes, support the validity of the findings, because they are in line with the suggestion put forward by Smith et al. (2009), that a superordinate theme should emerge in at least a third of the interview.

Reflexivity in the Data Analysis

IPA has often been critiqued for heavily relying on interpretation at the expense of the phenomenological component (Giorgi, 2010; Langdridge & Hagger-Johnson, 2009). Giorgi (2010) questions why phenomenology is part of IPA's name when "the originators of IPA have given no indication as to how the method is related to the method of philosophical phenomenology" and suggests that instead it should be called "interpretative experiential analysis" (p.5). However, IPA is firmly rooted within hermeneutic phenomenology, in which all description is seen to involve interpretation, interpretation is not seen as an additional procedure, but a basic structure of our 'being-in-the-world' (Heidegger, 1962). Therefore, IPA does not claim to transcend assumptions, but instead uses pre-knowledge reflexively in a cyclical manner.

That said, Langdridge and Hagger-Johnson (2009) describe how in IPA "there is a very real danger with phenomenological analyses of this kind that the researcher begins to theorise to quickly, moving beyond the data and therefore failing to truly grasp the meaning of experience for participants" (p.447). Therefore, it is *how* interpretation is included and reflexivity is applied that is essential. This research took the view that interpretation should highlight what might be implicitly revealed, drawing upon one's own understandings and meanings, but only when the researcher is very familiar with the data. This is to ensure that any interpretation is firmly grounded within the data and does not result from importing in external structures and frameworks that would impose meaning upon the participants' experience. As such, I ensured that I spent a considerable amount of time documenting initial thoughts and themes that came to mind both from conducting the interviews and initially reading the transcripts, so that I could become aware of my pre-assumptions and understandings, so as to then be able to see the data afresh. But also, so that I could return to these reflections to update them in light of the new insights reached. For example, language frequently used both in existential therapy and EE such as 'experimentation', 'depathologising', 'goal setting', 'worldviews' and 'phenomenological enquiry' would be at the forefront of my mind upon hearing participants' descriptions that seemed to be describing such aspects. However, it was of paramount importance that these were set aside in order to really capture the participants' meanings and see such experiences afresh, reaching a richer and more nuanced description of their experience of such aspects. Later, I could then re-examine these reflections in light of the new information and questions, in order to update them and exploit them reflexively as a source of insight.

As such, a rigorous cyclical process was applied to reflexivity and the process of interpretation, in which I moved back and forth from examining my personal assumptions as the researcher, to then returning to the participants' experience afresh, thus both bracketing preunderstandings and exploiting them reflexively as a potential source of insight (Finlay, 2009). I became aware of pre-existing beliefs, so that I could then temporarily set these aside in order to meet with a participant, or a participant's data afresh and strive to get an insiders perspective, before then moving around the circle again to re-evaluate my pre-existing beliefs in light of the new information and draw on any insights. Subjectivity was placed in the foreground so that I could see how it was impacting the research process and findings, and to see what belonged to both the researcher and the researched. As Finlay and Gough (2003) suggest, I ensured that researcher reflexivity was a process of reflecting upon my interpretation of the participants' experience of the phenomena studied, so as to move beyond the partiality of preunderstandings, but always ensuring that such reflexivity had the aim of focusing on the participant and phenomena and does not become a privileging of the researcher.

As with the interviews, I was acutely aware of my strong vantage point as 'insider researcher' and therefore the particular need to systematically approach interpretation and diligently practice reflexivity. It was therefore challenging to move from a hermeneutic of empathy, where the focus is on phenomenologically gaining an insider's perspective and prioritising the others' worldview, to a hermeneutic of questioning, where the focus is on making sense of the participants' experiences in light of the research question and requires a critical engagement with the participants' accounts, in order to enter a deeper layer of meaning and question it beyond that which the participants' may be able or willing to do (Reid et al, 2005). It required me to enter a hermeneutic circle, in order to use myself and my own experience as a touch-stone, whilst also keeping the participants' experiences at the forefront and capture the essence of the text, but also keeping in mind how it is influenced by the whole text and what it may mean for such a participant to have such an experience in such a context (Smith et al., 2009). To aid this balancing act of 'emic' and 'etic' components, I would ask myself if I could imagine the participant voicing my interpretation, or whether upon checking the interpretations in written format they would feel I had deepened their insights into their experience. While Willig (2012) suggests the use of a 'hermeneutic of suspicion' to draw upon theory and uncover that which is hidden in order to develop explanations, I followed the version recommended by Smith et al. (2009) and referred to as the 'hermeneutic of questioning'. This is a milder form

of interpretation that is more in line with a phenomenological exploration, because it does not rely on interpretation that is drawn from theories imported from outside, but instead is born out of playing close attention to the data and is a questioning elaboration of the participants' meaning from a different angle (Smith et al., 2009).

Concluding the Method of Analysis

This chapter has outlined the decisions made and process involved in the analysis of the data from the two interviews for each of the participants. The next chapter will look at the research findings, in which I will present each of the superordinate themes and their associated subordinate themes.

Chapter 5: Findings from the Analysis

This chapter presents the findings of the analysis, capturing the unique experience of each participant, within the context of commonalities in their therapeutic experiences of EE. Three superordinate themes and ten subordinate themes emerged from the analysis and are illustrated in Table 3. Three key temporal stages emerged as the participants described their accounts of their experience of EE, representing it to be a journey and thus I present my three superordinate themes in this way. There was a real sense of movement from one way of being, to another one that was largely unknown, but represented hope for increased wellbeing. The end of therapy either represented the end of this journey or was seen as a springboard to their own continued journey.

TABLE 3: Superordinate and Associated Subordinate Themes

1. The Experience of Beginning EE	2. The Experience of the EE Therapeutic Work	3. The Experience of Leaving EE
1.1 Loss Permeating Existence	2.1 The Value of a Personalised Approach	3.1 Reaching New Awareness & Personal Meanings
1.2 Living Behind the Mask	2.2 How the Therapeutic Relationship is Key to Change	3.2 Towards Acceptance & Authentic Living
1.3 In Search of How to Be	2.3 Stepping Stones to New Awareness	3.3 Short-changed by Time
	2.4 Key Ingredients of Client Openness and Active Participation	

The following section elaborates upon the superordinate and subordinate themes. The initial interview and follow-up were analysed as a "mega-interview", as explained in the 'Method of Data Analysis' (Chapter 4). However, I will indicate which interview the particular extracts are cited from, to enable the uniqueness of each interview to be revealed and to allow for the reader to observe the journey of reported outcomes across the three-month period.

Superordinate Theme 1: The Experience of Beginning EE

This theme describes that which led the participants to engage in the therapeutic process. Collectively, the participants articulated experiencing difficulties in living, largely in relation to facing significant loss of others, crises of identity and challenges to meaning and purpose. In response to much of these experiences, they had been attempting to suppress and mask their feelings from others, rather than expressing them. The participants conveyed a great sense of uncertainty in how to move forward, but put hope in EE to offer an opportunity to re-construe and re-evaluate their experiences, in order to discover a more fulfilling way to live. Entering therapy was experienced as taking a leap of faith from what was certain yet inhibiting, towards uncertain yet open to opportunities. I turn now to discuss each of the three subordinate themes.

1.1 Loss Permeating Existence

The participants presented with significant losses, including loss of self and others, with issues around identity, meaning and responsibility. As well as anticipatory loss in the form of facing up to one's own mortality and the potential loss of one's own and others' imagined future. Some of these losses had been traumatic and shaken the participants' sense of meaning and purpose, resulting in a feeling of isolation from others and disconnection from self. Prior to therapy, they had attempted to manage these feelings using comfort eating, compartmentalising and distracting strategies, but these no longer seemed effective options.

Doogie, Cyprian and Freddie described the enormity of loss of significant others that they had experienced, contributing to their own crises in identity, meaning and purpose:

> *"I lost my first partner at an early age, just as we were about to get married. I lost my best mate in the army, he blew his head off right next to me by accident, and the last counsellor I saw reckoned that I hadn't grieved properly over those and since then I've also had other losses. I've lost both my parents in the last ten years, I've lost my long-term relationship" (Doogie, I28)*

> *"I struggle to cope and talk about it (cries), the experience that I went through changed my life in every shape, form. I tried my hardest to not allow it to affect (ex-wife) and (daughter). The only one that really suffered at the end of the day was me. From watching that advert, I realised very quickly I was wanting to go straight back into comfort eating. I wanted to give up, I wanted to stop the pain" (Cyprian, I54)*

"My life circumstances were all characterised by a sense of loss - loss of my wife in a way, loss of my parents- both were in dementia. There was also a sort of unfortunate incident in my career" (Freddie, I2)

Incidentally, during therapy Freddie's sense of loss was compounded by the sudden loss of one of his parents and Cyprian experienced the sudden loss of a sibling post-therapy, prior to his follow-up.

The participants all described the wide-ranging consequences that these losses have had on every aspect of their lives, including the changing nature of their existing relationships, careers, responsibilities and their future. But there was a clear assertion that what was being experienced was situational, life difficulties and not the result of underlying psychological issues:

"I eat well, I exercise, I keep fit, you know, I'm enjoying, I love my job…I am happy with who I am, I am, but I'm not happy with what I am having to deal with" (Freddie, I12)

"Just a load of things that happened and it was just burn out…if you look at all the things, it's almost like all the ducks standing one after the other and it was just bad" (Casper, I22)

Casper had become overwhelmed by the number of difficulties that he was facing and his need to appear positive with others, had resulted in him becoming isolated from others and he had lost his sense of self. This sense of isolation and uncertainty in facing difficulties in living, was a commonly shared experience for the participants, as the extracts below further highlight:

"It's quite hard then when you have to stand by passively watching. I can't do anything, I can't help her…I just felt so incredibly helpless…she is just disappearing away and I looked at her and she is just so thin and it's just absolutely awful and I can't share that with anyone…I'm scared of the future" (Freddie, I30)

"I couldn't ask my own friends, because they would think I was a wimp. Yeah whereas, when my mum was still alive, or my aunt was still alive or when my cousin was still alive, I could ask them and know that I could get comfort, rather than 'pull your socks up and get on with it'" (Doogie, FU18)

"I found myself getting more and more isolated somehow" (Casper, I23)

Wilhelmina was struggling to accept her son's lost opportunities, and she was also consumed by worry in anticipating his potential future losses and the prospect of him not fulfilling her aspirations for his future. She wanted to protect her son from the difficult feelings that she assumed would be attached to such losses, but realised that this way of being and relating to him was not working:

> *"I would be putting layer upon layer…'what if he never gets married, he's never going to have a girlfriend' and that would be me and that's how my anxiety developed and I got to a point where I thought, this is ridiculous" (Wilhelmina, I13)*

Otto too was experiencing anxiety in relation to anticipatory loss. He came to therapy fearing the impending ultimate loss, that of his own mortality:

> *"It hit me - panic attack…I become like paranoid that something going to happen to me and I'm never going to see my son" (Otto, I16)*

He believed that his feelings of fear and panic in considering his mortality, was indicative of him going "mad". However, at his assessment he realised that he was facing the fragility of human existence and what he was experiencing was normal. As with the other participants, his experience resembled that of an existential crisis, which had resulted in him questioning his own identity, future and meaning.

Zilpah hoped to address issues of identity and meaning, in order to move towards a less painful existence:

> *"I was hoping to move forward, to not to be keeping having these bouts of deep depressions and to have some way to be able to cope with them and stop them becoming full blown" (Zilpah, I18)*

Zilpah's explanation for coming to therapy was fairly symptom-focused and she divulged limited contextual and background information within both interviews and therefore a sense of loss was not immediately prominent. However, that is not to say that it was not present for her and she did charactersise her childhood as one of sadness and aloneness.

To summarise, a strong commonality emerged amongst the participants in terms of what brought them to EE. Specifically, underpinning the presentations was a sense of loss – loss of

identity, crises of meaning, the realisation of one's mortality, loss of significant others and anticipatory loss in terms of the future as once known or imagined.

1.2 Living Behind a Mask

In order to cope with their losses, the participants were suppressing and concealing their emotions from others. They were seeking to convey wellness and functionality to the world by wearing a mask of strength, positivity and calm, whilst suffering deeply inside. The term 'mask' has been used, in order to capture the participants' deliberate disguising of their true feelings, so as to portray a façade deemed more desirable. To maintain this mask and distract themselves from emotional pain, the participants reported problematic ways of coping, such as comfort eating, smoking marijuana, overworking or busying themselves. Crucially, however, these strategies were no longer working for them, their emotions were no longer being effectively suppressed and/or they recognised that their identity and connection with themselves and others had been lost as a result of their inauthentic way of living. The nuances within this common theme of living behind a mask are conveyed in the following extracts:

> *"I put on an Oscar winning performance, because noone ever really knew that I had any problems or any feelings of being burnt up and eaten away inside, because I put on this persona, this happy persona on. It wasn't anybody else's problem, but my problem" (Cyprian, I24)*

> *"I built myself as a very strong person, very strong kind of look on myself and how I should be, how I should deal with things…Now I cannot control my feelings, I cannot control my emotions, something is going on with me that I thought should not happen ever…part of me just collapsed which I was being very careful of for many years" (Otto, I24)*

> *"I have to distance myself from what I actually feel…I often just find myself kind of just going 'okay there is just me and my little self and then there is me and my big coping self that I just get on'" (Freddie, I30)*

> *"I tend to be very positive with people, although I am by nature quite negative…it's weird that I can try and lift everybody else up, but I don't have time for myself" (Casper, I16)*

> *"That is internally, he wouldn't have seen any of that, you wouldn't have known that. My face would have been completely calm, but…I'd think 'oh my God, I've got to keep busy, because this is dreadful'" (Wilhelmina, I20)*

They had been focusing on the needs of others, so that all their efforts went into masking their true feelings. In fact, their mask had become so well-rehearsed that they were even denying the extent of their suffering to themselves and as their ability to mask their emotions faltered, the

way in which they perceived themselves to be and all that seemed certain crumbled, they felt lost in how to be with their feelings:

> *"To do in front of other people, it wasn't what I wanted to do. Before, I could hold that back, I could suppress it you know…Now I have no control over it, it just happens" (Cyprian, I61)*

When their feelings could no longer be masked, they were jolted from a place of perceived relative stability, certainty and contentment, to a place of uncertainty, fear and existential crisis. They had played a role for others for so long, that this led to crises in identity, because they had not been considering what they wanted or needed:

> *"It's almost a loss of your identity, losing your identity a little bit and that became magnified when the kids went off you think and I went 'well look at me, what am I doing here'" (Casper, I27)*

> *"I didn't think about me when it all happened and for twenty-three years I haven't really ever felt or thought about me" (Cyprian, I23)*

> *"I have built a very very strong masculine profile myself, so obviously looking for help from someone else was hard for me to accept at the beginning" (Otto, I2)*

> *"It's your job is to look after (wife), regardless come what may, but then of course I have also got to look after myself too and I think I have kind of lost myself a little bit along the way" (Freddie, I14)*

Moreover, the tensions involved in masking feelings were becoming increasingly difficult to bear. Otto's need to appear strong for his family, whilst feeling increasingly vulnerable was leading to considerable discomfort, whilst for Cyprian the tension of protecting and masking, versus the recognition of the inauthenticity of this had become increasingly difficult:

> *"I don't like to lie to my daughter, but if I don't lie to her, I'm giving her pain and if I am giving her pain then I'm not doing my job as a dad. Because you're there to protect your daughter, you're not there to make her suffer. So, I lie to stop her suffering" (Cyprian, FU25).*

> *"I'm a father and a husband…thinking about myself I like to be strong, so I found it hard accepting to myself these things. So, then I have obviously pain from stress" (Otto, I18)*

> *"I have then got to be the strong person who on one hand shows, 'no, I can't allow myself to get into that thing of feeling horrible on her behalf'…the truth is I don't want to be here anymore, I don't actually want to subscribe to this…the only way that I can really deal with it, is actually to shut it down" (Freddie, FU11)*

Their old ways of being, that of appearing strong, functional and positive to mask feelings of vulnerability and inner turmoil, were no longer working. Their reliance upon behaviours such as smoking, comfort eating and keeping busy, in order to keep up this mask and suppress emotional pain, was no longer enough. Faced with this realisation and fear in the face of unfamiliar feelings, they identified that they needed to find a new way of being and an extract from Cyprian's interview captures the participants acknowledgement for the need for change:

> *"I should not be lying to my daughter, so she stays happy, I should be happy myself and inside on my own and I'm not. So, it means I'm a liar, I have to put an act on and I'm fed up putting an act on" (Cyprian, FU68)*

Doogie too was suppressing his emotional pain of loss and lack of emotional intimacy and like Cyprian he was doing this through comfort eating, but also through the adoption of a stance of perceived masculinity and ambivalence towards his feelings and life:

> *"I haven't got anyone that's sensitive…my mates are very much bloke blokes and we don't chat, including me, we don't chatter much and if we see someone out of the group that's being a bit emotional it's a case of 'buck up your ideas will you!'" (Doogie, FU12)*

Though Doogie knew that his choice of eating to manage emotions was causing him physical difficulties, without alternative meaning in his life this was how he wished to get pleasure. Doogie was an anomaly amongst the participants because upon arriving at EE, it seemed that the mask was still working for him.

As with the previous theme, Zilpah presented the symptomatology of her difficulties without mention of her interaction with others or the world. Her current way of being involved employing strategies similar to the other participants, such as keeping busy to distract from emotional pain, however it is unclear how much of this was to maintain a mask with others, as she did describe always being functional at work, and how much of it was due to her way of coping by distracting herself from the discomfort of feelings. Nevertheless, it was clear that when she was forced to slow down, her depressive feelings returned and so in acknowledging

that distracting herself from feelings was not a long-term solution, she had begun to consider if there was an alternative way to be:

> *"I have had depression for most of my life really, well my adult life and so I sort of, I can cope with it most the time and deal with it and try to head it off in the past when it's coming, but sometimes I can't and I thought this I was ready to move on from" (Zilpah, I10)*

In attempting to hide their vulnerability and conform to the perceived expectations of others, that of strength, masculinity, control, positivity, calm, functionality and wellness, the participants had become disconnected from themselves and alone with their feelings. Although the adoption of a mask and particular way of being may have been adaptive to the participants at a particular time in their lives, it had reached a point in which the costs were outweighing the benefits and they realised that something had to change.

1.3 In Search of How to Be

In coming from a place of masking feelings and surrounded by uncertainty in how to be within their current emotional experiences and difficulties, some significant commonalities emerged in terms of the participants objectives for EE. By attending EE, they hoped a new perspective, understanding and the provision of some tools to cope might be provided, to aid them in finding an alternative way of being.

It was clear that having suppressed their feelings for so long, they were lost in how to be with them and were unsure what the alternative would look like. The way that they normally managed difficulties (through control, problem-solving or using various methods of escapism), had come to no effect and it was an overwhelming sense of fear, in recognising their sense of helplessness in the face of their unfamiliar emotional experiencing that led them to acknowledge that something was wrong and encouraged them to attend EE:

> *"The more and more sadness I got the more and more this table was sinking inside of me. And I just knew that wasn't the right feeling to have. I knew there was something wrong" (Cyprian, I65)*

> *"Something going not well, it's going longer and longer and from one symptom to another one, I need someone to help me, especially when I start having these little thoughts. You know strange thoughts" (Otto, I17)*

In fearing what might ensue, the participants were taking a leap of faith with EE, hoping that it would protect them against falling into the abyss and reassure them that what they were experiencing was a normal part of human existence. They wanted to be guided in finding a new way of being, through the reaching of a new perspective of themselves and their current difficulties:

> *"The hope it's going to help, I'm gonna understand myself, why it's happening…I was worried I was going mad" (Otto, I23)*

> *"To find I suppose a way of protecting myself I suppose from falling apart, because that's really the way I felt I was gonna go" (Freddie, I2)*

> *"I was hoping that I could maybe unlock some stuff that might make me feel better" (Casper, I34)*

"I can have like a business head…when you come out of that in my private life, what am I supposed to be doing? I really don't know what I am meant to be doing" (Cyprian, FU49)

For Wilhelmina, Otto, Cyprian, Zilpah and Casper, there was also a desire for some practical tools and strategies to be developed that might assist them in discovering a new way of being:

"I don't expect any magic wand, but just to be given the tools to stop it happening or to help me look after myself" (Zilpah, I24)

"*I want something that is practical" (Wilhelmina, I2)*

In contrast to the other participants, Doogie was ambivalent about therapy, stating that he was content with his way of being and felt that he was "sent" to therapy. While some of his current ways of being were perceived as self-destructive by medical practitioners, Doogie was content with his way of being:

"I said 'look, I'm not going to do anything drastic like dieting or have stomach bypass…I'm not bothered by living twenty years less, I would rather live five or ten years enjoying myself' she must have then come back to my doctor and said 'he's thinking about death'…No, that is not thinking about death, it's thinking about life. It's just I want to live life the way I want to live" (Doogie, FU53)

It seemed that Doogie had been facing the abyss and questions regarding life's limits and his own mortality and his embracement of this had been perceived as a "death wish". Therefore, for Doogie he was not so much in search of how to be, but defending his choice of how to live and given the confusion over his referral, expected EE to focus on weight reduction in some unknown way:

"*Considering that it was all about how overweight I am, why am I coming to this session, how is this session going to help me lose weight?" (Doogie, I22)*

However, at goal formulation Doogie ultimately began to recognise that his stance of ambivalence was not only in relation to weight reduction, but permeated many areas of his life. He acknowledged that he managed his feelings of meaninglessness, isolation and bereavement with eating and seemed prepared to explore this, albeit hesitantly.

Thus, while it seemed that the participants first needed their current way of living and experience of adversity to be understood and heard, they arrived at therapy hoping that it might introduce ways of reconsidering their currently held position, offer a new perspective to their life difficulties and guide them to find a new way of living and being with their feelings.

Superordinate Theme 2: The Experience of the EE Therapeutic Work

This theme captures the participants shared experience of the actual therapeutic work; how their presenting difficulties were worked upon in therapy, how the EE protocol looked in practice and the experience of the therapeutic relationship. The participants described how it was aspects of the therapeutic work that felt highly personalised that were key to their positive experience and change, whilst more generic components were detrimental to their sense of trust in the therapist and process. They needed to feel like they were being seen as an individual, with their subjective experiences attended to, which certain aspects of the protocol stood out as achieving, whilst other aspects clouded this. The style of questioning which was grounded in the participants' narrative and was both gentle and challenging, facilitated this need to be met and illuminated areas that had been cast into shadow, empowering them to reach their own answers and personal solutions. There were certain *being* and *doing* qualities within the therapeutic relationship and the participants' own attitude of openness and active participation, were fundamental factors in the therapeutic work and subsequent outcomes.

2.1: The Value of a Personalised Approach

This theme refers to how the participants greatly valued aspects of the therapeutic work that they experienced as highly personalised, in terms of attending to their subjective experience and needs, as opposed to a generic approach being taken. At the same time some depersonalising aspects of EE were highlighted, namely the integration of outcome measures and the fixed time-limit. These were felt to detract greatly from the positive experience of the approach.

Goals Setting

Goal setting resulted in mixed experiences, either aiding the approach in feeling very personalised for some and reductionist for others, but whichever end of the polarity was experienced it had a prominent impact on the overall experience of the therapy. The striving to develop a detailed picture of their individual difficulties, in order to develop goals was highlighted as an integral factor to EE feeling tailored to their needs and it was seen by all of the participants as a vital factor responsible for instigating all outcomes. Goal setting seemed to be especially important to Doogie, because it enabled him to move from the narrative of why

he had been "sent" to therapy, to realising that he had a choice in the direction that therapy would take:

> *"It wasn't until the end of the session that we started writing points down together like 'to get, to become less ambivalent', 'to not look, be down on myself'. Because to begin with I thought 'I don't know what I'm here for (laughs). You tell me'" (Doogie, I24)*

Freddie commended the mapping of his individual difficulties and his therapist's flexibility in adapting his goals based on his changing circumstances. Yet, he simultaneously described how he found the goal-oriented nature depersonalising and felt that it hindered his overall experience of EE and the development of trust:

> *"It was really important to set targets and all that, I get that, but there was something very depersonalising about that and for that reason it probably took me a while to buy into (therapist)…I understand that there are parameters in which all this needs to work, but that was very, those things actually impacted on my experience" (Freddie, I9)*

Unlike Wilhelmina, who explicitly welcomed the specific focus of the goals, Freddie described the need to take a holistic approach to difficulties and in describing the goal setting process, Freddie quotes the therapist saying:

> *"'We need to focus down and we need to find these goals'…It's quite hard to actually stipulate that it's this, this and this and then those things will be fixed, because I tend to think more holistically" (Freddie, I54)*

Exploration of the Temporal Stages

Another predominant component of the therapeutic work being experienced as personalised, was the flexible exploration of the temporal stages. The majority of the participants did not want to focus on their past and valued how it was only brought in when it felt relevant to open up their narratives:

> *"(In previous therapies) it was like, 'you are being trained by the same person…you've got like this little shelf where you have to ask things and do things right. You aren't listening to me and if I divert away from your little plans there you're snookered'….(In EE) as the sessions grew, small inserts appeared from my past" (Cyprian, FU81)*

> *"I'm not sure digging up the past was necessarily necessary…I've kind of accepted that what went on wasn't right…with (Ease therapist) we probably didn't touch on that at all" (Casper, I6)*

Conversely and yet further supporting the notion for the flexible exploration of the temporal stages, Otto described the great value of the rigorous exploration of his past in EE, which aided a holistic understanding of how this has shaped his current way of being:

> *"I was so happy and, in some ways, shocked how many things, it is important to bring whole life in how we shape ourselves. So, I think it was very eye opening, a lot like warm feelings" (Otto, I12)*

Zilpah experienced EE's approach to the exploration of the temporal stages as inflexible and depersonalised. She perceived EE to pitch itself as a present and future-focused approach and she saw such a separation of the tenses as both appealing, as she did not want to focus on the past, but also unrealistic and depersonalising, due to the interwoven nature of the temporal stages:

> *"It's as if they think you can start from here and go forward, but…you're talking about human beings and we are all different and we have all arrived here for different reasons, so I don't know how a therapy could help you unless they know a little bit about your background" (Zilpah, FU10)*

Zilpah was in search of an approach the works forward and frequently described wanting to "move forward". However, she also put great emphasis on the need for the therapist to have a thorough understanding of her past and what has shaped her. Thus, it appears that the approach was in fact holistic and modified to her individual needs by ensuring that she felt her past was sufficiently understood, but Zilpah saw this as at odds with the aims of EE as future-focused. It is unclear whether this was a miscommunication, or due to a mismatch in her expectations for a future-focused therapy, or whether the first outcome measure which is future-focused, confused the nature of the actual therapeutic work. Nonetheless, Zilpah's different experience reiterates that a personalised and holistic approach to exploring the temporal stages is essential within EE.

Intervention and Questioning Style

The participants all described the value of personalised interventions, such as summations, connections between experiences and psychoeducational examples, for facilitating personal meanings and understanding into their ways of being. Otto's extract reveals how the psychoeducational examples looked:

> *"Examples like with the cat and animals, if they are in an environment when someone is slapping them or screaming at them, they are always walking like very scared. So, when he gave me these kinds of examples, I understand like how my life was created. I was always looking for high high stress" (Otto, I32)*

The participants all described how they were encouraged to approach their difficulties in new ways, experimenting with this both within and outside of therapy, bringing it back to therapy to reflect on what solutions worked best for them:

> *"He said 'why don't you try just standing right back, see what impact, see how you feel, analyse how you feel after, maybe write it down'…we would do that and each week…I would say, 'ah you know I just, my anxiety levels just rise' and he said 'well why don't you tell him that?'...and I thought 'oh that was actually much better than me barging in'" (Wilhelmina, I11)*

Wilhelmina's extract highlights the value of this personalised experimental component, whilst simultaneously revealing the personalised nature of questions and challenges, in which they are grounded within the participants experience, as opposed to being generic questions, techniques or behavioural experiments.

The participants felt that questions were generated from attentively listening to their experiences and identifying areas for further exploration and clarification:

> *"It was all structured upon listening to what I was saying rather than 'this is the book, I've got to ask you this question now'. So, that's why I felt it worked so much better" (Cyprian, I22)*

Moreover, there was a belief that the therapists adapted their way of relating and questioning to meet individual needs:

"Different people need different things…it may be that (therapist) has that same skill set for everybody, but he may not hit it off with certain people, because they do need a different approach and I guess that's the skills of the person to actually pitch yourself on those different levels and see what's going to work" (Casper, I38)

It became apparent that the therapists' human qualities, such as their ability to identify and adapt to individual needs, as well as their warmth and personal disclosures, was an essential part of EE being experienced as personalised, with the terms 'personalised' and 'humanised' appearing as synonymous, particularly within the account provided by Freddie.

Outcome Measurements

While Freddie commended the questioning style and summations, this was overshadowed by a feeling that he was part of a formula:

"There was a formula attached. I was aware that I was part of a formula" (Freddie, FU31)

Freddie and Zilpah expressed how the integration of outcome measures, resulted in them feeling objectified and it greatly detracted from a human encounter, in which they yearned to be related to as an individual:

"From a distance looking back…I actually needed to feel more like an individual, rather than like a person who just pressed tick boxes" (Freddie, FU29)

"It seemed to be the constraints were on this card game (laughs), so they could quantify...I don't think it is a good way of dealing with people really, I suppose you kind of have to find a way of one size fits all, but it just doesn't I'm afraid, you know the brains, people we are different" (Zilpah, I42)

They experienced the forms as generic and reductionist in nature, reducing the opportunity for their unique experiences to be detailed:

"I hated filling in the iPad form, I found it for me it was a de-personalising experience…the broad nature of the actual questions seemed not to relate to me" (Freddie, I8)

"I didn't feel it was a very good way of getting to know me" (Zilpah, I2)

For Freddie and Zilpah, the depersonalising aspects affected their ability to trust in the therapist and process and they posited the benefit of clinical intuition and a human, personalised and holistic approach, over a generic and reductionist one.

What is evident is that a personalised approach that attends to individual needs is of significant value to the participants. The majority of the therapeutic work, including goal setting, an experimental component, the questioning and relational style and psychoeducational examples, were valued for their individualised nature by all of the participants. Moreover, the importance of a holistic, flexible and personalised exploration of experiences and temporal stages was conveyed. However, for a couple of the participants', their experience of EE was coloured by the depersonalised nature of the outcome measurements. The stark polarities in the experience of personalisation in EE, further strengthens the argument for the essentiality of a personalised and human encounter, over any generic form, technique or algorithm.

2.2 Stepping Stones to Awareness

All of the participants described a process in which the therapist opened up areas for deeper exploration and encouraged a self-reflecting and questioning stance to be adopted. They were not directive and did not provide advice or interpretations:

> *"Looking for answers or reasons for why, it was always looking for the positive as well…if something negative was talked about it, it was 'well why do you think it happened?'…looking at getting the full understanding of what I was actually really experiencing" (Cyprian, I68)*

Interventions were gentle and challenging in nature and consisted of exploratory questions that were grounded within the participants' narratives. This approach aided a detailed picture of their difficulties, their way of being and the functionality of their currently held position to emerge. Subsequently, experiences, beliefs, values and sedimented assumptions that had been cast into shadow were illuminated and challenged, with alternative possibilities becoming increasingly visible:

> *"It wasn't 'yes, no'…I expressed a feeling and I was getting information back to make me think more. I wasn't getting information back about getting the answers, cos I don't remember ever she came back and gave me an answer. She gave me things to think about, she gave me things to question." (Cyprian, FU12)*

> *"He seemed to put some interesting angles, asking some questions which I wasn't sure I had the answers, but then I did have the answers" (Casper, I14)*

> *"So simple the answers and the connections and then impacts and all the things and why it's happening…The answers that I received I was looking kind of for them" (Otto, I31)*

The style of questioning was seen to extract detail from the participants, from which the information was distilled into summations and reflections by the therapist, which enabled the essence of what was being experienced to be captured:

> *"The ability to just absorb and listen and put that little mirror in front of me and say back what I have just said, but not quite in the animated way that I said it and I think that is very useful…his ability to distil the information" (Wilhelmina, FU24)*

> *"He knows how to turn things and get the essence of the sentence and just connect them with the right things" (Otto, I52)*

*It was the strength of his summations, definitely it was, because it made me feel, yah I remember going home and saying "he's **good**"(emphasis) (Freddie, I19)*

It was through this process of description and clarification, that the participants described being able to open up more, which they saw as vital for increasing awareness into interrelated experiences, worldviews and meanings:

"Bring all those problems and those connections between your dreams, what you do, how you talk…things that we don't see and are just very close and sometimes we don't want to see them. But really they are there and they are connected with everything. So, he opened eyes for me" (Otto, I28)

"I think we opened more doors, because I think I opened up more, but I felt that was due to her talents of knowing how to get that information out of me, where the others didn't" (Cyprian, FU97)

This approach empowered the participants to reach new awareness themselves, as opposed to being directive, giving advice or answers:

"He would just tap it in you know, just very softly ask me stuff…they've sowed the seed without you actually realising they have sowed the seed…the ones that I think are skillful are the ones that have done something without you actually realising what they've done" (Casper, I10)

The questioning style and use of reflection and summation, served to validate the participants reflections, personal understandings and solutions:

"I said something to him and he replied and then he gave me answer it looks everything so simple. But maybe I had this answer, but wasn't sure maybe sometimes about this answer…he said exactly what I thought it might be, it just relief" (Otto, I29)

It seemed that for all of the participants, EE consisted of validating their feelings, own solutions and new awareness, which allowed them to feel more empowered and become more accepting of themselves. However, this validation was done at the same time as challenging the participants to develop further awareness into their current way of being and of alternative perspectives and ways of being, which Wilhelmina and Cyprian's extracts highlights:

"Rather than saying, 'no that's not the way', he didn't say that, he just said 'well how does he feel? How would it make you feel if you just stood back? How would

that help your anxiety?' So, it was 'oooh, well I would feel uncomfortable' and he said 'but how would it make (son) feel?'" (Wilhelmina, I11)

"It needed to be a blunt question of that nature, for me to, shall we say, have that light bulb come on because, like 'all you keep telling me is what you do for everybody else, but you never tell me anything about what you do for you'" (Cyprian, I34)

For Zilpah, it was challenges in the form of visualisations and body work exercises within sessions, that encouraged her to experience staying with feelings and thus facilitated new awareness:

"She was trying to work with me to get me to just allow that feeling and to have that feeling and see what happened…Sort of together we just sort of sat there and let it happen" (Zilpah, I23)

Though Zilpah and Doogie both valued the approach for facilitating awareness, they also described their fear and hesitation to engage in such challenges. Zilpah was afraid of her feelings and the unknown, while Doogie found the questions that sought to extract detail, both probing and intrusive:

"Asking probing questions and things, trying to probe, trying to get out of me why things, why certain things happened and I didn't wanna say" (Doogie, I2)

To summarise, it is apparent that at the core of EE is a questioning style, which consists of an endeavour to explore, describe and clarify the participants worldviews, whilst challenging possible blindspots and simultaneously validating reflections and new awareness reached. This approach was highly valued by all of the participants, particularly due to its ability to empower them to self-reflect, attain clarity and understanding within their experiences. However, a couple of the participants relayed how the ability of this approach to extract detail, encourage them to open up and self-reflect, as well as the pace of the challenges, felt uncomfortable initially when a trusting relationship had not yet been developed.

2.3 How the Therapeutic Relationship is the Vehicle to Change

The salience of the alliance between therapist and client was essential to outcomes in EE, yet establishing this did not seem hugely revelatory in itself, so what I convey here are key aspects of *how* the relationship was central to change.

The Importance of an Experimental, Feedback, 'Doing' Component

More than particular therapist attributes, all of the participants drew heavily on the importance of the experimental 'doing' feedback component within the relationship, as the conduit to gaining new awareness and experimenting with a new way of being. Feedback that centred around process in the 'here and now' of the therapeutic relationship was highlighted as particularly useful:

> *"'That's a good thing that you just said to me, I didn't think of that, that's really good I need to be thinking about that more', but had she not participated in getting that feedback I couldn't improve" (Cyprian, FU70)*

> *"He did probe, as I wasn't aware of how hermetically sealed or how compartmentalised I had become…he did make comments on how I seem to shut things down or I had a way of not really emoting" (Freddie, I4)*

> *"There were times, with his probing or what I had just said I suddenly realised and he would say to me 'you've become more protective again' and it was because I suddenly felt a victim" (Doogie, FU34)*

Feedback using the immediacy of the relationship was important to develop awareness into their difficulties and way of being, which in turn facilitated a more accepting relationship with their feelings. For example, Doogie began to open up and trust in his unique way of expressing emotion:

> *"He explained that I have got emotions, that he could see I had emotions just in the way I was talking and the way my body was reacting as I was talking" (Doogie, I31)*

The experience of expressing feelings without judgement in the therapeutic relationship, whilst receiving feedback and being validated, was an infrequent or wholly unfamiliar experience for

the participants. This experience was seen as integral in becoming more accepting of and authentically themselves and aided awareness into wider patterns or relating:

> *"I didn't kind of share with my feelings with noone. So, go and open and just cross this line, you know like I can do and can say anything. I can react like I want, if there's going to be tears, it's going to be like everything's fine. So, this is another relief for being yourself" (Otto, I61)*

The participants also described being encouraged to implement their new ways of being or insights outside of therapy, reflecting upon how this went within sessions. Cyprian, Zilpah, Wilhelmina and Otto described the benefit of this more directive experimental part of therapy:

> *"He told me like 'look try it, if nothing happens then do this, try think this, if everyone has it', so he gave me like homework" (Otto, I54)*

> *"Something to physically work on…I felt she gave me that or it arrived from somewhere (laughs)" (Zilpah, I42)*

> *"She always prepared and left me with something to think about at the end of every session for the following week and I felt that was very useful" (Cyprian, I51)*

> *"He said 'you know why don't you try just standing right back, see what impact, see how you feel. Analyse how you feel after, maybe write it down'…I would try it and I came back and actually I said 'well surprisingly it worked quite well' and so we would do that and each week" (Wilhelmina, I11)*

The participants repeatedly emphasised the importance of such interaction and therapist feedback for outcomes, which Cyprian's extract represents:

> *"I opened those doors cos I got the feedback, I expressed myself, I let it out, I set the world in two rights probably, but I got the feedback that started to open those doors" (Cyprian, FU75)*

In summary, it seems that an experimental feedback aspect to the therapeutic relationship was vital in the attainment of therapeutic outcomes. Noticing process in the 'here and now' of the therapeutic relationship was essential to foster awareness into current ways of being and possible patterns of relating in their wider world, as well as to facilitate the experiencing of an alternative way of being within the relationship. This could then be extended to an

experimentation with a new way of being and relating within their world and wider relationships, using the sessions to reflect on how this was experienced.

