DCPsych thesis

What is the meaning and essence of the lived experience of the outcome of existential therapy for depression?

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What is the meaning and essence of the lived experience of the outcome of existential therapy for depression?

Middlesex University
Catherine Barnes
March 2022

Acknowledgments

I would like to acknowledge and thank my supervisors and family for supporting me on this journey as well as the hundreds of clients/patients I have met and have worked with throughout my work and training. Having the opportunity to explore different modalities and ways of working has been invaluable as well as the change each of you have had on me and my life. Inspiring me to look at alternative models of working to fit with the many different people, meanings and experiences of difficulties that can so easily be placed under one label.

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Abstract

Depression is experienced by millions of people worldwide with the leading treatments being medication and cognitive behavioural therapy. It is important to consider the outcomes of other approaches to working with depression. The purpose of this study is to explore the question of what is the experience of the outcome of existential therapy for depression. It is important to understand the experiential outcomes of this type of therapy, to build on the many quantitative studies in the area.

This study has three aims 1. Explore the qualitative experience of depression before therapy. 2. Explore the change that existential therapy brings to participants' experience of depression/ any change in experience after existential therapy. 3. Explore factors that contributed to any change in the participants' experience of depression, and what they learned from being in existential therapy. Eight interviews were analyzed using interpretative phenomenological analysis.

The findings show themes of lost connections, and change in relationships with self and others, as well as participants' not understanding their depression and themes around their relationship with their experience. The strongest theme in contributing to the change was the therapeutic alliance helping the participants understand their experience of depression, leading to meaning-making and how they could draw on their values therefore changing their relationship with their experience resulting in an openness to life, and connections with others. This suggests that the therapeutic relationship is an important base when working with depression to help clients/patients develop an empathetic understanding of their experience leading to change in other themes of their depression.

Statement of Authenticity

I, Catherine Barnes, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

This research was accepted and approved by the Middlesex University Ethics Committee in [*February 2020*].

ADVISORY NOTE

Summary advisory notes to the oral presentation (viva voce) examining panel.

The *viva voce* for the final project is the final stage in the Doctorate in Professional Studies Programme. Candidates complete their master level stage before moving on to their doctorate level studies.

The detailed structure of their programme, including the award of 'Recognition and Accreditation of Learning' (RAL) and the final project plans and design are confirmed in the module 'Programme planning and Rational ' (details in programme handbook)

A summary of credit accumulation available through the programme is presented below:
Master stage: 180 credits
Doctorate stage: 360 credit to include 320 credits of projects (RAL is permitted for 100 or 140 credits) and Expert seminars (40 credits)
Total: 540 credits

Below is a summary of the candidate's full programme and some explanatory note for the RAL awarded for projects

Candidate: Name, current degree qualification(s) and ID number

Catherine Barnes BSc, MSc.

M00509963

Summary of the work-based doctorate programme

Please delete as appropriate

Module code and title	Level	Credits	RAL claim	Pass / submitted
Existential Theory and Practice, PSA4311	**Level 7**	**15**		**X**
Psychoanalytic Theory and Practice, PSA4312	**Level 7**	**15**		**X**
Critical Psychopathology Theory and Practice (Clinical Seminar), PSA4313	**Level 7**	**15**		**X**
Overview of Research Methods, PSA4314 (DProf) / Quantitative Research Methods, PSA4315 (DCPsych)	**Level 7**	**15**	**X**	

Introduction to Psychotherapy Theory and Practice PSA4316 (DProf) / Intro to Counselling Psychology and Practice PSA4317 (DCPsych)	**Level 7**	**15**		**X**
Advanced Existential, PSA4318	**Level 7**	**15**		**X**
Cognitive Behavioural Therapy theory and methods PSA4319	**Level 7**	**15**		**X**
Life Span Psychology, PSA4320	**Level 7**	**15**		**X**
Qualitative Research Methods, PSA4321	**Level 7**	**15**	**X**	
Programme Planning, PSA4323	**Level 7**	**15**		**X**
Research supervision (3 terms), PSA4322	**Level 7**	**15**		**X**
Placement supervision 1 (3 terms), PSA4323	**Level 7**	**15**		**X**
Programme Planning, PSA4234	**Level 7**	**15**		**X**
Family and Systems Therapy PSA5326	**Level 8**	**15**		**X**
Social, Cultural & Ethical Issues PSA5328	**Level 8**	**15**		**X**
Human Sexuality PSA5329	**Level 8**	**15**		**X**
Counselling Psychology Settings & Integration PSA5327	**Level 8**	**15**		**X**
Counselling Psychology Skills and Assessment PSA5327	**Level 8**	**15**		**X**
Small Project , (PSA4335) (exit MA only) / Small Project , (PSA4235) (exit MSc only)	**Level 8**	**30**		
Advanced research seminar, PSA5331	**Level 8**	**15**		**X**
Research supervision (3 terms), PSA5332	**Level 8**	**15**		**X**
Placement and supervision 2 PSA5332	**Level 8**	**15**		**X**
Research Project (Part 1), PSA5334	**Level 8**	**75**		**X**
Existential Supervision Training PSA5335	**Level 8**	**15**		**X**
Existential Group Training PSA5336	**Level 8**	**15**		**X**
Leadership Training PSA5337	**Level 8**	**15**		**X**
Preparation for viva PSA5338	**Level 8**	**15**		**X**
Research supervision (3 terms) PS5339	**Level 8**	**15**		**X**
Advanced placement and supervision (3 terms) PSA5340	**Level 8**	**15**		**X**
Final Research Project PSA5341	**Level 8**	**105**		

Programme overview – the candidate is intended to provide an overview of their learning: I started my post graduate journey after completing a BSc in psychology at Kingston University London where I began researching alongside my studies and presented at undergraduate research conferences. I worked on a

dementia ward at Kingston Hospital and in a drug and alcohol service to gain practical experience. Continuing this development, I went on to complete an MSc in Clinical Applications of Psychology where I graduated with commendation. I worked in research throughout this time, and afterwards used the knowledge I gained from both training and practical experience, to work with a team at the Kingston University to complete a publication on perceived needs for support among care home staff providing end of life care for people with dementia: A qualitative study (see below). I then joined this doctoral program where I completed placements over 4 years working in various settings from in-patient tier 4 hospitals to specialist placements with children. I also undertook a further two years masters training was well as the doctoral training modules on this course. I applied the learnings from the course in my placements and also my job in the NHS Improving Access to Psychological Therapies IAPT role providing primary care treatments for anxiety and depression.