Feeling Understood and Trusting in Therapist Competence

Feeling understood by the therapist and trusting in their competence was essential in the creation of a strong alliance and subsequently therapeutic outcomes. Understanding and competence have been grouped together, because a key part in the participants believing in the therapists' competence, was reaching a point where they felt sufficiently understood. This was an essential condition for the therapists' challenges to have any weight and for the participants to feel confident to experiment with making changes:

> *"I just felt she had got a handle on me…I believed what she was saying and I accepted that and I could have moved forward with that" (Zilpah, FU30)*

The participants spoke highly of the therapists' perceptiveness and how this was translated into exceptional reflections, summations, connections and challenges. The combination of these aspects were key contributors in the participants having faith in the therapists' skills, feeling understood and aiding understanding:

> *"It's like he didn't miss a trick… I would talk about things and he was quite comfortable with making his summations, mainly because I think he knew me really well…I was very impressed and that helped towards something about building the trust" (Freddie, I17)*

> *"Very pointly, like very catchy on the things like and accurate" (Otto, I52)*

> *"He was very good at picking things up like that. I would say those throw away lines like that" (Wilhelmina, I6)*

The participants credited the feeling of being understood to the professionalism and knowledge of the therapist:

> *"Very clever, for me very professional, he have a big knowledge and he was like professional in the matters and dealing with these problems" (Otto, I50)*

> *"I felt that the way, (therapist) reading of me was actually was spot on in ways that others were not…I need for my therapist to be brighter than me" (Freddie, FU40)*

While feeling understood was largely expressed through the therapists' perceptiveness, knowledge and "champion" summations (Freddie, FU35), Zilpah and Wilhelmina relay how the feeling of being understood was frequently experienced in 'being', non-verbal expressions such as humour and silence:

> *"Though we would both chuckle…I knew that she knew, where I was coming from" (Zilpah, I16)*

> *"There would be silences, when I could almost hear his brain wurring and thinking about what to say next. And he was very calm and very very understanding and I think he got to the nub of the issue quite quickly" (Wilhelmina, I3)*

In whichever way that understanding, perceptiveness and knowledge was conveyed and experienced, there was a view that in order to trust the therapist and take the risk to move forward with their difficulties, the therapist needed to be a knowledgeable, competent professional:

> *"I have to be in a position where I really believe that that person knows what they are talking about" (Freddie, FU41)*

> *"It's the same as a broken leg or arm, you've got to feel confident that this crutch is going to hold you whilst you move forward" (Zilpah, FU25)*

> *"I think comes from a knowledge…I didn't feel like 'oh he doesn't know what he is saying, or he is not the right person'…it was kind of shocking how much he knows" (Otto, I56)*

Feeling Heard and Cared for in One's Totality

Having a space to express themselves and feel cared for was an important part in how the therapeutic relationship was key to change. The majority of the participants described the benefit of having a space where they were attentively listened to and validated:

> *"I grew up with not so much space for my feeling and my thinking and always needing some sort of approval, which I didn't have from my father. So maybe there was this kind of person which was giving approval" (Otto, I30)*

> *"Knowing that at a certain time in the week, I can talk about stuff that is bugging me to someone who is not going to make a judgement" (Freddie, I36)*

"It felt like there was a bit of unloading…I'd managed to get some stuff out which probably I wouldn't have thought was relevant, but it was obviously stuff that I had to talk about" (Casper, I13)

"He was easy to talk to you know, he didn't make me feel like some of the doctors make me feel, they're all (pause), jobsworths" (Doogie, I15)

Upon asking Doogie for clarification of the meaning of "Jobsworths", he stated "whereas you actually felt that he was listening" (I16). It was this feeling of being attentively listened to, that was core to the experience of care for both Doogie and Cyprian in particular. Casper described the importance of tone in the experience of care and Cyprian, Zilpah and Wilhelmina divulged an embodied element to it, with the therapists' eye contact, lack of fidgeting, smiling and laughter perceived to convey interest and care:

"I've always said like with people I tend go with are people that would rather put an arm around me, rather than this lady I went to before, she would sort of bark at me a little bit" (Casper, I8)

"When a person is caring, when a person is paying attention, it's about how they are moving their bodies. If a person isn't interested in you, they become very fidgety" (Cyprian, FU66)

"I just felt totally relaxed talking to him…the trust, the listening you know, the smiles. The body language was very good" (Wilhelmina, FU25)

Additionally, for Cyprian containment and the management of time was experienced as an indicator of care:

"It showed that she cared, it showed that she didn't want to rush, it showed to me that she understood what I was saying" (Cyprian, FU88)

In summary, it can be said that having a space to be heard and fully be themselves, whilst feeling accepted and cared for, was key to change and the positive experience of the therapeutic alliance. There seemed to be a cathartic, nurturing and restorative element to this, but it also encouraged a feeling of comfort which aided the participants in opening up. Trusting in the safety of the relationship and feeling comfortable to open up, subsequently aided the development of personal meanings, new awareness and the experimentation with new ways of being.

Client-Therapist Attunement

The participants identified a sense of attunement with their therapists, which aided a feeling of collaboration, being understood, trust and subsequently outcomes. Casper, Cyprian and Doogie described the congruence in client-therapist relational styles, particularly in relation to addressing others difficulties:

> *"What she was asking me was like what I do with my friends where I don't tell my friends what to do, I get them to think 'well look do you think maybe you should be doing x, y and z'" (Cyprian, I40)*

> *"My relationship with people…you sow the seeds, you don't push them and you let them make their own minds up" (Casper, I49)*

> *"We were both overweight, we were both men…the way he was with me was the way I would be with other people" (Doogie, FU33)*

Doogie also drew attention to other commonalities, such as gender and weight, which he felt aided a sense of shared understanding. For Wilhelmina, a sense of therapist-client attunement arose from their differences, particularly in relation to approaching difficulties. Wilhelmina described how the therapist's calm approach, balanced out her animated nature and facilitated her in adopting a new stance of stepping back and calmly responding to difficulties:

"I'm quite animated and he was completely the opposite actually and I think that worked very well, so when I say the fit…personalities, in ways of dealing with things" (Wilhelmina, I5)

For Freddie therapist-client attunement took the form of levels of intelligence. In comparing the EE therapist to previous therapists, Freddie states:

> *"If intellectually there is a difference…it's quite hard then, in a circumstance like that, to take advice or once again trust or believe, but I actually felt it was a good match, definitely and that was the effective nature of the sessions" (Freddie, I17)*

The therapist was seen to attune and adapt according to the participants' ways of being, which was vital in aiding a sense of comfort, from which challenges could have an impact. For Wilhelmina and Zilpah this way of being was humour, for Cyprian it was a logical and direct approach, for Casper it was a gentle and calm approach, while for Freddie an intellectually-based dialogue. Wilhelmina and Cyprian's extracts are included to capture this:

"He obviously realised humour was important to me…I'm quite humorous at times and he would pick up on that, so for me he went with the way that I was" (Wilhelmina, I9)

"I was very logical and I think she picked up on those things and realised that for me, the more direct somebody is with me, the better I respond" (Cyprian, I35)

To summarise, the participants identified areas of client-therapist attunement, as being essential to aid a sense of comfort, which subsequently positively impacted the effectiveness of therapist challenges. The participants attributed the level of attunement reached to the therapists' perceptiveness and understanding of their individual differences, which enabled the therapists to adapt their ways of relating to meet individual needs, as opposed to it being seen as the therapists' general therapeutic approach, personal attributes or the EE protocol per se.

2.4 Key Ingredients of Client Openness and Active Participation

The participants consistently noted how their participation and attitude was integral for therapy to be beneficial. The following extracts reveal the essentiality of active engagement:

> *"My input was going to be just as important, so sitting there like a dummy and saying nothing, wasn't going to be effective" (Cyprian, I68)*

> *"I tried to read about it, try follow some kind of videos and see people with similar problems and try to find a way to maybe change my imagination or way of thinking about certain things" (Otto, I9)*

> *"Then he pointed it out and when he did point it out then I would find myself possibly doing that during the week" (Freddie, I6)*

> *"Open up really and look for the answers myself…I allow it to stay with me and think about it at quiet moments, what I've said or what's been said to me and that helps me move forward quicker" (Zilpah, FU32)*

> *"I try to sit, stand outside and look in at me and think where do I need to make some changes to help me move forward" (Casper, I23)*

Zilpah's depiction of her active stance extended to establishing the alliance:

> *"I learnt a lot from having counselling on how to work on things, you know to enable myself to be able to do it myself, but then I knew that I had to establish some sort of relationship" (Zilpah, I33)*

As with all of the participants, aside from Doogie, the participants referred to their open attitude towards the therapist and the therapeutic process:

> *"It was important to me that I trusted her and I do, I don't tend to put up barriers to people, so I was quite open to trusting her" (Zilpah, I13)*

> *"You get back as much as you put in…I needed to be open-minded and if I didn't come in with that approach then I wasn't going to gain anything" (Cyprian, I82)*

An openness to the therapeutic process included realistic and flexibly held expectations for EE:

> *"I would think 'it was very good, but have I achieved enough today?'…I would think 'I'm not sure, but I'm going to give it a go'" (Wilhelmina, I10)*

"I don't think the therapy gonna solve all our problems, we are human beings. We talk about many things in the therapy, but I think there is self-study as well, to know ourselves and deal with ourselves…I didn't have expectation, that they have to do this, this and after that I'm going to come out and I'm going to be like close this door, open this new one, I never thought that" (Otto, I47)

"It's possibly a big continuing battle, but at times I think keep moving forward and keep dealing with yourself" (Casper, I46)

They also recognised that a level of openness and willingness to face pain and be vulnerable was required:

"I am not saying it's easy, you have to open up, cos how's the other person ever going to be able to help" (Cyprian, FU76)

"Was hard for me to accept that I have, maybe I need someone and I need help from someone, but when I went there, I think it was the best decision" (Otto, I1)

However, Doogie took up a different position of defensiveness and described a lack of engagement both within EE and within life more generally:

"I thought 'what the hell am I here for?'...I started staring out the window thinking 'what the blooming hell am I doing here?'" (Doogie, I44)

Further expanding upon this, Doogie said that the disengagement was in part a lack of interest and ambivalence to both therapy and life, and also a mechanism to avoid facing pain. As such, he exhibited a defensive and closed attitude to trusting the therapist, the therapeutic process and in facing pain:

"If you tell somebody about one thing they then say 'why?' and then it becomes 'well actually I don't want to tell you why, because that's a bad memory'" (Doogie, I3)

It seemed that the lack of agency experienced in attending EE, alongside his current way of being, meant that issues with openness, engagement and motivation were rife. Nevertheless, he described becoming more open and engaged just as therapy ended, despite a continued discomfort in feeling vulnerable:

> *"I became more trusting though with him during the process…but even at the end there was still things that I felt I should have said and I didn't say and there was also things that I had said, that I wished I hadn't said" (Doogie, I6)*

Furthermore, he clearly identified the value of an active approach to therapy:

> *"Maybe that's been a bit lazy, because maybe I should be more proactive, than reactive" (Doogie, I39)*

Importantly, at Doogie's follow-up it was immediately apparent that this defensive and disengaged attitude had significantly shifted. He had started to take an active stance; making beneficial choices for his health, actively engaging with friends and he appeared to be significantly more open to the exploration of his feelings and participating in therapy. Thus, there was a clear recognition from all of the participants, that for therapy to be effective, they would need to actively participate and be open to the therapist and therapeutic process.

In summary, client-attributable factors of openness and active participation were fundamental in all aspects of EE. An openness to developing a strong therapeutic relationship, an openness to face their vulnerabilities, as well as an openness to the process of therapy, a new perspective and change, was a vital attitude. An active engagement with the experimental component of the therapeutic work, as well as in the continued implementation of learning was paramount to the therapeutic work and reaching of outcomes and continued progress beyond therapy.

Superordinate Theme 3: The Experience of Leaving EE

This superordinate theme encapsulates commonalities in whether EE achieved what the participants hoped it would, what the participants took from therapy and what was left unresolved, in other words therapeutic outcomes. Namely, there was a united sense that through EE a new level of awareness into their worldview (how they are uniquely in the world and relate towards themselves and others), was reached. Moreover, their individual difficulties were explored in a way that enabled personal meanings to emerge, thus facilitating a new understanding and perspective.

The reconstruing of meanings and development of awareness, was vital in aiding the participants in identifying new ways of being in their world. This new way of being consisted of an attitude of acceptance to life's inherent challenges and limitations, as well as towards themselves and their feelings. Alongside this attitude of acceptance, the participants also began to identify areas within their power to choose differently, that might ease their current difficulties and enable them to live more authentically and purposefully. As such, the participants began to implement their new ways of being both within therapy and their lives, to varying extents.

Finally, despite EE largely excelling expectations, there was a collective experience of feeling short-changed by time, with the time-limit experienced as insufficient for their individual needs. In detailing this superordinate theme, I include extracts from both the participants initial and follow-up interviews, in order to capture how the outcomes may or may not have been integrated into the participants' lives three months post-therapy.

3.1 Reaching New Awareness and Personal Meanings

A central component of this research was to grasp what, if anything, the participants collectively gained from EE and new awareness into their worldviews and the way in which they relate, was reported as a major outcome. This was interwoven with increased understanding, in the form of unravelling the personal meanings of their difficulties and how their current way of being developed. This outcome was discussed extensively and credited for the surpassing of their expectations, as captured in Cyprian's statement:

"What I expected to come out with and what I received, three, fourfold greater, no exaggeration…the opening of these doors that I wasn't ever aware of" (Cyprian, I83)

All of the participants reached new awareness into their tendency to shut off from emotions to cope and the impact this has on their presenting difficulties, as well as adopting a self-reflective and aware attitude more generally:

"I have I suppose, a shut off mechanism which (therapist) has alerted me to or reminded me about. Actually, it's probably quite important for me to deal with everything" (Freddie, I12)

"Therapy opened my eyes to many things. I think this is the biggest achievement of the therapy, to understand what I am going through, that there's a connection and that might be the reason why it's happening…I look kind of 100% differently from therapy on myself and my problems" (Otto, I45)

"One of the main doors that got opened up was the fact that I don't ever think about me…in a nutshell neglected myself, which on reflection was not a good idea (Cyprian, I23).

"I had cottoned onto something that I hadn't actually seen before, which was a light bulb moment and that was really great" (Zilpah, I42)

"It just gives you a realisation that nothing's ever going to be perfect…it definitely loosens stuff up, but I think what it taught me as well, was it taught me to look at myself" (Casper I32)

"I thought 'yeah you know what that does happen to me occasionally' (laughs), whereas I'd never thought about it before" (Doogie, I58)

The development of awareness into how their current way of being had forfeited their own needs and self-care, was linked to wider realisations about their roles in relation to others. For example, Wilhelmina became more aware of the limits to her responsibilities and how her way of relating with her son might impact him:

"Just being aware more, I mean I am aware and I always have been aware, but it's just I've always felt this is the way to handle it, it's just two heads are better than one and we will do it together, but that's not what is required" (Wilhelmina, I12)

In becoming aware of their ways of relating and worldviews, the functionality of their current ways of being could be examined and personal meanings within their difficulties emerged. Otto, Doogie, Freddie, Wilhelmina, Casper, Zilpah and Cyprian discovered the personal meanings of their symptomatology of panic, ambivalence, shutting down of emotion, anxiety, depressive and physical sinking feelings respectively:

> *"I know why I am reacting like this, why I am harsh on myself and now I can deal with it…It's because you grow like that, you have to be the best, you have to be protection for everyone" (Otto, I34)*

> *"They didn't think that I was sorry, didn't think that I was ancillary, didn't think that I mourned. So, I became…emboldened in the fact that you know I didn't let things bother me, because I knew that I couldn't, so I didn't feel as if I had any emotions" (Doogie, I29)*

> *"I was beginning to understand I suppose, more of what was actually going on with me…shutting down is linked to that of being worried about I suppose yah, exactly what bipolar is, which is the exaggerated form of normal scale of emotive responses" (Freddie, I4)*

> *"When people look at me, they look at a person that's really confident…actually that's just a big act…Dad I feel and my Mum to a certain degree were very selfish people and I have gone completely the opposite way, so much so that I don't have enough time for me" (Casper, I7)*

> *It's normal to be anxious…he said 'it sounds like you're a wonderful mother', he said, 'so you will have anxiety'" (Wilhelmina, I15)*

> *"I think it was quite clear what my problem was, which is a move forward…I have got a handle on this small sad person that I am carrying around on my shoulder" (Zilpah, I37)*

> *"I was good at putting an act on, but actually inside I was very sad. Very very sad, but I felt I was making strides to actually understand the sadness. Actually, understand what my body was going through and understanding also the mistakes I made" (Cyprian, FU52)*

Thus, a significant part of reconstruing their difficulties, emerged out of increased awareness and understanding into how the participants' previous experiences informed their current ways of being. Wilhelmina reached an understanding that her anxiety was a bi-product of being a caring mother, while Zilpah saw her depression to be unprocessed sadness from a younger version of herself. Doogie came to understand that his ambivalent stance was not only due to

a current sense of meaninglessness, but because he cannot express tears and his way of expressing emotion had been invalidated in childhood, he had come to question his ability to feel. Cyprian, Casper, Freddie and Otto all discovered how their belief that they needed to mask their feelings in order to appear strong for others, was developed. This was vital in aiding the participants to normalise their feelings, seeing them as meaningful, as opposed to something wrong with them. They stopped seeing vulnerability as a sign of weakness that needs to be masked from others, but instead began to see it as a strength, in which meaning can be found:

> *"I have weapons now to deal with it and I'm accepting it, so this is a road to accepting and it is not going to stop there…I have some more experience which makes me stronger as a person" (Otto, FU12)*

This encouraged the participants to start listening to the meaning of their feelings and with this new understanding identify new possibilities and choices. They switched from relying on their automatic mode of managing feelings, to adopting a position of conscious choice. Extracts from Doogie and Cyprian's interviews, relay how acknowledging that they used eating to manage difficult emotions, aided them in identifying their agency and alternative options:

> *"I couldn't cry, I therefore couldn't show my emotions, therefore everything that happened, anything bad that happened to me, I used to just eat, used to go into the bottom of my stomach, make a pit in the bottom of my stomach and then I used to feed on proper food to fill that hole" (Doogie, I69)*

> *"I didn't realise that some of my illness was self-inflicted, because of me going down the route of comfort eating and allowing me to get into the shape I'm in…and…not being able to know how to cope with my emotions and deal with the pain that I was suffering" (Cyprian, I45)*

Furthermore, the development of this outcome positively impacted the participants wellbeing and resulted in their difficulties appearing as manageable. A new perspective seemed to have a cathartic, calming and diluting effect on their difficulties:

> *"My problems are like pure lemon juice actually and the therapy and the alternate viewpoint gives me, it's like diluting…I would always feel quite centred, thoughtful and more in control than before I went in and also, I would notice that at home I could be clearer about what I needed" (Freddie, I42)*

> *"Cleansing, it felt like a little bit of putting the rubbish out" (Casper, I39)*

"I am a lot more calmer internally. And I am a lot more accepting" (Wilhelmina, I19)

"Warm feelings I had, because the answers he gave me, connections he showed me, they were so obvious, but so nice as well to find myself again, to become cool with myself again, maybe with the things which I didn't deal for a long time, they were just past, I experienced them and whatever. Now we kind of heal them" (Otto, I53)

Conversely, though Doogie commended the awareness and meanings developed, he described the double-edged nature of this outcome, as with increased awareness, an increase in unwelcomed memories occurred. Thus, Doogie's ambivalent stance towards therapy seemed to be serving to protect him from painful feelings:

"There are some things they made me think about, but it also brought up memories that I thought I had pushed right down…memories that I don't want" (Doogie, I9)

Though unwanted painful feelings were brought to the forefront for Doogie, it was evident that for the other participants, a new perspective on their difficulties aided a feeling of calm, centredness, acceptance, positive feelings and reduced symptomatology. Moreover, at the follow-up interviews it was evident that the diluting effect and increased sense of wellbeing had continued and facilitated the way that the participants approached new obstacles:

"I think everything was perfect, everything perfect because it touched me, it changed me, it changed me big time…We have these habits let's say and those things which are always there try get you, but they cannot because you just see different" (Otto, FU35)

The depth of insight into personal meanings and awareness was maintained or enhanced at follow-up, with all of the participants reiterating the importance of their new understandings. Zilpah and Wilhelmina's extracts have been included to convey this:

"This anxiety, panic, whatever when it comes, is just, is just this younger person in me, that that's still frightened, still scared, still insecure, all the bad things I had and identifying that and sort of feeling that I'm not like that anymore, I'm grown up now, nobody can make me do or say or be anything I don't want to" (Zilpah, FU43)

"I can't control everything. I mean, I you know I kind of grew up thinking this would be my life…then you think crikey, life is very different… and it's coming to

that acceptance. And I still haven't still quite accepted that, but I do understand it" (Wilhelmina, FU20)

Doogie, who was initially unsure about this outcome due to the side effects of painful feelings, had in fact further developed his awareness and meaning-making into his position of defensiveness and difficulty being vulnerable. He had identified with increased clarity that his emotional needs were not being met and that his loneliness was somewhat maintained due to his defences:

"I keep putting up brick walls, so that nothing can hurt me and in fact all that happens is that you become imprisoned by this brick wall that you put up. So, you have a hard outside that no one can tap into" (Doogie, FU19)

Moreover, Doogie had begun to reconstrue, understand and accept his unique way of expressing emotion and responding to loss:

"I have been told ever since I was four…'you're not like everybody else, you don't cry therefore you're not showing your emotions, therefore you're not really grieving'. When in fact you are grieving just as much as they are, it's just that you can't produce these tears" (Doogie, FU44)

As such, the outcome of new awareness and personal meanings can be summarised as being vital to reframe the participants' difficulties. It enabled the participants to see how their current ways of being had been shaped and how certain ways of being that had been functional and adaptive in the past, were no longer serving them. This seemed particularly integral in meeting the participants expectations for EE; to develop a new perspective, understanding and have their experiences normalised, in their search of how to be in their lives. Awareness into new possibilities was developed and choices were illuminated, which shifted the participants' sense of 'stuckness' and empowered them to take up their agency within their difficulties. Interestingly, in parallel with the development of this outcome, an increased sense of wellbeing and dilution of symptomatology was experienced, which was also maintained at follow-up. Moreover, the participants adopted an attitude of continuous self-enquiry and reflection, which continued to be implemented by all of the participants at follow-up.

3.2 Towards Acceptance and Authentic Living

As the participants reflected upon what they gained from EE, there was a sense that in their search of how to be, their current positions in life were confronted and alternative choices and substantively new ways of being with themselves, others and their difficulties, were identified and implemented. The participants began to shift from a position of avoiding and masking their feelings, to that of acceptance of self, feelings and adversity. With this, the possibility of attending to and communicating their feelings and needs emerged and the participants identified that becoming authentically themselves was a more fulfilling way to live. The participants seemed clear about the choices available to them, areas of responsibility and also their limits, enabling them to take ownership of their difficulties, so that they were no longer living in default, but consciously choosing.

In discovering the personal meanings of their difficulties and having their feelings normalised, the participants moved towards a position of accepting their feelings, as opposed to self-criticism and masking:

> *"I used to beat myself up and be hard on myself actually don't be so hard…You're doing fine and just enjoy being you and accept. I think it's almost like accept who you are. Love yourself…we are all different you know people might say I bring a lot of joy to other people and it's difficult…you get lost" (Casper, I33)*

> *"It's very much an acceptance that he has brought me around to, that it's normal to be anxious" (Wilhelmina, I15)*

> *"Feeling alright about not feeling alright, yeah that is the thing, or feeling alright with feelings, which have largely been a problem" (Freddie, I36)*

> *"Now I can deal with them not like I did before, by just putting some sort of skin, hard skin on myself, no just accepting those things" (Otto, I40)*

> *"Surprisingly I started to think 'well actually maybe I don't need to run away from this, maybe I can just let it in and gradually over time I will learn that it is not bad thing and it will come and it will go'" (Zilpah, I22)*

> *"I acknowledged where I was going wrong, so I was aware I was repeating certain mistakes, accepting why I was doing it" (Cyprian, I43)*

Though for Doogie this level of acceptance and movement away from masking feelings, was not reached:

> *"I still don't feel that I show my emotions and anything that doesn't go quite the way that I was hoping it would go, just goes into the pit in my stomach and then I don't like talking about it" (Doogie, I69)*

That said, Doogie entered EE with a significant level of acceptance towards life's inherent difficulties and leaving EE all of the participants had too become increasingly accepting of life's limitations and struggles, which Casper's extract relays:

> *"Sort of looking at the situation and saying sometimes maybe that just happens" (Casper, I43)*

Casper's transition towards an attitude of acceptance, led him to become more present and take stock of his life and what he values:

> *"Try and live in the present, because you can't change what's happened, you can possibly change what happens in the future, because of your spirit is from the past. So yeah become a little bit more philosophical" (Casper, I19)*

Likewise, in accepting both life's adversity and their feelings, Wilhelmina and Freddie began to identify their needs and the limits to their responsibility, enabling them to respond in new ways. For Wilhelmina accepting and communicating her anxiety, as well as responding in a way that empowered her son, as opposed to taking over his responsibility was discovered. While for Freddie the new way of being involved attending to his own needs, feelings and asserting boundaries:

> *"An acceptance of 'well yeah, that's how it is sometimes' and just by standing back and I had a better perspective, I think a much better perspective, rather than jumping straight in" (Wilhelmina, I20)*

> *"Rather than adopt the 'okay I should really listen now'…it's much easier for me to say, '…I'm exhausted and I need space'" (Freddie, I42)*

Thus, in accepting their current way of being and taking stock of their situation, they began to respond from a place of conscious choice, rather than relying on their default ways. Likewise,

Cyprian and Doogie described how they moved from defaulting to comfort eating to seeing alternative possibilities:

> *"I've always gone in that direction, 'well that's the way things are, so I'll just go on with it, just carrying on with it' in the past. But now I need to do some left hand turns to actually do something about it occasionally, to stop it becoming a pit in my stomach and then once it's a pit in my stomach, then I feed that pit" (Doogie, I45)*

> *"I can do something about my appearance and the onus is down on me now. So, I feel as if I've got a bit more acceptance and a bit more self-esteem" (Cyprian, I84)*

Combining both an attitude of acceptance and purposeful living, it seemed that the main answer the participants found in their search of how to be, was to become more authentically themselves, with their 'mask' and 'feelings' becoming more integrated:

> *"It's made my head and my heart feel a bit more joined together…now it's, 'things are going to be okay, things are going to work out'…I haven't gone overboard. So, there are lots of little things that we discussed in the therapy that have made me calmer and have made me react to situations in a more positive way" (Wilhelmina, I19)*

> *"I was beginning to allow myself to feel that which I was previously trying to shut out, that it was alright to feel angry or to feel annoyed or to feel actually to be honest, why this happened and why do I have to be lumbered with all this and all those kind of natural reactions" (Freddie, I4).*

> *"I need to re-establish who I am, so yeah I'm making steps to do that and I'm enjoying it" (Casper, I28)*

> *"If you have a fault, that doesn't mean that you are weak, if you have a fear, that doesn't mean that you're not manly. I am not having these things where I try and hide now, I just tell them how I feel" (Otto, FU18)*

In the process of reconnecting to what was meaningful to them, a number of practical changes were made. For example, Freddie made more time and space for himself by reducing his work and developing a support network. Casper started to involve himself in activities and with people that he valued. Wilhelmina and Cyprian too identified changes to their way of being to incorporate self-care:

"This job that's one thing and then like re-join the golf club is another thing, you see it's sort of things that I think of what I used to do" (Casper, I29)

"I've realised and appreciated now that I deserve to be having done things for myself, by myself and that I need to be more reflective on that as well, so I've changed and done that" (Cyprian, I27)

Having taken stock of their lives and in accepting their individual difficulties, it seemed that the participants had identified how to become more themselves. Thus, leaving EE they seemed better equipped to cope with their difficulties and were revitalised to implement change, in order to live more meaningfully and purposefully, which Cyprian's extract captures:

"I've got a bigger drive…my focus now is to make sure that I improve my health, make sure that my whole wellbeing overall is improved" (Cyprian, I43)

Conversely, Zilpah spoke highly of the 'tool' discovered, that of accepting feelings, yet she was reluctant to continue implementing this new way of being without the containment of therapy:

"It could make it worse potentially, if they left and there was nobody there to support you afterward, if you carried on trying" (Zilpah, I22)

Interestingly, by the follow-up interviews the contrast between Zilpah's and the other participants' sense of motivation to implement the new way of being, had narrowed. Other than Otto, all of the participants described struggling to maintain their accepting and authentic way of being, with their motivation beginning to dwindle. Nevertheless, they still viewed this way of being as preferable and their accounts suggest that they were in fact still implementing an accepting and authentic way of living:

"If I've felt it's starting to come, I have tried to not get busy (laughs) and just sort of think 'well what's the worst that can happen?', but I still feel very precarious when I do it" (Zilpah, FU39)

"I want to go up and just wrap him up in cotton wool, but I won't do that, I will just give him a hug and say 'well that's life and that is that's life. It can be unfair sometimes'" (Wilhelmina, FU15)

They appeared to be actively striving to accept their feelings, even if they had encountered unforeseen tensions and challenges. In fact, Freddie, Otto and Wilhelmina had developed

personal solutions to manage such tensions, in order to ensure their new way of being worked within their evolving situation. For example, Freddie identified a need to mask feelings when caring for his wife and discussing her deteriorating health with her, however he decided that if he was to continue masking feelings within that situation, he needed to seek emotional connection elsewhere, in order to re-establish his identity and ensure self-care:

> *"I just thought to myself, okay that's what I'm missing…I connected with what it is that I actually need which is interaction with other people" (Freddie, FU9)*

For Freddie and Wilhelmina, the benefit of incorporating practical changes, in order to ensure that an accepting and authentic way of living was adopted, became particularly apparent at the follow-up. They had made significant changes to give themselves more self-care opportunities:

> *"I've only been doing my full- time job and that's actually been really (accentuates) helpful, because that has shown me how busy I was before and how easy it was for me to hide behind my work" (Freddie, FU6)*

> *"If I am feeling like that, I just put my podcast on and I just walk and it's wonderful" (Wilhelmina, FU17)*

Similarly, although Doogie still expressed ambivalence about making changes to his current way of being, he was making alternative choices and implementing practical changes labelled as a "left hand turn", as opposed to his automatic "right hand turn":

> *"The last two weeks I've actually done five walks around a common, which is a bit of a left hand" (Doogie, FU72)*

Doogie seemed to be finding his own solutions to making changes and appeared to have more possibilities available by the follow-up. In becoming more accepting of his unique expression of feelings, Doogie, as with Freddie, had identified a need for a relationship that offered emotional intimacy, in which he could have his feelings accepted. He expressed a willingness to look beyond his immediate friends, so as to get this need met and it seemed that although he had not reached a significant level of acceptance within therapy, experimenting with expressing himself and having his feelings accepted, had awakened him to his need for this. Though he still exhibited a lack of self-acceptance by the follow-up, he relayed new awareness into how this was contributing to his difficulties in developing relationships:

"I could see myself in the full-length mirror and thought 'this fat person yeah', so I still have 'no one's going to fancy you', that kind of type thing" (Doogie, FU77)

In summary, while it was clearly a challenge to continue implementing this way of being and there were times when the participants would notice themselves entering their default way of being, all of the participants had continued to find ways to become more themselves and in accepting their feelings. For Cyprian however, the tensions involved in change seemed to have significantly compromised his new way of being and having been extremely motivated at the initial interview, by the follow-up he had returned to his default mode of masking feelings:

"Her happiness has always been my number one goal and it will always be my number one goal, so that if I have my leg chopped off, I will still turn around and say 'everything is fine'…I don't want to change that part" (Cyprian, FU29)

Cyprian had moved from masking one type of pain, that of sadness, to hiding his physical pain. He was caught in a tension of not wanting to mask feelings, but he was also operating upon the assumption that to maintain his daughter's happiness, he needed to appear happy. It seemed that he had hoped to change part of his way of being, without it effecting the whole and he had not been able to identify a way to navigate this tension to change.

Otto stood out amongst the participants, because he was still fully implementing his new way of being at the follow-up. It was evident that rather than being critical of any setbacks or feelings, he had been expressing and accepting them:

"Don't be angry, just accept. You know, we have problems, the problems may occur, we are just dealing with them, you don't need to judge yourself, it is normal" (Otto, FU17)

He was finding that by acknowledging and accepting his feelings, his symptomatology diluted:

"One day I just said 'if it is going to happen, then it is going to happen, it doesn't matter' and it just goes away…It's the same with the panic attacks, just accept it" (Otto, FU4)

Otto felt that he had become fully himself and was willing to reveal his vulnerable side and communicate his difficulties, which in turn had allowed him to live more fully. He reiterated

the participants' statements that this new way of being requires work, but he relayed that with each challenge he manages to overcome by accepting, the more empowered he becomes. He communicated an immense sense of pride in acknowledging his resilience and courage to continue implementing this new way of being:

> *"The point where I am now, I am very proud, I know I am strong and we all strong, but you need to find the strength yourself" (Otto, FU13)*

So, to conclude this theme, as the participants left EE, they had begun to adopt a stance of acceptance towards themselves, their feelings and life's difficulties. In reframing their experiences and feelings as normal parts of existence, they started to become more themselves, attending to their needs and allowing and communicating their feelings to others. They identified their limits and responsibilities, asserted boundaries and took ownership of their difficulties and alternative choices. At the follow-ups, the participants expressed that continuing this new way of being was challenging and in confronting certain tensions involved in affecting change, they had resorted to old ways of being in some areas or with certain people. Nevertheless, they still identified this new way of being as preferable to that which they arrived with. The participants that were experiencing the most continuing effects of this outcome and had been most effective in implementing this outcome at follow-up, seemed to have extended their accepting attitude to the process of change, seeing it as requiring time, practice, flexibility in the face of obstacles and an openness to what might emerge.

3.3 Short-changed by Time

Despite EE either meeting or excelling expectations for all of the participants (aside for Zilpah), as the participants left EE there was an overarching theme that time felt insufficient for their particular needs. There was a sense of incompletion and the ending was experienced as obstructive to progress and, in some cases, abandoning. Otto and Wilhelmina (though to a lesser extent at her follow-up), were unique in their experience of seeing time as sufficient and feeling empowered to continue their therapeutic journey outside of EE.

For all of the participants aside from Otto and Wilhelmina, there was a belief that with more time, more progress could have been possible and their journey may have reached a point of completion. Cyprian's analogy represents how the progress made, acted as a taster for what else was possible and thus they felt short-changed out of this:

> *"It's a bit like having the carrot dangled in front of you, then having it taken away…there's nowhere for me to go to, to say 'oh look this has been wonderful, I need more'" (Cyprian, I79)*

Cyprian felt that with more time, new awareness into blindspots would have been reached. Zilpah, Doogie and Casper believed that insights could have been cemented into new ways of being and the provision of further tools to help them manage their difficulties would have been provided with more time, which Casper's extract represents:

> *"To have some strategies in place, so that when I do feel that, how you switch off and you know think of twenty-five rabbits jumping over a roof" (Casper, I54)*

Moreover, Zilpah saw EE as a future-focused therapy and she felt that only her past and current way of being were able to be discussed within the time-limit. Thus, Zilpah felt short-changed out of the main focus of EE:

> *"Start from here and see a better place a bit further forward and how to get there. But I feel like I have only been given half the pack of cards" (Zilpah, I10)*

Zilpah described the essentiality of the therapist understanding her past, in order to then focus on the future, but that this takes time to develop, which the time-limit did not account for:

"To have any sort of relationship with a counsellor they would need to know that, before we could move forward…so I did feel the six or seven sessions that I had, probably weren't enough…I felt that we were just starting to get somewhere when it finished" (Zilpah, I3)

This extract touches on how Zilpah, Freddie and Doogie felt short-changed due to the time taken to develop a trusting relationship and this had just begun when EE ended, which Doogie's extract communicates:

> *"It took me the first four or five sessions to begin to trust, so therefore you are only just beginning to trust your counsellor and suddenly the counselling sessions are finished" (Doogie, I74)*

Doogie identified that he needed to work on being more vulnerable with others and allow his feelings, in order for his emotional needs to be met. However just as he trusted his therapist enough to do this, therapy ended.

Moreover, Cyprian, Zilpah and Doogie described the ending as sudden, abandoning and obstructive to progress:

> *"I was doing this mile run and we've gone one lap and boom I've pulled a muscle, because it stopped…I'm now in some ways not as bad as I was beforehand, but I know there is room for improvement…everybody is different and not everyone is going to be sorted in six sessions" (Cyprian, I47)*

> *"I had just jumped on the merry go round if you like and then someone kicked me off when I was just getting a grasp of it" (Zilpah, I9)*

> *"It takes you time to form a relationship, to become to trust somebody that you can actually say things to them…things start clicking…then 'oh by the way that's the end of our session now, I won't be seeing you again' (impersonates the counsellor)" (Doogie, I75)*

Cyprian, Zilpah and Doogie left feeling disempowered in continuing their journey alone:

> *"What I feel is a waste is, I feel like I'm in limbo…the first time in those twenty-three years, I actually feel as if I've made progress and there is nothing that I can do about it now. It's the end of it, it stopped. It's the end of the sessions, it's finished, done with, boom" (Cyprian, I78)*

"I'm not sure if I am really going to go forward with that, because I sort of feel I have got nobody to refer to now, nobody to say 'well this happened and I felt like that', I don't feel confident to move forward" (Zilpah, I23)

Casper viewed the therapeutic journey as continuing beyond EE and seemed empowered to do so, however there was a level of anxiety in having to face future difficulties alone, given that his new perspective and way of being was very new:

"I think it is an ongoing process. I said 'if I dip a little bit can I get in touch?'" (Casper, I19)

Casper's experience of being short-changed was slightly different in the sense that he was considered recovered after four sessions and therefore was discharged, despite a lack of clarity in the reasoning for this. Though he trusted his therapist's clinical judgement, he would have welcomed the opportunity to continue building his strength and gain tools to face future difficulties:

"I think he cut it short, because he didn't think, maybe we were going around and around in circles" (Casper, I42)

Wilhelmina too had a different experience of being short-changed, because it centred around the time taken to begin EE post-assessment. She felt cheated out of the support she would have liked in the height of her anxiety:

"Timing is everything in therapy. I mean obviously it's been very useful, when I really needed it the most, it wasn't available…I would have been in the height of my anxiety and he would have been able to see that affect" (Wilhelmina, I27)

That said, like Otto, at Wilhelmina's initial interview the time-limit seemed well-fitted to the nature of her needs:

"It's a very specific anxiety, so I think six sessions were enough. I got out of it what I needed" (Wilhelmina, I23)

However, by her follow-up like all of the participants except for Otto, Wilhelmina felt in need of further support to maintain her new way of being. A tapered ending, with sessions evolving to provide a supportive, motivational function was desired by the participants. They believed this would serve as a safety net, aiding the implementation of new ways of being:

"There should be more, not necessarily weekly. I don't think that there's a need for that, but maybe monthly for the next three months, just to keep that going, I just think it just cuts off very quickly" (Wilhelmina, FU1)

There was also a heightened sense of feeling short-changed in Zilpah, Cyprian, Doogie and Freddie's accounts at follow-up. Freddie relayed his dissatisfaction of time being wasted by the outcome measures and described how the overt presence of time, took away some of "the magic" (I58) and cheated him out of the therapist's full presence:

"I calculated from a time point of view, that if you subtract that form filling, then you kind of feel you're in a way being a little bit short-changed" ((Freddie, FU33)

Zilpah even stated that the time-limit could be "dangerous" (FU18), due to getting a taste for what is possible and feeling great hope, to then only getting a "snapshot" (FU18) of these potentialities:

"You need a lot longer, it's better to have nothing than a little bit of something…probably do more harm than good" (Zilpah, FU16)

Zilpah, Cyprian, Freddie and Doogie described how EE had only scratched the surface of their difficulties and though an understanding was established, they wanted depth work on the identified problem areas, or to have further support to cement their new learning into practice:

"Once you start realising it, you need then help to bring it out so that it stays there, rather than 'oh you can see the emotions, okay the sessions finished, right okay' and then everything shuts right down again" (Doogie, FU42)

"The length of time that is given and I know that's down to funds, is just skimming the surface" (Zilpah, FU50)

"They're only firefighting" (Cyprian, FU36)

At both interviews, Freddie conveyed that EE met his expectations of what was possible within the time-limit, especially given the unexpected bereavement changing the focus of therapy, but time was insufficient to develop a trusting relationship, receive support with the bereavement and take a holistic approach to his difficulties. Likewise, just as Doogie started to trust and

engage in EE, it ended and he too felt that the nature of his concerns were too large for a short-term intervention:

> *"With that type of thing happening to you, you do tend to put lots of defenses up. As I say today it's called PTSD…I haven't yet sorted it out thirty years after it actually happened. Yeah, so six sessions is not going to" (Doogie, FU49)*

There was also the issue of changing external circumstances, that both positively impacted therapeutic outcomes in EE for many of the participants, but for Freddie and Cyprian who experienced additional losses, it meant that their needs for therapy changed and heightened post-therapy:

> *"I wouldn't' change it, I just would like to have more of it…I had that therapy when things in my life were very much smoother to what I'm going through now. My life when I walk out of this surgery is a lot of turmoil" (Cyprian, FU33)*

> *"It has helped me, but I feel overall it was too short to be helpful, but that's nobody's fault. Nobody could have anticipated my Dad would pass in the middle" (Freddie, I10)*

Thus, for all of the participants with the exception of Otto, the time-limit was perceived as insufficient for their particular evolving needs. Furthermore, it seemed that the positive experience and progress made in EE, may have acted as a taster to the participants' potentialities and left them yearning for more. This resulted in a sense of disempowerment for those believing therapy is required for continued progress and there was a call for a continuation of support and for the time-limit to be personalised to individual needs:

> *"More time, more, more, more, more interaction of actually dealing with the problem isn't possible…The fact is that every individual person requires a different amount of time" (Cyprian, FU37)*

However, the participants that saw EE as a springboard for their continued journey, such as Otto, Wilhelmina and Casper (although we do not know how this may have changed for Casper had he attended the follow-up), did not experience the same level of being short-changed by time. Otto who experienced the time-limit as sufficient for his needs at both interviews and Wilhelmina whom while desiring further support at follow-up, seemed empowered and

determined to continue her journey, spoke at length about the importance of realistic expectations:

> *"It is a journey, you don't expect it's going to finish today, you need time, everything needs time like you have a wound, it takes time to heal…I didn't have expectation and I still don't have" (Otto, FU26)*

> *"Part of my expectation is that my anxiety is going to go away and he made it very clear from the beginning that it was highly unlikely that it's ever going to go away and that it's a natural reaction…but it's how I handle it and I think that was very good" (Wilhelmina, I3)*

Wilhelmina arrived in EE with unrealistic expectations and through the effective management of these she was able to view the outcomes she achieved as enough. Wilhelmina, Freddie and Otto accepted that the process of becoming and striving to reach their potential was a continuous process and saw therapy as a springboard to their own journeys, which they felt empowered to embrace:

> *"The rest is me now, I have the path, he told me what to do, how to look and how to think, try think and now I have to follow this route and so far it's working" (Otto, I48)*

Otto took ownership for his continued progress and his proactive and resilient stance shone through, which he highlights as contributing to the attainment of outcomes:

> *"I am the one who always wants to push myself to get better, so maybe this is part of the result. If maybe someone does have this willingness, it will be harder for him to achieve this" (Otto, FU27)*

Thus, it appeared that realistic expectations for EE and the change process, as well as a proactive stance was vital for participants to feel empowered to continue therapeutic progress post-EE, which was fundamental to the time-limit being experienced as sufficient.

To summarise, it is clear that most of the participants left EE feeling short-changed by time in varying ways and there was a belief that more progress would have been possible with more time and for many of the participants, progress was seen to end as therapy ended. The ending was largely experienced as being abrupt and most of the participants described how continued support was needed, to feel confident and motivated to implement changes to their way of

being and cement their learning. While some participants continued to make changes post-therapy, their confidence and enthusiasm had waned by their follow-up and it was clear that the time-limit was insufficient for their needs for support. Where the time-limit was experienced as sufficient, client-attributes of realistic expectations of therapeutic outcomes and the process of change, as well as a proactive stance stood out.

Reflexivity in the Presentation of the Findings

The richness and depth of the data for each theme meant that to reduce the data and present the findings, I had to carefully select an extract from just a couple of the participants' accounts that would capture the essence of the theme for all of the participants. This required me to reflect upon why I was choosing one extract over another, and why I might be drawn to rely on one participant's account more than another's. At this stage, I was particularly mindful that some of the readers of the dissertation would include the participants of this study and therefore this influenced my decision to include certain extracts over others and how I relayed my interpretation of them. I was particularly conscious to ensure that their identity would not be revealed, particularly as some of the extracts revealed very personal information about themselves or family members and I did not want them to feel exposed. I was also careful to ensure that every participant would feel that their experience was appropriately represented and understood from the way that I presented each theme. Likewise, I was aware that the participants' therapists and supervisors would most likely be readers of the dissertation and therefore I was mindful to ensure that the therapists would not be personally identifiable.

In the following chapter, I will provide a detailed discussion of the findings presented in this chapter, explicating the contribution to knowledge that this research offers.

Chapter 6: Discussion

This chapter will first discuss the limitations of this study, in order to be as transparent as possible before the discussion of the findings and consideration of the implications takes place. This will be followed by a review of the findings, in relation to the relevance and suitability of the EE intervention, for addressing the concerns and objectives of service users in primary care. The findings will be placed into the wider context of CoP and psychotherapy, by discussing the research findings presented in the previous chapter, in light of existing literature. The findings will be reflected upon in reference to the 'Literature Review' (Chapter 2) and additional literature will also be cited, in order to frame the new understandings developed. This is based on the premise that while the findings mostly relate to research already outlined, in accordance with IPA's understanding that, "the interview and analysis will have taken [the researcher] into new and unanticipated territory" (Smith et al., p.113), new ideas have emerged from the analysis, that enable a fresh lens from which to examine the experience of EE. Implications for clinical practice will be made explicit and ideas for future research will be conveyed.

It is important to acknowledge that a key premise of my epistemological stance is of 'Being-in-the-world' (Heidegger, 1962), as such this discussion is inevitably limited by my historical and personal background and thus conclusive claims cannot be made. This is just one of many possible discussions and has the aim to be understood in an explorative and tentative manner.

Limitations of the Study

During the planning and implementation phases of the research, some design issues emerged with potentially limiting consequences to the study. To ensure transparency, these will now be outlined.

In terms of methodological limitations, the study was conducted by a novice researcher in IPA, which is a limitation. That said, I meticulously undertook all measures to safeguard the quality and rigour of the study and though I do not have the level of experience and training as those more familiar with IPA might, I ensured transparency in the analysis and writing up process. Furthermore, my supervisors both of whom are experienced in IPA, facilitated my reflexive commitment, to the extent that I believe this study offers an accurate understanding of the participants' experience, that can aid the understanding of how the EE intervention is experienced in primary care.

A particular criticism of IPA, is the tendency for novice researchers to over focus on the interpretational component, at the expense of the phenomenological aspect (Giorgi, 2010; Van Manen, 2017). Consequently, I ensured that the interviews were as phenomenological as possible, building a description of experience and refraining from introducing interpretation into the dialogue. Interpretation was only included at a later stage of analysis. In fact, I think my striving to be phenomenological was a hindrance at times, because I tried to capture every aspect of the participants' experience, which inevitably is impossible. I struggled to make the interpretative leap with the emergent themes, for fear of not doing justice to the participants' experiences. Furthermore, in writing up the findings, I wrestled with not being able to represent each individual's account and thus trying to reduce the quantity of extracts included was a timely process. Discussions with my supervisors, helped to manage my struggle with balancing the phenomenological-interpretative process and I used my reflexive journal to consider how much of my own experience seeped through into my attempts at trying to make sense of the participants' sense making. Therefore, on a methodological level this aspect was addressed via a meticulous process of reflexivity and transparency strategies, as described in Chapter 3 and 4, but on a personal level this aspect will continue to be an interesting area for reflection.

As an 'insider researcher' I had clear ideas about EE, which has the risk of running in counter to the non-directive participant-led exploration key to IPA. Therefore, the construction of an

open and exploratory interview schedule was required, to reduce any preconceived ideas biasing the interviews. A number of predefined areas were included to ensure that the aims of the study could be addressed in a manner that safeguarded the depth and richness of the knowledge produced. However, these predefined areas were unpacked at length in my reflexive journal, in terms of how each question addressed the aims of the study and how the literature informed them.

It became apparent from observations during the interview, as well as comparing the general question to the predefined areas, that increased facilitation was required for meanings to emerge and descriptions to be extracted, particularly in relation to the process of the therapeutic work. Given the gap in process research for EE, the inclusion of a predefined area to aid the exploration of this, seems valid. Likewise, attempting to uncover the particulars of the therapeutic relationship in EE, another area where there is a gap in the literature, rendered the inclusion of a question regarding the relationship as vital, so as to reach a greater depth of knowledge. I believe that the questions were sufficiently open, to avoid biasing the flow of the dialogue and the inclusion of the general question at the beginning, enabled me to monitor how the defined areas had directed each participant and helped to aid transparency in the interview process (see Appendices O and P).

Similarly, the decision to include follow-up interviews took much consideration. The possibility of the follow-ups becoming more researcher-led, as mentioned in the 'Interview Design' (Chapter 3), was a concern. However, this is where my supervisors and 'critical friend' were particularly valuable, ensuring that the questions were not to satisfy my own intrigue and therefore allowing biases to influence the dialogue. Instead, they assured that questions focused upon reassessing outcomes and areas in need of clarification or expansion. Flowers (2008) described how cognitive overload can result in potential opportunities being lost and the inclusion of a second interview enabled me to revisit missed areas. Therefore, the inclusion of follow-up interviews aided me to argue with reasonable confidence, that my findings are grounded in robust and comprehensive understandings of the participants' accounts, with the possibility of unclarified meanings and subsequent interpretation in the analysis being reduced. Moreover, the inclusion of a follow-up at three months, aids the validity of the outcome findings, by accounting for the positive reporting bias that has been identified in outcome studies conducted shortly after therapy completion (Rosenman et al., 2014).

Another limitation of the study was the difficult and timely recruitment phase. I had not anticipated the complexities of recruiting within an organisation, or NHS setting. When the recruitment phase was initiated all clients were given a 'Letter of Introduction' (Appendix F) at their psychological assessment, however I had not foreseen that they would be on the waiting list for up to five months, with no guarantee that they would complete therapy, or volunteer upon completion. There was also therapist annual leave, therapist and room shortages, which delayed the speed of recruitment. This was in addition to the stipulation that the potential participants were required to make contact with me, I could not contact them myself. Consequently, I was reliant on the goodwill of the assessor to disseminate the 'Letter of Introduction' and I believe this was a significant limitation to the uptake of participation. Gaining permission to recruit across more than one surgery, thereby having access to more therapists and clients would have been beneficial. However, this is said with the benefit of hindsight and was not carried out due to the timely administration involved in getting further risk assessments approved via the ethics committee and agreements secured with the management team at each surgery. Though I did recruit the desired sample size, the challenges involved and time required for such a recruitment process, is an important consideration for future studies.

Discussion of the Findings

To reiterate, the rationale behind this research was to gain an understanding of the experience of EE from the clients' perspective. This research was born out of the lack of qualitative research and first-hand reflections of clients who had experienced EE, but also the general lack of an evidence-base for EPT in primary care. This study contributes to the process-outcome research and practice-based evidence for EE, an existentially-oriented intervention in primary care.

The research questions outlined in Chapter 2 consisted of an exploration of the following themes: the general experience of EE, presenting issues and objectives, the experience of the therapeutic process, outcomes and the therapeutic relationship. Themes relating to presenting issues, objectives and outcomes have been grouped together for the purpose of this discussion, to address what the participants were looking for and to what extent they found this. This is to determine the suitability of EE for addressing the concerns of this particular client group. There is an operational protocol for EE which outlines the process of this intervention, however there has been no assessment of how this looks in practice, nor how it is experienced by the client. For this reason, an aim of this study was to illuminate how the therapeutic work is experienced, so the findings from the analysis that seem relevant to understanding the therapeutic process of EE, will be examined. Finally, how the therapeutic relationship was experienced in EE will be discussed in light of the abundant existing literature on the relationship as conduit for change in psychotherapy. To ensure that each research question is addressed, I have structured this chapter as follows:

- The suitability of EE for addressing the presenting issues and achieving the desired outcomes of service users' in primary care
- The specifics of the EE therapeutic work
- The specifics of the therapeutic relationship in EE

The Suitability of EE for Addressing Client Concerns and Achieving Client-determined Outcomes

This section explores the suitability of EE, an existentially-oriented approach, for addressing the presenting difficulties and aims of clients' perspective in primary care, as well as for reaching their self-determined outcomes.

A Need for Difficulties to be Addressed at Their Personal and Interpersonal Roots

> *"Life is a constant cycle of ups and downs, achievements and failures, encounters and separations, joys and sorrows, hopes and disappointments. Exposure to these contradictions generates emotions that can easily swing us out of our precarious balance, bouncing us out of our comfort zone, pushing us towards the abyss" (van Deurzen, 2015, p.2).*

Though the participants were referred to EE for anxiety and/or depression, it soon became evident that while diagnostic disorders or intrapsychic struggles could be used to categorise these individuals' difficulties, they were insufficient as well as unnecessary in giving an adequate picture of their struggles, as lived and perceived through their own lenses. The quote by van Deurzen (2015) has been cited to illustrate how the nature of human existence and its inevitable challenges, means that a more personable and thorough elucidation, that more readily captures the breadth of client presentations and concerns may often be required, as was the case with this particular sample of clients.

Loss was being experienced in a number of forms; whether loss of identity, crises in meaning, or bereavement. Consequently, the participants had been grappling with a complex array of issues involving responsibility, freedom, loneliness, mortality and purpose. The participants were experiencing overwhelming and, in most cases, unfamiliar physical and psychological changes to their wellbeing, as a symptom of this. However, rather than organising their narratives around these ontic expressions of symptomatology, the focus of their descriptions of their difficulties predominantly gravitated towards the ontological, personal and interpersonal roots. The participants' concerns indicated the confrontation with difficulties in living and a grappling with the 'givens' of existence, which is aligned to the existential-phenomenological perspective, as the citation by van Deurzen (2015) encapsulates. Importantly, an aim asserted

by the EE intervention, is to explore the client's "relationship with the inescapable givens of their existence that cannot be changed and must be acknowledged and accepted" (Rayner & Vitali, 2015, p.9). It sets out to explore existential anxieties, such as isolation, mortality, meaningless, choice, freedom and identity, suggesting that EE is well-suited to engage with such concerns.

Furthermore, the existential-phenomenological perspective views symptoms as meaningful expressions of something deeper; they are perceived to represent an answer to what might otherwise be an unbearable situation in the life of the sufferer, as opposed to psychological disorders (Rapley, Moncrieff & Dillon, 2011). In connection with this perspective, a central tenet of EE is to explore what symptoms mask and in line with Kierkegaard's (1980) postulations, encourages the embracement of anxiety, viewing it as a sign of aliveness and part of owning one's responsibility and freedom. As Jeans, Sayers, Kauntze and Rayner (2018) convey:

> *"We challenge the medicalization of psychological problems by deconstructing the notion of illness and distress. We understand symptoms to be a reflection of the person's relationship to themselves, to others and to their world, rather than problems to be eradicated" (p.28).*

As such, the depathologising stance and conceptualisation of distress in EE, renders it well-suited for the concerns of this client group in primary care.

Undoubtedly, the participants were hoping that they would be facilitated in managing their overwhelming feelings, in relation to their life difficulties. But this was hoped to come in the form of a normalising stance towards their difficulties, a new understanding of their struggles and tools to help them manage their situation. As such, it could be argued that it was vital that the participants' concerns were met at a personal and interpersonal level, rather than focusing on symptom reduction. Concentrating on symptom reduction could risk invalidating their personal struggles and could potentially keep them embedded in old meanings around their experiences of difficulty; old meanings that were part of, rather than a way out of their 'stuckness'.

It is important to highlight that EE's aim to deconstruct the medicalisation of distress commences at assessment. It is hoped that clients might begin to set aside fixed narratives and classifications regarding their experiences of distress and begin to question how they can reconstrue their narratives without having clear answers. It is then through the body of the EE therapeutic work, that the embodiment of this demedicalised way of being takes place. Therefore, given that a significant component of the EE protocol and client-reported outcomes, is the reconstruing of understandings and meanings, it is impossible to know the extent to which the EE protocol itself influenced the participants' accounts of their presenting issues. This is reinforced by the fact that the participants described their experience of beginning EE retrospectively. However, the fact that the vast majority of participants described their presenting concerns in this way, suggests that the co-constructed conceptualisations that they reached resonated with them and best represented their concerns as they began EE. That said, perhaps future studies could include an interview at the point of referral, in order to develop a detailed picture of how suitable the EE intervention is deemed at this point, as well as to develop a deeper understanding of how clients' concerns become re-construed post-therapy.

The fact that one participant's account of her presenting issues did focus on her depressive symptomatology, despite the fact that she spoke positively of the outcome in EE of a newly co-constructed understanding, would suggest that her differing experience was not due to a lack of protocol adherence, or the unsuccessful deconstruction of her initial understanding. Instead, it could be that she was overwhelmed by her symptoms, to the extent that a new understanding was beneficial, but the experience of symptomatology and desired reduction of this was paramount. As such, I wonder whether EE was the most suitable intervention for her given her aims for therapy and the particular point that she was in within her cycle of distress and perhaps a more symptom-focused approach might have been beneficial first. This touches upon the importance of developing an inter-modality assessment and referral process, in order to most appropriately meet individual needs, which I will go on to discuss in more detail. But her account also suggests that it is possible to assess the suitability of EE for addressing client concerns in retrospective interviews, as her account is in line with her unique construct system, whilst also being able to highlight and appreciate the new co-constructed understanding developed in EE.

Overall, it seems fair to say that the findings of this study, suggest that EE is befitting and necessary to address the breadth and depth of client concerns in primary care. But I believe that

one participant's aims and expectations may have been better suited to a symptom-focused approach and not wanting to ignore individual differences this is vital to be addressed. Perhaps a screening process that can identify the level of attunement between the concerns and objectives of the client and EE, could be incorporated to ensure that individual needs are most appropriately attended to. This would require healthcare services to become increasingly integrated, to enable seamless inter-service referral and though this would require considerable effort, it seems a vital step to facilitate increased choice in primary care. Therapeutic technique has been identified as a relatively minor factor in outcomes, yet goal consensus, collaboration, the management of expectations and treatment choice, play a significant part (Norcross, 2002). Cooper and McLeod (2011) state that different clients are likely to require different therapies at different stages. Therefore, it is important that this is considered within the assessment and referral processes not only within EE, but across psychological services in primary care. In fact, link workers who are now common within GP surgeries, could be well-placed to make this assessment and refer to the most appropriate psychological therapy.

Confronting the Consequences of Inauthentic Living

> *"Emptiness. The attempt to overcome it by intoxication… The attempt to submerge oneself…in any kind of working routine, any silly fanaticism; a confusion of all means, illness as a result of a general lack of moderation" (Nietzsche, 1968, p.32).*

From an existential-phenomenological perspective, the participants conveyed a sense of ontological anxiety, that was disguised "under layers of such defensive operations as displacement, sublimation and conversion" (Yalom, 1989, p.44). Nietzsche's (1968) quote above highlights how the participants' ontic manifestations of eating, smoking, keeping busy, playing certain roles, are part of the human tendency to distract from inner despair and vulnerabilities. However, as Kierkegaard (1980) pointed out, fleeing anxiety does not cure, but just perpetuates anxiety and this seemed to resemble what the participants described. Their distractions that had once aided a sense of security were no longer enough to mask their feelings from others. Difficulties in living had brought these ontological anxieties to the surface, forcing the participants to confront their vulnerabilities and recognise that they needed to find an alternative way to live.

In terms of existential thinking, there is an uncanny likeness in the participants' descriptions of this presenting difficulty, to that of Laing's (2010) idea of a divided self, even though it was based on schizophrenic presentations. In response to ontological insecurity, there is a tension between two identities within an individual, which leads to a divide in their identity; a false, public self is presented to the world, while a private, authentic, real identity is hidden inside (Laing, 2010). This split arises, to acquire a greater sense of safety and protect from vulnerability. Yet this divide between self and the world also limits an individual's potential for genuine connection with self and others.

Though to varying extents for each participant, the mask portrayed to the world also seemed to be an act of self-deception and pretence, in order to conform to the wishes of others. Sartre (1943) describes in his concept of 'bad faith', how humans spend the majority of their time pretending that something is the case when it is not, as this is often seen as preferable to facing the anxiety that comes with the freedom of choice. Though, to pretend that we are something other than what we are is to diminish one's possibilities and live inauthentically (Sartre, 1943). While there could be a lengthy discussion on the similarities and differences between Laing's (2010) concept of a 'divided self' and Sartre's (1943) concept of 'bad faith', it is important to mention that the clients' presentation of wearing a mask around others, while feeling vulnerable, neglected and distressed inside, seemed to be along a spectrum of both these two concepts.

The adoption of roles, masks, meeting of the expectations of others and the reliance upon ontic expressions to manage inner vulnerability, can be a vehicle for temporary liberation from feelings (Schneider, 2005). But in taking this stance "the person cuts himself off from possibilities for authentic relatedness and lives instead in a 'wish world'", an illusion of escape from insecurity (Heidegger, 1962, p.240). Conversely, in facing one's nothingness and freedom and recognising one's choices and possibilities, one can exist authentically. All of the participants described masking their true feelings and manipulating their sense of self, distracting themselves in a 'they' mode of existence, in order to meet the expectations of others. Yet, they appeared to have reached a pivotal point, in which there was a willingness to look at how they had been caught in everyday ontic struggles and inauthentic ways of being, in order to find a new way to be. Therefore, in light of the existential-phenomenological theory just discussed, EE seemed aptly attuned to conceptualise and work with the participants' concerns. Furthermore, because the participants seemed to be grappling with issues of relatedness to

oneself, being-with-others and being-in-the-world (Heidegger, 1962), the relational approach taken by EE, EPT and CoP seemed fitting.

In Search of How to Be

Finally, part of an appraisal of the appropriateness of EE for addressing the participants' concerns, involves an evaluation of their objectives. I wondered if the participants would mention the therapeutic orientation that they were desiring, however this was not the case. Instead, the participants' accounts were reminiscent of Kierkegaard's (2012) 'leap of faith', that by staring at the abyss and facing their freedom, the participants were recognising that the path forward was filled with uncertainty, but also possibility and hope. In facing up to their current situation permeated by loss and inauthentic living, the participants were grappling with issues of identity and were hoping to find a new way to be with themselves, others and the world. But, teetering on the edge of the abyss and facing one's freedom, is a position of immense angst, so EE was viewed as a vital aid to guide them in their search and help them to actualise their potentialities.

Spinelli (2015b) discusses how we are in an era that puts great value on "the expert", and "experts in living" are increasingly being sought (p.82). He deliberates how this may have always been the case and it might just be that some of the attention has shifted from wise men and priests, who might illuminate a path to follow in times of need, to therapists (Spinelli, 2015b). Accordingly, the majority of the participants expressed a desire for guidance as they faced an unfamiliar landscape. This was in hope of finding an alternative way of being and receiving reassurance that what they were experiencing was normal and not a symptom of madness. While uncertain of the form this assistance might emerge in, the participants hoped for a new perspective, understanding and some tools to help them better manage their current situation.

EE encourages clients to concentrate on "who the client is being" and how that way of being is both inter-relationally experienced and expressed, which is based on the principle in EPT, that by encouraging clients to "stay still" with their experience of problematic change, a shift is more likely to happen (Spinelli, 2015a, p.87-88). Clients are encouraged to engage with areas in which they have agency, as well as the limits, tensions and paradoxes inherent in their life, in order to live more purposefully. EE draws upon ideas proposed by Sartre and Barnes (1992)

in an attempt to "bring into the light the subjective choice by which each living person makes himself a person" (p.574). This is based upon the existential and humanistic perspective, that one's sense of self is fluid and in a continuous process of becoming. It is thought that as soon as a client acknowledges and connects with that which really matters in their lives, together with that which is hindering change, they naturally start to engage in a purposeful process of adjusting their ways of being and life path (Schneider, 2016). Furthermore, unlike most EPT approaches, EE combines the exploration of "who the client is being", with "who the client might become", with the goals for therapy focusing upon moving towards these wished-for positions (Rayner & Quinault, 2018). Clients are supported in reaching towards an as-yet undiscovered self-construct, which although uncertain and unfamiliar, may be less impeded (Rayner & Vitali, 2017). This shift in self-construct, which could be seen as a new way of being, emerges from the phenomenological exploration of the client's feeling of 'stuckness' and then a "leaning toward a sense-of-self- as-not-yet-clear" (Rayner & Vitali, 2017, p.6). As such, it seems that the approach taken in EE is well-suited to facilitate the participants' objective of finding a new way to be, in a manner that is individualised, culturally and contextually sensitive.

Likewise, EE, as with EPT, takes uncertainty as a core principle, seeing it as a position of strength and possibility, whilst viewing certainty as frequently hindering. Part of the protocol is aimed at acknowledging the struggles involved in moving away from a familiar sense of self and embracing the unknown as an opportunity for growth, challenging fears with a sense of hope (Rayner & Vitali, 2015). Therefore, the fact that the participants entered EE in a position of uncertainty and open to what may unfold in their search for a new way to be, resulted in their objectives seeming aligned to the embracement of uncertainty and ambiguity in EE.

A Final Note

The presenting concerns and objectives identified in this study, appear to be in line with a thematic analysis conducted by Rayner and Sayers (2016), in which five main themes of what clients wanted to achieve from attending EE were identified. These included, 'Understanding Self', which links to the participants' sense that they were losing their identity and experiencing unfamiliar feelings and sought to understand this. 'Understanding relationships', connects to the participants' concerns with responsibility, freedom, choice and their need to wear a mask to hide their vulnerabilities from others. 'Understanding emotions', which ties into the

participants' feelings of being overwhelmed by unfamiliar feelings and their tendency to distract from, suppress and mask feelings. 'Dealing with Givens', expressed as processing events that had occurred or those that will occur, such as facing the future, limitations in health, feeling responsible for others behaviour, certainly maps onto what the participants of the current study described. 'Letting go versus holding onto something', which involved wanting to move on with life, but realising to do so would require a change to an area that was unfamiliar and unappealing. This links to the participants' expressed desire to find a new way to be, but their fear of the unknown. Consequently, the existing findings, together with the findings of this current study, serve to strengthen the argument for EE's appropriateness for meeting client concerns and objectives in this particular context.

Moreover, the depth and breadth of the participants concerns, highlights the necessity for an approach that can address the diverse needs of primary care and draws attention to the complexity involved in trying to quantify objectively how these types of concerns and objectives might have been met. Symptomatology scales clearly do not adequately address the complexities and nuanced descriptions that the participants of this study described, in relation to their experiences or objectives for therapy. Likewise, these findings emphasise the importance of an approach that takes a holistic stance to attending to subjective experience, to ensure that each individual's reality and way of being is understood, so that their search for a new way of being can be aligned to their particular needs and contextual factors. Finally, a relational approach seems crucial, because relational and identity issues underpin all that was described, with the core of distress being that of loss, isolation and disconnect from self and others and a yearning for emotional needs to be met. Therefore, this group were not only attuned to what EE can offer, but also the core components that CoP and EPT behold.

A Meaningful Form of Change; Meaning-making and Self-awareness

Part of the assessment of EE's suitability to address the concerns and objectives of the participants, was to evaluate the outcomes reached, which this section will discuss.

> *"The sufferer is locked dogmatically in the terms of some theory, belief or dogma…Self–understanding requires realizing that it is we who have made such representations of ourselves…Failure to understand this leads theorists of psychotherapy as well as their patients to become identified with a theory and fixed on some representation of themselves and others which confuses factual statements with necessary expressions. Thus, because someone was abused as a child (a fact), then he must act (a necessary expression) in certain ways. To the victim, it may seem to be an absolute necessity" (Heaton, 2010, p.8).*

The quotation by Heaton (2010) is cited to represent how the participants' views about themselves and their difficulties had become sedimented, deterministic and confused as fact. But through a process of phenomenological exploration, of 'staying with' the clients' current way of being, the definiteness of their narratives was challenged. From here, personal meanings, new awareness into blindspots and the functionality of their current ways of being emerged and enabled alternative perspectives and possibilities to develop. As such, leaving EE the participants had reached a substantially new level of awareness and developed personal meanings into their difficulties, that seemed aligned to Ihde's (1986) concept of becoming polymorphous in experiential phenomenology. This entails moving from a position in which one can only see from one perspective initially, with alternative perspectives, meanings and possibilities seeming impossible to reach. To the development of a more creative and varied repertoire of meanings, understandings and perspectives.

As the participants entered EE there was a real concern with 'what is normal?', particularly what is normal emotional experience and expression. As their difficulties were explored, they were reconstrued into understandable and meaningful reactions to facing difficulties in living, that had emerged due to various contextual constraints, but had become outdated. Through the process of phenomenological exploration, in which the therapist adopted a stance of naïve unknowing to fully explore the clients' worldview, how they attribute meaning to experience and sedimentations in their being-in-the-world, as well as the validating and normalising of

their feelings, the participants were guided to reach updated personal meanings of their difficulties, listen to the implicit messages relayed in their emotions and adopt a self-reflective and aware attitude.

Though EE does not explicitly describe itself as a meaning-making endeavour, it does focus on deconstructing symptoms into personal meanings and goals, as well as encouraging the temporary suspension of a client's sense of certainty about themselves, others and the world. This is to facilitate a confrontation with the unknown, from which the opportunity for new meanings can arise and alternative choices can become visible (Rayner & Vitali, 2015), which would suggest that meaning-making is a core concern. Furthermore, while meaning is approached from various stances in existential thought, meaning-making is unquestionably at the core of EPT (van Deurzen, 2002; Hoffman, Vallejos, Cleare-Hoffman & Rubin, 2015) and a number of existential-phenomenological interventions have meaning-making as their primary focus (Vos, 2016a). Spinelli (1994) relays how existential-phenomenological therapists are "governed by their aim of 'entering into' the meaning-world of their clients so that their assumptions and theories concerning their current self/other relational constructs can be more adequately exposed to clarificatory examination" (p.125). While Wong (2012) conveys how "Every philosophy of life leads to the development of a certain mindset—a frame of reference or prism—through which we make value judgments" (p.5) and it is the task of existential therapists to encourage clients to explore the meaning in their lives, reflecting upon what guides their priorities, decisions and behaviours (Frankl, 1984; Hirsch, 2009; Hoffman, 2009a; May, 1991; Wong, 2012; Yalom, 1980). Frankl (1959/1984) frequently spoke of the role that meaning can play in transforming suffering, "suffering ceases to be suffering at the moment it finds a meaning" (p.117) and it seems that the development of personal meanings to the participants' difficulties, at least in part, contributed to their increased sense of wellbeing. Therefore, this finding would suggest that a primary outcome in EE, and perhaps EPT more generally (Hoffman, 2009), is that of the reconstruing of that which has been meaningful, but is no longer desired and the reaching of new more updated meanings.

The designers of EE state that understanding is a valid form of change (Rayner & Vitali, 2014) and this finding supports this assertion, but provides a more nuanced depiction of what form this understanding takes, specifically that of meanings of difficulties and awareness. There have been many questions raised about how to define client change and what the phrase "meaningful outcome" encompasses (Craig, 2010, p.198). Accordingly, in a review of efficacy

and effectiveness research, Lambert and Ogles (2004) draw attention to the fact that researchers have started to reduce the weight put on statistical significance and instead have started to identify clinically meaningful change in their pursuit of effective outcomes. This has aided the recognition of individual differences in psychotherapeutic change, but it remains unclear as to whether this refers to behavioural, symptomatology, insight, awareness or something else (Craig, 2010). While no conclusions can be drawn, this study provides overwhelming evidence that an increase in awareness and the development of personal meanings is experienced as a meaningful outcome. The participants endorsed this form of change as far exceeding expectations and for a number of the participants, the successful nature of this outcome was a key aspect separating EE from their previous therapy experiences.

Craig (2010) infers from the findings of her single case efficacy design, that change across three modalities (Personal Construct Therapy, EPT, Psychodynamic) is in the form of learning. Crucially though, the nature of this learning and the way the learning process arises, varies across the modalities. In support of Craig's (2010) findings regarding the nature and process of learning in EPT, the findings from this current study suggest that by exploring an individual's worldview, in a unprescribed and non-judgemental way, the possibility for the client to adopt a stance of openness develops. This subsequently allows the therapist to shine a light upon areas that are consciously accessible, but have been cast into shadow (Spinelli, 1993). This in turn enables the re-examination of beliefs, values and assumptions that might have become sedimented. The information had always been available to the clients, it had just not been reflected upon. As a result, the therapist does not act as the revealer of truth by accessing the unconscious, but instead encourages clients to take an active part and reflect upon where they have cast themselves as fixed and where these ideas come from and what might be keeping them stuck. This is to help them to become more aware of their choices and realise that they do not have to continue approaching their situation, relationships or difficulties in the same way (Cohn, 1997). This process behind the outcome of new awareness and meanings, contrasts with psychoanalysis for example, where awareness and meanings might be developed through the revealing of the unconscious, via therapist interpretations.

Though, insight has sometimes been described as an insignificant condition for change, the current findings support existing research, that clients' value it as an outcome (Elliott, 2010; Hanna & Ritchie, 1995; Horvath, 1984; Strupp, 1988; Timulak, 2007; Westra et al, 2007). This suggests that insight, self-knowledge and a new perspective, is seen as a valid outcome in itself

by clients. Additionally, this outcome demonstrated long-term effects, with the positive effects strengthening and deepening at the follow-up interviews. Furthermore, it was also seen as a precondition to other forms of change, such as the implementation of a new way of being. Again, Craig's (2010) findings regarding change in EPT are relevant here, because she puts forward a theory, that increased self-awareness is what motivates a new way of being, which the current findings further support.

Finally, the amelioration of symptoms is not the primary aim in EE, nor was it for the majority of the participants. Yet, it seems that in exploring symptoms as interrelated expressions of each client's worldview from which personal meanings could be reached, there was a subsequent diluting effect on symptomatology. This finding adds to a significant body of existing research that reveals the development of meaning to be a valuable outcome, that is linked to increased psychological wellbeing (Dezutter, Casalin, Wachholtz, Luyckx, Hekking, & Vandewiele, 2013; Jafary, Farahbakhsh, Shafiabad, & Delavar, 2011; King & Hicks, 2012; Maddi, Khoshaba, Harvey, Faxel, & Resurreccion, 2011; Neimeyer, Baldwin, & Gillies, 2006; Solomon, 2012; Steger, 2012; Tavernier & Willoughby, 2012; Vos, 2016a) and physical health (Thompson, Coker, Krause, & Henry, 2003; Krause, 2012). It also supports research into EPT in secondary care conducted by Stephenson (2011), in which symptomatology was commonly found to reduce in synch with increased understanding, awareness and meaning-making and credited to its position of 'being with' and 'being for' the client. Moreover, this finding sheds light upon how EE consistently demonstrates significant reductions in symptomatology (Rayner & Vitali, 2015), despite the fact that it does not seek to reduce symptomatology. This raises questions about the possibility of existential-phenomenological practitioners being able to engage in producing an evidence-base that demonstrates symptomatology reduction, whilst keeping the core value of demedicalising distress, by aiming for the development of awareness, understanding and meaning-making. As such, further research involving a mixed methods design, that could investigate the correlation between the reaching of awareness and personal meanings and that of symptomatology reduction, could be beneficial for building EE's evidence-base. Though paradoxically, this finding also questions the evaluation of psychological interventions based on symptomatology and calls for a more nuanced client-determined assessment measure, that could more adequately address the divergences in aims, outcomes and therapeutic style amongst therapeutic orientations.

Becoming More Oneself as a New Way to Be

> *"I see now that the path I choose through the maze makes me what I am. I am not only a thing, but also a way of being –one of many ways –and knowing the paths I have followed and the ones left to take will help me understand what I am becoming" (Keyes, 1966, p.153-154).*

The experience of having their current way of being accepted, resulted in the participants beginning to approach themselves and their difficulties in an accepting manner. Rogers's (1990) paradox states, "When I accept myself as I am, then I change" (p.19) and similarly, once the participants accepted themselves, a new way of being in which they began to attend to their own needs and honestly communicate their feelings with others developed, as opposed to automatically masking them. This attitudinal shift served to recalibrate their engagement with the adversity that had entered their lives, enabling a more revitalised, authentic and purposeful way of being.

Many existential-phenomenological philosophers (Heidegger, 1962; Kierkegaard, 1992; Nietzsche, 1968; Sartre, 1943) and humanistic thinkers (Bugental, 1981; Rogers, 1957), describe how as humans we can become inauthentic and alienated from our primary feelings, instead internalising the Others' objectifying view of us. We get absorbed into "the jostling crowd, the mass, the mob" (Kierkegaard, 1992, p.67), "the rabble" (Nietzsche, 1968, p.148) and this comes to define how we act and relate to our being. In EE, the participants got in contact with their feelings, developing their sense of identity by making conscious choices in alignment with these feelings and values, as opposed to defaulting to living for others. In becoming aware of the meaning and functionality of their masks and roles adopted, more choices became available and a position of openness to experience was reached.

Consequently, EE did not remove the participants' difficulties, instead it aided their sense of courage to stay with feelings and use them as a compass to connect with their own needs and not just that of others. This enabled the participants to find a new way of living in two main ways; one option was to identify ways to reshape and become more themselves, tapping into their own resources which for many involved practical changes, which in turn led to more deliberate and authentic living. The alternative option was to foster a level of acceptance and compassion towards themselves and their difficulties, which also resulted in more authentic

living. But what stood out was that whether they decided to accept certain ways of being or make changes, a position of ownership and conscious choice was adopted. The quote by Keyes (1966) has been included to represent how the participants began to recognise their own capabilities for authorship and personal responsibility, both in relation to who they can become and within their lives more generally. This resulted in a position of increased ownership towards their current and past choices, which Heidegger (1962) describes as a move towards an authentic mode of existence.

The participants moved from a position in which they viewed themselves and their feelings critically, to that of acceptance. They saw their vulnerabilities as a strength that were vital attributes in becoming more themselves. Thus, while the new way of being involved practical, behavioural and relational changes for many of the participants, the most fundamental shift from which all other changes followed, constituted an attitudinal, perceptual shift. This is in line with Sartre's (1943) thinking, in which he states:

> *"We are a choice, and for us, to be is to choose ourselves. Even this disability from which I suffer I have assumed by the very fact that I live; I surpass it toward my own projects. I make it the necessary obstacle for my being, and I cannot be crippled without choosing myself as crippled. This means that I choose the way I constitute my disability (as "vulnerable", "humiliating," "to be hidden," "to be revealed to all," "an object of pride," "the justification of my failures," ...)" (p.432).*

Like Sartre (1943) and Merleau-Ponty's (1962) view of situatedness, in which one's facticity is likened to the sediment of a river, which is both an obstacle to the flow of the river and also the most fertile part for growth, there is a sense that the participants had embraced their experiences, difficulties and choices (the sediment) and decided to transcend and use them to propel them towards reaching their potentialities. In line with this, van Deurzen (2002) explains how the task of EPT is "not to suppress, disguise or deny anxiety, but to understand its meaning and gain strength to live with it constructively" (p.35). So, importantly the new way of being of acceptance and authenticity, whether this was a perceptual, attitudinal, or behavioural shift, converges with outcome objectives at the heart of both EE and EPT. Furthermore, the current findings that reveal how a new way of being, involving increased acceptance and authenticity is a valid client-determined outcome, supports existing research for change in EPT in secondary care (Craig, 2010; Stephenson, 2011).

Finally, in terms of the processes behind this outcome, the aim of EPT is "to lean toward potential and 'enable a person to live more deliberately, more authentically and more purposefully' (van Deurzen, 2006, p.389) and as such this outcome seems to represent what is at the heart of EPT. However, the experimentational component of EE was repeatedly cited alongside the development of this outcome and this seems to be fairly unique to EE. The experimental component is aimed to nurture a client in building the courage to experiment with a wished-for sense of self and facilitate them in moving from a position of 'stuckness' (Rayner & Vitali, 2015). Accordingly, in the obtainment of this outcome the participants described how they began to embrace and experiment with new ways of being, both within the therapeutic relationship and wider world. That said, the extent to which the participants achieved this, varied along a scale from that of being open to and imagining an alternative way of being, to implementing a new way of being within their lives. As such, the philosophical underpinnings of the existential-phenomenological approach, combined with EE's experimental aspect, seemed fundamental for the particular way of being that the participants reached.

Why is a New Way of Being so Hard to Maintain?

> *"Learning to live well is really very much like learning to swim well. It is risky and sooner or later we have to jump in at the deep end and discover that we are buoyant if we don't thrash about in panic. The more we practice the better we get at it…wrongly assuming that swimming is too dangerous, we grow still and afraid" (van Deurzen, 2015, p.11).*

The participants expressed great hope in implementing their identified new way of being at their initial interview and though this way of being was still viewed as preferable to the position that they had previously adopted, most of the participants were finding it challenging to implement such changes, defaulting to old ways of being by the follow-up. Spinelli (2015a) describes how clients hold the tension of both wanting to change and to remain the same. This is because by accepting a new way of being, it risks a temporary disruption to all aspects of being. Accordingly, it seemed that by changing part of themselves, unpredictable changes had occurred in other aspects of the participants' lives, that threatened their sense of security and had resulted in ambivalence to change. While for some of the participants, the risk of implementing their new way of being was deemed too threatening to continue alone, an

experience commonly grappled with in the process of change, as depicted in the quote above by van Deurzen (2015).

As Spinelli (2015a) relays, the courage needed to embrace the threatening and undesired change, comes from a "willingness to risk everything that we claim to be, know and value about and expect from ourselves, others and the world. It is precisely that courage which permits us to leap into the uncertain and unknown possibility which is, perhaps surprisingly, already an inevitable actuality" (p.18). Thus, it is not surprising that for those who continued to successfully implement their new way of being, client attitudes of openness, ownership, determination and patience were integral. In cases where change was considered to disrupt to the point of being too threatening to their sense of stability, the participants requested further therapy to act as a safety net, to give them the motivation and courage to continue their new way of being. Perhaps there is an opportunity for EE to more explicitly address this frequent difficulty with changing one's way of being. This could be achieved by relaying the importance of client-related factors and frame the follow-up sessions as ongoing containment, reminding clients that they are still 'in' therapy for six months post the seven sessions. Or the inclusion of client support groups, or more regular follow-ups that might facilitate a more long-term outcome, could be considered for the future development of EE.