Vandrevala, T., Samsi, K., Rose, C., Adenrele, C., Barnes, C. and Manthorpe, J., 2017. Perceived needs for support among care home staff providing end of life care for people with dementia: A qualitative study. International journal of geriatric psychiatry, 32(2), pp.155-163.

Overview of RAL claimed (where applicable):

Based on my previous MSc training and having done a yearlong module in advanced research methods I applied for RAL for the masters level research modules qualitative and quantitative which were running for 10 weeks on this program. I demonstrated my learning and understanding of the learning aims and objectives for the modules on the program in a 5000-word essay for each quantitative and qualitative submitted along with my transcript to be granted recognition of prior learning.

Chapter 1

The Researcher

My interest in depression and anxiety started with the frequency of cases that I observed in clinical practice. One of the significant things I noticed was that although clients/patients experiencing depression reported similarities in their experiences, I found that what they needed in order to improve was different depending on the person as well as differences in the origins of the depression they were experiencing. I later worked in an NHS Improving Access to Psychological Therapies (IAPT) service specialising in depression. I identify as an integrative practitioner and found I was working with many clients/patients experiencing depression from an existential perspective as numerous clients/patients at the service were experiencing challenges in living rather than something that could be worked on by addressing thoughts and behaviours as in the case of Cognitive Behavioural Therapy (CBT). This CBT approach was much the idea on my initial MSc in Clinical Applications of Psychology. Exploring the different modalities recommended for the treatment of depression by the National Institute of Clinical Excellence (NICE), I noted existential therapy is not listed. None the less clients/patients treated with this modality were reporting improvements and moving into recovery on the measures on which they were assessed. Therefore, I wanted to look further at existential therapy and its outcome on depression.

Introduction

The psychiatric definition of depression is discussed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This definition suggests that in order for the person to meet the criteria for a diagnosis of major depression they need to have at least 5 of 8 symptoms and one of the symptoms must include 1) depressed mood, or 2) loss of interest and pleasure. These diagnostic criteria are detailed further in section 2.1. However, though this is the psychiatric and diagnostic definition of depression, contrasting modalities within the field of counselling psychology can view

depression and its causes from various perspectives influencing the treatment and approaches one may take to working with this condition.

This research will start with a chapter looking at the history of depression and the different theories and discussions around this condition. This is an important chapter to set a base and to understand how our knowledge of depression developed, as well as understanding the different ideas around its causes and treatments. I will explore the different understandings of depression used by different schools of thought and how each approach and treatment or therapy aims to consider and tackle this issue. I will then progress to looking at existentialism and how this latter approach views and can be used in the treatment of depression.

Furthermore, I will discuss the current literature around depression and existential therapy as well as the effects of existential therapy on psychopathology and outcomes leading us to the gap in research that this paper aims to fill. This study itself will then be discussed. I will look at how this study aims to contribute to filling the gap in research, exploring the chosen methodology, data collection and analysis leading to the findings of this study and a discussion of how these findings fit within the current literature as well as any limitations and recommendations for the further development of research in this area.

Statistics from January 2020 show that over 264 million people suffer from depression worldwide (Duko et al., 2021). Depression has been a problem for centuries, with the earliest accounts dating back to Mesopotamian texts in the second millennium B.C. Depression used to be referred to as melancholia around the second millennium when the earliest descriptions first appeared (His and Llop-Radula, 2021). All mental illnesses were thought to be caused by someone being taken over or possessed by demons (Jackson, 1986). This belief called for them to be treated by priests as physicians would treat physical injuries, though not all depression was classed as a spiritual or mental illness rather than a physical one; this was the belief about depression for many years. The early Babylonian, Egyptian and Chinese civilisations also viewed mental illness as demonic possession. They

used exorcism techniques, including restraints, beating, and starvation, to drive demons out of the affected person's body (Horwitz, 2020).

However, when getting to the ancient Greeks and Romans, we can see a division around the thinking of the causes of melancholia. Literature of that time was still filled with references to possession by evil spirits and demons. However, early Roman and Greek doctors speculated that depression was both a biological and psychological disease. Treatments changed to include massage, special diets, music, baths, and gymnastics (Tacchi and Scott, 2017).

Hippocrates 460 BC, a Greek physician, suggested that imbalanced body fluids called humours could be behind personality traits and mental illness. He classified four of these humours: blood, black bile, yellow bile, and phlegm (Goodacre and Naylor, 2020). Hippocrates further classified mental illness into categories that included Phrenitis (brain fever), mania, and melancholia (depression). He believed that melancholia was caused by too much black bile in the spleen (Goodacre and Naylor, 2020). Here treatments moved to include physical and psychological treatments as he used a technique that involves removing blood from the body called bloodletting, as well as exercise and dieting to treat depression.

In contrast, Statesman Cicero believed that depression was caused by violent rage, grief, and fear. They were providing a more psychological explanation rather than a physical or spiritual one (Arikha, 2007). The influence of Hippocrates did not last, and the predominant view among educated Romans was that depression was caused by the anger of the gods and demons, with doctors at the time continuing to recommend shackles and beatings as treatments (Prioreschi, 1996). In Persia, they viewed the brain as the cause of mental illness and melancholia. Treatments including hydrotherapy and positive rewards for good behaviour were an early form of behaviour therapy (Zimbardo et al., 2003).