That said, if Heidegger (1962) and Sartre's (1943) assertion that we continually oscillate between modes of authenticity and inauthenticity, due to the overwhelming anxiety of our own freedom and responsibility is correct, then can we really expect clients to continue this way of being without occasional distractions in the 'they', or without reporting their difficulty in maintaining it? In light of this, perhaps the process of change they described was a reflection of this and as such an interview at a later point in time would have been interesting to see if the oscillation had once again rebalanced. Furthermore, perhaps as part of the management of expectations in EE, an exploration into a client's ability to accept disruption and continuity in their worldview, take risks and their need for control, predictability and security, could be fruitful.

In sum, it is clear that the new way of being identified within EE was viewed as desirable and was reached to varying extents. However, unlike the outcome of awareness and personal meanings, in which the effects had been maintained or enhanced by the follow-up, the participants relayed the challenge involved in maintaining this new way of being. This outcome

ranged from it no longer being implemented, to it being implemented but with an increasingly demotivated stance, to it being implemented with valuable changes in all aspects of their lives being experienced as a result of this. Vitally, whichever position the participants had taken up, there was an evident sense of conscious choice and ownership, which is a significant outcome within EPT. It seems that client-related factors played a major role in the long-term maintenance of this outcome and thus identifying ways to activate a feeling of containment, to aid a sense of courage in implementing unfamiliar ways of being seems essential.

The Suitability of a Time-limit

> *"When we have not time, the time granted to us oppresses us. Time affects us. Time concerns us" (Heidegger, 1962, p.77).*

The fixed time-limit in EE was pinpointed as an unhelpful aspect, that was seen to fail to consider the time required for developing a trusting relationship, changing contextual-factors and was seen to deter from the continued implementation of outcomes. As such, the time-limit posed a challenge to the suitability of EE for meeting the participants' objectives. Existing research suggests that time-limited therapy can be as efficient at reaching therapeutic outcomes, as its longer-term equivalents (Gelso & Johnson, 1983; Howard et al., 1986; Keilson et al., 1983) and in accordance with this, the majority of the participants described EE as exceeding their expectations for therapy. It is therefore intriguing that the participants simultaneously described EE to excel their expectations, but that time was insufficient, believing that more change would have been possible with more time.

This could be indicative of an increased sense of urgency to live their lives more fully, that might have been provoked by the timeframe increasing the participants' engagement with their temporality. There was a prioritisation on what is 'not yet', which connects to Heidegger's (1962) deliberations about the human tendency to focus on the future, the context for utmost possibility, purpose and demise. The nature of temporality means that clients can never quite reach that which they could become and it is only once they have reached one horizon (limit or goal), that they can see further possibilities. As such, it could be argued that both within human existence and therapy there might be a constant feeling of lagging behind, or incompleteness. This could explain how a number of the participants felt their expectations for therapy were excelled, but that there was still room for improvement. Consequently, I

questioned whether the feeling of time as insufficient would be alleviated even if the time-limit was readjusted, because the nature of human existence means that "We are never a 'finished' item or totalised entity in our lifetime: we are always ahead of ourselves in the process of becoming, until we become no more" (Weixel-Dixon & Strasser, 2005, p.229).

From an existential perspective we are all beings in time, "Dasein exists as thrown Being towards its end" (Heidegger, 1962, p.295) and therefore time is the single most significant aspect of existence for human beings. Time and temporality are inescapable 'givens', however we rarely honestly face their existence acting as if life is infinite and become caught in "the inauthentic temporality of everyday Dasein" (Heidegger, 1962, p.477). In accordance with existing literature, the existence of a concrete time-limit may bring to the forefront the preciousness of time (Coren, 2001; Lamont, 2012, 2015; Mann, 1973; Strasser & Strasser, 1997) and serve as a painful reminder of this inescapable given and that we have finite possibilities.

The robust positive outcomes described in this study, suggest that EE is very effective at producing change within the time-limit and there has been a surge in research over the past decade in the field of EPT describing a brief timeframe as valuable and often a factor in itself for change (Breitbart et al., 2010; Cooper, 2003; Fegg et al., 2013; Fillion et al., 2009; Henry et al., 2010; Ioannou, 2017; Koebbel, 2016; Lamont, 2015; Langdridge, 2006; Lantz & Walsh, 2007; Lee, Cohen, Edgar, & Laizner, 2006a; Rayner & Vitali, 2015; Schneider, 2008; Vos et al., 2007). However, unlike some previous literature suggests (Koebbel, 2016; Strasser & Strasser, 1997), the positive outcomes in the current study were not attributed to an increased sense of urgency from the time-limit. The participants acknowledged a sense of urgency due to the time pressure, and there was a clear aim of fostering change, however this urgency was seen to adversely impact the therapeutic relationship, potential wider therapeutic outcomes and general experience of EE. The participants conveyed how they rapidly made changes and aspects of the protocol such as the use of goals, strong challenges and homework experiments seemed to rush them along in this process (which was welcomed by most), but just as they were settling into the therapy process and relationship, they were then told that they were ending. In light of the sense of helplessness, abandonment and pain that ensued for many of the participants as a result of this sudden ending and given that a couple of the participants described the time-limit and ending as dangerous and potentially harmful, there is a serious question for EE and all brief interventions as to whether their protocol and attitude towards

change is mindful enough of how clients' experience ending. It seems of paramount importance that this ethical dilemma is addressed by EE and considered seriously by all brief therapies.

Strasser and Strasser (1997) relay how existential time-limited therapies can have an advantage to longer-term therapies, given that the time-limit "mirrors, in many, the time-limited nature of human existence (such that) clients are brought face-to-face with issues of finitude and temporality in a very direct and immediate way" (Cooper, 2003, p.130). Thus, there might be an opportunity for EE to address the ending at the beginning of therapy as is recommended by Lamont (2015). This could involve exploring a client's previous experiences of endings and the meaning that they give to endings, which could then inform a thorough consideration of how to manage the ending for each individual. Additionally, the time-limit could be used to engage clients in grappling with the tensions and paradoxes that are paramount to our temporal existence more generally, in order to help them face their possibilities and limits in life. Such explorations could help to address the experience of ending as sudden, painful and abandoning in EE, and could also be valuable in relation to the effective management of expectations towards the change process and outcomes, considering that this emerged as a key component in the experience of the time-limit and outcomes.

The therapeutic journey ended when therapy ended for a number of the participants, rather than EE's aim for sessions to be a springboard to the clients own continued journey of self-inquiry and development (Jeans et al., 2018). Ioannou (2017) researched therapists' perceptions of an existential-phenomenological time-limited way of working and interestingly she found that all of the participants experienced time as insufficient, regardless of whether it was a six or twelve session contract, with feelings of dissatisfaction, powerlessness and anxiety provoked. So, a question raised is to what extent did the EE therapists' attitudes towards the time-limit and their expectations for the therapeutic outcomes influence the participants' experiences of time being insufficient and how can this be addressed? But also, the participants that continued implementing outcomes post-therapy, spoke of their sense of empowerment and the importance of their realistic expectations. Moreover, an attitude of acceptance towards the limits of therapy and ownership for their continued progress had been adopted. This supports findings by Lamont (2015), that clients of a time-limited existential-phenomenological intervention found the effective management of expectations to be fundamental to overall experience. As such, Burman and Gurman's (1988) argument that the state of mind of both client and therapist are essential in short-term work seems relevant and exploring client and therapist attitudes towards

a time-limit and the management of expectations, seems important for the development of EE, and brief therapies more generally.

Lamont (2015) suggests that an integral aspect of time-limited settings, is that therapists are realistic regarding what can be achieved in the number of sessions available, so as to manage their own and client expectations effectively. Therefore, perhaps there is an opportunity for EE to not only investigate the therapists' attitudes towards the time-limit and how this impacts the management of expectations, but also to more explicitly present clients with the limits of therapy; that not every problem presented can be addressed, stressing that change takes place beyond therapy and will require patience and persistence. Additionally, if clients were made more aware of the function of the follow-up sessions; that they are an opportunity to reflect on the reaching of personal goals, as well as to reflect upon their experiences of implementing their identified new way of being, it might provide the sense of security that the participants were desiring. This in turn could more adequately harness factors such as client ownership, responsibility and empowerment post-therapy.

My position as an 'insider researcher' enables me to have a detailed understanding of the current format for follow-up sessions, which can aid insights into where developments could be made in light of the findings. The follow-up sessions are frequently conducted by a different therapist to the clinician that saw the client on an ongoing basis. Furthermore, follow-up sessions are frequently used as shadowing opportunities for new trainees. The findings from this study enable a strong argument for ensuring that the same therapist who treated the client conducts them, because this could provide the sense of continued support that the participants desired, albeit less regular. Also, while EASE Wellbeing articulates that the function of the follow-ups is to reassess how clients have implemented the goals worked upon in their life, by the time the outcome measures have been completed and if it is a new therapist, then by the time they have understood the nature of the initial goals, this function is not being served. Moreover, if the session is shadowed by a trainee clinician then this might restrict how open the client feels that they can be. As such, shifting the function of the follow-ups to be more client-centric, which would involve the treating clinician conducting the follow-ups, seems vital.

In sum, the time-limit does not deter from EE's ability to address client objectives, as expectations and outcomes were excelled, but it does raise serious ethical considerations about

how the time-limit and ending is experienced in EE. An ethically considered ending process, which can also be used as a means to reflect upon wider experiences of endings and limitations, seems an urgent component to address. Moreover, the management of expectations seems to be at the heart of the finding that the participants felt both short-changed by time, but also that their expectations for outcomes were excelled. Within the participants' accounts whom expressed a sense of powerlessness and abandonment upon ending, there was a prioritisation upon what was 'not yet' and a sense that such progress could only be reached in EE. While the participants that seemed empowered upon leaving, had realistic expectations about the nature of change, what was possible in time-limited therapy and took a stance of ownership towards continuing their therapeutic journey post-therapy.

As such, the management of expectations regarding the time-limit, change and ending is a vital component to be added to the EE protocol. This could include psychoeducation for the client into what time-limited therapy is, how it cannot address every difficulty and hopes to act as a springboard to the clients' continued therapy journey. Furthermore, significant consideration needs to be given in the protocol to the fact that time-limited therapy may not be right for everyone and a more through ending process is required. I would recommend introducing the ending at the beginning, which could also bring in existential themes of temporality and finitude in an immediate way. As mentioned, the findings enable a strong argument for a client-centric approach to the follow-ups, clearly articulating the aim of these sessions and ensuring the same therapist who treated the client conducts them, because this could provide the sense of continued support that the participants desired, albeit less regular.

The developers of the EE intervention have always promoted the benefit of its timeframe, reporting the successful quantitative data upon leaving EE and at follow-up, but this qualitative piece of research reveals how quantitative data does not represent the whole picture and the fact that the service users may be feeling abandoned is arguably of greater importance. As a clinician working with the EE intervention, I had believed in the beneficial properties that a time-limit could provide and had expected the timeframe to be experienced as sufficient. Consequently, this finding highlights the essentiality of giving clients a voice when developing protocols, to facilitate understanding into how it is experienced in practice and ensure an ethical approach. Furthermore, the value of an external individual exploring the experience of interventions is highlighted, because despite asking for feedback as a clinician, I was unable to obtain such rich and constructive feedback.

Finally, Koebbel (2016) speaks of the brief time-limit of EPT in primary care, as serving as the fundamental distinguishing feature that separates it from what is seen as more "generic" or "pure" EPT (p.122), Similarly, the brief timeframe in EE is one of its defining features that enables it to adhere to requirements of primary care and helps distinguish it from other existential-phenomenological approaches. As such, the participants' account about the insufficient nature of time within EE is of great importance for EE's continuing development. Primary care requires a structure for clinical delivery and the six-session model initially delivered by EASE was conceived of in line with IAPT's 2008 model for issues around comparability (Rayner & Vitali, 2015). However, there is no evidence for an optimal amount of therapy within primary care, or more generally (Lyons & Low, 2009) and the question raised by this research is, how in a setting that requires a standardised time-limit, can the most effective length of therapy and ethical ending be established? As such, research investigating a longer-term option of the EE intervention and the consideration of alternative means to meet individual needs post-therapy, would be instrumental to the development of EE. Fortunately, a benefit of being an 'insider researcher' is that findings from this study could be instantly acted upon and accordingly a longer twelve session time-limit for EE is being piloted. The clients of Lamont's (2015) study found that the twelve session time-limit for the existential approach they experienced was sufficient and although this could be the result of their objectives being non-specific or more aligned to an EP approach, as well as the ending being addressed at the beginning and expectations effectively managed, it seemed valuable to explore an increased timeframe as a starting point.

The following section which focuses upon the participants' actual experience of EE, shows how the participants' concerns and objectives were addressed in the therapeutic work, in order for these outcomes to be reached.

The Specifics of the EE Therapeutic Work

Finlay (2012) suggests that in order to grow EPT's evidence-base, perhaps a "new game" can be played, in which the focus can be shifted from RCTs and outcome research to processes (p.185). This involves exploring the therapeutic relationship and helpful factors, as well as developing practice-based evidence in everyday clinical settings, in which the clients' or therapists' experiences are the focus (Finlay, 2012). This research study has acted on the proposition to play a new game, by providing detailed descriptions about the clients' experiences of the processes involved in EE, within the everyday clinical setting of primary care.

Correia et al. (2018) put forward the argument that in order to rigorously develop research regarding the efficacy of (existential) practices, assessing adherence to a treatment protocol is essential. Adherence can be defined as "the extent to which interventions considered integral to the treatment model are delivered" (McLeod, Smith, Southam-Gerow, Weisz, & Kendall, 2015, p.315). This piece of research contributes to this by identifying how EE works in practice, how the participants' concerns were addressed and how the relationship is experienced within this intervention.

Time to Rethink Manualisation and Standardisation in Primary Care

> *"Therapy is concerned with the unique character of the individual. Each person we meet is for us a new experience, an expedition into unknown territory…To hang onto diagnostic labels, to similarities of other experience, to our own personal experience, is to play safe…and to get nowhere" (Marteau, 1986, p.17).*

The findings from this study make a strong argument for a personalised, operationalised protocol over a standardised and manualised one in primary care. This finding has significant implications for the British school of existential therapy, because its non-manualised nature has stood in the way of it being recognised in medicalised settings, and the findings of this study indicate that this might not have to be an obstacle to entering primary care. Moreover, the value that the participants' placed on personalised and relational aspects has vital implications for the current surge towards using technological methods to deliver standardised treatments and makes a strong argument for CoP. Interestingly, it was the aspects of the

protocol that are incorporated to meet the demands of primary care, such as the fixed time-limit and measuring of outcomes, that had a detrimental impact on the service users' overall experience of EE. Therefore, it is evident that while Ease Wellbeing state that they have found a way to maintain core values and principles of EPT, whilst also meeting the demands of primary care (Rayner and Vitali, 2015), the picture presented by the service users reveals that while EE has made considerable steps towards this, core values of EPT and CoP are still being undermined on some level for some individuals and as such the challenge is still very much needing to be addressed. Nevertheless, it did appear that some aspects could be addressed at a more individual and immediate level. For example, therapist effects seem key to the experience of personalisation and attitudes towards timeframes and outcome measures. Therefore, addressing *how* outcome measures and the time-limit are incorporated seems vital to be attended to in training, perhaps via the inclusion of reflexive activities on therapist attitudes to such components. Another avenue in order to address the more standardised aspects in a more personalised way, could be through the phenomenological exploration of client attitudes and expectations towards therapy, limitations and change and perhaps using outcome measures in a phenomenological way. The following section will now discuss these aspects in more depth.

As the quotation regarding brief EPT by Marteau (1986) captures, the findings from this current study suggest a need for service users to feel like they are seen as individuals and not part of a generic, standardised treatment plan. EE's personalised components, such as its focus on subjective experience, played an integral role in EE being experienced favourably, as well as for the development of trust and the attainment of client-determined outcomes. The participants described certain components such as the personalised feedback and experiments, the therapists' ability to adapt to individual relationship styles, the personalised goal setting, as well as the style of exploration and questioning, as being particularly beneficial. The participants described how interventions were not generic or prescribed, rather they were grounded within their experience, with questions and challenges enabling their narratives to be unpacked and new awareness and personal meanings to be developed. Likewise, there was an appreciation of the flexible and holistic approach to the temporal stages, in which all facets of experiencing were treated equally and explorations were dependent on individual needs.

The style of questioning and exploration that the participants depicted, seemed to describe phenomenological enquiry (Husserl, 1970), which EE claims to be its core mode of exploration. Besides, the components highlighted as facilitating personalisation were core aspects of the EE

protocol. This not only indicates treatment adherence, but that the nature of the operationalised and flexible protocol itself, is experienced as individualised and integral to the success of the approach. This has significant implications for EPT, within which substantial concerns about the integration of protocols have been raised, for fear of it endangering EPT's core values (van Deurzen & Adams, 2011). Crucially, this finding suggests that an operationalised protocol that can be flexibly applied and draws on the core tenets of phenomenology can in fact accentuate principles at the heart of EPT and CoP, such as attending to subjective experience.

This finding is in line with a study conducted by Stephenson (2011), which found that successful therapeutic change occurred for clients experiencing EPT with therapists that did not adhere to a manual in secondary care. As well as findings that emerged from a meta-analysis, that was conducted on the effectiveness of manualised treatments for depression, whereby manualised interventions did not result in superior outcomes (Robinson et al., 1990). Thus, these findings taken together contradict the argument that non-manualised therapy is not effective and provide a robust argument for an operationalised, flexible and personalised protocol over that of a manualised and standardised one. This is significant for the British school of existential therapy, which is not grounded within a clearly circumscribed model and instead presents a "rich tapestry of intersecting therapeutic practices" (Cooper, 2003, p.1), with therapeutic practice ensuring that it is responsive to idiosyncratic client presentations and needs. EPT's non-manualised nature is something that has hindered it being recognised by NICE, but these findings suggest that perhaps it does not have to be an obstacle to entering NHS settings. In fact, Koebbel (2016) evaluated how existential-phenomenological therapists perceive their way of working in primary care and revealed how they described their practice in terms of a "multi-faceted practice, integrated by a flexible existential-phenomenological 'attitude'", which centred around the individual needs of the particular client (p.4), which the participants of the current study seem to be reiterating. Together, these findings suggest that a personalised way of working in primary care is possible, valuable and arguably essential.

This finding is noteworthy in the current climate of evidence-based treatment, with a demand for increased standardisation, due to replication being a compulsory requirement (Cooper, 2008). In response to the demand for standardisation and cost efficiency, the use of technological methods to deliver standardised treatment programs is being increasingly implemented (IAPT, 2019; Woolfe et al., 2010). Therefore, these findings relaying the value of personalisation and humanisation, should be considered seriously. The need for

personalisation identified in this study, alongside research highlighting that therapist effects are far greater than technique (Barkham, Hardy & Mellor-Clark, 2010), as well as those indicating that flexibility leads to improved outcomes (Chu & Kendall, 2009; Ghaderi, 2006), and manualised techniques are associated with poorer outcomes (Castonguay, 2005; Castonguay & Beutler, 2006) or lead to the therapist being experienced as less warm (Henry, Strupp, Butler, Schacht & Binder, 1993), put forward a strong argument for a personalised, humanised and operationalised protocol.

What is more, existing research has suggested that high or rigid levels of adherence can be detrimental to outcomes (Imel & Wampold, 2008; Wampold, 2001), so while it appears that knowledge and skills in specific practices may lead to enhanced outcomes, as this current study echoed, rigidity and inflexibility within an interventional style does not. Instead, it seems that a fine balance between ensuring therapist accountability and competence is experienced by the client, whilst safeguarding personalisation and flexibility is required (Shaw et al, 1999). Yet, it is recognised that the stipulation for manualised therapy is born out of the need for rigour in experimental trials, in which replication is a necessity (Marks, 2002) and it cannot be negated that for EE, and EPT to gain credibility in primary care, a manual is desirable if not obligatory. EE has demonstrated this should not need to be standardised, directive, formulaic or all-embracing and it seems that the phenomenological method and the operationalised protocol in EE, makes a significant effort in managing these tensions.

A vital point also to be noted, is the critical impact that the depersonalised, generic aspects of the protocol had on some of the participants' overall experience. The fixed time-limit, as well as the outcome measures had a detrimental effect for some of the participants, resulting in a feeling of dehumanisation and mistrust towards both the therapist and process. This overshadowed the positive personalised components, further reiterating the importance of a personalised approach. These more standardised aspects of the protocol are incorporated into the EE intervention to meet the requirements of primary care, which does raise the question of how to integrate such aspects into an existential-phenomenological approach or CoP, without undermining their core values. These client experiences are echoed by existential-phenomenological therapists in primary care (some of whom worked with the EE intervention), where the use of psychometric measures is described as problematic, because they reduce "clients to numbers and disregard the holistic perspective practitioners take on their

clients…takes valuable in-session time and compromises the therapist's independence from the medical model" (Koebbel, 2016, p.107).

One of the participants of the current study described the unnatural, dehumanised, passive and distant stance adopted by the therapist during the completion of the outcome measurements, while another described the therapist's rigidity in implementing the outcome measures. This stance taken by the therapist does not seem a necessary part of outcome implementation, or representative of an existential-phenomenological therapeutic relationship. Though, this is certainly not to suggest that the outcome measures themselves are not reductionist and generic, it does alert the reader to the significance of 'how' outcome measurements are integrated into EE. This is similar to the finding that it may not be the time-limit per se, but *how* the time-limit and ending are integrated (whether the ending is introduced at the beginning and given space each session, if limits are explored and expectations managed) that impacts the experience of being short-changed by time. Identifying ways to approach such 'givens' that may enable them to be experienced in a more personalised, phenomenological and ethical way is something that can be immediately addressed.

Ioannou (2017) and Budman and Gurman's (1992) research into therapist attitudes in brief timeframes, seems relevant to the need for outcome measurements in EE to be integrated in a way that is experienced as more humane. Perhaps therapist attitudes towards outcome measures play a part in the way in which they are experienced by the client. To address this depersonalising aspect to the therapeutic relationship and work, an integral development would be to explore therapist attitudes towards outcome measures and other restraints, such as the time-limit. But also, the inclusion of rigorous training on how to implement outcome measures and introduce the fixed time-limit in a way that is warm, humane and transparent seems key. Also, exploring and managing client expectations towards therapy, the change process and their relationship to limitations, could be a way to address the more standardised components of therapy, in more personalised, existential-phenomenological and beneficial manner.

In fact, Koebbel (2016) suggests the possibility of using outcome measures as a "phenomenological tool" and reveals how measuring therapy does not need to equate to a negative impact on the therapeutic relationship (p.148). Koebbel (2016) puts forward a way of working with psychometric measures in primary care, whilst at the same time offering a humanised and personalised experience by staying engaged with the clients' concerns. Such

an approach seems well-fitted to the values and epistemology underpinning EE and therefore a movement towards using outcome measures as a phenomenological tool, could be a positive development to address the concerns raised by the participants. Likewise, incorporating training in relation to the integration of outcome measures and time-limits into training programs, could be a valuable addition to prepare existential-phenomenological clinicians for working in medicalised contexts. If clinicians became more fluent in the medical discourse, perhaps they could integrate outcome measures and requirements of the medicalised setting, in a way that could be experienced as phenomenological, humanised, personalised and thus potentially valuable to service users.

Personalised Goal Setting; A Phenomenological Tool?

It appears pertinent to highlight that goal setting using CORE-OM, was largely described as an esteemed and personalised component of the therapeutic work. Recently, there has been a movement towards goal setting within EPT (Cooper & Law, 2018; Cooper & McLeod, 2015), however this is still shrouded in controversy amongst the British school of existential therapy, where EPT is seen as a non-directive, spontaneous approach (van Deurzen & Adams, 2011). Furthermore, Strasser and Strasser (1997) articulate their view that goal setting is "inapplicable" to brief EPT, as it is perceived to separate concerns that are inherently interlinked and complex (p.60). Conversely, Langridge (2006) has integrated solution-focused work into EPT and Rayner and Vitali (2014) have argued the benefit of goal setting to demedicalise distress and measure outcomes in primary care. The findings from the current research, support Rayner and Vitali's (2014) use of goal setting and in line with Cooper and Law's (2018) understanding, render it predominately a client-centric intervention, that enables an individualised approach to therapy.

The process of developing goals appeared to be a valuable phenomenological enterprise, in which blanket terms such as 'anxiety' were unpacked, in order for each individual to reach an individualised and nuanced understanding of their worldview. Goal setting was therefore fundamental to EE being experienced as tailored to individual difficulties, but also as Koebbel (2016) recommends, goal setting was a psychometric measure that was integrated into EE in a way that enabled it to serve as a phenomenological tool. The current findings serve to support Koebbel's (2016) existing findings that discovered using Grounded Theory, that setting goals was part of established procedure for EPT in primary care and was seen as beneficial in

mapping out the process of therapy, in a way that could be updated as therapy progressed. Goal setting was being used in a phenomenological way, as opposed to a prescriptive or rigid manner and as with the participants of the current study, goal setting was seen as a way of attending to "expectations, desires and needs of clients in a flexible, yet purposefully and directed way" (Koebbel, 2016, p.125). Existing literature (eg. Castonguay, 2005), as well as the current study, emphasise the link between the effective management of client expectations to outcomes and it appears that the nature of working with goals, facilitates the effective management of expectations to take place. Therefore, perhaps goals setting using CORE-OM is not only an outcome measure that might be aligned with the epistemology of EPT, but can be a useful tool to explore difficulties phenomenologically, as well as manage expectations. As Sir Winston Churchill (1874-1965) said, "However beautiful the strategy, you should occasionally look at the results" and until there is a shift towards other forms of research being accepted as robust evidence by NICE, CORE-OM goal attainment offers hope for EPT to join in with the drive for evidence-based practice and find a way to demonstrate accountability, whilst protecting its core values and principles.

As I will go on to discuss in more detail, client participation is vital in outcomes and Cooper and McLeod (2011) suggest that by setting goals, the therapist orientates themselves to what the client wants, consequently setting up a collaborative manner of working. In setting client-determined goals it denotes that the client is an "active agent, engaged in constructing their lives and relationships" and that they are a separate person with their own views (Cooper & Law, 2018, p.58). Considering that client participation and empowerment was key within the therapeutic work, perhaps the goal setting component played a significant part in empowering and engaging clients to actively participate, which is arguably the most important factor for outcomes. I propose that comprehensive training for the effective implementation of client-determined goal setting, could not only ensure that subjective experience is attended to, expectations are effectively managed, but also that clients feel empowered. This could offer a valuable way to work in an existential-phenomenological manner, within the limitations of primary care, or a brief timeframe.

A Phenomenological Approach; An Investigative and Empowering Enterprise

> *"One repays a teacher badly if one always remains nothing but a pupil" (Nietzsche, 1885, p.22).*

The style of phenomenological questioning and enquiry was a key component in EE feeling personalised and underpinned all of the therapeutic work. The participants went to great lengths in trying to depict how explorations, questions and challenges looked in practice and how this style of enquiry provided the stepping stones for them to reach new awareness. This finding is significant for understanding the process involved in EE, particularly the change processes involved in reaching new awareness, in addition to uncovering the potential empowering properties of a phenomenological mode of enquiry. What stood out was the robustness and consistency of the use of phenomenological enquiry in EE, which demonstrates high levels of treatment adherence to the protocol and indicates that perhaps the phenomenological method could offer EPT a way to demonstrate a level of treatment consistency.

The participants detailed what looked to be an 'investigative enterprise' (Spinelli, 2015b, p.108), in which the clinician acted as an ally, staying with the client's subjective experience. An inquisitive and explorative attitude was employed, which aided the gentle extraction of details about the client's worldviews and the functional qualities of their current way of being. The process was one of a dialogue, rather than didactic, hence the participants never felt that they were given advice. Instead, a non-directive approach of description, clarification, validation and Socratic questioning was used. This served to loosen the client's narrative, aiding an increased sense of clarity and understanding of their experiences and the identification of sedimented assumptions and beliefs. Such aspects are key to the phenomenological reduction applied in both EE (Jeans et al., 2018) and EPT (van Deurzen, 2014a) and the participants described how as a result of this exploratory style, they opened up more than they had anticipated, which was essential for new awareness and meanings to be reached.

Part of this phenomenological questioning and exploration, involved a holistic exploration of all experience. The therapist examined the seemingly familiar, to uncover potential blindspots and thus areas for new awareness and possibilities. This seemed indicative of EE's encouragement of Heidegger's (1962) notion of openness and the existential-

phenomenological therapists' adoption of a stance of 'not-knowing' (Jaspers, 1963), "welcoming the Other" in their unique way of being, in a manner that is free from any agenda to quantify, classify or change, while also respectfully challenging when deemed appropriate (Levinas, 1969, p.47). The discovery that EE provides the stepping stones to new awareness, in a way that is characterised by openness and a dedication to subjective experience is of paramount importance, because as Cooper (2009) argues, this approach to therapy is in fact an ethical imperative for counselling psychologists. Therefore, this finding provides hope that EE might be able to help CoP to keep its core principles within primary care.

The experience of the therapeutic work in EE, depicts an approach that is aligned to humanistic, EE, EPT and CoP's values. This is particularly in relation to respecting client autonomy and ensuring that therapeutic change is not something that therapists *do* to clients, but something that clients feel empowered to actively work upon and Nietzsche's (1885) quote above has been included in an attempt to capture the emphasis upon this. The portrayal of EE's interventional style resembled Bohart and Tallman's (1999) depiction of the role of the therapist as less akin to a medical expert who heals patients and more like a home decorating consultant, who helps clients identify what and how they might go about getting it (p.17). Importantly, this is aligned to a relationship characteristic of EPT, which is described by Evans (1981) as follows:

> *"Rather than present themselves as 'symptom removers', 'treatment providers', 'directive educators' or 'professional helpers', existential psychotherapists return psychotherapy to its original meaning; the attempt to 'stay with', 'stand beside' and 'accept the Otherness of the being who is presented" (p.xix).*

EE was seen to illuminate a path forward and empower the participants to reach their own insights, an approach they felt that they had been searching for, without explicitly knowing this beforehand. The high levels of client satisfaction reported in relation to the phenomenological method in EE and the suitability it demonstrated for addressing concerns and reaching client-determined outcomes in primary care, is of significance for the British school of existential therapy, which has a phenomenological mode of enquiry at the heart of its practice.

A question raised is to what extent the efficacy at reaching awareness and the high regard for this phenomenological style of questioning, was the result of it effectively activating client-

factors? That by engaging the client in the process of self-discovery, their sense of autonomy and motivation was activated, hence increasing the therapeutic impact of this mode of exploration for attaining new awareness. Therefore, it would be useful to further investigate client experiences of client-related factors and aspects of EE that may have facilitated or hindered their activation. Wampold (2015) speaks of the intertwined nature of the common factors and critiques research that has tried to evaluate approaches without paying attention to the therapist. With this in mind, this research and future investigations must resist the temptation to categorise and separate factors and instead the recognition of how the delicate interplay of these factors was integral for the therapeutic work and outcomes in EE, is vital. Therefore, these findings provide some reliable evidence for how and what 'works' within the EE protocol, but also reveal how this cannot be separated from the experience of the therapeutic relationship and client-related factors, which the next section will describe.

The Specifics of the Therapeutic Relationship in EE

How the Therapeutic Relationship is Conduit to Change

> *"Efforts to promulgate best practices or evidence-based practices without including the relationship are seriously incomplete and potentially misleading" (Norcross, 2011, p.100).*

The finding that a strong therapeutic relationship is connected with positive therapeutic outcomes, correlates with decades of research in this area (eg. Assay & Lambert, 1999; Blatt et al., 1996; Cooper, 2009; Lambert & Barley, 2001; Mollon, 2009; Steenbarger, 1992). EE, as a subsystem of EPT, places strong emphasis on the notion of relatedness (Spinelli, 2007), and so the specifics of *how* the therapeutic relationship in EE was key to change is discussed below:

At the Heart of the Therapeutic Relationship is an Experimental 'Doing' Component

Central to the therapeutic relationship in this study were *doing* aspects. The participants described this as a stance that is collaborative and interactive and comprised questioning, summations, paraphrasing, validating, making normalising statements, managing expectations, challenging and making hermeneutic interpretations about potential connections between experiences.

At the heart of this *doing* component was feedback on the clients' process (observations regarding their ways of relating and embodied experiencing) in the 'here and now' of the therapeutic relationship. This encouraged the experimentation with a new way of being within the relationship, whilst reflecting upon and receiving feedback on how this was experienced. The participants also welcomed the opportunity to experiment with this new way of being with self and others, within their wider context. This took place between sessions, with clients' reporting back in their next session how they experienced this and how this was responded to by others. Some of the participants described this component as 'homework', 'practical solutions' or 'tools' and relayed how this *doing*, interactive aspect to the relationship was fundamental to change. On one hand, the experimental *doing* component seems to indicate a core tenet of the EE protocol; that the 'experimental' part of the intervention is being adhered

to and was highlighted as a personalised and vital aspect in outcomes. Yet, it was very much described as a key quality emerging within the therapeutic relationship, hence it is cited in this section.

It is clear that the relationship itself was used as a vehicle for change and this was a significant aspect of the *doing* experimental component. EE and EPT view the "therapeutic encounter as the microcosm through which the macrocosm of the client's stance toward the possibilities and limitations of inter-relational being in the world is both explored and expressed" (Spinelli, 2015b, p.109). Thus, using the 'here and now' of the relationship as an intervention, strongly underpins the experimental aspect of EE, but is also common practise in EPT, with Yalom (1999) suggesting that therapists should always "try to find a 'here-and-now' equivalent of the client's dysfunctional' interactions to make a focus of the therapeutic work" (p.102). However, empirical research has not demonstrated strong support for working with the 'here and now' relationship (Cooper, 2008, 2015). Yet Norcross and Lambert (2011) categorise the use of immediacy in the relationship as "promising but insufficient research" (p.309) and the current study highlights its perceived value from the clients' perspective. On the other hand, the experimentation with new ways of being in the participants' wider context and specific questions that some of the participants described being given to contemplate between sessions, seems fairly unique to EE within the field of EPT. This sheds light on the distinctive therapeutic relationship and process of change in EE.

This finding that an experimental *doing* aspect to the therapeutic relationship in EE was integral to outcomes, highlights how the dominant discourse advocating *being* qualities within the existential-phenomenological therapeutic relationship (Moja-Strasser, 1997; Wilkes & Milton, 2006), might be undervaluing a *doing* aspect within the relationship. Homework and behavioural experiments are often associated with CBT or solution-focused work, however Mahrer's (1986) last stage of experiential change in an existential/humanistically-oriented psychotherapy, involves experimenting with new ways of being in the world. In considering Mahrer's (1986) conceptualisation, alongside the current findings, it could be suggested that as long as the experiments or homework are collaboratively developed and specific to each individual's experience and context, and there is flexibility in the type of change (behavioural, relational and perceptual), such a component is in line with EPT principles.

Moreover, meta-analyses examining the effects of homework in CBT, have identified that it can aid collaboration (Kazantis, Deane & Ronan, 2000) and therefore it might be that this *doing*, experimental, homework aspect aids a sense of collaboration in EE. Collaboration has been found to be the relational variable most consistently linked to outcomes (Horvath & Bedi, 2002; Norcross, 2002; Winograd & Tyron, 2002), so it could be that the reported positive impact of this *doing* aspect, is a result of it mobilising client factors known to be essential to outcomes (Duncan et al., 2004). Therefore, this is another area in which the exploration of how client-related factors and relationship factors might get activated by the EE protocol, would be useful in order to develop a richer understanding of such processes.

The importance of *doing* something in the form of feedback and the interwoven nature of factors, is in line with Claiborn, Goodyear & Horner's (2002) study. They examined eleven studies that empirically investigated feedback (defined as descriptive and evaluative information provided to clients about their behaviours) and identified a 73% positive link to outcome. The outcome was enhanced if the therapist had a high level of credibility, enabling the feedback to be more readily accepted. They highlighted how there needs to be a belief in the therapist's competence and understanding for a new perspective (reframing of their difficulties) to be accepted (Frank & Frank, 1991; Wampold, 2007), which takes me onto the second key aspect in *how* the therapeutic relationship that was key to change; feeling understood and perceived therapist competence.

Feeling Understood and Trusting in Therapist Competence

It was vital that the therapist was felt to understand and relate to each individual's predicament and this seemed to act as a fundamental foundation for the relationship and therapeutic work to build upon. While some of the specific components that aided a feeling of being understood, seem specific to EE and EPT, the wider picture resembles empathy. Empathy is a common factor which Rogers (1957) defines as a "therapist's sensitive ability and willingness to understand clients' thoughts, feelings and struggles from their point of view" (p.98), which is key to existential-humanistic practices (Mahrer, 1986; Rowan, 1983). As empathy has frequently been linked to outcomes (Bohart, Elliott, Greeberg & Watson, 2002; Norcross, 2014) and feeling understood can increase satisfaction, comfort to disclose and client involvement (Orlinsky et al., 1994), this finding supports the existing research on common factors. This

finding is also aligned to findings of Timulak (2008) and much EPT literature (van Deurzen, 2005), suggesting the importance of relational aspects over specific strategies for change, because what the participants described was a need to feel heard, understood and cared for, before any experimental or *doing* elements could have an impact.

Yet, interestingly the processes involved in reaching this factor were linked to the specific components of the therapeutic protocol. The phenomenological method of enquiry, facilitated the holistic exploration and subsequent understanding of who the client is, their difficulties and how they were shaped, to be reached by both therapist and client. Additionally, the therapists' normalising attitude towards the clients' difficulties, aided a reconstruing and reframing of current ways of being and a feeling of being deeply understood.

It was clear that feeling understood was linked to the participants' belief in the therapists' competence and this in turn facilitated a sense of trust and hope to move forward in their difficulties. This ties into the concept of prescribing hope that Ryan and Brogan (2018) described as an essential quality of recovery in psychological therapies and it seems that the participants needed to believe in their therapist and trust that there was hope for change. Client hope is linked to change in medical procedures (Wampold, 2005), so it is not surprising that hope and expectations are critical to outcomes in therapy (Greenberg, Constantino & Bruce, 2006; Kirsch, 2005; Wampold, 2007). It seems that in EE it is the therapists' perceptiveness, which aids their ability to make accurate summations and connections between experiences, that is pinpointed as the integral factor in trusting in the therapists' competence and feeling understood, which subsequently facilitates a sense of faith and hope in the therapeutic process. Arguably, the therapists' perceptiveness could be regarded as a key aspect of the protocol, specifically the phenomenological approach. This highlights how *being* qualities, such as feeling understood, are needed for the development of the therapeutic relationship and subsequent therapeutic work, however the processes involved in developing these *being* qualities, involve *doing* interventions and methods outlined by the protocol.

Feeling Heard and Cared for in One's Totality

As well as feeling thoroughly understood, another *being* quality of the relationship that aided outcomes, was the experience of feeling heard and cared for. This resembles Rogers's (1957)

concept of positive regard, which means a "prizing of the person… it means a caring for the client as a separate person" (Rogers, 1957, p.101). This relational quality in EE, is in line with previous research identifying how clients' perceptions of positive regard, validation, affirmation, respect of self-worth and non-possessive caring, are linked to therapeutic outcomes (Farber & Lane, 2002). Furthermore, Norcross's (2014) statement that "Every human knows intuitively in his or her bones, it is the nurture and comfort of the other human" that facilitates change (p.113), is supported by this factor of care and feeling heard, alongside the strong advocation for personalisation, warmth and humanity within the implementation of a therapeutic protocol.

The relational stance in EE seems to be aligned to Buber's (1923) I-Thou concept, which as Cooper (2015) states, "many existential therapists would consider to be the optimal therapeutic stance: a holistic, affirming openness to the client as a freely choosing subjectivity" (p.49). Furthermore, this caring and accepting stance, facilitated the participants in not only adopting an accepting attitude towards themselves, but in feeling comfortable to open up with the therapist, which was seen as integral to achieving all outcomes. This supports existing literature that describes how care and an "accepting embrace" is a precondition for safety to be felt, in order for dialogue to occur and the unspoken to be drawn out (Cooper & Spinelli, 2012, p.153). This has implications for therapists who verge towards adopting a distant stance within EE and psychological therapies more generally, because it seems the extent to which a therapist is open to reveal human qualities and demonstrate warmth within the therapeutic relationship and protocol implementation, is fundamental to change.