This progression stopped after the fall of the Roman Empire. During the Middle Ages, religious beliefs dominated European explanations of mental health, and it was believed to be infectious, with treatments including exorcisms, drowning, and

burning. Some doctors continued the belief that mental illness is caused by an imbalance in body humours and grief (Behere et al., 2013).

The Renaissance in Italy, which began during the 14th century and spread throughout Europe, was a time where there were both treatments such as witch-hunts and executions and on the other hand, some doctors were returning to the views of Hippocrates, in that mental illnesses were due to natural causes. They concluded that witches were people who were mentally disturbed and in need of medical treatment (Drayton, 2001).

There was a change in 1621 when Robert Burton published a book called *The Anatomy of Melancholy*, where he discussed both psychological and social causes of depression, including issues such as poverty, isolation, and fear. He recommended various treatments, including music therapy, diet, exercise, travel, distraction, bloodletting, herbal remedies, purgatives, and marriage (Heinrich and Gulone, 2006).

During the 1700s and early 1800s, at the beginning of the Age of Enlightenment, it was believed that depression was a weakness of temperament that was inherited and unchangeable leading to the belief that depressed people should be shunned and locked up. This belief resulted in many people with mental illnesses being committed to institutions and becoming poor and homeless (Maher and Maher, 2014).

Explanations of depression started getting more complex during the late 1700s and 1800s, with some doctors suggesting aggression as a cause. Treatments moved to drugs, diet, exercise, and music. Discussing problems was also viewed as necessary. Some believed that depression was caused by internal conflicts between a person's conscience and unacceptable impulses. As medicine advanced, scientists began to search for the physical causes of depression (Chopra, 2015).
New therapies started being developed, including water immersion and a spinning stool to cause dizziness to rearrange the brain's contents. Benjamin Franklin

introduced electroshock therapy in an early form; enemas and vomiting were also recommended (Sarris et al., 2014).

Depression in 1895 was first distinguished to be different from schizophrenia by a German psychiatrist Emil Kraepelin (Ordieres, 2018). This time is also the period in which psychodynamic theory was developed. Psychoanalysis became increasingly popular as a treatment for depression (May, 2018; Sailsbury and Baraitser, 2020). In an essay in 1917, Freud described melancholia as a response to loss, either real or symbolic loss. Psychoanalysis believed that the unconscious anger over loss weakened the ego resulting in self-hate. He recommended the treatment of psychoanalysis to manage the need for self-abusive behaviour and thoughts (Aron and Harris, 2012). He also believed psychoanalysis would be good to resolve unconscious conflicts that could lead to self-abusive behaviour. During this development, other doctors viewed depression as a brain disorder and physical disease (Horwitz and Wakefield, 2007).

Treatments during the late 1800s and early 1900s often did not work for people who were severely depressed. Therefore, this led to many people being treated by a surgical procedure involving the destruction of the frontal portion of a person's brain, known as a lobotomy (Joseph, 1999). They were often unsuccessful and caused personality changes, including difficulty making decisions and poor judgement, and patients potentially ending up in a coma or death. Another treatment at the time was electroconvulsive therapy which was commonly used for the treatment of schizophrenia and depression (Freeman and Watts, 1942).

The medical community has debated over many years as to whether depression is best to be thought of as a mental or physical problem. After gaining increasing knowledge of the brain and brain chemistry, the medical community decided that it would be best to accept a classification that categorised and divided depression into subtypes based on causes (Lammers et al., 2020). Depression that seemed to come from within the body caused by physical problems or genetics was endogenous depression. The people experiencing this form of depression were told to view themselves as the reason for their suffering (Beck and Alford, 2009). Their

depression was thought not to be affected by the people around them. Another type of depression was considered neurotic depression, also known as reactive depression, which was thought to be caused by a significant change in the environment, such as the death of a spouse or other significant grief or loss. Individuals experiencing this type of depression were told to view their depression as caused by something extreme itself (Bonime, 1976). They were thought to develop bodily symptoms later and make suicide attempts to get support from people around them. These people were believed to feel often isolated, victimised, and abandoned (Gilbert, 2016).

In their search for organic treatments and medication, doctors noticed that medicine for tuberculosis helped treat people with depression (Paz-Soldan et al., 2013). After this finding, the use of medication in treating mental illness gained favour, and psychiatry started to emphasise using medications to treat mental illness rather than looking to psychotherapy as a preferred treatment (King and Johnson, 2018). During this period, new theories in psychology added to the approach in psychotherapy which was being used as treatments. Popular treatment options came to include the Cognitive Behavioural School of thought as well as Family Systems, person-centred Humanistic therapy and Psychodynamic psychotherapy (Jones, 2013).

In the current view, professionals recognise depressive symptoms as having multiple causes, both physical and mental, at the same time, making it no longer necessary to choose a single reason (Kring and Johnson, 2018). Depression became recognised as having numerous causes, including biological, psychological, and social. It has also become recognised that multiple approaches and professions have essential roles in helping people overcome depression (Kring and Johnson, 2018).

1.1 Biopsychosocial Model

The biopsychosocial model is widely accepted today by mental health professions (psychology, psychiatry, psychotherapy etc). Cardiologist Dr. George Engel first developed it in 1977 (Deter et al., 2017). It suggests that all biological, psychological, and social parts are linked together and essential in causing disease and promoting health. It indicates that the mind and body are connected and are not separate as previously thought. It suggests that these different parts are dependent on each other. For example, what affects one aspect, the body, will also affect the mind and vice versa. It suggests that health is not just after someone's physical state but influenced by those persons' psychological and social status (Ezra, Hammerman, and Sahar, 2019). The bio-psycho-social model encourages clinicians to examine all relevant factors, including the body-mind and any social factors contributing to the development and maintenance of the condition (Hatala, 2012).

Looking at depression's relationship with biological factors, it is known that people with depressive disorders are often affected by their neurotransmitter systems and endocrine system (IsHak, et al., 2018). Research such as De Hert et al., (2011) have examined and also shown that depression increases a person's chance of developing other physical conditions. This link can also be seen the other way around, where a person with a physical condition is also more likely to develop depression (Katon, 2003). Depression has also been shown to run in families from generation to generation, meaning genes can influence the transmission of depression (Ezra, Hammerman, and Shahar, 2019).

Psychological factors that have been found to influence depression include negative patterns of thinking, judgments, emotional intelligence, and a lack of coping skills. Emotional intelligence is the ability to identify, understand and show emotions. This link can also be influenced by biology. Personality characteristics can affect a person to be more or less likely to respond in ways that can lead to depression (Batool and Khalid. 2009).

Social factors also play a role, such as the coping styles modelled by their parents or teachers when growing up (Kivela et al., 1996; Leigh, 2019). Other social factors that can lead to depression are early separation from parents or caregivers, lack of social

support or bullying, and experiencing traumatic situations. This link is again related to biology in that research has shown that stressful life events can lead to genes being turned on and off, resulting in changes in brain functioning (Feder, Nestler, and Charney, 2009). Other social factors can be more subtle than trauma, and trauma is not necessary for people to grow up feeling pessimistic about themselves or the future. This can also happen because of how they have learned to think about their self-worth and their ability to manage daily tasks and stress in their lives (Leigh, 2019).

This model concludes and has evidence to confirm that the independent biological, psychological, and social factors all influence each other, and depression can be caused by several factors that influence other aspects. These factors can appear to be independent of each other but are related, such as having a bodily reaction to social or mental stress or having a mental response to a physical problem. This understanding of depression could lead to treatment involving all these factors with the clinician considering biological, psychological and sociological elements.

1.2 Diathesis-Stress Model

This model talks about the relationship between the potential causes and people's sensitivity and vulnerability to react to those causes. It is believed within this model that people have different levels of sensitivity to developing depression. This relationship is what this model refers to as diathesis (Ingram and Luxton, 2005). These include some biological and psychological factors mentioned in the bio-psycho-social model, with some people having a higher sensitivity to developing depression than others by having more of these factors (Jeon, Amidfar, and Kim, 2017). The model suggests that having a higher sensitivity to developing depression is not enough on its own to cause depression. Here it indicates that this higher sensitivity must interact with stressful life events, biological, psychological, or social, leading to depression. It is also suggested that the greater a person's sensitivity, the less environmental stress is needed to become depressed. If someone has more minor sensitivity levels, more significant environmental stress is required to develop

depression (Hammen, Henry, and Daley, 2020). This model believes that a person's sensitivity will remain hidden and will live life generally until the necessary amount of stress has been reached. These life events will impact people differently, and a significant loss may be enough to trigger depression in one person but not another. It would depend on the individual's sensitivity to depression (Abramson, Alloy, and Metalsky, 1988; Colodro-conde et al., 2018).

Both the bio-psycho-social and the diathesis-stress theories agree that depressive disorders are caused by a combination of many biological, psychological and social factors. The factors interact with each other but are also impacted by a person's sensitivity to these factors. They both suggest that depression needs to be thought about in an integrated way. Research has been done looking at the causes of depression, identifying many biological, psychological, and social factors related to depressive disorders. Therefore, treatments from within this view of depression can involve looking at biopsychosocial elements to help the individual develop better resilience to stress.

1.3 Biological Factors

It has been suggested by scientists in the 1950s and 60s that depression is a result of a simple imbalance of chemicals in the brain (Leo and Lacasse, 2008). The brain uses a range of chemical messengers to communicate with other parts of the brain and nervous system. The nervous system is made with nerve cells being the primary type of cell in this system. These are called neurons (Furness, 2000). They communicate through neurotransmitters which are chemical transmitters released and received by the brain's neurons. This communication system is essential to brain function, with neurons constantly communicating (Carey, 1990; Robinson et al., 2008).

A neuron has a cell body and tail-like structure called an axon. These neurons are spaced apart by synapses which are tiny gaps between the neurons. In a simple case with two neurons, one being a sender and one being a receiver, the sender will

send a neurotransmitter message across the synapse to the other neuron, the receiver. The receiver neuron will then be activated by whichever chemical it has received and send the signal down the chain to the next neuron (Dispenza, 2008). For this to happen, the perfect matching signal needs to be received by the receiving end of a neuron that has receptors to receive the chemical signals. When the ideal signal is received, this activates the receptor, and the signal is then sent to the next neuron by way of neurotransmitters. It is not just the signals that make up the communication but also the spaces and rests between the transmissions (Fields and Stevens- Graham, 2002). There needs to be rest time between the neurotransmissions for them to be accurately registered and help receive the next burst of neurotransmitters. For this to happen, the receptors relax and release the captured neurotransmitter back into the synapse, where 90% of them get taken up again by the original sending neuron. This process is called reuptake (Wrobel, 2007). The neurotransmitters are then reused the next time a message needs to be sent. This cycle is a process that takes seconds, and any interruption to the smooth functioning can have negative impacts on both the brain and nervous system. Psychiatry uses the above and the below information in the treatment of any mental health issues including depression, as antidepressants can be used to alter these neurochemical processes.