Interestingly, within both the *being* qualities of being heard and cared for, as well as feeling understood and trusting the therapists' competence, there were *doing* components that led to the experience of these. For example, care was conveyed through listening and validating feelings and answers reached by the participants, as well as keeping professional boundaries. Whereas understanding was indicated through perceptiveness, holistic exploration, summations and connections made by the therapist. As such, this research has paved the way to uncovering some of the processes behind the relational factors in EE and highlights the complexities behind the core factors contributing to change in the therapeutic relationship.

Client-Therapist Attunement

Another key component in how the relationship was central to change, was a feeling of therapist-client attunement. Again, it seemed that certain aspects of the EE protocol played a significant role in this experience, in particular the use of phenomenological enquiry and yet the credit was given solely to each therapist's unique ability, or personhood. That said, the form of attunement taken did demonstrate qualities that seem more specific to the therapists' personhood, such as their use of humour, calmness, directness and intelligence. This seems aligned to Spinelli's (2015b) view of attunement as *being* qualities or attitudes, that stand out as expressions of the therapist's willingness to remain present in the encounter. It additionally aligns with Rogers's (1957) description of congruence bringing aspects of one's personhood into the therapy, in a genuine and authentic way.

EE therapists are likely to be on a spectrum from being warm, human and truly *being with* a client, to a stance of an expert, objective professional. So, in addition to the findings earlier suggesting the need for humanity in the integration of outcomes, the fact that human aspects of the therapist were important in feeling a sense of attunement, seems vital for our understanding of the value of bringing one's personhood into therapy and the use of personal disclosures. Personal disclosure was highlighted as a helpful factor by many of the participants. For example, one of the participants described how the therapist's unintentional personal disclosure in the form of T-shirt symbolism, was an integral moment in the development of trust and subsequent outcomes. This indicates the value that authentically bringing one's humanity into the encounter can have and the essentiality of resisting an expert persona, which for a couple of the participants resulted in a distant, expert-receiver relationship, in line with existing literature (Sherwood, 2001). This is relevant for approaches that tend to put emphasis on techniques and the specific model-led *doing* factors of therapy, over the value of the experience of the *being* qualities in a therapeutic encounter.

This finding opens up a discussion for the use of self-disclosure as an intervention in EE, or potentially brief therapies in primary care, where the development of a therapeutic relationship is required to be accelerated. Self-disclosure is one of the most controversial interventions (Hill & Knox, 2002), but perhaps the well-considered use of personal disclosures, particularly in the form described by the participants, which was that of non-verbal communication and feedback in the form of therapist perspectives and feelings, could enhance the relationship and outcomes.

Accordingly, humanistic theories appreciate the potential that self-disclosure has to enhance perceived therapist genuineness and positive regard, help therapist realness, humanism, authenticity and demystify the therapeutic process (Kaslow, Cooper & Linsenberg, 1979; Robitschek & McCarthy, 1991). All of which are necessary conditions for trust, openness, intimacy and change (Rogers 1957). Moreover, self-disclosure has been found to assist clients in not feeling alone with painful experiences and confirm their humanness (Cornett, 1991), which could perhaps aid therapists in navigating the more standardised aspects in EE, so that they are experienced in a more humane way.

Final Word

Barkham et al. (2010) relay that some therapists are ten times more effective than the average therapist, with successful outcomes ranging from 9%-94% for individual therapists. Therefore, it is worth mentioning that it cannot be ruled out that the positive experience of the therapeutic relationship in EE and its impact upon outcomes, was not due to the three therapists involved being 'supershrinks', as opposed to more general qualities that EE clinicians possess per se. Research into the specific qualities of the EE therapeutic relationship, drawing upon a larger sample of therapists, would be beneficial to protect against therapist effect bias. Furthermore, Norcross (2002) and Beutler et al. (2004) have relayed that the extent to which the alliance is of importance, depends on the particular client group and presenting issues, and that individual differences should not be discounted. Thus, I do not attempt to make a uniform assumption from these findings, but what I can conclude is that this particular client group in primary care, unequivocally deemed a therapeutic relationship with the following qualities to be essential to successful therapeutic work and outcomes:

- An experimental *doing* component
- Feeling understood and trusting in therapist competence
- Feeling heard and cared for in one's totality
- Client-therapist attunement

The last three factors are common across a number of therapies, which is in accordance with the aim of EE. Specifically, this is to concentrate on the key common relational factors established by Norcross and Lambert (2011), which includes the alliance, defined as a partnership and mutual collaboration, empathy and goal consensus with the relationship being adapted to different stages of therapy (Rayner & Quinault, 2018). However, these findings

provide a more nuanced portrayal of how such factors might be activated and experienced in practice within the therapeutic relationship in EE. Moreover, the processes behind the experiences of feeling understood, cared for and attuned with the therapist, seem representative of EPT's core tenets of being-with-others and relatedness. The therapists seem to have dedicated themselves to stepping into the Others' shoes, seeing the world from the clients' perspective (Heidegger, 1962), whilst also authentically bringing themselves into the encounter, rather than acting as a blank screen upon which projections are made (Cohn, 1997; McGinley, 2006; Spinelli, 2005).

Likewise, while therapist feedback has been highlighted as a potentially vital factor across modalities (Craig, 2010; Norcross & Lambert, 2011), the particular form of feedback described in this study, seemed specific to EE and EPT. The provision of feedback on process in the 'here and now' of the therapeutic relationship, to increase awareness into ways of being, is akin to practice common of an existential-phenomenological approach (Yalom, 1999), suggesting that this could potentially be a vital aspect of the therapeutic relationship in EPT more generally. However, the way in which new ways of relating and being were subsequently tested out in experimental homework within the life of the client, with this being brought back to sessions to reflect upon, seems specific to the therapeutic relationship in EE.

In sum, a relational but collaborative *doing* therapist was experienced as an integral factor in therapeutic outcomes in EE. While the participants needed to believe in the therapists' competence, at times when the therapist adopted a more detached and distant position, this was detrimental to the development of trust and subsequent outcomes. This raises questions about therapists that staunchly assert boundaries, because this yearning for relational depth and the importance of sensing therapist-client attunement, care and understanding, requires the therapist to genuinely bring themselves into the encounter, give genuine relational feedback, consider the value of personal disclosures and adapt to the individual client needs. As such, these findings shed light on the importance of both *being* (humanised) and *doing* (experimental and interactive) qualities of the therapeutic relationship and that value should not be placed on either one of these polarities exclusively.

Client-attributable Factors: Client Openness and Activeness

> *"The time has come to set the story straight, to spotlight the largest yet most neglected factor in treatment outcome: The client" (Bohart & Tallman, 2014, p.84).*

In any reference to the therapeutic relationship or outcomes, there was an acknowledgement of the essentiality of an interactional, collaborative relationship, in which the clients' own open and active attitude was key. This involved an openness towards the therapist, particularly in terms of trusting their competence, an openness to face painful feelings and be vulnerable, as well as an openness to a new perspective on their difficulties. The adaptability of a client's expectations for therapy and the process of change was also linked to this. Alongside this an active engagement in therapy, in which the client opened up, reflected and experimented within and in-between sessions was recognised as being integral to therapeutic progress.

The significant role that the client plays in outcomes in EE, is in synch with the conceptualisation of EE, in which Rayner and Quinault (2018) describe:

> *"The client and the client's lived experience and relationship with their therapist are key, not the specific techniques or model used. EE therefore focuses on both the therapeutic relationship itself and what clients themselves need to own and work on to achieve recovery" (p.265).*

Moreover, this finding supports a study conducted by Cuijpers et al. (2012), that examined the contribution of common non-specific factors responsible for change across non-directive therapies for depression and found that extra-therapeutic factors, namely client-attributable factors, amounted to just over 33%. Furthermore, given the strength of this finding, Cooper's (2008) assertion that client-attributable factors are likely the largest determinants of outcomes, accounting for up to 70% of therapeutic effectiveness, particularly the extent to which the client actively participates in therapy (Orlinsky, Grawe & Parks, 1994), seems likely.

In examining what separated the participants that felt empowered to continue making changes post-therapy, it was a stance of acceptance, openness, activeness and ownership that they had towards continually addressing their difficulties and embracing the change process, that prevailed. In fact, the level of ownership that a client takes towards their difficulties has been

identified as a significant predictor of change within EPT in secondary care (Craig, 2010) and across other modalities, for anxiety and depression in primary care, such as MBCT (eg. Finucan & Mercer, 2006). Across modalities client motivation and client involvement, defined as "a high level of self-exploration and active involvement in the therapy" (Hanna & Ritchie, 1995, p.180) has been found to show the most consistent relationship with outcomes (Gomes-Schwartz, 1978; Luborsky, Cristoph, Mintz & Auerbach, 1986; Mason & Hargreaves, 2001; O'Malley, Suh & Strupp, 1983; Reandeau & Wampold, 1991). This is similar to what Budman and Gurman (1988) relay, that the attitude of the therapist and client towards a time-limit is key to the extent of change. So, perhaps this finding highlights an opportunity to manage client expectations, explore their attitudes towards change and their view of their role within therapy, in order to enhance the level of engagement and facilitate a sense of empowerment to continue their therapeutic journey beyond EE, which seemed to be a major issue that is discussed in detail in Theme 3.3 (Chapter 5).

These findings are interesting from the perspective of client agency and engagement. Though the findings of this study cannot be considered conclusive and generalisations cannot be made due to the exploratory design, it adds to existing literature to shed light on certain client variables that seem to be fundamental prerequisites for change (Bergin & Lambert, 1978; Hanna & Ritchie, 1995; Lyddon, 1990) and according to the participants of this study, is the key variable for continued long-term change. EE, EPT and CoP have as a defining feature the aim of an egalitarian stance, where clients are encouraged to embrace their agency and feel empowered to confront their difficulties, rather than the therapist acting as a "superior, objective instructor" (Spinelli, 2005, p.151). By avoiding pathologising and instead taking up a position of wonderment and curiosity, the individual's worldview and reality is explored from which their own solutions, ownership of their difficulties and responsibility for their life can occur. Thus, there is a possibility that the drive of the EE intervention to activate client-related factors in this way, contributed to client involvement. However, as self-efficacy is a common factor it could as easily be asserted that these were qualities that the participants possessed as they entered EE. Further research into how one might assess or facilitate levels of engagement and motivation for therapy would be an interesting avenue to explore, as well as examining what might encourage someone to be involved and motivated to change both within and post-therapy and also what holds them back. Moreover, it would be useful to further breakdown factors such as self-efficacy, openness, activeness, engagement, motivation and hope, to get a

deeper understanding of how they might work alone and in combination with other factors involved in EE.

These findings should act as a wakeup call to professional discourse that too frequently privileges the perspective and position of the therapist, seeing clients as passive (Bohart & Tallman, 2014; Duncan, 2013; Johnstone, 2000). Instead, it is evident that clients need to be seen as the protagonists and experts within their own lives and therapeutic encounter. As Orlinsky et al. (2004) state "the quality of the patient's participation…(emerges) as the most important determinant of outcome more than therapist attitudes, or techniques" (Bohart & Tallman, 2014, p.88), thus practitioners and researchers need to appreciate how the client is critical to success. Lambert (1992) estimated that 40% of outcomes were due to client variables and extratherapeutic events, which increases to 75% when you include client expectations for change and their contribution to the therapeutic relationship. Wampold (2001) using what has been deemed as a more exact method of calculation, estimated that 87% of change is due to the client, as well as events in a client's life. Yet, despite these findings, client contributions to therapy continue to be neglected by most theoretical models of change, with a few exceptions (Bohart & Tallman, 1999; Duncan et al, 2004; Duncan & Moynihan, 1994). Unfortunately, with the intensification of evidence-based practice, the emphasis on technique and the therapist as the primary change factors may only rise. This study demonstrates that clients recognise the importance of their contributions within therapy for the development of the therapeutic relationship, therapeutic outcomes, as well as the long-term effectiveness of change. EE values client contributions, whilst also being able to demonstrate evidence-based practice, which hopefully sets the ground for other therapies to move their focus to harnessing client-related factors.

It appears to be the client's ability to use what is offered, that surpasses any differences in technique. As Cooper (2008) states:

> *"For different clients, different kinds of therapist input may be more or less helpful; and there may be certain kinds of input that are particularly helpful for clients with specific psychological difficulties; but the evidence suggests that the key predictor of outcomes remains the extent to which the client is willing and able to make use of whatever the therapist provides" (Cooper, 2008, p157).*

These points are certainly not intended to minimise the importance of therapists, as it is clear that the interactional dialogue was desired and required. But rather intends to put forward an argument for the centrality of the client and more than acting as an expert or taking a technical stance, the therapist needs to nurture and guide the client in their efforts to change, which may happen to involve particular interventions.

Reflexive Response to the Research

In the discussion of the findings, I became acutely aware that some of the readers of the dissertation would be members of EASE Wellbeing. I was therefore conscious to report the findings in a constructive but honest way, that clearly suggested avenues to develop the protocol in light of the participants' feedback. I wanted to use my unique position as 'insider researcher' to provide insights into where specific changes could be made to the protocol in light of the findings, without this being seen as disloyal or presumptuous. I continuously asked myself 'how would I teach or present the findings?', in order to ensure that I relayed the key points in a constructive manner.

Conducting this research has been both challenging and stimulating on a professional and personal level. My position as 'insider researcher' resulted in a number of ethical dilemmas and organisational obstacles to work around, primarily within my role as a clinician and supervisor. For example, I had to limit the number of trainee clinicians that I could supervise and avoid group supervision meetings to avoid hearing the participants' therapy being discussed, as well as to avoid dual relationships with clinicians. At one stage, there was a possibility that the contract at the GP surgery that I was both recruiting and interviewing at might be terminated, and I was required to make a contingency plan for my research within the confines of the NHS ethical requirements. Moreover, I stopped my clinical work at the GP practice I was recruiting from to avoid any contact with potential participants, however this resulted in a shortage of psychological assessors and clinicians, leading to lengthy waiting times and therefore a delayed recruitment process. I found the need to rely on others' for the recruitment of participants and also for the adherence to the therapy procedure (ensuring all outcome measures were administered with each client and avoiding long breaks being taken for therapist holidays) to enable them to meet the inclusion criteria, was very challenging. However, it was through this experience that I became aware of the imperfect nature of service delivery and how the ideal protocol process is rarely uniformly adhered to in clinical practice,

due to both organisational factors and client and therapist external circumstances. Also, the fact that outcome measurements play a prominent role at EASE Wellbeing, meant that clients who had already taken time off work to attend RGT sessions, were reluctant to sign up to two further sessions involving research. This was added to by the fact I could not make contact with potential participants myself, so my research was perceived initially as further research for EASE Wellbeing.

That said, my position as 'insider researcher' enabled a high level of sensitivity within the interviews, as I was able to understand complex aspects of the process or intervention described. For example, Zilpah referred to "the card game" and my experience of the RGT enabled me to automatically make sense of this reference without requiring more factual detail to pinpoint what she was referring to. I could draw on my understanding of each therapists' way of working, in order to reflect upon whether aspects reported were the result of therapist effects or the intervention per se. I could also draw on my own understanding of the protocol to determine aspects that were clearly part of the protocol or more generally what would be considered EPT.

The 'insider researcher' position afforded me a unique opportunity to look at the participants' experiences within the context of my experience of delivering EE and what is taught in training. This has been vital in identifying specific ways that the EE protocol can be developed in light of the findings. For example, I am aware that while the time-limited nature of the therapy is clearly communicated to clients in the assessment, there are no guidelines about how to manage the ending or explore the time-limit within the work. Furthermore, the goal setting component serves to manage expectations about what issues will be worked upon, however there is room for psychoeducation about the nature of change, time-limited therapy and continued exploration and management of expectations. Additionally, I am aware that despite the follow-up sessions being included to encourage clients to experiment with their new sense of self, in the hope to aid ownership and autonomy, this function is infrequently communicated and the current format does not seem to be maximising the opportunity that they could offer. I noticed as a clinician that when follow-ups were conducted by myself as the treating clinician, the space could be used as a way of validating progress and acknowledging difficulties. As well as using my prior experience of the client to reassess whether further therapy would be beneficial. However, my experience of attempting to book in follow-ups with clients that I have not seen myself is that clients perceive them as inconvenient requests for further data collection and not for their benefit. This knowledge about the follow-ups might be useful given the finding for a

desire for more continued support and the fact that relatively minimal adjustments made to the protocol could address this concern.

Finally, my 'insider' position meant that important findings such as the experience of the time-limit, could be immediately acted upon and I could guide future research projects and pilot studies born out of the findings. This has enabled the participants' contributions and voices to be instantly applied to clinical practice, rather than remaining as theory, which is too often the case.

Willig (2012) states that phenomenological research changes a researcher's worldview and my view towards time-limited therapy, the management of expectations and endings has been changed substantially. The findings have challenged my pre-assumptions and made me aware of how certain I had been about the benefit of time-limited therapy. As such, this research has not only challenged my assumptions and expanded my understanding of EE, EPT and time-limited therapy, but changed the way in which I practice therapy and manage aspects such as expectations, inspiring hope, managing endings and goal-orientated therapy. For example, my personal practice has moved to incorporate more open-ended contracts based on each client's preference and needs and this research has encouraged me to reflect on how I have a tendency to 'do' more than 'be', most likely linked to adapting to working in a goal-orientated and time-limited way. I have realised that perhaps there have been times that I have encouraged a faster pace than the client is seeking and I need to consider how this may have implications for long-term change and the client's sense of empowerment upon ending. I have also become more open to the fact that the function of therapy can shift at different stages, in order to incorporate a more supportive, 'checking in' aspect if required by some clients. At times my relationship with EE felt like I was on a rollercoaster, with my perception of it and how I applied it shifting throughout the process of research. As such, the research process seeped into and informed my clinical practice, while my role as a clinician also inevitably influenced the research.

Finally, in the process of selecting key discussion points from the data and in re-reading this final thesis, I became aware of the differing responses that I had to the data each time I revisited it. I found myself re-evaluating my previous interpretations on the basis of the insights and experiences that I had gained since that point in time and this highlighted how this research is placed within a particular context, which involves the temporal, emotional, physical and intersubjective. I conducted and wrote up this research at a particular time in my life, when

particular concerns or questions were salient for me and equally my intersubjective encounter with the participants took place in a certain environment at a particular point in time for them, which will have impacted the structure, analysis and findings of this research. The incorporation of a three-month follow-up attempts to capture a differing point in time and emotionality and I have also tracked my own changing circumstances and emotional and professional preoccupations though reflective exercises, using my research diary, research supervision, and personal therapy. That said, this research is a product of particular circumstances and is likely to take on an alternative form under different circumstances.

Critical Evaluation of the Study

Since the previous section discussed the findings from the analysis in detail, this section aims to take a holistic view of the findings. This is for the purpose of considering how the findings might add to a better understanding of the experience of EE from the service users' perspective in primary care. I will critically evaluate and convey the implications of this study, with regards to the clinical practice of EE and EPT in primary care and the division of CoP.

There are a number of concerns around the validity of qualitative research methods. In particular, it has been criticised for the subjectivity it accepts in terms of the researcher and its reliance on interpretation (Cho & Trent, 2006). However, qualitative research does not align itself with the positivist and objectivist epistemology of quantitative research and thus the same principles and concepts of reliability and validity cannot be applied in qualitative research. Besides, such principles are at odds with the EE intervention, EPT and CoP which embrace subjectivity.

In more recent years, the critique has focused on the extent to which a researcher's claims about knowledge, correspond to that of the research participants' perspective on reality (Eisner & Peshkin, 1990). I believe this is a valid concern and therefore while IPA welcomes creativity and flexibility, it is clear that a rigorous criterion for assessing the quality and validity of qualitative research is required (Vos, 2013). It is for this reason that the following section will describe the deliberation given to assessing the reliability and validity of this study.

Stiles (1999) states that reliability and validity of qualitative research refers to trustworthiness. Similarly, Lincoln and Guba (1985) state that trustworthiness takes the place of criteria of generalisability and reliability used to assess quality in quantitative research. In accordance with this view is Yardley (2008), who argues that assessing the trustworthiness of research aids its validity. Consequently, Yardley (2008) developed four neutral validity principles, which are widely accepted in health psychology and across other disciplines. These include; sensitivity to context, commitment and rigour, transparency and coherence and the impact and importance of the research. As such, to evaluate this study the framework for evaluating the validity of qualitative research set out by Yardley (2008), was employed. How each of these criteria were considered and adhered to will now be relayed:

Sensitivity to Context

This requires an understanding of the context to be explored, including how the study fits within the context of existing research on EE and the experience of existential-phenomenological time-limited therapies in primary care, which has been outlined in the 'Literature Review' (Chapter 2). Moreover, the literature review argues how this study fills a gap in the literature for CoP and EPT. The context of IPA has also been studied, with an overview of its phenomenological and hermeneutic underpinnings and how its epistemological position fits with the present study, which has been detailed in the 'Choice of Methodology' section (Chapter 3).

Commitment and Rigour

In terms of commitment to the study, I hope that my persistence to gain NHS ethical approval, as well as my immersion within the intervention, publishing of journal articles on my research and dedication to this dissertation for four years, demonstrates the strength of this commitment. Moreover, I have attended relevant conferences, training days and IPA groups and I hope that my continuous attention to reflexivity, reveals my commitment to IPA's principles of trustworthiness, transparency and phenomenology. I believe that my commitment to rigour is represented by the step-by-step account of the analyses, frequent meetings with supervisors to check portions of the transcript analysis and to facilitate reflexivity. This is in addition to providing the option for participants to check my transcripts for accuracy and involving independent researchers to assist with the coding of some of the interview transcripts. This was a rigorous process that served to provide credibility checks of the analysis and ensured that my analysis of the data was plausible. In places where the independent researchers highlighted diverging codes or emerging themes, I engaged in discussions with them, returning to the transcript to review my emerging themes and safeguard that the final themes were grounded in the data. Two independent researchers were involved in this process and I ensured that they had varied backgrounds to benefit from a variety of lenses through which to view the data, allowing for alternative interpretations to be considered, which due to my own biases may not have been initially apparent.

Transparency and Coherence

My commitment to transparency is revealed in my continuous use of a reflexive journal and incorporation of certain reflections on challenges encountered during this research project and how certain decisions were made. I systematically present each stage of the research process in what aims to be a coherent manner and the quoted extracts in the 'Findings of Analysis' (Chapter 5) are cited to capture the essence of the theme and to clearly detail how such themes were developed.

Impact and Importance

As Smith et al. (2009) put forward, the true validity of research rests upon the extent to which the research is useful and tells the reader something new and important. The core intention of this research was to provide a valuable contribution to the knowledge-base of CoP and in particular increase the understanding of a short-term existential-phenomenological intervention delivered in primary care, from the clients' perspective. Much has been done to grow a robust quantitative evidence-base for EE, but its qualitative research-base and research into exploring the clients' experience of the intervention is limited. To my knowledge, this is the only research dedicated to bringing to light the experience of EE, or an existentially-phenomenologically-based therapy, from the clients' perspective in primary care and is one of only three research inquiries into existential-phenomenological practice in primary care. Thus, the principal strength of this study is that it provides innovative data and gives voice to an understudied group.

Consequently, this study provides practice-based knowledge for practitioners working within the EE intervention, as well as highlighting areas for the intervention to be developed, or further researched. The findings aid the understanding and add to the sparse research into the application of EPT in time-limited contexts (Ioannou, 2017; Lamont, 2012; Strasser & Strasser, 1997) and even less in primary care (Koebbel, 2016; Rayner & Vitali, 2015). As well as encourage an increased dialogue within training institutions and supervision contexts, about the implementation of EPT in NHS and time-limited settings. However, more than anything these findings reveal the complexity of psychotherapeutic change and process research and highlight the need for a stance of openness and a willingness to stay with complexity, uncertainty and paradoxes as a therapist and also as a researcher.

It could be said that the thrust of this research is directed towards the community of existential-phenomenological practitioners, particularly those that might be sceptical of, or unsure of how to move 'inside' the NHS, whilst maintaining the core values of EPT (Rayner et al, 2017), perhaps more so than policy makers and commissioners given the idiographic nature of the study. However, by illuminating how EE, a short-term existential-phenomenological intervention is experienced in primary care, it might increase the appetite of existential-phenomenological practitioners to enter primary care, or encourage further research to be conducted in the area, in order to increase EPT's evidence-base. This increase in prevalence in the evidence for EPT, as well as existential-phenomenological practitioners within NHS settings, might eventually influence service provisions and commissioning decisions. Likewise, this research alongside a larger evolving body of quantitative and qualitative evidence for EE could certainly impact local primary care service provisions, or at least bring awareness to the presence of EE and other such EP-orientated interventions and practitioners within primary care.

The main themes developed in this research suggest that EE is well placed for addressing the concerns and objectives of this particular client group in primary care. On a level specific to EE, the data largely supports the epistemological conceptions, principles and tenets outlined by the operational protocol, thus revealing that the protocol is adhered to and recognised as beneficial to clients. This is important as it seems clients experienced EE as an effective intervention for addressing their concerns and meeting their hopes and expectations for therapy and thus for this group of individuals, EE can be said to be a valuable therapeutic option. With IAPT pledging to increase the choice of therapeutic interventions in primary care (Clarke, 2018), this study alongside an evolving body of research for EE, helps to pave the way for EE to be seen as a frontline therapeutic option.

Specifically, what is new about these findings is the provision of some reliable evidence about how and what 'works' in EE, in terms of both the protocol, the relationship and client-related factors. The *doing*, experimentation component that was part of the description of the protocol and the therapeutic relationship, as well as the personalised goal setting, integration of outcome measures and a time-limit, seem specific to EE within the field of EPT. However, aside from these components, what the participants described in terms of the therapeutic work, relationship and outcomes, seemed to be representative of an existential-phenomenological approach per se. This is an encouraging finding which could embolden other existential-phenomenological

practitioners to develop EPT-based models that can fit within primary care. Or simply for the practice of EPT in primary care to be increasingly seen as possible and valuable, as research conducted by Koebbel (2016) into therapist perspectives also highlighted. Therefore, while these findings hope to facilitate the development of the EE protocol, I additionally hope that it leads to pioneering existential-phenomenological clinicians to enter NHS settings and push for existentially-oriented interventions to be a treatment of choice.

However, it is important when discussing the study's contribution that being idiographic in nature, it is recognised that it has made no intention to produce generalisable conclusions or generate theories that can be attributable to a wider population. As such, conclusions cannot be drawn about the effectiveness of EE outside of this particular setting and client group. Moreover, this was an exploratory study, without a search for causal explanations and thus any observations or ideas cannot be seen as conclusive and instead merely highlight potential areas of interest for future research. A final point to note, is that this study did not include a comparative research design and given the extensive research revealing equal outcomes, this study does not intend to suggest that EE is more appropriate than other modalities for addressing client concerns or reaching desired outcomes with the same client group in primary care.

Contributions to Counselling Psychology

The findings on the essentiality of the interactional relational space, the collaborative stance to therapy, a humanised encounter, the importance of the therapeutic relationship, as well as identifying client-related factors, such as client openness, activeness and their sense of empowerment as core aspects for change, reflects CoP's collaborative, human and egalitarian understanding of the therapeutic encounter (Strawbridge & Woolfe, 2010). Moreover, the desire for a personalised approach to address individual needs, in order for their subjective experiences to be heard, understood and attended to, is relevant to CoP. As a result, it seems that this client group are not only very attuned to and in need of what EE offers, but also that of CoP.

EPT tends to aim for a change in understanding (Barnett, 2009) and this emerged as the main aim and outcome in EE. The participants' expectations for therapy were exceeded, in terms of gaining increased awareness, meanings and acceptance. But, for some of the participants, it seemed that understanding was a vital first part of their journey, but it was not the end goal and help with translating insights into practice was desired. Although they wished for more sessions of EE, arguably at this point a more structured, behavioural-orientated therapy like CBT could be beneficial. Cooper and McLeod (2011) suggest that different therapies may benefit clients at different points in their journey and this is in line with the drive for increased integration of services in the NHS (Clarke, 2019). It seems that an integrated system with referrals between modalities and services, though admittedly complex to implement, is needed within primary care and all service delivery within the NHS, in order to most adequately address individual client needs. CoP, a pluralistic approach, is in the perfect position to offer such a holistic and pluralistic approach to client needs, in a seamless and potentially within-service manner. Consequently, these findings are of great importance for the potential continuing existence of CoP in primary care and the NHS.

James (2013) states that 50% of counselling psychologists work in the public sector, with some in IAPT. As outlined in the 'Literature Review' (Chapter 2), a climate of increasingly technique-based, mechanised clinical treatments is facing CoP and unsurprisingly it is struggling to keep its pluralistic identity and client-centric focus, within these constraints (Strawbridge & Woolfe, 2010). Developing alternative modalities to CBT, that can work within time-limited settings in the NHS, seems a key contribution to safeguarding the continued

presence of CoP in statutory services and ensuring its equivalence of competence status with clinical psychology. This research has shown that EE, an existentially-phenomenologically-orientated intervention is well-placed to fit within the constraints of primary care and is highly attuned to the needs of the clients in this setting, successfully reaching client-determined outcomes. Based upon the service users' perspective, along with EE's existing evidence-base, it is evident that EE is appropriate as a treatment of choice within primary care and provides a vital alternative to the more technique, symptom-focused interventions. Importantly, it incorporates central values of CoP, such as focusing upon relatedness, subjective experience and depathologising distress. Thus, EE offers a way for CoP to keep its pluralistic underpinnings within statuary services.

There also seems to be an opportunity for CoP, as an inherently humanised approach, to act upon the findings of this study, which stress the essentiality of a wholly personalised and humanised approach and support existing research confirming the need for an honest and authentic encounter (Sherwood, 2001). CoP could facilitate EE and potentially all psychological therapies in primary care, to navigate the constraints of a medicalised setting, in order for the relationship and protocols to be increasingly experienced in this humanistic, relational way.

However, I also hope this study raises awareness regarding the potential challenges and opportunities involved in this context and to provide therapists with a greater reflection and understanding of their practice. I think this research has relevance for other theoretical modalities, particularly the humanistic approach, because it illuminates some of the challenges involved in ensuring a personal, human and empowering approach, despite working within the constraints of time-limits and outcome measurements.

Conclusion

The findings suggest that this group were not only attuned to what EE can offer, but also the core components that CoP and EPT can provide. This suggests that EE is well-placed to be a psychological treatment option for clients presenting with anxiety and depression, in primary care and provides promise for EPT to increase its presence, as well as for CoP to maintain its core values within this setting.

In terms of how the participants' presenting issues and objectives were achieved, this was primarily characterised by a phenomenological method of bracketing, horizontalisation, description and clarification and a hermeneutic dialogical exploration. The immediacy of the therapeutic encounter was integral for the *doing* aspect of therapy, in which clients received feedback on their process (ways of relating and being) and experimented with new ways of relating. This was experienced alongside a personalised experimental aspect, in which clients experimented with a new way of being, within their particular context and bringing these experiences back to sessions for reflection. This experimental *doing* aspect was credited for reaching new ways of being and was seen as a vital part in the protocol seeming personalised, as well as being a core attribute in how *doing* qualities of the therapeutic relationship were key to change. Other key qualities involved in the therapeutic relationship that were conduit to change, included the experience of feeling heard, cared for, understood and client-therapist attunement. As such, the therapeutic relationship in EE, comprised a complex interplay of both *doing* and *being* qualities, as well as an active participation and openness on the part of the client.

The approach taken in EE, resulted in the participants gaining new awareness, finding personal meanings and discovering new ways of being with themselves, others and the world. This mainly constituted the participants becoming more themselves, with a shift towards acceptance and authenticity. These findings support the view that EE uses phenomenological methods, taking a holistic, relational, interactive and collaborative approach to clients' difficulties, which empowers and engages clients to re-evaluate their past and current choices, in order to live in a more meaningful way. In doing so, core principles of CoP are reached, such as realising client potential and wellbeing, emphasising the suitability of EE, an existential approach, as a way for CoP to keep its pluralistic stance within primary care.

The CBT tsunami in the NHS has result from it being a short-term approach, with measurable outcomes. This enables it to be readily empirically tested, resulting in a robust evidence-base (Dalal, 2018). Finlay (2012) relays how research has come to be seen as irrelevant to practice and taking place in "academic ivory towers" in EPT (p.183). Without a comparable evidence-base, EPT and other therapies have "remained on the fringes of mainstream practice" (Keshen, 2006, p.285), not being recognised by NICE as a therapeutic option in a context of "evidence-based reimbursement systems", such as the NHS (Correia et al., 2017, p.220). This research has acted upon Finlay's (2012) appeal for existential-phenomenological practitioners to take up their responsibility to tackle this "existential predicament and affirm and redefine our professional identity through research" (p.183). McLeod (1999) suggested the need for "small scale 'practitioner research' in everyday clinical activity placing therapist/client concerns at the core" (Finlay, 2012, p.185) and taking the view that client accounts of process and outcomes are valid forms of evidence, this study has endeavoured to develop holistic understandings from the clients' perspective of what happens in EE.

This research study acted upon Finlay's (2012) consideration above, as well as Cooper and McLeod's (2011) active encouragement of research that is grounded in client perspectives, rather than continuing the trend of privileging therapists and academics accounts. I hope that this research has highlighted further research questions, that can be grounded in client feedback and considerations of what makes therapy more and less useful. Client feedback, not unsurprisingly, has been found to improve the quality of services, quite often dramatically (Lambert & Bartley, 2001) and I would like the findings from this study to not only improve the quality of the delivery of EE, but potentially services in primary care more generally. I hope that this study will encourage services to engage with their service users' perspectives and for individual practitioners to incorporate client feedback into their practice. Finally, the EE intervention now has both a robust quantitative and qualitative evidence-base and discussions to improve the service delivery of EE, in response to the participants' recommendations, are already underway. This serves to accentuate the great value that a democratised, client-centred and continuously evolving existential-phenomenological intervention such as EE, can offer in the attempt to meet the changing principles of primary care.

Future recommendations

I hope this study will be followed by further research that deepens the understanding and knowledge-base into areas that I have identified as requiring further clarification or understanding. Wampold (2014) suggests that further research is needed to understand the process of therapy and how outcomes can be improved across all orientations and contexts, to improve mental health services and to better understand the important elements of therapy. Accordingly, research that more specifically explores the components the therapeutic relationship in both EE and EPT, would be useful to build up a more detailed understanding of 'what' and 'how' the relationship can facilitate change. It would be valuable to identify both commonly shared factors across modalities, as well as the more specific processes behind these factors, that may be unique to EE and EPT.

Likewise, qualitative research that could unpack client experiences of client-related factors, such as client participation, engagement, openness, both in EE and in psychological therapies more generally, would be vital to develop a deeper understanding of these processes and potential avenues for them to be activated by a therapeutic protocol and relationship. Alternatively, RGT can access the tightness and rigidity of one's self-concept and this could be employed as a quantitative measure to further understand the role that client-determined factors, such as openness, play in recovery both within EE and in other psychological therapies.

Although this might seem contradictory given the argument against the need for high levels of treatment adherence, because the research for the value of treatment adherence and manualisation is mixed and no clear conclusions can be drawn, further investigating treatment adherence and process would seem beneficial if the EE protocol is to be rolled out on a wider scale. This is required to allow for the rigorous evaluation of the effectiveness of its processes, from which clear evidence-based recommendations could be made, which the current climate in the NHS requires. Observational instruments have been developed for certain therapeutic paradigms to assess orientation-specific processes and Correia et al. (2018) have established an observational grid for existential practices. This could offer an exciting prospect for taking research into EE's protocol adherence and process research further, in a manner that seems most in line with EPT and EE's epistemological and ontological roots.

To address the experience of being short-changed by time in EE, as well as to further assess the suitability of a time-limit, establishing the parameters for testing and delivering a longer-term protocol could be established. Future research comparing client experiences of the current EE protocol to a longer-term format, would be valuable to better understand this phenomenon of time as insufficient, its impact on longer-term outcomes, as well as to determine what might be an optimal time-limit for EE.

More generally, I hope that this research will encourage other counselling psychologists to engage with NHS ethics and research centering upon client experiences in such settings. Decision-makers and services within the NHS are increasingly recognising the value of involving experts by experience (NICE, 2018) and I believe that part of this movement should be in giving a voice to service users. I would argue that enabling the clients of EE to describe their experience, makes a step towards acknowledging the value of the lived experience of those who are experts by experience for the development of service delivery in primary care. As Slay and Stephens (2013) state, we should aim for "a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make, in order to improve quality of life for people and communities" (p.6). As such, more than anything else, I hope that this research encourages a shift in perspective from favouring evidence from RCTs, towards recognising the value of evidence that can emerge from the exploration of clients' experiences of processes and outcomes, providing practise-based evidence across psychological therapies in primary care.

Finally, in order for EPT to be recognised within primary care and NHS services more generally, a robust evidence-base is required. This research intends to encourage existential-phenomenological practitioners to take up their ethical responsibility to ensure that there is a choice of psychological therapies in statutory services and find ways to develop evidence in all manner of forms. This study has demonstrated the value of evidence in the form of client experiences and as such I would advocate further qualitative studies into client perspectives of outcomes and processes in EPT, but also across psychological interventions. Nevertheless, while I advocate qualitative research methodology for building an evidence-base for EPT, given the current climate demanding quantitative research and the sparsity of an evidence-base for EPT, a pragmatic stance has to be taken towards this in future research considerations.

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Appendices

Appendix A: Initial Interview Schedule

The experience of Existential Experimentation therapy from the service users' perspective in primary care.

Opening the Interview:

Introduce myself, ask if they have read the PIS, remind them of confidential nature of the interview. Reiterate that the purpose of the research is to explore the subjective experience of clients of the therapy service.
Introduce consent forms
Ask if they have any questions before we begin.
Introduce the voice recorders

So, to start with a general question,
Q1. Please can you tell me about your experience of the therapy you received?

Prompts –can you tell me a little bit more about this? Can you give me an example? Could you elaborate on that? Is this everything you have to say about this particular topic? Is there anything else that you would like to say in answer to this question? How did this impact your experience of therapy?
Probes – can you tell me what you mean by X?

Therapeutic Relationship:

Q2. Please can you say something about your experience of your therapist? And I just want to remind you that this is completely confidential.

Goals:

Q3. Please can you tell me what brought you to therapy?
Q4. Please can you tell me what you hoped to achieve from therapy?

The Therapeutic Process:

Q5. Thinking of what brought you to therapy and what you hoped to achieve from it, how do you feel that this was worked on within the therapy?
Q6. What did you find particularly useful about therapy, if anything?
Q7. What did you find less useful during therapy, if anything?

Outcome:

Q8. Would you say that your aims/expectations for therapy were achieved?
Q9. How has life changed, if at all, for you since you have had therapy?
Q10. Was there anything you felt that was left unresolved in therapy?
Q11. What would you change about the therapy you received, if at all?

Q. I have finished all of my questions, so is there anything else that you would like to tell me?

Closing the Interview

Thank participant and ask the participant to reflect on their experience of the interview, how they are feeling and if they have any questions. Provide information of how they can receive help if they feel distressed after the interview and provide contact details for any questions about the study.
Remind the participant of the follow-up interview, describe the purpose and time required for this follow-up interview and schedule an appointment if possible.

Appendix B: Follow-up Interview Schedule

Opening the Interview

Outline the purpose of the follow-up interview and explain how it is an opportunity for the participant to share any further thoughts about their experience of therapy, having had some time to further reflect upon it. Describe the confidential nature of the setting and introduce the voice recorders.
Ask if the participant has any questions before starting.

General Question:

Q. Do you have any further thoughts on your experience of therapy that you would like to share, or anything that you would like to add to what you have said previously?

Outcome:

Looking back in terms of your overall experience what would you say about it now, how are you now?

Q. Would you say that your aims for therapy were achieved?

Q. How has life changed, if at all, for you since you have had therapy?

Q. Was there anything you felt that was left unresolved from the therapy?

Q. What would you change about the therapy you received, if at all?

Specific questions

I will explain that I listened to the participant's initial interview and there were some things that were mentioned that I would like to explore a little bit further with them. I will check that they are comfortable with this. I will describe that I have brought the verbatim transcript with me so as to get clarity upon their exact words.