Depression has been linked to imbalances with the neurotransmitters, namely serotonin, norepinephrine, and dopamine. Antidepressant medications used to treat symptoms of depression are known to act upon these neurotransmitters (Wrobel, 2007). Serotonin has been linked to and controls many bodily functions such as aggression, sleep, mood, sexual behaviour, and eating. Current research suggests that a decrease in the production of serotonin can cause depression or a mood state in which people can feel suicidal (Hsu, Groer, and Beckie 2014). However, a recent study by Moncrieff et al., (2022) conducted a systematic review of evidence as to whether depression is associated with lower depression concentration or activity concluded that there is no consistent evidence of there being an association between serotonin and depression and no support for the hypothesis that depression is caused by lower serotonin activity or connections bringing question to the chemical imbalance theory of this condition.

In the 1960s, scientists suspected that the neurotransmitter norepinephrine caused depression and was responsible for creating a depressed mood. Research has found that people with depression have low levels of norepinephrine (Nutt, Baldwin, and Clayton, 2006). It has also been found looking at this during autopsy studies that people who have experienced multiple depressive episodes have fewer norepinephrinergic neurons than most people with no depressive history (Delgado and Moreno, 2000). However, this could also suggest that not all people experience these mood changes in response to decreased norepinephrine levels. Some people show higher levels of norepinephrine-producing neurons. Therefore, more recent studies suggest that low serotonin levels might trigger a drop in norepinephrine levels, leading to depression (Nedic-Erjavec et al., 2021). This neurotransmitter also has other roles in our bodies, including helping us recognise and respond to stressful situations. It has been looked into in another line of research as to whether people who are more vulnerable to depression have a norepinephrinergic system that does not function in helping to manage the effects of stress efficiently (Albert and Newhause, 2019).

Another neurotransmitter that has been looked into and should not be forgotten is dopamine, as it has also been linked to depression. Dopamine has a role in managing our drive to seek out rewards and our ability to obtain a sense of pleasure (Blum et al., 2019). This change in dopamine could potentially explain why people with depression report having less pleasure in activities then they did before they became depressed (Vollenweider and Preller, 2020).

More recent research has also identified other neurotransmitters, including (GABA) the primary inhibitory neurotransmitter, acetylcholine, and glutamate, which might play a role in depressive disorders. However, further research is needed to identify and understand more about their role in depression (Nemeroff, 1998; Mann et al., 2000). Therefore, this view of depression can lead to treatments involving altering chemicals in the body including antidepressants.

1.4 Neuroplasticity

The brain constantly responds to the environment and remodels itself based on genes, experiences, and behaviour throughout our lifetime. Our brain responds by forming new neural connections. These connections allow for memory and learning to take place. Neurons can also adjust their responsiveness by growing new synapses and strengthening existing ones depending on the stimulation they receive (Wills, 2007). These changes can include neurons being reprogrammed in response to situations. If we look at this in the case of brain damage, the brain can reroute axons from one part of the brain to another region to enable functioning in an area that may have been damaged (Pittenger and Duman, 2008).

This property also involves the monitoring of neurotransmitter activity. Our body, mind, and environment are connected. Specific receptors aid neurons to sense the environment and turn on particular genes, causing the production of neurotransmitters and the turning on and off of receptors (Herlenius and Lagercrantz, 2004). For example, after experiencing a stressful event, the brain senses this rise in stress levels and might choose to turn down and turn off genes that make the neurotransmitter receptors. Therefore, by doing this and with fewer receptors available, messages sent across synapses are received slower with less sensitivity (De Kloet, Joels, and Holsboer, 2005). If the receptors that have been altered are linked to regulating mood, this can also be linked to depression. We are constantly throughout our lives generating new neurons and generating new pathways in areas of the brain linked to memories and emotions (Becker and Wojtowicz, 2007). Linking back to the bio-psycho-social idea, long-term stress has been linked to decreased cell growth in these brain areas leading to slower reactivity and depressive symptoms (De Kloet, Joels, and Holsboer, 2005).

Exercise and other physical activities have been shown by Ploughman, (2008) and many other studies to affect neurotransmitters that stimulate the growth and recovery of brain cells. Therefore, this could explain why exercise has been linked to relieving symptoms of depression. Other treatments for depression that have been connected with the growth of new neurons in areas of the brain associated with memory and

emotion are antidepressant medication and electroconvulsive therapy (ECT) (Bouckaert, et al., 2014). Therefore, looking at this evidence, it appears that a decreased number of neurons in the emotional centres of the brain can lead to slower reactivity and depressive symptoms. However, further research is needed to find causes, develop diagnostic tests, and develop treatments based on the ideas around depression and these brain systems (Fuchs et al., 2004; Singhal and Baune. 2017). Therefore, this view of depression leads to treatments that stimulate growth and recovery of brain cells and neurotransmitters such as exercise, antidepressant medication and ECT.

1.5 The Endocrine System

Neurotransmitters are not the only chemical messengers that the body uses. The body also has a system in which hormones are used as messengers (Muller, 2012). These hormones are produced in the endocrine system and circulate between organs through the bloodstream. The receiving organs interpret these chemical messengers and respond accordingly (Rhee, Cheong, and Levchenko, 2012). The hypothalamus is the exceptionally complex brain region responsible for controlling many functions, including blood pressure, immune responses, appetite, maternal behaviour, and body rhythms, including circadian and seasonal rhythms (Rhee, Cheong, and Levchenko, 2012).

The circadian cycle is the approximately 24-hour cycle of the body. This timeframe is determined by the amount of light the hypothalamus senses in a day-night cycle. This cycle has also been linked to the amount of activity seen in brain waves and hormone production (Mong et al., 2011). Mood disturbances have also been linked to disruptions in the circadian rhythm (Walker et al., 2020). Like circadian rhythms that depend on light, seasonal rhythms are also determined by the amount of daylight in a given season. Individuals with a type of depression known as a seasonal affective disorder or major depressive disorder with a seasonal pattern begin to feel more depressed as sunlight decreases in the winter. These individuals usually experience a lift in mood in the springtime as more sunlight approaches.

They report experiencing normal mental health during other times of the year (Magnusson, 2000).

This same region in the brain is also responsible for releasing hormones in response to situations that are detected as threatening, with people who report experiences of depression showing an increased level of stress hormones (Van Praag, 2005). Other organs have also been linked to depression, including the adrenal gland, ovaries, testes, and thyroid. The thyroid gland, which is located in the neck, is responsible for producing thyroid hormone (Ahsan et al., 2021). Depression has been linked to low levels of this hormone (Ahsan et al., 2021). Mood elevation has also been associated with high levels of thyroid hormone. Sometimes symptoms of depression can be alleviated by regulating thyroid hormone (Tichomirowa et al., 2005).

The adrenal glands, which are found in the kidneys, are also involved in the stress response. They produce stress hormone cortisol as well as being involved in immune function and metabolism. Cortisol is higher in people who are depressed (Van Praag, 2005).

Research by Johnson, Nachtigall, and Stern (2013) has also shown a possible link between testosterone, a hormone produced in the testes, and depressive symptoms. It is known that testosterone decreases in men over 50 (Kenny et al., 2002). This decrease in testosterone could partly explain why men of this age are more likely to report feeling depressed. However, unlike the relationship between estrogen and depression, the relationship between testosterone and depression is not clear.

Women are known to be at a higher risk of depression than men (WHO, 2021). Though it is worth considering that data collected by the WHO may sit within a particular context and be collected for a particular purpose. Nonetheless, this gender difference could be down to the hormone estrogen, and it is one of the main reasons developing depression is higher in women than men. Decreased estrogen levels at times in women's lives, such as the premenstrual phase, following the birth of a baby, or menopause, are common times for women to have increased vulnerability to depression. Decreased estrogen can impact neurotransmitters such as serotonin

and norepinephrine, which have been linked to depression (Stein, Keller, and Schleifer. 1985; Robles, Glaser, and Kiecolt. 2005). Therefore, this view on depression leads to the clinician using a combination of methods to support the client/patient including medication, supplements, and exercise.

1.6 Genetics

It has been known for a long time that depression runs in families (WHO, 2021). Family members who feel depressed are often able to point out others who have experienced the same. Many early studies looking into genetics and depression used twin studies. Identical twins share the same genes, whereas nonidentical twins and other siblings only share 50% of genes (Petrill et al., 2006). Research has found that when one identical twin is depressed, the other twin will also develop depression 76% of the time, with this being the case with non-identical twins only 19% of the time (Ormel., Hartman, and Snieder. 2019). Other studies have added to this and strengthened the evidence for a genetic link. Studies have looked at twins who were raised in separate homes; similar results were found. When one twin developed depression, the other twin also had depression 67% of the time (Mullins and Lewis. 2017).

It is not known how many genes are involved in the cause of depression. Depression is not caused by a single gene like some diseases such as cystic fibrosis, but rather a combination of genes like diabetes or high blood pressure (Belmaker and Agam, 2008). Scans of whole genetic codes of individuals with depression show a linkage to major depressive disorder on chromosome 15 and possibly chromosomes 8 and 17 (Holmans et al., 2004). However, there appears to be a clear genetic component that can make people more vulnerable to developing depression when exposed to particular environmental stress (Holmans et al., 2004). It is not yet known how we can use this information in diagnosis and treatment. It is also important to remember that environment and life experiences play a huge role in developing major depressive disorder (Levinson 2006; Mullins and Lewis, 2017; Hagden, 2011).

Therefore, it could be helpful to combine this information with other ideas of depression to help treatment,

1.7 Imaging

Using brain imaging techniques such as Magnetic Resonance Imaging (MRI) has found that people who are depressed have less activity in certain parts of the brain, as well as having certain parts of the brain functioning more slowly (Liu et al., 2020). This activity in these areas is connected to our ability to focus on the outside world. This decrease in activity could explain why people with depression are often more focused on their thoughts and feelings than their surroundings (Jacobson, Martel, and DimidIjan, 2001). The prefrontal cortex has been believed to enable us to regulate emotions and helps up inhibit or regulate inappropriate or crippling emotions; therefore, if the prefrontal cortex is less active, negative emotions may be displayed more frequently and intensely (Declerck, Bone, and De Brabander, 2006).

Developing areas of research are in deep brain stimulation (DBS). This area is where neurosurgeons have reported successful treatment of severe and treatment-resistant depression by implanting a pacemaker type device into particular parts of the brain known to be linked with depression. It has so far been shown to have a noticeable antidepressant effect. This research is being done in many countries worldwide with development now progressing to home use headsets. Leading centres in this research are in Europe and North America (Wise et al., 2014; Gong and He, 2015; Mayberg et al., 2005: Harmsen et al,, 2022). Treatments within this view can include a combination of approaches including DBS discussed above as well as CBT discussed below as this has also shown to increase grey matter in the prefrontal cortex as well as activity in other brain regions (Yoshimura et al., 2014).

1.8 Psychological Theories

Unlike biology, psychology is still not a genuinely unified field. There are still many disagreements on what theories are important to focus on and how best to study them. Different schools of thought take diverse views and approaches. Personality factors, early childhood experiences, interpersonal relationships, and history are essential contributing factors to depression. However, different schools of thought within psychology have developed their theories as to why a person may become depressed.

1.8.1 Psychodynamic Theories

During the first part of the 1900s, the psychodynamic theory was the leading school of thought within psychiatry and clinical psychology. Early approaches focused on the interrelationship of the mental, emotional and motivational forces that interact to shape an individual's personality. Sigmund Freud invented psychodynamic theory and psychoanalysis; his theory suggests that the unconscious mind is divided into three parts: ID, Super-ego, and Ego (Hossain, 2017).