Appendix C: Participant Information Sheet

Information about a research project:
The experience of Existential Experimentation From the service users' perspective
Being carried out by Chekkie Kauntze
As a requirement for a Doctorate in Counselling Psychology from NSPC and Middlesex University

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London NW4 4BT

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?

This study is being carried out as part of my studies at NSPC Ltd and Middlesex University. It is hoped that your participation in this study will help us to understand your experience of Existential Experimentation therapy (EE) and uncover what aspects of therapy you found particularly useful and what could have been done differently. Research on your experience could help the development of this approach, ensuring that EE is providing the most beneficial therapy to you and others and additionally the research could help determine EE's wider use within primary care. Researchers have studied the outcomes of EE therapy using quantitative methods and also therapists' perception of working in this way, however this study is interested in your experience of the therapy you received. You are being asked to participate because you have recently been referred for this therapy.

What will happen to me if I take part?

If you decide to take part in this study, you will be asked to attend two interviews; the first interview will be soon after your therapy has ended and then there will be a three-month follow-up interview. The first interview will explore your experience of the therapy you will have just received, while the follow-up interview will allow you to share any further thoughts you may have had about your experience of therapy and for certain comments from your initial interview to be clarified or expanded upon.

I will contact you at the end of your therapy (via email), in order to invite you to the initial interview. This interview will take place two weeks after your therapy is completed and will last between 60 to 90 minutes. It will take place in a private room at Longrove Surgery during opening hours, at a time that is convenient for you. All effort will be made to accommodate your preference with regards to the timing of the interview. During the interview, I will ask you a number of questions about your experience of therapy. There are no right or wrong answers and if any questions make you feel uncomfortable, please be reassured that it is completely acceptable to not answer the question.

In the initial interview, a time will be scheduled for you to attend a three-month follow-up interview. This will also be at Longrove Surgery, and will last between fifty and sixty minutes. Both of the interviews will be recorded on an audio recorder and I will transcribe them later. At the end of the interviews there will be time for you to reflect on any feelings brought up by the interview and details of further support will be provided. The information that I obtain from both these interviews will be analysed with a qualitative method, known as Interpretative Phenomenological Analysis, in order to extract the main themes of your and other participants' experience of therapy.

Additionally, you will be given the opportunity to be sent the anonymised transcripts of the interviews to check for any discrepancies in interpretation and give written feedback on them. This is an optional step and is to ensure that your experiences of therapy is represented as accurately as possible.

<u>What will you do with the information that I provide?</u>

All interviews will be treated as strictly confidential, however confidentiality may be broken in the event of disclosure of poor or unsafe practice by your therapist. In the case of such a disclosure, the information will be reported to your therapist's supervisor at EASE Wellbeing, for it to be looked into internally. However, depending on what comes out of this report and the nature of the complaint, the researcher may encourage you to file an official complaint to your therapist's professional accrediting organisation, which the researcher will help to identify.
Also, although this is very unlikely, should you tell me something that I am required by law to pass on to a third person (such as risk of harm to yourself, others, safeguarding children and issues around terrorism), I will have to do so.

I will be recording the interview on an audio recorder, and will transfer the files to an encrypted USB stick for storage, deleting the files from the recorder. As the researcher, I will personally transcribe the interviews. All of the information that you provide will be identifiable only with a project code and stored either on the encrypted USB stick, or in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet. No personal data will leave NHS premises. Data will be stored according to the Data Protection Act and the Freedom of Information Act. The audio recordings will be destroyed after examination. For the purpose of further publications the anonymised transcripts will be stored for one year after I graduate, following this they will be destroyed and any personally identifiable data will be modified.

My research will be published as partial fulfillment of my Doctorate and I may also use the findings for further publications to journals. I will make sure that neither your name nor other identifying details are used. The doctorate examiners will have access to the anonymous

transcripts of the interviews and my research supervisor will have partial access to the anonymous transcripts. EASE Wellbeing, in its role as sponsor, will have access to research data, which will be treated as confidential, and only looked at where it is relevant to participation in this research, or to ensure that the research is conducted correctly. Your therapist will not have access to the data, they will not see the anonymous transcribed interviews, and they will only have access to the anonymous published findings.

What are the possible disadvantages of taking part?

This study is unlikely to cause harm, but talking about personal experiences may be distressing and unprocessed feelings may be discovered that may need to be treated. If so, please let me know, and if you wish, I will stop the interview or we can have a break. If you decide not to take part or to withdraw from the study, your current therapy plan and any future therapy will not be affected.

What are the possible benefits of taking part?

We do not know about Existential Experimentation therapy from your perspective and it is possible that the information that you provide about your experience of therapy, will be helpful for some clients in the future. Although being interviewed about your experience in therapy has no direct benefit, some people may find the opportunity of reflecting upon their therapy in depth and sharing their experiences beneficial.

Consent

You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign a consent form before the interview begins.

Participation in this research is entirely voluntary. You do not have to take part if you do not wish to. If you decide to take part you may withdraw at any time without giving a reason. If you decide not to take part or to withdraw, your current therapy plan and any future therapy will not be affected. If you decide to withdraw, transcripts from interviews will be destroyed and recorded data will be erased.

Complaints Procedure

If you have any concerns about the conduct of the study and would like to make a complaint, please use the following contact details:

Complaints to the researcher's university:
NSPC
61-63 Fortune Green Road
London NW6 1DR
admin@nspc.org.uk
0207 4358067

Complaints to the NHS:
PALS (Patient and Liaison Services)
Barnet Hospital
Wellhouse Lane
Barnet
EN5 3DJ
bcfpals@nhs.net
0208 2164924

You can also visit PALS at Barnet Hospital at the above address. It is located on the ground floor, near to the main entrance, and is open Monday to Friday, 10am-4pm.

Who is organising and funding the research?

This research forms part of my Doctoral degree in Counselling Psychology at the New School of Psychotherapy and Counselling and Middlesex University. It is self-funded.

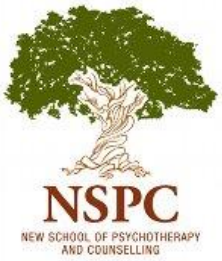
Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by 'East of England – Cambridgeshire and Hertfordshire' Research Ethics Committee. The NSPC research ethics sub-committee have also approved this study.

Thank you for reading this information sheet.

If you have any further questions, you can contact me at:
Chekkie Kauntze
NSPC Ltd
61-63 Fortune Green Road, London NW6 1DR
chekkieresearch@gmail.com
07444343206

Appendix D: Informed Consent



Written Informed Consent:
The experience of Existential Experimentation
From the service users' perspective
Being carried out by Chekkie Kauntze
As a requirement for a Doctorate in Counselling
Psychology from NSPC and Middlesex University
Researcher's Email: chekkieresearch@gmail.com
Supervisor: simon.duPlock@metanoia.ac.uk

NSPC Ltd
61-63 Fortune
Green Road
London NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Date:

WRITTEN INFORMED CONSENT

Please read each point requiring consent carefully and provide your initials in the boxes provided, in order to indicate that you have fully understood each point requiring your consent.

1. I have understood the details of the research as explained to me by the researcher, and confirm that I have **consented to act as a participant.**

   ☐

2. I have been given contact details for the researcher in the information sheet.

   ☐

3. I understand that my participation is entirely **voluntary**, the data collected during the research will not be identifiable, and I have the **right to withdraw** from the project at any time without any obligation to explain my reasons for doing so. I understand that whether I take part in this study or not, will not affect my current or future therapy with EASE Wellbeing.

   ☐

4. I understand that EASE Wellbeing, in its role as sponsor, will have access to research data, which will be treated as confidential, and only looked at where it is relevant to participation in this research, or to ensure that the research is conducted correctly.

   ☐

5. I understand that the data I provide may be used for analysis and subsequent publication, and I provide my consent that this may occur.

   ☐

6. I understand that all interviews will be treated as strictly confidential, however confidentiality may be broken in the event of disclosure of unsafe practice of the therapist or information legally required to be passed on, such as changes in risk information (concerns about harm to yourself, others, children or acts of terrorism).

   ☐

Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Health and Education Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you **do not** wish your data to be included in audits: _____

Please tick here is you **would** like to receive information regarding the findings of this study. Please note, in order for this to be possible we **will need to keep your email address on file**, which we would not do otherwise: _____

Please tick here if you **would** like to be sent your anonymised interview transcripts by email, in order to give written feedback on it: _____

Print name: _____

Sign Name: _____

Date: _____

(1 copy to be given to participant and 1 copy to be kept by the researcher)

Appendix E: Debriefing Letter

Debriefing Letter:
The experience of Existential Experimentation From the users' perspective
Being carried out by Chekkie Kauntze
As a requirement for a Doctorate in Counselling Psychology from NSPC and Middlesex University

NSPC Ltd
61-63 Fortune
Green Road
London NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Date:

DEBRIEFING LETTER

Thank you for taking part in this study. Your time and efforts are much appreciated and make a valuable contribution to existential-phenomenological psychotherapy in primary care.

Should you have any questions, concerns or difficulties as a result of this research study, please contact me, my research supervisor or NSPC. All contact information can be found on the Participant Information Sheet.

Alternatively, you can speak to your GP to get re-referred for therapy with EASE Wellbeing.

The Samaritans also offer a 24-hour free helpline where you can discuss your difficulties.
Contact Number: 116 123

If you would like longer-term therapy, you might find the following websites useful to find a therapist:
UKCP: https://www.psychotherapy.org.uk/find-a-therapist/
BACP: http://www.itsgoodtotalk.org.uk/therapists

Your information will now be kept until publication of the research and will remain confidential. When the research is published, I will make sure that neither your name nor identifying details are used.

You can contact me at:

Chekkie Kauntze
NSPC Ltd
61-63 Fortune Green Road
London
NW6 1DR
chekkieresearch@gmail.com

Should you have any concerns about the conduct of the study, please contact my supervisor:

Prof Simon du Plock Metanoia Institute 13 N Common Road London W5 2QB simon.duPlock@metanoia.ac.uk	OR	The Principal NSPC Ltd. 61-63 Fortune Green Road London NW6 1DR admin@nspc.org.uk 02074358067

Appendix F: Letter of Introduction

Introduction Letter:
The experience of Existential Experimentation From the service users' perspective
Being carried out by Chekkie Kauntze
As a requirement for a Doctorate in Counselling Psychology from NSPC and Middlesex University

NSPC Ltd
61-63 Fortune
Green Road
London NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

I am carrying out a research study as part of my doctoral studies and I would like to invite you to take part in it.

If you decide to take part in this study, you will be asked to attend two individual semi-structured interviews, to explore your experience of the therapy you will have just received. The initial interview will take place two weeks after you have completed therapy and will last between 60 and 90 minutes. The follow-up interview will be conducted three months after you have completed therapy and will last between 50 and 60 minutes. Both of these interviews will take place at Longrove Surgery at a time that is convenient for you.

It is hoped that your participation in this study will help us to understand your experience of this therapy; uncovering what aspects you found particularly useful and what could have been done differently. This is in order to ensure that we are providing the most beneficial therapy to yourself and others.

Please contact the researcher using the details below if you are interested in taking part in the study and would like to receive further information:

Chekkie Kauntze
chekkieresearch@gmail.com
NSPC Ltd
61-63 Fortune Green Road
London NW6 1DR

Kind regards,
Chekkie Kauntze

Appendix G: Reminder Email to check transcripts

Dear X,

This email is being sent as a reminder, since you agreed to check your interview transcripts. This is an opportunity for you to check that my interpretation of the interviews is an accurate reflection of what you said in the interviews, in order to ensure that your experience is represented as accurately as possible. I would be grateful if you could let me know if you still wish to participate. If I do not hear from you within two weeks, I will assume that you no longer wish to take part in this phase of the study and will not contact you again.

Kind regards,

Chekkie Kauntze

Appendix H: Socio-demographic questionnaire

ASSESSMENT FORM

Name: _____ Date: _____ Site: _____

Address: _____ Email: _____

_____ Phone: _____

_____ Pref. contact method: _____

Hello,

We ask every one of our clients to complete this questionnaire at the beginning and at the end of the programme. We also care about how you are getting on in your work with us, so we will also ask you to complete a quick one page monitoring form every time you come and see us. This questionnaire and the monitoring form are very important. Our team of experts will look very closely at your answers because your voice and experience is crucial and will help your therapist and our team to find out how you are, evaluate our work and ensure it improves.

In this brief questionnaire you will be asked about your personal details, your current physical and psychological wellbeing and your goals for the programme.

Gender: _____

Date of Birth: _____

Ethnicity: _____

Employment status: _____

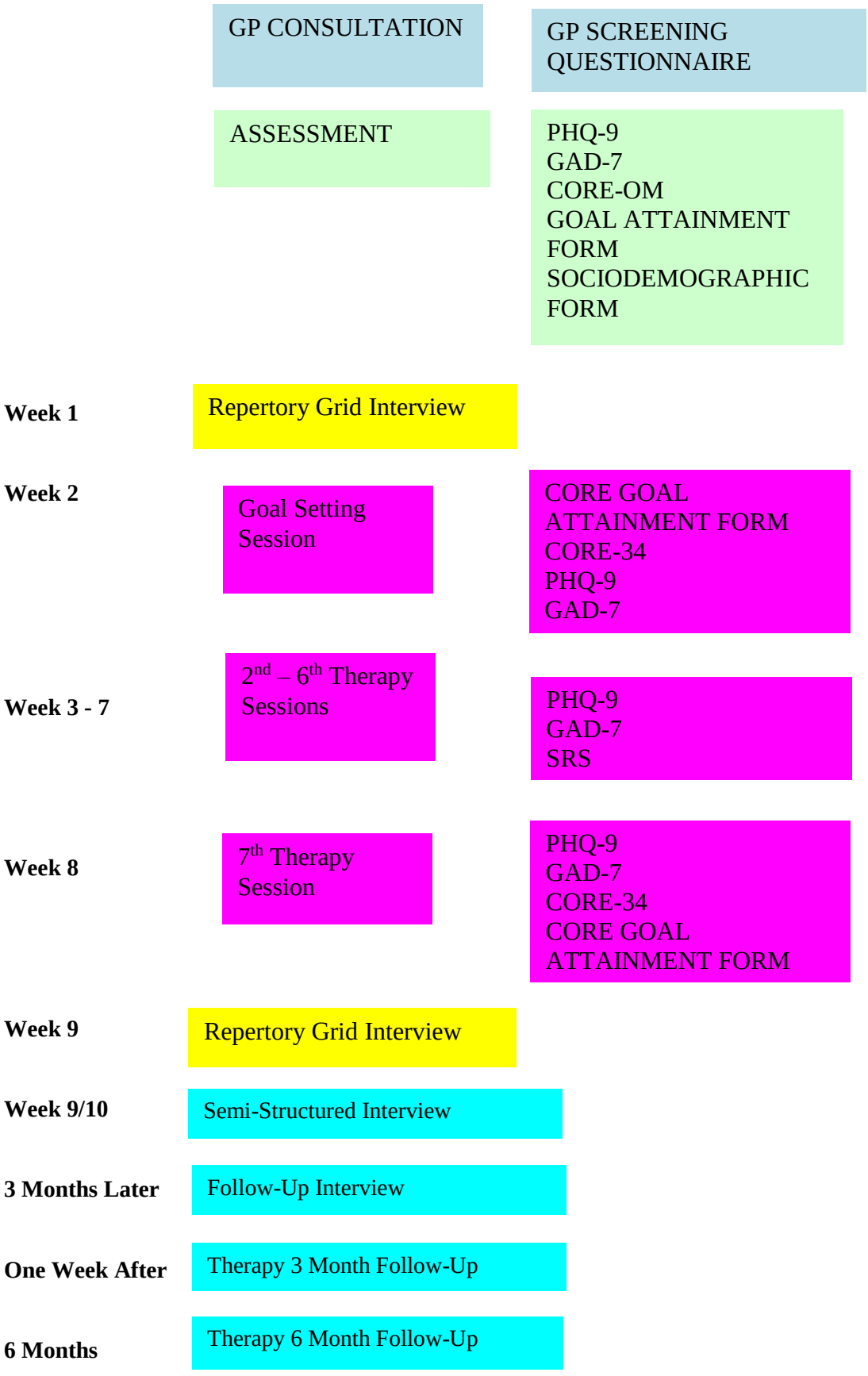
Do you have any long term condition? □Yes □No

If yes, specify_____

Do you recognise yourself as having a disability? □Yes □No

If yes, specify _____

Appendix I: Recruitment Process and Measures



Appendix J: EASE Wellbeing Consent Letter

From: Diego Vitali <diego@easewellbeing.co.uk>
Subject: Letter for Chekkie's ethics application
Date: 20 December 2016 11:08:58 GMT
To: "chekkie@easewellbeing.co.uk" <chekkie@easewellbeing.co.uk>
Cc: Mark Rayner <mark@easewellbeing.co.uk>, office@nspc.org.uk

Dear Chekkie,

I am aware that your research involve recruiting participants through the NHS. We have discussed that if you wanted EASE and our platform to help you with your data collection, this should happen in agreement with both the confidentiality policies and agreements that we have at EASE and with those that EASE has agreed with the NHS surgeries with which it cooperates.

Therefore, if you successfully engage with the NHS Ethics process, I and EASE will be very happy to support you and your work and to be available in case you have any issues or doubt in the process of preparing your IRAS application and in that of carrying out the research. In any case, if you decide to explore other options of your research that may not involve NHS ethics I am available to discuss or advise on them.

I know your work as a therapist and as a colleague and I trust you will do an excellent and careful work, therefore I am happy for you to recruit participants through EASE wellbeing and for you to have access to our databases for the purpose of your research work.

Best Wishes

--
Diego Vitali

EASE Wellbeing
Research and Development Director

Appendix K: Letter of NHS Sponsorship

EASE Wellbeing

Churchill House
120 Bunns Lane
London NW7 2AS

Katherine Chekkie Kauntze
NSPC
61-63 Fortune Green Road
London NW6 1DR

28th March 2017

To Whom it May Concern.

Re. NHS Ethics Application
Title: As assessment of Existential Experimentation therapy from the users' perspective in primary care.

This is to confirm that Chekkie Kauntze is a doctoral student at the New School of Psychotherapy and Counselling and is conducting the above research.
EASE Wellbeing will act as sponsor for the research. Devitt Insurance Services Limited, which covers liability and professional indemnity related to all clinical activity and specifically Chekkie Kauntze's research, insures EASE Wellbeing. EASE Wellbeing does not provide universal cover for non-negligent harm although each case would be considered individually. A copy of the policy document has been provided.
Please do not hesitate to contact me should you have any queries or require any further information.

Yours sincerely,

Mark Rayner
CEO of EASE Wellbeing

Appendix L: NHS Ethical Approval Letter

NHS
Health Research Authority

East of England - Cambridgeshire and Hertfordshire Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

12 June 2017

Miss Katherine Chekkie Julia Kauntze
EASE Wellbeing, Suite 216
Churchill House
120 Bunns Lane, London
NW7 2AS

Dear Miss Kauntze

Study title:	**An assessment of Existential Experimentation therapy from the service users' perspective in primary care.**
REC reference:	**17/EE/0215**
IRAS project ID:	**224451**

Thank you for your letter of 05 June 2017 responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Appendix M: NSPC Ethical Approval Letter

Catherine (Chekkie) Kauntze,
16b Devonport road
Shepherds Bush
London
W12 8NY

NSPC
NEW SCHOOL OF PSYCHOTHERAPY AND COUNSELLING

admin@nspc.org.uk
www.nspc.org.uk

Prof. Emmy van Deurzen – Principal
Prof. Digby Tantam – Deputy Principal

1st April 2017

Dear Chekkie,

Re: Ethics Approval

We held an Ethics Board on 21st March 2017 and the following decisions were made.

Ethics Approval
Your application was approved with some conditions.

Conditions
Please see the attached comments and resubmit your application accordingly. It will be reviewed for chair's action once received.

Please note that it is a condition of this ethics approval that recruitment, interviewing, or other contact with research participants only takes place when you are enrolled in a research supervision module.

Yours sincerely

Prof Digby Tantam
Chair Ethics Committee
NSPC

existential ACADEMY

61–63 Fortune Green Road, London, NW6 1DR
+44 (0)203 515 0223 | +44 (0)207 435 8067 | admin@existential.academy | www.existential.academy
Registered Company No: 07239892. Directors: Prof. Emmy van Deurzen and Prof. Digby Tantam

Appendix N: Sample of Initial Interview Transcript

This is a full transcript of the initial interview for the participant called Wilhelmina. This has been anonymised to protect client confidentiality and anonymity. I have highlight in bold, the questions that directly relate to the interview schedule.

R1	**So, my first question is if you can just tell me a little bit about your experience of the therapy you received?**
P1	Okay um so I had six, no that's not true, I had an assessment I would think, session by somebody, then I think I had a pre-counselling session, I think that's what it's called and then I had six sessions with my counsellor and I think it was very well handled um. I think we set very clear objectives, um and I think it was a great help. That was my summary *(laughs and pause).*
R2	And when you say 'well handled', can you tell me a bit more about that?
P2	*(Speaking very fast throughout)* Well, I think it was very well explained in terms of expectations and I think that the goals and the objectives were kept in mind. So, there was reference to them mid-way through, it was, you know they came from me as opposed to being, you know they were very good. They were very specific, because it was you know my therapy was around anxiety and it was anxiety around one particular area, it it's around my son. Um and so it's a very specific anxiety and so in that respect it was probably easier (*separates 'eas' and 'ier', making easier sound very tentative)* to, well it was quite easily identifiable as to where the anxiety came from and it was easier to identify areas to work on and it was very much a, really an evolving process, to work on certain behaviours and then to feed that back and then to try something different and so on. So, it was for me, I would say it was very well handled, because I'm not one to go back and "what's happened in the past?". I don't want that, I want something that is practical, right. I would like a little spreadsheet that says action here and you know tick a box and you know we were laughing about that because that's part of my anxiety, is you know a bit of control here and so it was very much, "well how do we get over that?" and "how do we make things work for me?" and you know "what am I comfortable with?", "what am I not comfortable with?". And quite practical, but again at the same time saying "it may be that we can't resolve it totally, but you know, it's about feeling comfortable where you are accepting things" and so on and so I think it's about sometimes reigning in expectations, revisiting original objectives and I think that was very useful. So, when I say it was handled very well, it wasn't unrealistic and we kept, you know, a very clear objective, or three very clear objectives in mind, so I think that was handled very well. But I think the lead up to it you know, as to what to expect, how it will work was very good. I mean I think the only thing that I would say is that my anxiety had abated by the time I got to therapy and it's a real shame that it didn't happen earlier. I am not really an emergency case, so I, I, in one sense I actually said to the counsellor "I feel like a bit of a fraud, because while I feel my anxiety is real to me, in comparison to many other people it's probably actually very small, but it's very real to me". But by the time I had got to the counselling, it was less than it had been initially, but that is something that is out of their hands totally and I understand that *(long pause and nodding).*
R3	**And in terms of your therapist, can you tell me something about your experience with your therapist, bearing in mind it is confidential and … (interrupted).**
P3	Very, I was very comfortable with him and I felt that he, he smiled a lot and I, which made me feel very comfortable. He was very good in that he would think about things

	and there would be silences, when I could almost hear his brain wurring and thinking about what to say next. And he was very calm and very very understanding and I think he, he got to the nub of the issue quite quickly. I think whilst I, I think part of my expectation is that my anxiety is going to go away and he made it very clear from the beginning that it was highly unlikely that it's ever going to go away and that it's a natural reaction and I am probably always going to end up being anxious about my son, but it's how I handle it. And I think that, that was very good, and I think he was very clear, he was very good. He was very, he had a sense of humour as well, which I think is very important and he would just pick up on certain things that I would say, a throwaway line, but he would actually find that quite important to pick up on it and we would expand that and realise when it wasn't actually important, it might have been important to me, but he felt that actually he would, there was something else that he wanted to pick up on rather than pick up on that. He obviously handled what I felt was important, but actually sometimes he would turn it on its head and in fact it was probably less important than I thought it was, but there was something else that I might have overlooked, do you know what I mean?
R4	Hmmm *(nod).*
P4	*(Speaking much slower)* So, I think he, yeah, he was good and I think it was a good fit.
R5	A good fit in what way?
P5	Well I would have hoped that the two pre-sessions would have said 'well this is the nature of her issues and this is her personality and we think this person would probably suit her best'. I would have hoped that was part of the process, because for me it's very important that when I sit in front of someone and I bear my soul on my anxiety, that I firstly feel a sense of trust, which I have no issue and I'm sure that would never be an issue. But also, that I felt very comfortable with someone and he is very calm. I'm quite animated and he was completely the opposite actually and I think that worked very well, so when I say the fit, I think that, I would hope that was part of the process. It might just be coincidental, I don't know. But that's what I would have said in terms of personalities, in ways of dealing with things and so on.
R6	And the other thing that struck me was this picking up on throw away comments. Can you give me an example of that?
P6	*(Smiles)* I knew you would ask me about that *(laughs),* there you see you picked up on that! No, well for example, I would say "I feel like a bit of a fraud being here", and then carry on with something else 'and people have got far more important issues than I have', and he would say, "why do you think you feel you're a fraud?" And I said, "well because my anxiety is less now than before" and so he would pick up on that and say "well, but why would you not think that's important, when it's the way you feel?" and "tell me more about how you are feeling now compared to before". So it was, in that respect, it's yes you have been handling it well and I'm not losing sleep, I can get up every day and I can manage things and I'm not depressed, so in that respect, so I said "I feel like I'm answering these questions here and they're all, 'not really', 'not really', 'yes I don't sleep very well' and 'yes I feel worried and anxious', but everything else it's 'not really'"" and he goes "but it's really important to you and this worry has taken over part of your life". And so we would sit there and I would say "yes, but in comparison to everybody else", so he was very good at picking things up like that. And so, I would say those throw away lines like that and he would do that on quite a few occasions. Um so I can't give you another example, because I can't remember another example.
R7	No that's a brilliant example.

P7	Yes yeah.
R8	And as well with the humour, how do you feel that impacted the therapy?
P8	Well I mean, well I actually think that's very useful. To me I think humour is very important. Um and I think that, (heavy sigh), I don't feel it was ever an intense session, I mean you know I wasn't crying you know, but I just felt you know, I'd say "you must just think I'm some sort of control freak", you know. I'd say "I'm not" and he would say "well I don't think that at all" and he would just smile and he would say "why do you think you are?" and I would say "that's because I like spreadsheets" and so on (*laughs*). And he would say "when you actually think about it you're not" and I said "I know, I know, but it's just because I like everything planned just so", but we would smile about it and we would laugh about it and so that to me was the humour; that he understood why I said it, but he didn't believe it. Well you know, it's not that he didn't believe, he just didn't think what I thought about myself was true, so he made me see it differently.
R9	Hmmm *(nod).*
P9	So, um so humour to me is very important and he obviously realised humour was important to me, he would smile, because you know when things are difficult, sometimes humour is maybe not the right way forward, but with me I think he assessed the situation well and realised that was actually a good way, because I'm quite humorous at times and he would pick up on that, so for me that was, he went with the way that I was, so he was very empathetic in that way. And I think that's important, well it was important to me.
R10	And are there any less positive aspects of the relationship?
P10	Um, I think probably my expectations initially were that we would have more, um actions. So "right we are going to, let's try this and this" and that is part of my control, that's part of the list. I'm very much a list person and I like "right we'll do this, we'll do that, we will do" and that's part of my problem with my anxiety is that, you know, I've got this long list and things don't actually get achieved, you know. So, I think that possibly I thought that, 'ah well, oh you know, what is he telling me?' You know I would come out sometimes and I would think, 'it was very good, but have I achieved enough today?' and actually I would think 'I'm not sure, but I'm going to give it a go'. And it was actually very effective and in my mind during the session, I'm thinking (*groans*), I think I'm a little bit disappointed in that, but then when I went away I thought about it and I thought 'well what else could he actually do and say and so on' and so, so in that respect I think my expectations were quite high. But I mean, again, most times, virtually every time, he would say "we have got to be careful of what the expectations are and your anxiety whilst it's less now, there will be times when it's worse um and it's how you deal with it. It's putting some of these behaviours into play" and so on and and he said "if that has worked, think about how you will do with that in the future". And then we would look at and talk about sessions in the future and what situations will happen in the future and how I will handle that. So, coming back to your question, I think that I probably thought, 'well there will be six sessions and I will come out and next time I have anxiety I will just put boom boom boom boom into place and it will all go away' and he made it very clear that that's not going to happen. But he's also given me strategies to cope and acceptance of what will happen and that's been part of my process. So, have there been things that I wasn't as happy with, probably my initial expectations, but I think those were handled very well, so no I don't think so I don't think anybody else would have come out with anything differently, because that is how I would think about it.
R11	And these strategies to cope that you got, is there an example of that?

P11	*(Disengages eye contact and speaks very fast)* Um there would be things like instead of, one of my issues is to, if I am quite anxious, I like an action plan – 'right we are going to do this and this is how we are going to resolve it and so on'. Now when it comes to a 30-year-old who is very unhappy in his job and has decided to give up his job and is now living at home and looking for another job. My view is 'right, okay, let's have a list of what we are going to do' and he is 30 years old and I'm his mother and it's like 'stop', you know, and so his view was like, "Well what about just standing back? What about just listening?" And because what my son will probably want is to share and "yes, he may well need help, but is it the sort of help that your giving? How do you think he is feeling?" So rather than saying, "No that's not the way Wilhelmina", he didn't say that, he just said "well how does he feel? How would it make you feel if you just stood back? How would that help your anxiety?" So, it was "oooh well I would feel uncomfortable" and he said "but how would it make your son feel?" and I said well probably more comfortable and so he said "okay so how do we get some middle ground?" So, it would be things like that, how do we explore that and things like he said "why don't you try just standing right back, see what impact, see how you feel? Analyse how you feel after, maybe write it down" and so it would be things like that and so I would try it and I came back and actually I said "well surprisingly it worked quite well", and so we would do that and each week. I would say "well I tried this and that worked quite well and I tried that and even though that worked well I still went back to my default position slightly, of going back to that, but I tempered it" and so on and so it was really small things, actually very small things, but actually, really good things. He sometimes said, there would be things like I would say "my son sometimes shares with me, in fact what he does he dumps, he just dumps, he is very emotional and he would just dump it all" and I would say, "ah I just, my anxiety levels just rise" and he said "well why don't you tell him that? Why don't you say to him 'when you do that it makes me feel very anxious and worried and what is it that I can do to help?'" And I said "errr oh I don't think I could do that, because then they would worry, then they wouldn't tell me" and he said "well try it, try it on a small thing". And my son actually funnily enough something happened that week and so I thought 'right I will try it' and I didn't say "oh my god you make me so anxious", I just said "it just concerns me, what is it I can do to help? Do you want any help?" And he would go "well actually yes" and then we would talk about it and I thought 'oh that was actually much better than me barging in and saying right we are going to do x, y and z' and so it's just, *(pauses and suddenly reengages eye contact and looks concerned)* am I making sense?
R12	Yes absolutely.
P12	It's just changing things slightly, it's just tweaking things and it's just being aware more, I mean I am aware and I always have been aware, but it's just I've always felt this is the way to handle it, it's just two heads are better than one and we will do it together, but that's not what is required. And so, my anxiety levels go up when their anxiety levels go up. And so, it's a matter of, it's actually finding a balance. It just depends on the situation as well. It's little things like that we would discuss and it was very much "well how does that make you feel? And what has happened in terms of your anxiety levels? What makes your anxiety levels go up? If you do this, does it make them go up, down?" So, we would look at those and also "what's the impact, on you know, on all your children?", and so on. So those were very practical ways forward. Not huge steps, I think probably again my initial expectations were much bigger steps, but when I sit down and analyse it, I um think well I'm not really sure what my expectations were, in any sense as to what the big steps would be. Um and

	I you know, so the fact that I have been able to try different things and discuss it and some have worked and some haven't, but you know it's exploring those. I think he has done very well in terms of you know sort of teasing those out, because they were the ones that I came up with, but in a very roundabout way *(pause).*
R13	**And you've mentioned your son and the anxiety, but I was wondering if you could tell me a little bit more about what brought you to therapy?**
P13	Well I have had this before; I've got three children and it's my son and I've you know I would say to (therapist's name) "he is my worry child'. He always has been, he's got dyslexia, and he used to have severe dyslexia, but now it's quite moderate. Um and so it's always worried me, because he has just, certain things have been harder for him and I've got a younger daughter, she's three years younger and life has been a lot easier for her in terms of friendship groups, in terms of studying and so on. She's one of those people who seem to have breezed through, whereas my son seems to have had things harder. My daughter graduated three, well a couple of years after my son and she has gone into a very well paid, high flying job and my son hasn't, because he studied something differently and he is a different sort of person anyway. But it's and my son has been very unhappy recently in his job and when he graduated and I was, he didn't do as well as he'd hoped, he was very worried about finding a job and my anxiety, and I'm talking about three years ago and my anxiety levels were horrendous, absolutely horrendous and I came to the doctor and was put on some sort of citalopram I think it was, a very low dose and I was on it for no more than six months and actually I think three months, and my son sorted himself out, got a job and that's fine. And then we have gone through three years and then all of a sudden he's moved jobs and the job wasn't what is was, what he'd hoped it to be and he would come home in a really bad way and what would happen is, I would get myself into a real state, oh around July time of last year, just before he would come home I would think, 'what mood is he going to be in? What's he going to do? What happens if he's really unhappy?' I have a habit of layering, so I would say to the counsellor, I would say "well right what's it going to be like when he comes home? So how am I going to react and then so what happens if he doesn't go out with friends over the weekend, what am I going to do? What happens if he never gets a girlfriend? What happens if he never gets married?" So, I would just compound everything, so it's a bit like an onion, so instead of unpeeling the onion, I would be putting layer upon layer, upon layer and I would end up and if he hasn't even come home yet and 'what if he never gets married? He's never going to have a girlfriend' and that would be me and that's how my anxiety developed and I got to a point where I thought, 'this is ridiculous!' It's not as bad as it was three years prior, it's better but my head would say 'Wilhelmina, he's going to be fine. If he walks out of his job, which is likely, he will find another job, he's wanted to change career, so it's taken him a bit longer, but he's got years of experience, he will be fine'. But my heart would say, 'oh my God, how am I going to cope with the emotion', and so I got to a point where I came back to the Doctor and I said "I'm in a state. It's not that I can't function, I'm not suicidal, I'm not depressed. I can function, but I'm very anxious and I can't have him seeing me like this, and I don't want this to happen every two, three years or if something isn't going well with him and he shares it with me my anxiety levels go up. I can't have this happening". I'm the last one who wants to take any medication and I said, but so I have gone on an even lower dose this time of medication. God knows whether it's working or not, I've no idea. It may well be a placebo type effect, I don't know, but I said you know she said "why don't you try counselling this time", cos I said I wasn't sure I needed it last time, but and so that's how I got here.