- ID is the irrational and impulsive part that represents our primal animal desires.
- The super-ego is a more critical part; it is the internalised representation of society's rules.
- The ego is the rational part that tries to bridge the other two pieces.

This theory suggests that the different parts of the conscious and unconscious mind can come into conflict, leading to repression, a state where one is unaware of having certain troubling motives and desires but is still negatively influenced by them. It is suggested that early developmental conflicts must be resolved to achieve positive mental health and overcome depression. This resolution can be made by gaining successful interpersonal relationships, mastering body functions, gaining trust and affection. Mental illness can be viewed as a failure to resolve these conflicts (Bempoard, 1994).

There are many explanations as to why one might develop depression. It was historically believed within this school of thought that depression was caused by repressed anger turned into self-hatred (Busch, Rudden, and Shapiro, 2004). For example, a child brought up by inconsistent parenting, and inconsiderate, angry, or selfish parents build a hostile world for a child. The child can feel confused, alone, and angry. However, the parents are the child's only way to survive. Therefore, the child represses their anger towards the parents and turns it inward. This internalised anger becomes anger directed towards themselves. It starts to form a self-concept finding it comforting to believe thoughts such as I am unlovable, or I am a terrible person. The child also wants to present a perfect and idealised image of themselves to their parents to deal with the faults that make them unacceptable. Being stuck between this need to present themselves as perfect and feeling unacceptable can lead to a child experiencing anxious and depressed feelings, feeling they are not good enough no matter how much they try. This feeling of needing to please and failure can be carried beyond the situation where it first appears. In psychodynamic therapy, the therapist's goal might be to help the adult gain insight into the mistaken foundations of inadequacy to decrease the person's need to punish themselves (Busch, Rudden, and Shapiro, 2004).

The umbrella of psychodynamic theory has grown in many branches over the years. One popular branch is known as object relations theory. This branch is concerned with people and their relationships with others and how these relationships are mentally represented (Ford and Harding, 2011). Objects represent people, and people can only be understood through the relationships they have experienced, which influences later relationships (Sandler, 1990).

Here depression is caused by lacking healthy relationships. People who develop depression face an ongoing struggle to maintain emotional contact with desired objects. They suggest the result can be divided into two patterns: the analytic pattern and the interjective pattern. Some therapists have used these to label different types of depression though these terms are not currently used in the DSM.

Another type of depression linked to relationships that can be explored through this psychological theory is Anaclitic depression. This is where a person feels dependent on relationships with others (Reis and Grenyer, 2002). They grieve the loss of relationships, either actual or threatened. The foundation for this is said to happen when the child's caregiving relationship with a primary object is disrupted. A person who experiences this form of depression experiences intense fear of abandonment and struggles to maintain contact with the 'need-gratifying' object (Herbert, McCormac, and Callahan. 2010).

On the other hand, introjective depression comes from a person feeling like they are a failure, having not been able to meet their standards, as well as the standards of important others. Feeling they cannot meet these standards creates a feeling of worthlessness and guilt and comes from a highly critical superego—the fear of losing the approval and love for the desired object (Harding, 2018).

Another branch of the psychodynamic theory is interpersonal therapy (IPT). This theory suggests that depression is caused when a person has negative interpersonal behaviours that cause others to reject them as part of a cycle leading to them wanting reassurance from others; those others then start to reject the person with depression or sometimes themselves become depressed. This rejection and avoidance make the depressed person's symptoms worse. IPT treats depression by breaking this cycle (Kemberg. 2009). Therefore, treatments from this understanding of depression can involve braking unhelpful cycles and relationships dynamics which reinforce negative patterns as well some treatments centring around talking about internal and unconscious conflicts.

1.8.2 Behavioural Theories

Behaviourism began as a science in the early 1900s. Behaviourists worked on the research, and only began to consider therapy and mental illness in the 1930s and 1940s (Watrin and Darwich, 2012). Here it is believed that depression is related to behaviour, and depression is a learned form of dysfunctional, unhelpful behaviour

(Brewin, 2006). They further think that because depression is learned, it can also be unlearned. Depression was suggested by Peter Lewinsohn in the 1970s to be caused by a combination of stressors and a lack of personal skills (Dimidijan, 2011). This lack of personal skills could mean that a person receives less positive reinforcement, which is present when they do something they find rewarding. It is stated by learning theory that people will repeat actions that give them positive reinforcement. For example, getting paid for a job is the reinforcement that maintains the person repeating the act of going to work (Guilbert, 2016). Depression occurs when there is a lack of positive support and people with depression do not know how to cope. For example, a person who gets fired from their job and has trouble finding a new job can become depressed. People with depression emphasise this feeling as they often have a heightened self-awareness about their lack of coping skills (Folkman and Moskowitz, 2000). This process starts its cycle as this often leads to self-criticism and withdrawal from social events. This avoidance of social events means they are getting even less positive reinforcement. Sometimes, family members and social networks can start to give positive reinforcement for being depressed for example by doing the depressed person's chores while the depressed person lays in bed. If the person with depression did not enjoy doing these chores before, remaining depressed as not having to do these chores might start to be rewarding (Meeks, Young, and Looney. 2007).

Initially, behaviourists focused on external and directly observable behaviour. They did not believe that thoughts, perceptions, and evaluations influenced behaviour and could not be measured accurately (Liberman, 1979), and therefore, they did not pay much attention to them. More recently, it has been shown that internal events such as values, perceptions, and attitudes affect behaviour and are essential to consider. As a result, the traditional behavioural approach is less prevalent in therapy today (Martinsen, 2008). Treatments from this perspective involve looking at the helpful and unhelpful behaviours and the reinforcing and/or changing of these behaviours.