R14	**Okay and you have mentioned a little bit about what you hoped to achieve from therapy, but was there anything else you wanted to mention?**
P14	Um no not really. You know I think it was very specific my anxiety. I didn't need to explore anything else, it was 'how do l deal with my anxiety around my son?' I can deal with most things, I can deal with worry, you know I worry like anyone else, I would worry about things, but I don't get myself in that state with anything else, other than my son *(pause)*. So, it was very specific.
R15	**Hmmm, yes, and thinking about what brought you to therapy and what you hoped to achieve, so you mentioned the anxiety with your son, how do you feel this was worked on within the therapy. You mentioned some of the questioning, but…**
P15	Yes, I think it's worked as well as could have been expected really, you know. It's, I think it's very much an acceptance that he has brought me around to, that you know, it's normal to be anxious, and it's actually, he said "it sounds like you're a wonderful mother", he said, "so you will have anxiety" and he said and "it's also learning to let go" and I said "I can't wait, I can't wait for them to leave home and I don't have to take on some of these anxieties!", you know and it's that sort of thing and um so, god I've forgotten what the question was?
R16	It was about how it was worked on...(interrupted).
P16	Yes, how it's worked, yes yes, so I felt it has worked well, because there are some practical solutions. Um so it's worked in that I can, I mean, I know it's about standing back, it's about assessing how I feel, cos one of the things was that "it's always about how your son feels, but what about how you feel?" I said "well I couldn't do this, because what happens if I do that to them?" He said, "yes, but if that makes you feel better then why can't you do that?", so it's things like, "oh well why can't I do that?" So, it's actually just accepting that I'm going to be anxious, but putting strategies in place and as I said to him, three years ago it wasn't so bad and this time it was less and hopefully next time it happens, and it will happen, it will be less because I've also got some of these strategies. So yes, it worked as well as it could do. Um but it wasn't, you know, it's not going to take it away. Um and which is probably, ideally, in an ideal world is what would have been wonderful, but that's not normal. And you know we discussed that in the first session and he made that very clear. So, managing expectations were done very well.
R17	**Yes, and what did you find particularly useful about the therapy, if anything?**
P17	Um practical, I just think the practical side, I mean you know, for me it is, it's got to be action-orientated, I can't just sit down, talk about my feelings, you know all the time. I just need someone to say "alright if you can try x and let's see what happens". Um and "how do you feel and blah blah blah" and it's practical solutions that for me were very important, because it was so specific, or it is so specific so um yes you know, that's what I felt I got out of it and I think the other thing is that for someone to say "that actually what you are feeling is very normal. Yes, there are anxieties and yes sometimes life is hard with someone else and as a mother that can be very difficult sometimes. You can think it's unfair, but it's a very normal thing". That's actually quite comforting as well, so I think just to hear that, I mean I know that I'm not an unintelligent woman and I know that. But when the emotions get in the way you think, 'oh my God was it me?', but of course it's not, but it's quite nice to hear it. So, I think there is a comfort there to be able to talk through those sorts of things um with someone. Yeah (*smiles*)
R18	**Yes and what did you find less useful about the therapy, if anything?**
P18	Um no. Not really, I think that was really in terms of what I said before, no

	I don't think so. I mean I, no I don't think there is anything I can say there really.
R19	**Okay so we are moving onto the outcome of it, how has life changed if at all for you since the therapy?**
P19	Yeah um I think it's actually, it's actually quite an interesting question, because you know, during the time I was thinking, well how have things been changing and so on and of course the problem is, is where in the anxiety journey I am. So had this happened in September it would have probably been very different, because I probably would have found it a lot more, there would have been bigger changes then, because my anxiety levels were at a much higher level, um now sort of my son has been home now for nearly three months and I have kind of got used to that, but what I do think over the last six weeks, is six, seven weeks, is that I am a lot more calmer internally and I am a lot more accepting. Things are happening, he's going out to interviews and so on and things like that, things are happening and if I sometimes have some time and I sit down and I actually look at jobs and I will say to my son, "I've actually had an hour, and I've looked at some jobs, do you want me to send the links to you?" And he would say "yeah I've no problem at all" and that actually sometimes it will help me, because before I would question "Should I do this, should I, how is he going to feel if I do that?" Now, I just do it and say "do you want them?" and he would say "well yeah that's actually quite useful" and so that quite good. So, it's, it makes me feel better, so why shouldn't I do it. Whereas, before it would have always been him so there are, it's made me calmer, it's made my head and my heart feel a bit more joined together, joined up thinking, which is quite good. Because, you know before my heart would be saying something and my head would be saying something else. And now it's, 'things are going to be okay, things are going to work out, it's all about timing and when he was a bit down and he was the other day, and it was just, for me it wasn't 'well let's wrap him up in cotton wool, let's say it's all going to be fine and so on', I said "well you know that's life sometimes" and being very honest with him and that's helped me, because I haven't gone overboard. So, there are lots of little things that we discussed in the therapy that have made me calmer and have made me react to situations in a more positive way for my son.
R20	And this calmer internally, what does that sort of look like?
P20	Well I don't, well before I would go ah (*breathes in to indicate panic*) and internally I would be going 'oh my God, oh he's really unhappy, oh this is really awful'. That is internally, he wouldn't have seen any of that, you wouldn't have known that. My face would have been completely calm, but internally and then I would go outside into another room and I'd think 'oh my God, I've got to keep busy, because you know this is dreadful', and so there is much more sense of calm. So, it was about two, three weeks ago, maybe it was last week, he said "ah I'm so fed up with this, life is just a real bummer sometimes" and I went "yeah" and he said "I'm 30 years old" and I said "yup" and I said "yeah you know, it can be" and then he said "next year I will be 31" and I said "yes and then you will be an older age and yup and what you are feeling is totally normal". And I said "let's have a look, why don't we turn it on its head and look at all the good things you've got?" and he goes "well yeah" and I thought, 'gosh that's very big of me to have done that', because before I would have gone, "yes but you've got this and you've got that" and I would have listed them all for him, whereas it was very calm saying "well what about..." and you know it was quite a short conversation. I left him feeling better, I hadn't gone overboard, I stood back and I hadn't gone through all that 'oh my God' and the panic inside and I think part of it was also an acceptance of 'well yeah you know, that's how itis sometimes'. Um and

	just by standing back and I had a better perspective, I think a much better perspective, rather than jumping straight in and I think that well yeah, that's what it was yeah.
R21	Yes, so by being calmer internally it means that you can sort of relate and communicate in a calmer way as well?
P21	Absolutely, absolutely. I mean you know, the children would never have known what I was going through, I mean I'm very good at hiding things. My partner Ranulph, whose home at weekends, he works in Brighton during the week, and he would know and I would say "oh my God". "Oh I know, I know", he would say and he is very good at sort of listening um, but yes it's the calmness I think, internally. You know, when I talk it's that sense of just everything is just overwhelming at times and it's just panic and my heart would race. Three years ago, I was actually finding I was sometimes breathless. Um and my head would spin sometimes. I was almost having panic attacks. Nothing like that this time, nothing.
R22	The physical side of the anxiety…(interrupted).
P22	Yes, the physical side has gone. You know there is that sense of you know, kind of that surge of panic coming up, but no panic, nothing this time. But it was just, over the six weeks there is more calm that's come in. But, you know is that just as a direct result of the counselling, or is it that things are happening with my son and you know, you know, and interviews and so on. I think it's both, but it's also just me standing back has I think has helped me and my son, so yup.
R23	**And was there anything that you felt was left unresolved in therapy?**
P23	Um, unresolved, *(pause)*, no I don't. I actually felt by the last session that it was enough. I actually almost felt do I need the last session? I think it probably was, it rounded everything up. But I felt it's done as much as it can, so no I don't think there was anything unresolved, but as I say it's a very specific anxiety, so I think six sessions were enough. I got out of it what I, what I needed and we will see. It's terribly difficult to know unless or until another incident happens and then I'll see how I react. Um because you know from September to now, we are talking sort of five months and my anxiety levels have gone down and up and down, but you know they were quite intense around September, October time um and then again when he has been at home, since sort of December, they have lessened as I have seen things happening. Um but that is in conjunction with the counselling, so it's very difficult to say if it's one thing or the other, or both or whatever. But I didn't feel we could go any further in the counselling.
R24	**And you touched on the fact that your expectations when you came in changed, but would you say your aims and expectations for therapy were achieved?**
P24	Um yes, I think they were. I mean, I think, I think there's, uh (sighs), I think I came in with slightly unrealistic expectations and I think people, you know, you talk to people, not that I talk to many, I mean about counselling, but when you talk to people they go "oh counselling really helps with anxiety" and so on and I said "oh that's great" and "whenever you get anxious or whatever, you'll be able to put all these strategies into place and the anxiety will go away" and I thought 'oh great', although logically I knew that wasn't going to happen. Um and the therapist made that very clear. You know, "how are you going to feel if it doesn't happen?", I think that was one of the things, or "how are you going to feel if your son doesn't get a girlfriend? Doesn't get married?" and so on and so forth you know. He said "this isn't going to make that go away", but you know. So, for me they were unrealistic expectations and I think when we looked and we put down what my expectations were of the counselling, you know in terms of lessening the anxiety, because he made it very clear that it's never going to go away, so it's me adjusting. It's like everything it is,

	if you can manage expectations from the outset then, you know, I wouldn't be disappointed and I wouldn't feel 'oh my God, you know, not only am I anxious, but you know counselling doesn't work either', you know. So, it was laying the groundwork very early on. Um and being very realistic in what to expect and what to accept and so I think from that side yeah, I mean you know, I can't even remember what the question was *(moves from speaking very fast to pausing and laughing*).
R25	Well, it's about whether expectations were achieved, but it sounds like you are saying that it's not so much a question of whether they were achieved, it's more that it was a constant managing of expectations?
P25	It is, that's right and even though you know it's, I think if you set those expectations, so you know as to what this will achieve from the outset, um and you revisit it, which was what was happening, you know. Are we anywhere near achieving this, how do you feel against what we have set as our goal at the beginning? Um I think then you know you can get more out of the therapy. Um and um but yes, I did feel that it achieved what we had agreed at the beginning. Um and um but yes, I did go in with unrealistic expectations.
R26	And the goal you mention, was there just one goal for the anxiety?
P26	No, no there were three. There was one which was lessening the anxiety, and and and dealing with, you know, with the anxiety and my feelings, you know, and and kind of just checking on my feelings. There was one which was standing back, there was one of acceptance. Acceptance of you know that life can sometimes be unfair on one child and more so than the others and if you know, all this list of things isn't going to happen to my son and accepting it doesn't mean that I have to get anxious about it every time. But it's just accepting that's how it is and dealing with that you know, and how I'm feeling about dealing with that. And so, we explored that as well you know, it's just more of an acceptance of things and I think that it's actually quite a good word for me. I think he picked up on that quite early on, that sometimes you can't make things better, you can't use your excel spreadsheet, you can't do this, you can't do that, that's just the way it is and you know, you can just support, you can just listen sometimes, but you can't always make things better. And and people have to just accept that, and that's actually a big thing for me. Um so those were the three things and I think just, you know, it's interesting how many times acceptance came up in our counselling, so um so yes, so those were the three.
R27	**So, one more question, what would you change about the therapy you received, if at all?**
P27	Um I mean timing. I think timing is everything in therapy. I mean obviously it's been very useful. When I really needed it the most, it wasn't available, um yeah, I mean, I know I laughed and said "I felt a bit of a fraud" in my time, I wasn't an emergency in comparison to some. And you know one of my reflections is that if someone is in a severe case of, in a highly anxious state, I think that it needs to come sooner rather than later and I know that's out of your hands, but I would say that's it, it's very much a timing issue. Because I think that personally, I would have been in the moment of my, in the height of my anxiety and he would have been able to see that affect and it's very difficult to replicate that when you're further down the line, if that makes sense. Um but that's very difficult, because that's out of a lot of people's hands. But other than that, would I have changed anything? Not really, um I don't think so you know. I think, we were in a very small room for part of the sessions and that was through no fault of (therapist's name removed), it just happened to be, we just had to move rooms, so it was again I just think in terms of atmosphere. I mean it was fine

	with him, it was absolutely fine, because I knew him by then, but it's kind of quite box like and very straight chairs. I think just having a little more thought as to where it happens, something that's a bit more comfortable, um again not that it stopped me from talking, but I just um you know, you kind of feel well, I don't know there needs to be more of, I don't know but I think it would have been nicer had it been in slightly nicer surroundings.
R28	This sort of room? *(signal to the room we were in)*
P28	This sort of room is fine. Actually, we ended up in quite a small room you know and it was literally, you know, the wall was here and the wall was there so quite a narrow room, so quite dark, it was inward looking you know. There were lots of boxes and files and a desk and very squashed and you know he did apologise for it and it's not of his doing at all, but I think for in terms of when you are going for counselling, I think it helps to have more air around, more light, you know. In terms of how it makes you feel and um, but I'm actually thinking about it not so much for me, but maybe for other people you know, so so um that's what I would say, but those are practical changes, you know.
R29	It's all important.
P29	I actually think it is very important, um and um but it's not as though it had an impact. Though it's just you know, when you come in and it's pouring with rain, and you come into a little space, um it could for some people, so it's just, it's an observation. But other than that, there isn't anything more I can add really.
R30	I'm just going to back to what you just mentioned before going on to the room. When you said if you had come a bit sooner, he could have actually seen your anxiety, how would that have impacted it?
P30	Because I, in terms of some of the questions, you know, um and how I was feeling you know. The constant worry, the feeling of 'oh God I'm not doing a good job'. Those feelings in terms of the questionnaire I had to fill in every week, those would have been different, so in terms of my heightened state of anxiety, um you know, um the way that I was feeling at the time. You know the way that I was you know the way that the anxiety was with me at all times was different to how I was when I was doing the counselling. So, you know it it it was far more part of everything I did during the day from the moment I woke up, to the moment I went to bed was just this constant worry and anxiety and by the time I came to counselling it wasn't like that. And that's when my anxiety is at its highest and you know, when it first starts and it it's like almost a panic, but this time it wasn't panic my son was in a different place, he has three years' experience, blah blah blah so in terms of work experience and so on so I was in a slightly different place, I was slightly calmer, but it was still eating up, eating me up and that was very different to how I was feeling around September time to when I came and saw (therapist's name removed) and that was no fault of his.
R31	So, if I am understanding correctly, if he had seen you in that state, he could have more accurately got a sense of your difficulties and anxieties?
P31	It's not that he didn't, because I had explained to him, but it might of actually, it would have actually helped me through that heightened state, um at that time which was when I really needed help. It's not that I don't need the help now, because it is very useful for the future, but that was when I was really at my worst. And it's at that point that I could have really done with it. Um as I say it's not that I haven't needed it, but it's, I suspect for him to have been really understanding of where my anxiety was and what it was doing to me personally. Because you know answering the questionnaires every week, again I would say "I feel a bit of a fraud, because some of these questions I would have answered differently a few weeks ago". Um you

	know, not many but some of them and I said "so I am in a different part of this journey", and um so I would have to go back and try and explain how I feel then and how I'm feeling now and so on. So, I think it would have had, it would have been different in that, it would have not necessarily been more useful, but I think it would have been slightly more comforting to me in that height of my anxiety if there was somebody who was listening to me and giving me, work with me to have some strategies in place and I could in the height of my anxieties put those into place and see how that's affecting me. Whereas yes now I have put some of those into place, but I'm in a better place myself, so putting those into place will they work totally when I'm in the next state of anxiety, if I'm ever there? So, that's my slight question, um because he never saw me when I really needed it the most. The doctor did um you know, but the doctor gives you nine minutes you know what I mean,
R32	So, you're working slightly retrospectively?
P32	I'm working slightly retrospectively, yes.
R33	And how long did you wait?
P33	Um I must have gone to the doctor; how long have I been taking these things, because I want to come off them.
R34	I think it's around September.
P34	Yes, I think it's around September. I did I'm pretty sure it's September, September, October that I would have been here, so it's actually not that long, but it's a few months. So, it's started the, the sessions started towards the beginning of January.
R35	Yes that's a few months.
P35	Yeah well middle of January, we ended last week, that was six weeks so yup so it was I think it was actually in total ten to twelve weeks that I waited. That's quite a long time.
R36	Yeah.
P36	I mean, listen in the overall scheme of things it's not that long, but it's a long time when you are anxious. Um and and um so that's why when I first saw (therapist's name removed), I said "I feel a bit of a fraud because actually I'm coming through it", but actually it will probably happen again so.
R37	It's the long wait yeah.
P37	So, it's the long wait.
R38	**Um so I have finished all of the questions so is there anything else you would like to add?**
P38	No, I don't think so we've discussed most things, I you know. It's um, I've been very fortunate you know and um and it's, I found it a very useful journey to go through as well. So that was good for me and um we will just see. You know, um as I say it's just that slight concern as to whether or not it will really work, but I have got to follow-up session, three months and then six months and that's quite good to have that continuity as well. Um and err, I'm ever positive and I'm sure you know, I shall accept it if it isn't, but I'm sure it will be better next time. I've no doubt, because you know things do get better as we move on and I have more of an understanding of it all so um, that's it no, thank you.
R39	Thank you. So just before we end, I was wondering how you have found this interview?
P39.	Yeah, it's been good to just reflect on everything and see what I have actually taken from it, where I am with it all, so yeah *(smiles and nods).*
	Continued to the debriefing and provided 'Debriefing Letter'

Appendix O: Sample of Follow-up Interview Transcript

This is the full transcript of the follow-up interview for the participant called Freddie. This has been anonymised to protect client confidentiality. I have highlight in bold, the questions that directly relate to the interview schedule.

R1	**So just to start, do you have any further thoughts on your experience of therapy that you would like to share?**
P1	Um yeah, I mean I was actually thinking in mini preparation for the session today whether it was about me or whether it was about the counselling or what it was?
R2	This particular interview you mean?
P2	Yeah, because the question you just asked is, I'm thinking, actually there are a number of things which you would probably say to me is (therapist's name removed) area. Or is it just about me, or how I'm feeling? Or?
R3	It's your experience of the therapy, so anything related to that, that you would like to speak about. It's more researched-based, compared to the follow-up with (therapist's name removed), but it all intertwines, so whatever feels important to you and I guess it's more thoughts on things you have previously said about it, or anything that you wanted to add.
P3	Yeah, yeah, I mean I think that er, I haven't really thought about it in detail. I mean obviously the, going back to the initial reason for the therapy was fundamentally, the priority was to deal with my wife's illness and the way that I felt that I wasn't really dealing with it very well. When I mentioned that to her today, she said "well I think you are actually dealing with it a lot better". So, in that case from an overview was it successful? From that point of view, it probably would be, I think that what was problematic for me was that the therapy was really about that and the focus was taken away because my family member passed away, so I kind of felt ambivalent I think about how successful the therapy was. I mean I felt, I think I mentioned before, you know, in retrospect that I felt that I had got to a point where I felt I had developed a good understanding, or let's say a good counsellor-client relationship between me and (therapist's name removed) and then it just finished. So, it kind of, from that point of view it kind of felt too short for what I, for what I needed actually.
R4	And how do you feel about it now in terms of the length?
P4	I still feel it was too short, um yeah, I mean certainly, you know, the last, since the beginning of the year it has been very difficult, very busy at work, not difficult busy and you know the reason I couldn't come to the session last week was not because of work, fortunately I don't have to do much manual work, it's getting the work in at the moment, chasing deadlines, which is not easy, you know. If there's a deadline it's kind of think a week afterwards, you know, so it was just that, there was a lot of stuff you know collecting things. So, it was only now in this holiday and actually I played for a concert. I've been away from music, I cut down my work and so it was interesting going back to play over the break. There were 5 concerts I needed to play for and the first one I just thought about my (deceased family member). And and I hadn't thought about him since er last year, and so, it was just that quiet space thinking about him and so on and then I think today actually. I was just thinking well how are things and I think that I do need to have more therapy and either it's through this mechanism or I have already spoken to a friend of mine who is a therapist and certainly he, if I needed to go privately or whatever then that's what I need to do. So, I think in short, it's probably the intensity of my problems need a longer time.
R5	Hmmm *(nod).*

P5	And I think also that the longer time would probably take less stress off, cos I did actually feel, and I commented before, that I felt that although the sessions were focused and the therapist was very good at focusing the sessions, that actually the kind of things that I am having to cope with are too big for a short session like that.
R6	Yes, I remember you saying.
P6	Yeah and I will tell you something else actually which is quite nice that happened is that um I applied for an extension to my MBA submission and for a long-term one and I actually got it! (*smiles and sounds surprised and pleased)*. I only found that out about five weeks ago and that has been a hugely, and you can imagine, and I mean you know it was like for a few years I did nothing and then I applied for this um and so having stripped back, you know, my fundamentally my four jobs- my full time job at (work place name removed), my extra job and my concert job and I've taken effectively seven months off the extra ones, so I've only been doing my full time job and that's actually been really (*accentuates really*) helpful, because that has shown me how busy I was before and how easy it was for me to hide behind my work.
R7	Hmmm *(nod).*
P7	Which I know how to do quite well, but then you know, the need for therapy is still there, I know that. I mean I don't find my wife's illness any easier to deal with, in fact it's just getting worse and the effect that it has on me is, you know, it's all-encompassing, it just eats away at me. And it's so er, I just feel scared about the future I suppose, because I don't really have any mechanisms to lock into. I've got the solace of religion, I've got the support of a lot of people and so on which is good, but it still doesn't subtract from the fact that it eats away at the core of everything I am as a person.
R8	So, on the one hand, your wife is saying that you've made positive changes in how you have interacted with her, but for yourself you are still being eaten away?
P8	I said to her, (*laughs*) my response to her was, it was something glib like what I had given up. Her complaint to me was "you were very judgemental before; you were expecting too much from me or that you were critical and stuff and you seem to forget from time to time that I have an illness" and so on and now I know that in a way the best way to deal with it is to shut up and say nothing. Which doesn't really help either, you know. I mean a case in point is like last night, yesterday, um I arranged to meet er the conductor of the concert I play at, which I have taken a sabbatical from, because they want to know if I am coming back, and um so I went to meet him. A nice place in town actually, the Golden Square, I don't know if you know it? It's near Soho you know, a new place there?
R9	Oh, I think I have seen it, I didn't know what it was called.
P9	A nice place yeah and it's near the garden thing and it's actually really nice and so on. And um it was great, I mean there I was and it was actually nice meeting up with someone and having what I would describe as a normal interactive conversation, which is good. He then went, because he had to leave about an hour later, and I called another friend of mine who I hadn't seen for a while and we met at this place and we had a whole long chat and so on and I felt, I just thought to myself, 'you know okay that's what I'm missing', because you know along with my wife's illness and kind of her psychological aspects, mental, you know she would sit for ages and not say anything which drives me dilly, because I actually like to talk *(smiles).*
R10	Hmmm *(tilt head to the side to indicate that I am listening closely).*
P10	And um, but I cope with it because I do and I also feel frustrated, because I can't fix anything, I can't do anything. So, it's a double bind and I'm sure that it's what people

	who have partners with illnesses have to go through. So, the useful thing about last night was I connected with what it is that I actually need, which is interaction with other people. Where I don't have to sit there with someone who is just and recently her um movement, has kind of deteriorated, it's got worse, so she is always moving and it makes me, I've said to her it makes me feel seasick.
R11	I remember you saying with the TV…
P11	Yeah with the TV, but now you know we went to, we were celebrating recently and we went to, we met friends and we went to a comedy and so on and she went up to the bar to get drinks and stuff and it's terrible, because on the one hand I do I feel terrible because I can't fix it. And I can't do anything, I can't, it's almost like being locked in a space, I can't do anything and I just watch this deterioration and become completely unhelpful to do anything about it. And it eats away at my very core, because I was, I will get back. Last night actually I got back and my wife had been to an art gallery with our grandson and she picked me up from the drinks and we got home and the conversation went, was about how she was feeling, how her medication was and all this stuff and I went from this state of 'gosh I am now reconnecting with myself' and had gone home, straight back into hospital mode, right, because that's what it is like. And in addition, you know as part of the MBA extension application, I had to map out how I was going to complete it over the following year, what was I going to do with this extra year and I had to draw up, I had to take stock of where it actually was. So, I did that so I did that about 6 weeks ago before applying for the extension and I had a meeting with my supervisor and all was good and so on, but it all hinges on me actually having the space and the time to do it. So, my MBA time is next week. This week is you know family time or today, *(blows out/sort of laughs)* you say the weather, I was out for a little bit, but I have got some tax stuff I have to deal with. So, there I am, so I was rushing through my figures and stuff before I came up here, but so um yeah. I don't know if that, I don't know if that helps, but that that's where I'm at. It's just that messy, because I know, I know I have to be ready for anything like um five nights ago, um I can't remember but it was, yup no I got back from one of the concerts, yes that's right, and they're full on because there are three per day, there's one late at night, and there's one that I have to start preparing for at 5am in the morning, and so I get through all of those and then my wife says to me "I can't, I can't take this anymore, I don't see the point of going on" and immediately I am having to jump into positive mode and "of course you've got to keep going, you're going to be fine, and this is a passing phase and things, these symptoms will go for a little bit" and all that kind of thing. But it's like (wife's name removed) never complains, that's an amazing part of her character, so when she does it's really serious. So, I said to her "when is your next appointment at Chelsea and Westminster?" and it's months away and I'm thinking *(blows out and pauses*) 'that's me, I'm the carer'. I have to part with all that other stuff that I have to deal with, I have then got to be the strong person who on one hand shows, no, I can't allow myself to get into that thing of feeling horrible on her behalf or going "oh this is terrible". I can't really empathise, it's hard to explain and what it does I think is it eats away at me, because actually all of this will only get worse, that's the tragedy of it. You know and at the same time I can't really, you know there are just a number of times when I think to myself, the truth is I don't want to be here anymore, I don't actually want to subscribe to this. And that's awful, because then I scold myself for thinking that. But one thing that did come through the sessions, now that I'm thinking of that and talking about it is that (therapist's

	name removed) said "it is fine, it is fine to acknowledge that you have these feelings" and of course it's counter-productive not to acknowledge them.
R12	**Yes, that was something that later on I was going to pick up on, because you mentioned (*reading from transcript*) "I was beginning to allow myself to feel what I had previously been trying to shut out. It was alright to feel angry or feel annoyed or to feel actually" and so that was something that I was going to see how you are with that now?**
P12	Er, well when (wife's name removed) said to me today "now I think you are coping with things a lot better", all I thought to myself was 'you really just don't know me very well actually'. Either that or I'm just covering up what I really think. She has changed a lot and continues to change, so it's like living with a chameleon, because I never know how she is going to be. I never know whether she listens really to anything I say or hears it really, I don't know. So, the only way that I can er, the only way that I can really deal with it, is actually to shut it down. Because there is no point in saying anything, there's no point. I actually, well sometimes I think um, when I was in the car with her the other day and she was driving and I thought 'jeepers you shouldn't be driving, you shouldn't be driving'. You know, but whereas I might have said that before, I just think, I rehearse everything in my head and think if I say this then that's going to happen and that's going to happen, so actually there's no point in saying anything. Even if I know that actually from a safety point of view she should not be driving, it's true you know. Er and the risk is that if something happens, then what happens. So, I don't know, you know, do I say something you know. It really just goes back to the thing that I, I don't think that I am really dealing with it very well.
R13	Hmmm. So even if you have thought that it's okay to have these feelings, the expressing it isn't necessarily there? You don't necessarily say it to her?
P13	No yeah, I don't, I mean her world is pretty much it is her condition. You know and my world is my full-time job and her condition and my MBA and my various other bits of jobs and so on and you know sometimes I can deal with it and sometimes I can't, I don't know. All I know is that on, if I think of myself as who I actually am, I reconnected with myself last night when I was talking with my friends, with my colleague and my friend and colleague (name removed) you know. It was just good, it was just nice, you know. It was not my clients, it was not my other colleagues, it wasn't any, it was just my good old friends talking about stuff that I know about, you know like music and this and that and it was just a nice good one-to-one flow of conversation and then going back into this, this realm of silence and you know strategies and this and that and also this is a holiday week you know and I think to myself um it's not, because I know when I get back tonight it will be, once again it will be either no conversation at all and I've become very used to it, I'm used to it. I will try and promote conversation or get it going or whatever and invariably it will either just default to her conversations about the medications and the symptoms and all these kinds of things and it's tiring and then it will probably, and then it will end up that we will watch TV. So, we will watch TV and then the body movements are going and so I suppose in a way I just get more angry with the situation, but have no, I have nothing to do, I can't do anything with it, you know, and then you know she needs to get a good night sleep, so she is off to sleep anyway at about 7 o'clock. I'm a late bird so I am always up till 1am or whatever and it's like when she goes to sleep then I am really on my own. It's like I am on my own with her and I'm on my own when I'm not with her. Though one feels normal and the other one doesn't. It's

	terrible, sorry I hate painting such a horrible, you know it sounds, you know, it sounds tragic, but it's not tragic it's more like that's really where I am at you know.
R14	Yes.
P14	That's why I say that in a way what, going back to the focus of the therapy, for your research and stuff, the therapy that I had with (therapist's name removed) was I would say marginally helpful, marginally. But of course, nobody could have anticipated that my family member would pass in January, literally smack bang in the middle of the sessions and we had already done the setting up of the priorities and the hierarchy of what to deal with and all this and then suddenly it was just like bang and then everything just changes, because I then had to shut out everything. The complete priority was dealing with the funeral and arrangements and all this sort of stuff, you know.
R15	**Hmmm (*pause*), so yeah that leads me to some of the questions that I asked before of 'would you say your aims of therapy were achieved?'**
P15	Yeah yeah *(nods and long pause).*
R16	**And how has life changed, if at all, since you had the therapy? I suppose we have largely covered that, that the situation is still there, but are there any other changes elsewhere or…**
P16	Er no. Yeah I know, I think that my plan, the sabbatical from both the what I call my supplementary or my extra jobs was exactly the right thing to do. In fact, when I started, I will never forget, it was you know, that was the first Saturday that I obviously had free for eight years, free, so you know. So, it's a kind of a weird thing, because there are a couple of concerts on a Saturday and the fact that the morning concert, I'm there from 9 o'clock warming up and so on. Then I'm home by 1 o'clock, so that including travel, that's you know, that's four hours in the morning. Then the afternoon, it's not that I can go into my MBA mode, because I know in the back of my mind that at 6 o'clock I've got to stop everything and go and play for another concert. Which is just a few hours and it might just be a one hour thing, but with the travelling once again it's already a few hours. So, it's already some hours in the day and I'm too, some people say to me "well if you organise your time that's fine, get back and have lunch and then in the afternoon you would work on your MBA". No, I can't do that. Whereas if I know that I have the day clear, then I would get up at 7am and I would be working at 8am and I don't have, it's important that I don't have the stress at the other end of the day. I have got this whole day to pursue my own project at my own pacing and there is nothing else that gets in the way. So, colonising that day was the best thing that I ever did. What is problematic is that the sabbatical was before I knew that I had the extension. So, it's kind of bonkers now, because had I known that the extension was possible, I wouldn't have taken the sabbatical this year, but I had to put things in place, because other people had to be arranged to cover and all this and now I'm not in the position to take a two year sabbatical, you know so it pretty much you come back in April or we get someone else. Which is understandable so yeah.
R17	So, you've taken a bit more time for yourself then I suppose to focus as much as you can on your…(interrupted).
P17	Yeah, yeah and I kind of think that yeah because I certainly, as things have changed, yeah that freedom knowing that the Friday um is my one rest day. So, I allow myself not to do anything on Friday at all and then that in turn that one day off is enough to separate from my weekly job, to go into my project thinking mode and that's great. And then just having done that on pretty much all the Saturdays this year, you know, I've done a lot of really good work. And even though it's just been once a week, it's

	been good work, quality work so. Yeah so, I, I, I think that's important, but there's also, you know I mean I turned 65 about two weeks ago and that's another thing that changed and that's quite funny, because firstly I don't feel 65, I can't relate to 65. And even with all the stuff that's going on in my life, I still maintain I suppose a sort of youthful outlook on things and of course working at concerts with younger people, you can't fail not to be in that zone *(laughs).* But um also, having reached that age there's another kind of liberating aspect to it, where I don't really care. I know that sounds funny, but I don't, there are certain aspects that used to be er a worry, or a concern for me, but now they aren't anymore. Just aspects of things that I wanted to do or things I wanted to achieve or whatever. I'm happy with what I have achieved, I'm happy with my lot, you know. With the exception of all this other stuff.
R18	**And was there anything you would say was left unresolved from therapy. Obviously, it sounds like the continuing support in terms of (wife's name removed), but do you feel like there is anything else in particular?**
P18	No, no I mean I think what we did do, what I did achieve with (therapist's name removed) was mapping out. There was enough in the preambles, the early introductory sessions, to work out a plan, an overview. So even if we didn't kind of dig down into all those areas, there is still that which is clear for me. So, yeah, no the problems remain the same.
R19	Yeah.
P19	And probably if I think about it, the dealing with my family member's passing and dealing with (wife's name removed) stuff you know, there was a spin off I think from the sessions, for the last few months there was definitely. And I still go back to that it was marginally helpful. Only marginal, because it kind of felt, I think what was frustrating about it, it sort of felt there were aspects or strands which were just kind of coming together. And a lot of that was probably facilitated by the trust, which I think I spoke of before. I only just felt that that all-important trust between me and (therapist's name removed), I think that was from both sides too. I think that there was a kind of er, I suppose in any sort of early stages of forming some kind of understanding between two people, it takes a while and I just felt like we had just got to that point, when you know er things could have worked and it just felt like well yeah. Obviously, I'm repeating myself here, it just wasn't, it wasn't long enough.
R20	No.
P20	But I suppose the um, I forget sometimes um cos I think there is enough there for me to be really gloomy about my life for sure. You know and I can think back to when I went back through my um bipolar episode when I was really low and thank god none of that's happened. There's been no, I don't feel, I don't have dark thoughts, I don't feel suicidal or anything like that, but what I do know and what's strange is that with the amount of things going on I'm surprised that I haven't actually cracked up.
R21	*(Nod and pause).* I think you said exactly that last time.
P21	Yeah no and so what was funny and you would appreciate, because of university regulations and so on, I got caught in that strange scenario where I started talking about applying for an extension during my research period, cos I'm in the writing up period and I got to a certain point with the Director who then went on a sabbatical. So, then his replacement came in and although he knew me from before, because he was at the beginning of the process, he didn't really know how far we had got and she hadn't written up sufficient notes. So, when I spoke to him and I was actually

	fully resolved that I went "I have to have an extension. I cannot at this stage guarantee that I will complete this by September". And he says to me "well we will do the best and of course you will get all my support, so fine but um I would say to you that you will not get a year's extension, nobody's going to do that, six months is as much as you will get". And he said "even then it's debateable, it depends on whether the circumstances warrant it and it has to be really serious". So, when I sent the application off and the various bits of evidence, then I thought 'okay so we have got my family member's death certificate for the evidence. We have got the legal paper signing me as the curator persona for both my parents who are in dementia, and there's a medical report where they are both at and there's um my wife's diagnosis with a write up from one of the recent sessions and so on'. And I remember sending those and thinking 'well what more do they want? A little capsule of my blood or something, you know?' *(laughs)*
R22	It's an overwhelming amount of difficulties *(nod).*
P22	Do you know? And when I looked at this I thought, yeah that is a lot.
R23	Yep.
P23	So, I suppose what does worry me is that because I did have the bipolar experience and what I learnt from that was you know, the self-monitoring that one needs to go through, to watch out for you know. I am aware that, you know, that I'm in remission and have been for um 20 years or more. There is no reason why that should spark up again, but there is always that worry, 'could that happen?' And in addition, would I know if it did you know? And that's always the worry, ever since the bipolar when people said to me you know, "we didn't recognise you, we didn't know half of what you were talking about, it didn't make sense" all this kind of thing and I remember at the time replaying all of that stuff in my head and going "Really? It made perfect sense to me". You know and I have never been able to resolve that, the fear of that I suppose. That thing of 'wow, you can go loopy and you don't know you are'.
R24	Yes.
P24	That lack of personal insight and I think that er, I think actually the reason why I was looking for therapy again was because, I didn't think at the time, it didn't feel like I was going bipolar again, but I knew that I needed help to help me through. And I think that it's also that. I think that probably the as I say, the therapy that I had helped to a point and it probably might have been sufficient if I didn't have that potential, if that makes any sense?
R25	That does make a lot of sense.
P25	Yeah?
R26	Yep it's sort of the fear that you have got so much going on and at what point…(interrupted).
P26	Yeah absolutely um hmmm.
R27	**And so just last question from the previous interview is, what would you change about the therapy you received, if anything *(pause).* Anything to add from last time?**
P27	Oh yeah, did I say about the iPad? *(smiles)*
R28	(*smile*). Yes, you did say about the iPad *(laughs).*
P28	Go and change the colour at least, make them green or something or other *(laughs).*
R29	So that's the main thing, other than the forms and maybe the length I guess.
P29	Yeah, I think, I mean I don't know if I explained fully, but now from a distance looking back again, I did feel also that (*sighs*), in the same way that I have to learn as a manager, that the team will have different ways of learning about things, so I

	have to take into account the individual needs of each person and be aware that some people are you know tactile learners, some people are visual, some people say to me you know. I find it very difficult, because I don't use PowerPoints, that's my thing. Everybody uses them, I don't like to use them and I don't actually need to use them in my line of work, but people do say to me "it would really help, it helps me to focus in if you just have something up there that I can see". So that's completely different from then another person who is sitting so high up above all her colleagues, her peers. This is a person who has extreme talent and her needs are completely different to the other members of the team. So, going back to that, I just felt that I would have wanted, I actually needed to feel more like an individual rather than like a person who just pressed tick boxes and I hope that it wasn't the fear of technology. I'm not a lover of that, but I'm quite comfortable to use iPads and computers and so on. It's more like um, I would have preferred for there to have been a more instinctive, you know working with me (*emphasises 'me'*), rather than an awkward bit at the beginning of the session, where there's no eye contact between us. It's a little bit like, that same talented colleague, she said to me, she said "I am writing a piece at the moment which is dedicated to the lack of communication between people, particularly on the London underground" and I went wow, this is a young woman making this comment. And I said well "what, tell me more about it" and she says "well I know everybody uses phones and all this sort of stuff, but there I was sitting in the tube carriage the other day and looking around at all these people and nobody was talking to each other. Even friends are sitting next to each other and all they do is look at these screens" and I thought gosh this is now a new wave, I think, of people kind of going that way. So that's I I, yeah, I felt it was awkward, because also then you think, well intellectually I can understand why it needs to be done, and I also understand why (therapist's name removed) had to prioritise things in the way he did. I understand there is a system there and that time is short, but then that also made me panic, because I knew, I knew exactly when he was looking at the clock and the just being able to catch that glance means that it's a detraction from, it detracts from the trust of being you know involved in the sessions so. Yeah.
R30	Detracting from the trust, can you tell me how?
P30	Well yeah, I mean it's a little bit like, I kind of feel it's a little bit like the, what you get at parties, you know. You get those people when your hanging, your chilling, you've got a drink and your introduced to someone and then that person decides when they are done right, and so they are looking around for someone else they can go and talk to and you are aware. You can see, you know that and so I think what it is um, if you're aware that someone is looking at the time, then you're aware that they have actually not heard what you have said even marginally, even though it's very short. You know, it's like I'm listening then I'm thinking right I'm looking there and of course you can't fully, so I think it's that thing of er, I suppose when I used to teach the drums regularly, I had various time lengths that I would teach. I would be giving 20-minute lessons, or 45-minute lessons or 60-minute lessons and I could deliver all those lessons without consulting my watch or clock. I knew how long they were. Not because I did exactly the same thing, but I just knew. I'm not saying everybody has that capacity or wants to work that way, but does that explain?
R31	**Yes, it does and it's actually something that I was going into with the more specific questions about the relationship, because I noticed that you said "a lot of it is in the eye contact" (*reading from transcript*), so I guess that's probably, is there anything more to add to that?**

P31	Yeah, I know, I suppose my, as an overall feeling about the therapy, you know when I was thinking about it earlier today, I just felt that it was that, um formula thing. There was a formula, there was a formula attached, I was aware that I was part of a formula. Um.
R32	Hmmm. Is that just connected to forms or the whole therapy?
P32	No, no, no, you know I'm aware obviously there are systems and everybody uses them for how to run a session, for techniques for yeah, but I think it was that. I think the form, the form even, even filling in the form by hand, me actually writing it down, but then being aware that that information was being, that it went off somewhere. Which I didn't have a problem with, but there is something outside the room that is involved in making calculations about me. And that's a weird thing actually. I don't know, that's just me really.
R33	Um hmmm. And do you think that did impact the rest of the therapy the initial forms and feeling like you are part of the formula?
P33	I was aware before I came to the second session, because I thought the forms and stuff were for the first session, but when I realised that it looked like it was going to be every session, I kind of resisted it, I didn't like it, I have to say. It's a little bit like going to the dentist and you've got a hole there and you've got to have a filling. Okay you'll go anyway, because you need to have the filling done and then I also thought when I calculated from a time point of view that if you subtract that form filling then you kind of feel you're in a way being a little bit short changed. Not that, I'm paying for it but.
R34	No, I see.
P34	But yeah, I think it's really that thing of I suppose my take on it is that counselling is much er, or therapy is as much as science as it is intuitive.
R35	Can you say more about that?
P35	Yeah, I think that the science is within the applying the er the um theory and the understanding which I do feel and I think I said last time I think (therapist's name removed) is very good. Often times I went away thinking 'wow his summations were champion'. You know, cos he and I think it was in those that the trust over the weeks, those actually counteracted my feelings of negativity from the form filling. That was enough, because he is really good at that and I still, um I remember that from before and I wouldn't change that, he was absolutely spot on and that's why I also said to him you know, I asked him, I said "you know if you took on clients after, can I see you?" so yeah and I wouldn't have asked if I hadn't felt that he was good um.
R36	And the intuition side part of therapy?
P36	Yeah and I think, I think the intuition part is err *(sighs).* I can't really explain; I don't know actually what I mean. It's probably that, in my job, part of my job, so because I run this team and I am responsible for 50 colleagues, I have to liaise with them, and other teams and managers and I have to use intuitive judgement sometimes. This is not based on any theory and often times I am right and it's normally about, it's normally about working out 'what is the back story here?' I mean working out with what this colleague is presenting, if there is a particular problem and I meet or discuss the issue with them. I discuss it with another member of staff and so on and then I make an intuitive assessment about what I think and normally I am right and that comes from no place other than a combination I suppose of, um um empathy and I suppose a logical process of you know committed to, you know it's nothing more than coming up with a reason why normally, why the individual is not actually achieving to their best. And often at times it would be something like, you know "I

	think that your skills are better suited to this, or is it the dynamics of the team or mental health. I think it's, I don't know, I'm not qualified to diagnose it or suggest, but have you considered anxiety?" And normally they haven't and this, because there has been a stigma attached to it. When they are eventually encouraged to address it, then it's of no surprise to me to find out that they are in fact not reaching their full potential for these other factors. So, it helps, but that would not come from any, there are no forms that I can fill in to get to that place. It's about, it's making the judgements from what I see and the interaction and observing that person very very carefully and then putting it into context with how others are impacting what they are doing and that's what I mean, by intuition yeah.
R37	**That's a good example and it sort of leads me onto because you mentioned you know "what therapy works for you and what kind of therapist works for you or doesn't" (*reading from transcript)* and I was wondering if you could expand on that a little bit?**
P37	*(Heavy sigh) u*m *(heavy sigh),* I'm just thinking back, my er *(pause)* let me think.
R38	We can always come back to…(interrupted).
P38	No, no it's a really interesting question. I mean, I've you know, when I was, I think I was just a teenager, that was the first time I think I had therapy and that was a er it was via a psychiatrist, who I think he was pretty old school and he, I just remember he looked like Sigmund Freud it was quite funny, but he was er, he was er, yup he was a psychiatrist. He was offering support as I had, I was going through some sort of anxiety and that was the first time that I was put on tranquillisers and so on and then um my dad actually intervened, he came, he pushed himself to come to one of the sessions and when it got to the point where it seemed to be, part of the discussion was not blaming, but it was, there were problems being traced back to my parents and so my dad pulled me out of there, just stopped everything. He said, "I'm paying for this, you're not going there, it's got nothing to do with me or your mum end of". But then obviously there were still problems so then I went to another guy who was a, he was based in Behavioural, I don't know. But it was different, he was a, he was not a psychiatrist, he was a er consultant, he could prescribe, but he wasn't a psychiatrist and he wasn't a doctor um *(long pause).* Yup I mean there's too many actually, I then even went to the er what the institute in North London?
R39	Er St John's Wood. It's not the Tavistock is it?
P39	Yeah yeah, is it? Yeah, it's rooted in, it's not Freudian, it's Jung, Jungian doctors. It was psychoanalysis actually.
R40	Yes.
P40	Yeah yeah I think that was it and I went, I found that was quite useful, that was quite helpful in a weird way, because if I didn't say anything, he didn't say anything. It was all that and that was interesting. And then I did try CBT,I don't know, um but I would go as far as to say that in all, and I suppose because *(laughs)* I have had my fair share of therapy and I think that certainly, um er I felt that the way (therapist's name removed) reading of me was actually spot on in ways that others were not. Or I think there was another thing that I felt too, is that if I feel, *(laughs)* this is terrible to say, I mean the easiest way to say is, if I feel that my therapist, I need for my therapist to be brighter than me.
R41	Yes, I was going to pick up on that as well *(nod).*
P41	Yup, yup, yup and I mean it's just a terrible thing to say, but I have to be in a position where I really believe that that person knows, they know what they are talking about and that's nothing to do with other than. It's only that the surgery here did arrange for therapy for me a number of years ago. I can't remember whether it was, yeah it

	was after the bipolar thing. I was already off of antipsychotics and the rest of it and I came for some therapy and I just really found the comments the therapist, I just really found, I didn't have it in my heart to actually say "I think, I don't, I think you're wrong", and I didn't get anything out of that and mainly because I just didn't feel there was a meeting of the minds really.
R42	Well that's interesting *(smile and pause)*. Well we are going to have to end there unfortunately. Thank you so much. Do you have any final comments before we end?
P42	No thank you, what is the time actually?
	Continued to the debriefing and provided 'Debriefing Letter'

Appendix P: IPA Analysis Sample Extract

This extract is taken from the middle of the initial interview with the participant called Cyrpian. This has been anonymised to protect client confidentiality and anonymity.

Emergent Themes	**Who**	**Verbatim**	**Descriptive, *linguistic* and <u>interpretative</u> comments**
	R23	Can you give an example of these doors that were opened?	
New awareness that put others' needs before his own New insight that neglecting self (needs & feelings) is problematic	P23	Yeah, one of the main doors that got opened up was the fact that I don't ever think about me. I didn't think about me when it all happened and for twenty-three years I haven't really ever felt or thought about me. It was always about making sure that (child's name removed) and my ex-wife was taken care of, that they were happy, they were looked after and whatever their needs were, I did my best to make it happen for them. And, in a nutshell I neglected myself. Which, on reflection, was not a good idea.	An example of a 'door' that got opened (area of awareness that was illuminated) is how he doesn't think about himself and has always focused on caring for others and meeting their needs, at the cost of neglecting his own needs, which he realises is a problematic way of being. <u>New awareness developed into his role in relationships and how this way of being has contributed to his current difficulties and may be serving to perpetuate them. By focusing on the needs of others, he has not had space to grieve his loss and attend to his feelings.</u> <u>New awareness into the importance of self-care; considering and attending to his own needs and not just the needs of others. New awareness into the possibility of living for himself and not just for others.</u>
	CK24	Can you tell me more about that?	
New awareness that paying attention to feelings important Realisation that hiding & denying feelings is harmful Hiding feelings linked to comfort eating Awareness of how deliberately hiding feelings from others	P24	Um, it's sort of dawned on me from the conversations that I had with this lady, that it would have been more beneficial to me back then to be more aware of my feelings, of what I was going through, rather than hiding it, because I probably would have then not, and I'm not saying I wouldn't, but I probably would not have resorted to comfort eating to the extent that I have done. Um, I put on an Oscar performance, because no one ever really knew that I had any problems or any feelings of being burnt up and eaten away inside, because I put this persona, this happy persona on. It wasn't anybody else's problem, but my problem. So, I wasn't ever sad or unhappy in front of my ex-wife or in front of (child's name removed). I always tried to make them both happy and in front of family and friends, you know, I put on an act that you know it's okay.	Through conversations with the therapist, he has realised that at the time of his loss, being more aware of his feelings, expressing and not suppressing or hiding them, would have been a beneficial option. Instead, he took a route in which he suppressed and hid his feelings from others, relying on comfort eating to maintain this pretence and deal with his emotions alone. He has pretended to others that he is happy and managing, whilst hiding a feeling of depletion and pain inside. *Speech is slowed and very reflective.* *Uses the phrase "Oscar performance" to describe his ability to hide his true feelings of pain from others, appearing happy and well. This phrase signifies a highly successful performance/act.* <u>He describes how through therapy he became more aware of how he has been living in bad faith - role-playing and pretending with others, in order to meet their imagined expectations/wants (for him to be happy and managing). However, this pretence has resulted in a stark divide between his inner and outer experiences.</u>
	R25	So, you carried a lot all to yourself?	

Awareness of position of taking responsibility for others Living for others New insight that neglecting self (needs & feelings) is problematic	P25	Totally, and during all that period people were always coming to me for help or "when in trouble go and see Cyprian, he will know what the answer is, he will tell you what to do. He will sort it out for you, he will deal with it, he will get it done" and that is exactly what I was doing. I wasn't actually doing anything to help me.	He realised how he had been neglecting himself, whilst continuously caring for others and taking on others' problems and responsibilities. *Speech in monotonous cycles of intonation with "he will' emphasised and representing the start of each cycle and request put upon him. This appeared to reflect the relentlessness of people seeking advice and help from him. There was a clear element of exhaustion in his monotonous tone and recognition of the pattern of relating he had been involved in.* He became aware of his position in life - how he had been living for others, pleasing people, taking on others responsibilities and problems, caring for others, whilst neglecting his own feelings and responsibility for self-care.
	R26	And when you say what you were doing, how has this understanding impacted your life now? The understanding that you don't help you?	
Practical change – Making time for me Practical change – Self-care activities Change in perspective – Consider own needs and wants	P26	I've decided now to make time for me, um I've made it like going forward, each month I'm going to do something that's actually for me. Which could be anything, from something very small, like maybe buying a jumper or something, to going away for the weekend or whatever. It's a case of once a month it has to be something that's dedicated to being beneficial to me. Um. It's very new. I've only just started it, it's very very new, because it's not something that I normally do. See I check to make sure, you know, has (child's name removed) got everything that she needs. I check to make sure has (ex-wife name removed) got everything that she needs, and you know I would give them money, financially etc to make sure that that was the case and then if there was anything leftover, I might then do something, so.	The participant relays the changes that he is making, in relation to his new insight that in living for others, he has neglected self-care. He has decided to make time for himself and each month will do something that is beneficial to him, rather than only thinking of his family's needs and wants. He emphasises how new and unfamiliar this change is. *Repeats "very" and "new" to potentially emphasise how new this change of doing beneficial things for himself is.* Significant behavioural changes to his current way of being- consider and live for himself more. He seems to be re-engaging with his sense of identity, feelings and what authentic existence might mean.
	R27	You would always be last?	
Self-reflection upon own needs important Acceptance of own feelings & needs Move towards self-care	P27	Oh, without question. I'd be last even in the sense that friends and family would even be helped in front of me and um like I say, the light bulb has come on and I've realised and appreciated now that I deserve to be having things done for myself, by myself and that I need to be more reflective on that as well, so I've changed and done that.	He would help friends and family before helping himself. From therapy he has gained awareness into this tendency and realised that the cost of this way of being is that he has seriously neglected himself. He now appreciates that he also deserves to have his needs attended to, by himself. He feels he needs to be more reflective about the consideration of his needs and so has made the relevant changes to implement this stance of incorporating self-care. *Emphasis on "for myself, by myself" – could be representative of him taking up his position as an 'I', separate to others? Although*

Taking responsibility for change			*perhaps it also seems to emanate a sense of aloneness in his emotional world?* Taking responsibility for self-care, the importance of reflecting upon his needs and making changes within his difficulties.
	R28	That sounds really huge.	
New awareness into blindspots	P28	It is, that's a huge change, that has been a very huge change and again that was a door that got opened up that I was unaware of.	The consideration of, as well as the attendance to his own needs, has been a huge change and this was an area that he had not realised needed addressing until attending therapy where a light was shone upon it and he was able to see how it was contributing to his current difficulties. *Repeats that it has been a "huge change" to signify the importance of gaining this awareness or perhaps the contrast to how he was previously living?* Outcome of EE –new awareness into the importance of self-care; considering and attending to one's feelings and needs. Outcome of EE – the implementation of a new way of being; practical changes to attend to own needs. The importance of gaining awareness into blindspots in worldview.
	R29	And what…(interrupted).	
Therapist as facilitator of self-awareness	P29	But I realised afterwards, once it was sort of shown to me.	The client gained awareness into how his current position in relation to others was problematic in some ways, once it was shown to him in therapy. An outcome of EE seems to be the development of new awareness, by shining a light upon blindspots in an individual's worldview and way of relating to self and others. The importance of the therapist facilitating new awareness to be reached.
	R30	Hmmm yes, *(pause)* and what does it feel like to actually have that time for yourself, I know it's early days but?	Should have explored how it was "shown" to illuminate therapeutic process, but I was wanting to get a fuller understanding of the impact of this change.
Awareness that coping strategy for managing feelings was harmful Change in approach to feelings – self-care over self-harm	P30	Well I suppose what I'm realising now is, it's all well and good always helping others, but you know at the end of the day, I helped myself by stuffing myself with food, which was totally wrong. So, if I'm going to help myself now, I'm prioritising on doing things that are more beneficial, rather than harmful, so I resorted to comfort eating beforehand because it was an easy fix and it was something you really didn't even have to think about. And I did all that when (child's name removed) and (ex-wife's name removed) were asleep. So again, I did it within the privacy of myself as well, when everyone wasn't there, I was all on my own again. So now it's a case of doing	The client realised that it is fine to help others, but not if he does not help himself as well. He had been managing his own feelings with food and realised that this is harmful and something he wants to change. Instead, he is going to help himself by prioritising doing things that are nourishing, rather than harmful to himself. He relied on comfort eating, because it became a default mode of manging feelings. He felt it was an easy fix that required little thought and could be done in private away from his family. Now he is going to help himself in ways that are less isolating, which may include his family. He has been surprised to see how by incorporating self-care, it has had a secondary positive effect, it has made his family happy

Awareness of choices made & alternative options Ownership taken for role in difficulties Familiar automatic patterns of behaviour replaced with new way of responding Problems & feelings kept private Changing part effects the whole		things that are for me, but it might involve doing something where my wife or my daughter might be with me etc or buying something new or different so when they see me they can say "oh that looks nice on you". So, it's like a reaction of, you know, it makes them happy as well, because I didn't realise as well, their happy to see that I'm actually doing some things for me, because they've always known that I would always do it for them and in the past they've always said "you know get yourself something" and I've said "no it's okay, it's okay", so in many respects I was ignoring what was said to me for a very long time.	too. He realised that despite always striving to meet his family's needs, he had ignored their desire for him to consider his needs too. *Smiling and light, positive tone when describing the secondary effect of how by him helping himself more, this in fact benefits his family.* It seems that emotion has moved from being something suppressed and dealt with in private - "on my own again", to something that can be attended to in a nourishing way, that enables him to be less isolated and helps fulfil his purpose of making his family happy. The fact that his family have wanted him to take care of himself and fulfil his needs for a long time, but he has ignored this, perhaps highlights the importance of him reaching his own awareness and not being advised, or the importance of an outsider making such observations or challenges.
	R31	So, your whole shift has actually made things better for you and for them as well?	
Insight that considering self, positively impacts others Balance in caring for self and others Awareness that coping strategy for feelings no longer working Therapist as facilitator of new awareness New awareness positively	P31	Yeah, because they are seeing, they are getting pleasure as well, by seeing that I'm actually now treating myself, that I'm actually doing things for me, so um yeah, it's it's been a huge shift in that respect, but beneficial I think all round. But I mean I haven't stopped helping, but I've been a bit more balanced, in the sense that I said to myself, you have to do something for you now. So, um it was a door that I think that was a problem without me actually realising and was being um destructive in some aspects to my happiness. Which obviously now being made aware of, it's actually now making me happy, but also the people around me, who mean the most to me, happy as well, which is like a double-edged sword of it is benefitting everyone all round.	He describes how his family are getting pleasure from seeing how he has changed and is treating himself and doing things for himself. He states that this has been a huge change in his way of being, but beneficial for everyone. He describes how within this huge change he has found a way to ensure that he is still helping others, it is just that he is just more balanced, so having attended to others' needs, he then ensures that he does something for himself. He reiterates that neglecting his own needs and self-care was an area that was a major problem, without him being aware that it was destructive to his happiness. However, therapy facilitated awareness into this blindspot, which has resulted in him being able to identify alternative options and make changes to address it. The changes that have come from this new awareness has not only made him happier, but his significant others' happier too. *Repeats that it benefits "everyone all round"- his tone suggested some surprise in the realisation that changes he makes to become less selfless, could positively benefit others. But, it could also suggest the importance of external factors on the long-term implementation of change – on some level his family's needs are still being considered*

impacts sense of wellbeing/ mood Changing part effects the whole			*before/alongside his own and so changes need to be seen to not have negative consequences to them?* *Repeats "happy" – significant emotion to reach for the participant?* *Tone of voice throughout this section is more upbeat, no hesitations.* <u>The awareness that he gained in relation to this blindspot, and the behavioural changes that he has made, has increased a sense of positive mood and had unexpected positive effects upon his family. Idea that you cannot change a part, without changing the whole.</u> <u>It could highlight the importance of contextual factors for implementing continued changes. Making changes for himself is potentially mediated by the impact upon significant others– client-factors for change?</u>
	R32	Yeah.	
Therapist as facilitator of new awareness	P32	But I wouldn't have done it without coming here and having that pointed out to me.	He comes back to the fact that he feels he would not have made this change had he not come to therapy and had this blindspot illuminate for him. <u>Therapist integral for reaching outcome of new awareness.</u>
	R33	Um hmmm, and when you say pointed out to you, can you give an example of how that came about?	
Direct challenges facilitated awareness Observational challenges on worldview	P33	Um it came about really being with the young lady quite bluntly saying to me, "why aren't you ever doing anything for you?"	The way this new awareness was reached, was by the therapist using a direct challenge, in the form of an observation born out of the participant's narrative. This challenge was a question about why he never does anything for himself. *Tone emphasis on "quite bluntly" which seemed to suggest that this bluntness and challenge really impacted and stayed with him.* <u>Therapist challenges essential to new awareness and change.</u> <u>Therapeutic work consists of challenging observations on a client's way of relating/position in life.</u>
	R34	Hmmm..	
Blunt challenges vital to reach new awareness into worldview Direct & specific challenge made an	P34	And there was nothing wrong with the question she asked, don't get me wrong, there was nothing wrong with that. And it needed it to be a blunt question of that nature, for me to, shall we say, have that light bulb come on because, like you know, "all you keep telling me is what you do for everybody else, but you never tell me anything about what you do for you". So, she was very direct about it, she was very specific as well. And I think because of that, it did allow me to actually take in	He describes how he welcomed the therapist's blunt challenges and that they needed to be blunt, in order for him to gain new awareness. He describes the impact this challenging observation about putting others needs before his own had on him. He states that the direct and specific nature of the observational challenges meant they had an impact in which he absorbed what she was saying. The therapist used this sort of intervention frequently.

impact Challenges involve reflection upon process Interventions based on client narrative & subjective experience Frequent use of observational challenges		what she was saying. And she said things like that on a lot of occasions and…(pause).	*Uses a direct and clear voice when relaying the therapist's challenge.* *He repeats that there was "nothing wrong" with the therapist's question" – is this due to blunt questions having negative associations and he wants to reassure me that it was in fact very useful? He seems conscious of how his words may be coming across to me? Does it suggest that he does not want to portray his therapist in a negative light? When he recited his therapist's question, the tone of voice appeared to lack empathy and veered on frustration to me, so perhaps he anticipated this and felt it was necessary to caveat it with this reassurance. Or is it to emphasise that the blunt nature was essential?* <u>Therapist direct and specific observational challenges vital for new awareness.</u> <u>Frequent use of observational challenges.</u> <u>Challenges based on client narrative and subjective experience.</u> <u>Challenges involve reflection on process in the therapeutic relationship.</u>
	R35	The direct and specific?	
Felt heard & understood Direct challenges important for outcomes Client-therapist attunment in way of relating Client-therapist attunement important for impact of challenges	P35	Yep, yep, yep, not in a bad way. I think because of she was listening and knowing my nature, she realised that lots of things were either black and white with what I do. Um, I live in what I call a very logical way. There's no such thing as magic. You can't make that bottle of water go from there to there without some sort of action taking place, you know what I mean? So, I was very logical and I think she picked up on those things. And realised that for me, the more direct somebody is with me, the better I respond. Um I don't suffer fools, never have done and if I've got something to say, I'm not bothered if I upset someone, because I don't say it in a rude way, I don't belittle anyone when I say something either, but I say it as it is, so you know and...	The therapist frequently used direct and specific challenges and this was received positively. The participant felt that the direct and specific approach taken by the therapist, was a result of her listening carefully, understanding and attuning herself to his logical, black and white stance. He describes how he is also direct in his interactions with others, but similarly, this is not done in a way that is rude or belittles the other. He felt that the therapist realised that he responds best to directness and adapted her approach accordingly. *Sentences become shorter, with more pauses between them, resulting in his speech seeming more abrupt and direct as he describes directness.* <u>The importance of feeling the therapist adapts their approach to individual needs.</u> <u>The importance of therapist–client attunement for the impact of challenges.</u> <u>The importance of feeling understood and seen as an individual by the therapist.</u> <u>It seemed to be important that the therapist and her interventions were not seen as bad, "not in a bad way", casting her in positive light only?</u> <u>Significance of the therapeutic relationship and idealisation in therapy?</u>
	R36	So, are you saying you're quite direct in a sense?	
Desire for honest &	P36	I'm very direct and again as I say, if the situation was where it's best to say nothing, I'm also wise enough to realise you	The client describes how he is not afraid to be direct with someone and point out their role in a problem if he feels that something needs to be

direct feedback Client-therapist attunement Dialogue important for awareness into worldview Direct challenges facilitate new awareness Ownership of problem important for change Direct challenges important for change		don't have to say something always, but if something does need to be said etc, then I say it and I don't, you know sugar coat it shall we say. But again, as I say, I don't say it in a rude, insulting, or belittling way. I say it quite in a nice way, but quite direct. So hopefully they understand why I'm saying it and what the reasons are and I think that's also why I think people come to me for help, because I will turn around and say to them, "no, you're in the wrong and then unless you change, it's not going to change" and I think some of my friends needed it to be said to them in that way. Because I think, because I did, they were able to solve their problems. And I think because people sugar coated it, you know, pussyfoot around with it, you know, if those are the right words to use right, nothing was getting done.	said. However, he describes how he has a flexible approach with this, as he also gages when it is best to say nothing. He describes how he is direct in a constructive way, where it's not rude or belittling, and is delivered in a way that the individual can understand why he is saying it and identify ways to solve their problems. He thinks some of his friends need things to be said in a direct manner and not sugar-coated, in order for them to make changes. *Speaking in a direct and clear way*. *"Sugar coated" – the importance of truth, not made more superficially attractive or acceptable.* *"Pussyfoot" – act in a cautious and non-committal way.* Importance of honest and direct feedback from the therapist for change. Dialogue important for illuminating blindspots in worldview. Importance of taking ownership for one's difficulties for change. Recognition of personal power within difficulties and that change comes from within. Idea of client-therapist attunement or congruence in styles of addressing difficulties. He seems to be inferring from his own experience of being direct, how the therapist can be both direct and not rude or belittling and the significance of this direct approach for encouraging action to be taken. Directness coming from a place of care important? Therapist qualities of how to challenge important part of therapy? He seems to be suggesting that if you sugar coat or pussyfoot around, nothing gets done – directness seems essential for change? Implications for taking a tentative, cautious, person-centred approach?
	R37	So, it's the directness that…interrupted)	
Direct challenges important for change Direct challenge as motivational factor Soft approach less effective at instigating change	P37	Yep, I have a friend who used to be taking drugs and his parents were, shall we say, not direct enough. And when it came to me having chats with him, then I'd said as it was and I didn't hold back and, in some aspects, it was like a little kick in the backside that he required on there and um touch wood, hopefully, he will carry on reacting in the good way that he has done from it. But for many years it was handled too softly.	He provides an example of how he was direct with his friend about his drugtaking and the positive change that occurred as a result of this approach. He feels that for too long it was handled too softly and he needed to be shocked into taking action. *"kick up the backside" means 'the act of telling someone forcefully to start doing something' or 'a forceful gesture or message of some kind (usually delivered with good intentions) that acts as motivation to the (previously unmotivated) recipient' or 'shock them into trying harder to do something'.* Importance of direct challenge, not just a soft approach for change – relevant qualities in how the therapeutic relationship is key to change?

			Direct challenge important motivational factor for change?
	R38	So just thinking about this connected to the therapy, is there some sort of parallel in the way you are and the way you sort of help others and the way you experienced your therapy?	The example above seemed linked to how the participant might have been feeling also - that he was handled too softly for years, as he mentions his family saying he needed to do things for himself and he ignored this. Perhaps he needed "a little kick in the back side" to motivate change and this came in the form of the therapist's direct challenges. As such, this question was to explore if there was in fact a link, without making any assumptions.
Felt heard & understood Client-therapist attunement Approach adapted to individual needs Client-therapist attunement important for outcomes	P38	Yes, I do. I do, but I think a lot of that is down to the attitude of the therapist, taking time to actually listen to what I was saying, I think also working out some of what my nature was as well, so she could actually respond in the correct way. Like I was saying, some people you need to put an arm around and some people you need to kick them. I felt she picked things up very quickly in the relationship as to what were the right buttons to push, to, shall I say, get the right responses.	He describes the link between how he dealt with his friend's issues, to the approach taken in therapy. He states that it is the attitude of the therapist that is key – the fact that he felt she attentively listened to him, understood his characteristics and attuned her approach to his individual needs. He describes how some people will need a soft approach, while others will need a more forceful approach. He needed a forceful approach, which he felt that the therapist realised and adapted accordingly. He felt that she realised quickly how to relate to him and what sort of questions or attitude to take, in order for him to respond in the most effective way. <u>Importance of feeling heard and understood.</u> <u>Therapist attitude vital to outcomes.</u> <u>Importance of paying attention to subjective experience and adapting the approach to individual needs, suggests the value of the phenomenological method of enquiry, as well as therapist-client attunement?</u> <u>EE experienced as a flexible and personsalised approach.</u>
	R39	Hmmm.	
Therapist attitude/ approach facilitated awareness into presenting difficulties Therapist attitude/ approach facilitated awareness into blindspots New awareness facilitates growth	P39	And again, I think that's why I can say that doors got opened up, that had been opened up in the past, but maybe just a little bit before, now they were properly opened up and there were doors that I didn't even think about that also got opened up, which I felt was a benefit to me as well. I learnt from them doors being opened up.	It seems that the therapist's ability to attune to individual needs and make the right challenges or interventions, in order to get the right responses from the client, allowed for new awareness into areas requiring further unpacking, but also new awareness to be gained into blindspots (areas that he did not know needed opening up). This new awareness was beneficial for the development of learning. *Repeats "doors" and "opened up" – new awareness is a very important part of EE therapeutic outcomes?* <u>Awareness into difficulties and blindspots a key outcome in EE?</u> <u>Increasing complexity of experience and narrative, over simplifying important?</u>
	R40	**And I mean we are sort of going onto**	

		it anyway, but I was wondering if you could tell me about your experience of your therapist? Bearing in mind that obviously, she won't find out about this, it is completely confidential.	
Importance of feeling cared for Felt heard & understood Interventions grounded in subjective experience & narrative Explorative questions facilitate dialogue Felt comfortable & at ease Continuous flow over silences welcomed Therapy as a collaboration Client openness important Felt heard & understood Interventions grounded in subjective experience & narrative Therapist's non-judgemental attitude facilitated openness Interaction & feedback key	P40	If I've got problems, I would say it to you, I would say it to whoever, to her if she was here cos again, I'm only gonna be honest with you. Um very much like I have been saying to you, as we have gone along, right, she did show a lot of care, understanding and paying attention to the things that I was saying. Um, again I felt she knew the right things and the right questions to be asking me to make the conversations carry on. I never ever felt that in any of the sessions that we had, we had any awkward moments or silent moments or anything like that where we was having difficulties in trying to find out what we should be doing next. If anything, we was always getting into the situation of running overtime, because it flowed from the start to the end. Um, I felt I went about it in the right way, in the sense that I knew that I had to open up, I had to give my feelings that I was having at the time to her, for her to really be able to understand, what I needed to move forward. And I think she took a lot of that in, she again, as I say, was asking what I felt at the time were the right questions at the right time. When she talked about my childhood, when she talked about how things were with my parents and my upbringing, there was no judgmental side from her either. She took in what I was saying to her, whatever her opinions might be about, if it was correct or right or wrong etc, she never let on and I felt that was nice, because I felt that it made no difference what I was saying. I wasn't being judged, so it allowed me to open up freely, as much as I wanted to and in many ways I opened up more this time round, because of the feedback I was getting from her and from the interaction that we was having again cos I felt she wanted to know more, she wanted to ask and a lot of what she was also asking me was like what I do with my friends, where I don't tell my friends what to do, I get them to think "well look do you think maybe you should be doing x, y and z" and I felt comfortable, because that's exactly what she was making me think about -what I was doing, why I was doing it, what was wrong about what I was doing, how could I change what I was doing to go forward, and at the end of every session she would always have prepared something for me to think about. She'd leave me with a question to	He describes how the therapist showed a lot of care, understanding and paid attention to what he was saying. As a result, the therapist knew the right things to say and questions to ask to facilitate the flow of dialogue. The conversations organically flowed, so much so that they would run overtime. He describes his contribution to the therapeutic relationship, that he went into it knowing he had to make an effort to open up and express his feelings, in order for the therapist to gain an understanding into how he could move forward. This was matched by the therapist attentively listening to his subjective experience and thus asking what he felt were the right questions at the right time. The therapist's non-judgemental attitude when he discussed his upbringing and not expressing her opinions allowed him to open up more freely. The interaction that he had with the therapist, her interventional approach and feedback allowed him to open up more in this therapy than previously. This was aided also by therapist-attributable factors - the fact that the therapist seemed to be genuinely interested in his experience and asked a lot of questions, in order to encourage him to develop new awareness and understanding into his difficulties. This questioning approach is similar to how he interacts with his friends; he doesn't tell them what to do, but gets them to reflect on their experiences, options and alternative perspectives or ways of doing things and therefore this client-therapist attunement in approaching others' difficulties felt comfortable to him. At the end of each session the therapist had prepared a question for the participant to think about in between sessions. *"never ever" suggests an emphasis on this not being the case.* <u>Importance of feeling cared for in the therapeutic relationship.</u> <u>Importance of feeling heard and understood in the therapeutic relationship.</u> <u>Positive experience of interventions grounded in subjective experience.</u> <u>Non-directive stance of questioning.</u> <u>Interventions to extract detail and facilitate flow of dialogue – seems to be describing Socratic questioning and the phenomenological mode of enquiry?</u> <u>Running overtime because sessions flowed continuously = linked to the experience of time?</u>

to client openness Genuine interest of therapist important Exploration of past & current choices Building a detailed understanding Client-therapist attunement Questions to empower reaching own understanding & solutions Reflective homework		contemplate and think about for our next session.	Significance of client-related factors for engagement and motivation with the therapy; client openness key. Therapy as a collaborative process, in which the client needs to take responsibility for his change process, by being open and adopting an active stance, reflecting beyond the sessions. The importance of dialogue and feedback for new awareness. "He felt she was interested in what he was saying and wanted to know more" – the importance of human 'being' qualities of the relationship, such as a feeling of genuine interest and care. Client-therapist attunement. The explorative approach taken that empowers the participant to reflect and find his own solutions, rather than being given advice is welcomed - Leaping ahead and not leaping in (Heidegger, 1962)? Therapeutic work taking place beyond the sessions important. What meaning could the act of the therapist preparing a question, tailored to the individual's difficulties, to reflect upon behold? It could be that she put in thought, care and commitment to the work? Adds to the approach feeling personalised to individual needs? Working outside of therapy key to change? Reflecting outside of sessions could help ownership of the therapy process, encourage a sense of empowerment & develop the skill of reflective practice? Experimentation part of EE therapy important.
	R41	Can you give an example of what sort of question?	
Reflective homework on current way of being	P41	Well, again I go back to the one about, you know, 'why you not doing things for you', err, although I might be repeating myself, from what we talked about earlier, I think it was in many respects like I'm saying.	An example of the type of question the therapist prepared for the participant to contemplate between sessions was the one he mentioned previously of why he is not doing things for himself. Homework is reflective, as opposed to behavioural or practical. Timing of observation important for how it is received?
	R42	That is an important question.	
Felt heard & understood Reflective homework on new insights into worldview Approach personalised Felt motivation	P42	For me because that door had never been opened up beforehand and I think she realised it hadn't been opened up before. She made me use the time from one week to the following week, because I think she realised that I would listen to what was said to me from her. It was a two-way interaction so when she asked something or said to me "think about something", when we talked about it the following week, she saw that I did actually spend time.	He feels that the therapist realised that he had never considered doing things for himself previously and therefore got him to use the time between sessions to contemplate this, acknowledging that he would listen to this and put in the work. He states that the therapy was a two-way interaction and therefore she would see the following week that he had spent time thinking about what she said. Strong sense of feeling understood by therapist. Reflective homework seems personalised to his individual difficulties and worldview. Sense that the participant feels the

& active engagement recognised Client active engagement important Therapy as a collaborative process			therapist trusts and acknowledges his active commitment to the therapy – trust is a two-way process? It seems that the therapist's recognition of his active role is vital. Importance of a two-way interaction, therapy as a collaboration. Client attitude and engagement in therapy essential to the change.
	R43	So, she saw you were putting in effort?	
Therapy as a collaboration Client motivated to engage & change Commitment between sessions to demonstrate motivation Client willingness to be vulnerable & reflect Ownership of choices & role in difficulties Acceptance of choices Understanding of current way of being Identification of purpose & meaning Increased sense of purpose motivates change Change – motivated to improve whole wellbeing	P43	Um, so what was good about that was I think it proved to her, that you know I was serious about the fact that I do want to improve my lifestyle and not just a case of saying it for the sake of it. I also admitted to my mistakes, you know I, I acknowledged where I was going wrong, so you know, I was aware I was repeating certain mistakes, accepting why I was doing it, because of the fact is that my depression, I felt so low that I sort of gave up. Because I've now got more focus, I've got more things happening for me going forward um, I've got a bigger drive, um my daughter has met someone, they're moving into a new place soon, at some stage in the next few years hopefully they will have some children. As we speak of today, I will be limited as to how much I could do. I could do a lot when it was a baby. Once it started moving around and walking etc, I would then really struggle. So, because I know I've really got time on my hand, my focus now is to make sure that I improve my health, make sure that my whole wellbeing overall, is improved. Um emotionally as well as physically and because I know that I've got this period of time in front of me, I feel that it's achievable. I haven't got this time restraint; well I've got to get it done in the next six months or whatever.	Working on himself between sessions, was important to demonstrate his commitment to change to the therapist. Another important aspect of this was owning his role in his difficulties – facing up to his choices, certain patterns that had contributed to his difficulties and accepting his mistakes. He describes how he had reached such a low point in his depression that he had given up. However, now his circumstances have changed; he now has more focus, more things in the future to motivate change. He recognises that in his current physical state, he would be limited in how much he could get involved with any future grandchild. However, he feels that change is achievable as he has a considerable period of time to work on improving his health, both emotionally and physically. Therapy as a collaboration. Important that client engagement is recognised. Using time between sessions to reflect, linked to motivation and engagement? Importance of revealing vulnerabilities and taking ownership for his role in current difficulties and past and current choices. Outcome - Taken stock of his life and identified a purpose/area for meaning. Importance of increased purpose and meaning (grandchildren) to motivate change. Outcome - drive to improve physical and emotional health. Importance of time for making changes – realistic and achievable expectations and goals important.

Realistic expectations for change			
	R44	Yes, it sounds like this awareness has meant that you really have set yourself some huge… (interruption).	
	P44	Yes.	
	R45	*(continue what I was saying in R44)* but achievable goals really.	
Insight into how one's current way of being impacts others Ownership of choices & role in difficulties Insight that emotional & physical wellbeing linked Insight that comfort eating to manage painful feelings Feeling alone in painful feelings Desire for painful feelings to be understood	P45	Yea, I also realised that with me falling ill to the levels that I fell ill, that really upset my daughter a lot and because her happiness always meant so much to me, I didn't realise that some of my illness was self-inflicted, because of me going down the route of comfort eating and allowing me to get into the shape I'm in. Um so self-inflicted in that respect and the other side was not being able to know how to cope with my emotions and deal with the pain that I was suffering, because it seemed only a very few people out there actually could understand what I was going through and they were like people who'd lost a child, lost a baby. It was as if we was able to talk our own language.	He describes how he has realised that his wellbeing impacts his daughter and her happiness matters a lot to him. He has realised that some of his illness is self-inflicted due to comfort eating and therefore putting on weight. He describes how he did not know how to cope with his emotions and the pain he felt as he felt few people could understand his experience. Only those that had experienced losing a child seemed to share in this understanding and it was as if they had their own language. It seems that realising that his lifestyle choices and wellbeing impact those most important to him, acted as a motivating factor to change. It seems that realising his role and responsibility in his ill health also acted as a motivational factor to change. Outcome – New awareness into his choices and the functionality of comfort eating, and the impact it has on himself and others. Outcome - New awareness of how the suppression of emotional pain through comfort eating, impacted his physical illness. Discovered where his agency lies within his difficulties, identified areas where he can make different choices & take responsibility for his change. Sense of isolation in painful feelings. Importance of another person understanding his experience of loss, to help cope with emotions and pain.
	R46	People who had also lost…(interruption).	
Feelings not easily conveyed Desire for painful feelings to be understood	P46	People who lost a child yep and if I came out of that environment, I felt the majority of the time people just didn't really understand the pain and suffering to the level that we was experiencing and it was very difficult to get that across.	He felt that unless he was with others that had lost a child, people didn't understand his level of suffering and it was hard to communicate this. Sense of isolation in experience of loss. Importance of others understanding lived experience and pain. Challenging to articulate feelings.
	R47	Um and has… (interruption).	
Felt heard & understood	P47	I'm not sure how much that has got across to the lady in question, alright, but I felt she has got the closest out of all the people that	He is unsure if the therapist understood his experience in its entirety, however out of the people he has spoken to who have not had the

Attendance to subjective experience & feelings Facing & expressing feelings key to healing Ending experienced as sudden Ending obstructs the healing process Progress ends when therapy ends Further improvement remains		I have spoken to, to understand the level of pain that I was actually suffering. So, I felt that that's why the sessions were being so beneficial because, although it was painful at the time, although at the time it was opening up a lot of wounds that meant that I cried a lot in these sessions, they were also things that I had to actually go through, to allow the healing process to start to take effect. My only down side now is that I felt as if I was doing this mile run and we've gone one lap and boom I've pulled a muscle, because it stopped, because the sessions have stopped and now, I sort of feel like, like I say, I was able to do that journey, I was able to do it and like I say, you know, um as an analogy I'll say that it feels as if I have pulled a muscle and boom. I'm now in some ways, not as bad as I was beforehand, but I know there is room for improvement still within me.	same experience of loss, she did get the closest to understanding his level of pain. He describes how the sessions were particularly beneficial, because although they made him face some painful feelings and experiences and he expressed a lot of emotion within the sessions, he felt he had to go through this painful process, in order to heal. However, just as he had started the healing process, therapy ended abruptly. While he feels better than before therapy, he still feels that there is room for improvement. *Speech speeds up when describing doing the mile run and then abruptly stops with a strong emphasis on "boom" each time – could represent the abruptness of ending and impediment to his therapy journey.* *Idea of "pulled a muscle" – ending as an obstruction to progress/healing?* <u>Helpful aspect of therapy – sessions facilitate vulnerability, facing pain and expressing feelings. Experiencing his feelings in this way and not suppressing them was integral to healing.</u> <u>Idea of pulling a muscle when he was on a mile run – idea of lack of control over therapy being stopped and depicts a sudden unexpected and painful experience to ending.</u> <u>Idea that therapy journey is stopped when sessions stop, and doesn't continue between the follow-up sessions.</u>
	R48	Um hmmm.	
Therapeutic connection aided emotional & physical wellbeing Therapeutic work aided emotional & physical wellbeing EE well-suited to hopes/ expectations for therapy Time-limit seen as limitation Time-limit insufficient	P48	Um so that's my only sort of frustration that I've got, because I found the connection, the work, the progress, the things that I felt were making me better emotionally, and physically as well from that, um was something that I've been striving to find for a long time. And sort of at last found it and then because of how things are set up, and I know you are only allowed a limited time on there, it seems a shame because I know everybody is different and not everyone is going to get sorted in six sessions.	A downside to the therapy he received, was that just as he found a therapy that worked for him and he was making progress emotionally and physically, the therapy ended. He found the therapeutic connection, the therapeutic work, the changes that he was making, were what he had been searching for and were working making him better. Yet due to the time-limitation for EE it had to end. He feels that everyone is different and the six-session timeframe is not enough for him to feel recovered. *Emphasis upon "at last found it" and uses a hand gesture of clasping fists together – perhaps indicating finding and wanting to hold onto something, or to show a sense of euphoria/celebration in finding the therapy*? <u>Key components of the therapy and contributing to improved emotional and physical wellbeing– the connection, the therapeutic work, the progress. These aspects were highly valued in EE and suggests a complex interplay of these factors.</u> <u>Unhelpful factor in EE – The experience</u>

for individual needs			of the time-limit and resulting sense of incompletion to therapy journey, sense of loss/abandonment? Desire for a flexible approach to session amount to meet individual needs. Idea that might be able to get "sorted" with more therapy – what does this sorted look like? Importance of expectation management? Has the EE/existential-phenomenological approach and aims of not trying to remove symptoms been conveyed?
	R49	No. So, while it was flexible in some ways the time-limitation…(interruption).	
Significant change in therapy Therapy journey incomplete	P49	As I said at that time, the limitation was whereby I had really started that journey. I really was making progress, as I say I was being able to run around that track now, when beforehand I was still at the starting line.	He reiterates that he was making significant progress on his healing journey, when therapy ended. *Repeats "really" when describing how he had started the journey and was making progress – to emphasis he had made a big change and how involved he was in the therapy process?* Significant progress made in EE. Therapy ended before he gained a sense of completion in his journey/progress.
	R50	Yep.	
Therapy journey incomplete Therapy acted as a taster for what is possible Progress ends when therapy ends Time-limit insufficient for individual needs	P50	And I use the analogy of a mile, because I feel that we have done the first lap and then we still have a couple more laps to still go through. Well it may not be as many as that, but as I say, I know there's still some period that still needs to be done for me to be able to get to where I want to go.	He states that he uses the analogy of a mile, because he feels that he has done part of the mile run, which is significant progress in itself. However, there is still some way to go before he can reach the desired end goal of a mile, which he seems to believe would have been possible with more time in therapy. He made significant progress in therapy, but he seems to believe that this is not enough. He seems to think that more progress would be possible with more time in therapy. Ending therapy was seen to obstruct his full potential and continued progress. Rather than the end of therapy signalling his own continued journey, therapeutic progress seems to stop when the sessions stop – questions of autonomy, empowerment, sense of agency, dependence and the insufficiency of the time-limit in EE for meeting individual needs.
	R51	Hmmm.	
Reflective homework on new insights beneficial Therapist as provider Interactive & collaborative stance important	P51	I feel I have taken on a lot from what was said from her, um a lot really from the fact, as I said, she always prepared and left me with something to think about at the end of every session for the following week and I felt they, that that was very useful. So again, as I say, there was a lot of interaction, but on a very worthwhile basis.	He feels he has gained a lot from the therapist and a vital part in this was being given questions to reflect upon between sessions. He describes how there was a lot of interaction, which was very important. *He says "interaction" as two separate words, 'inter-action' - potentially highlighting that action or an active stance from both therapist and client was required; the therapist by preparing questions for reflection between sessions and the client in terms of reflecting upon these questions between sessions, with the*

			two combining to enable an interactive and collaborative approach? There is an active, interactional 'doing' aspect to the approach. The therapist is perceived to have put effort into providing personalised homework – is this part of the experimentation part of EE? Does this interactive component activate client-related factors such as empowerment, active participation? Significance of a collaborative, interactive nature of therapy.
	R52	So, just thinking of the questions, I'm probably going to end up repeating… (interruption).	
	P52	No worries.	
	R53	Some stuff because I guess we have covered many areas…(interruption).	
	P53	Oh sorry, sorry.	
	R54	**No no, that's a good thing, but if you can just tell me a little bit about what brought you to therapy?**	
Facing painful feelings of loss Facing loss of significant other Suppression of painful feelings	P54	I saw an advert *(loud whistling, starts to have tears and I pass him tissues)* hmm, *(pause),* I saw an advert that cut me up. It's um a pampers advert for premature babies. Um the whole advert – the song, the words, I still struggle now with it (*pause).* Um, it talks about coming home *(pause).* I didn't have that luxury, I didn't get to bring my baby home *(pause),* um it made things very painful. It was a harsh harsh harsh reminder of a lot of shall I say the pain I was supressing.	The client describes watching an advert about nappies for premature babies and everything about the advert acted as a harsh reminder of the pain he was suppressing in relation to the loss of his baby and the fact that he did not get to bring his baby home. *Becomes very present, long pauses, whistles and breathes out with emotion, starts to cry and I give him a tissue.* *Speech slows.* *The repetition of "um" and the long pauses, suggest that he was struggling to express and contain some very strong emotions in the interview.* *Repetition of "harsh" may signify the painfulness of experiencing the advert & his current sense of grief.* Presenting difficulties – loss of significant other and being reminded of the pain of this loss that he had been suppressing. He was no longer able to avoid and suppress this pain?
		This is a short extract and the interview carries on from here.	