1.8.3 Cognitive Theories

Theories developed considering thoughts and feelings by cognitive theorists who also tried to integrate this way of thinking into a behavioural framework rather than rejecting these behavioural principles. These became cognitive-behavioural theories (David and Szentagotai, 2006). They try to address mental events such as thinking and feeling in the context of learning theory which formed the basis for behavioural theory and is now the basis for the most well-researched psychotherapeutic treatment today, Cognitive Behavioural Therapy (CBT). In cognitive theory, it is suggested that depression stems from distorted thoughts and judgments Beck noticed these patterns of thinking when working with his depressed patients in the 1950s and 1960s (Beck, 1987). This way of thinking can be learned socially or from parents failing to cope with stressful events or a lack of developing coping skills (Bebbington, 1985).

Therefore, according to cognitive theory, depression is characterised by a different way of thinking to those who are not depressed (Gotlib and Joorman, 2010). It is suggested that based on this different way of thinking, they become depressed (Beck, 1987). Depressed people tend to view things negatively and may negatively misinterpret facts and blame themselves for negative experiences (Lim, 2008). This way of thinking increases the chances that one will develop depressive symptoms in response to difficult situations (Beck, 1987).

Cognitive-behavioural theories have also developed to have branches, with one being the cognitive theory of Aron Beck (1987) who suggested that negative thoughts are generated from dysfunctional beliefs. There is also a direct relationship between negative thoughts and depressive symptoms, with three main dysfunctional belief schemas:

1. I am defective.
2. All of my experiences will result in failures.
3. The future is hopeless.

Not only can events be perceived by one who is depressed through these three schemas, but they can also change the attention a person has, to be focused on

particular thoughts and events. Beck suggested that people with depression have selective attention, which means they only pay attention to certain parts of the environment which confirm what they already know. This bias in attention leads to a failure to acknowledge all the evidence around them, known as faulty information processing (Persons and Miranda, 1992; Alloy, 1988).

These failures in processing or faulty information processing are characteristic of depression. People with depression pay attention to information that matches their negative expectations, disregarding any information that challenges them. They will find and focus on the one comment that could mean their view is correct, magnifying adverse events and minimising positive events. These functions help maintain negative core themes and leave them feeling hopeless about the future in the face of evidence against them (Nieto, Robles, and Vazquez. 2020). Therefore, treatments from this understanding of depression focuses on challenging negative thinking and can include attempting to alter unhelpful behaviours in an aim to change negative core beliefs one might hold and break unhelpful thought patterns.

1.9 A Different Approach: Existential Theory

In 2015 a definition was given to the field of existential therapy by The World Congress for Existential Therapy. This definition stated that existential therapy is a philosophically informed approach to counselling and psychotherapy that focuses on understanding human existence to help clients/patients find new meaning and purpose. This therapy is aimed to be done in a creative, active, and reflexive manner while enabling the individual to engage with problems in living (Existentialpsychotherapy.net, 2019). There are differences in existential therapies nevertheless, they are all centred around the central theme of existence and living.

1.9.1 Differences in Existential Therapies

There is a broad range of insights, values, and principles underneath the umbrella of existential therapy, and different areas and philosophies are focused on by

practitioners who use it. “Existential therapy means something to everyone, yet what it means precisely varies with the exponent” wrote Norcross (1887:42) in an attempt to describe the meaning of existential therapy. Though all existential therapies have commonalities in their interest and the exploration of how a client/patient makes sense of their existence and difficulties in life. Norcross accurately described how the definition of existential therapy changes. He stated that it changes with the philosopher or practitioner discussing the subject—giving rise to the diversity in existential thinking.

If we go back to the beginning existential philosophers and practitioners such as Kierkegaard (1813-1855), Nietzsche (1844-1900), Husserl (1859-1938), Buber 1878-1965), Jaspers (1883-1969), Tillich (1886-1965), Marcel (1889-1973), and Heidegger (1889-1976), all spoke of something different in the area of philosophy of existence focusing on various aspects of life and what it means to be. This idea has not changed moving into the more modern philosophies of existentialism. With philosophers from Sartre (1905-1980) who focused on freedom and choice to Frankl’s (1902-1997) logotherapy concentrating on meaning and encouraging clients/patients to focus on their responsibility towards others (Frankl,1984). Bugental (1915-2008). Bugental (1978) focuses on clients’/patients’ subjective experiences and existential identities Whitaker (2018) and Yalom (1980) encourages clients/patients to look at the world, exploring and facing up to it through what he refers to as the four ultimate concerns of existence (death, freedom, isolation, and meaninglessness). It can be seen that each practitioner has focused on different aspects of this therapeutic approach to help clients/patients through their difficulties and times of crisis. There are also many other philosophers with other diverse ideas between the developments of Sartre and Yalom; however, the aim is to highlight the diversity in existential thinking. This pattern of various ideas continued up to the most recent existential developments in the field, such as Wong (1937), Cannon (1943), Holzey-Kunz (1943), Craig (1944), Langle (1951), and Van Deurzen (1951), Spinelli (1949) and Schneider (1956).

According to Vos, Craig, and Cooper (2015) existential therapies refer to so many practices that a key feature is that there is not one single model for working existentially (Cooper, 2003; Moja-Strasser, 1996).

There are four main schools of existential therapy:

1) Daseinsanalysis – this was developed by Binswanger (1963) and elaborated on by Boss (1963). This form of existential therapy focuses on clients/patients being in the world and their expression of it. It explores clients'/patients' relationships with life including their relationships with themselves.

Daseinsanalysis forms from both Freudian theories and Heidegger's later teachings. This form of existential therapy also involves dreamwork (Cohen 2002).

2) Logo or meaning therapies. "Logos" in Greek means meaning. Logotherapy is cantered to discovering a person's meaning to/in their suffering (and life). This type of existential therapy was developed by Frankl and centres on establishing a client's/patient's meaning in life and uses a combination of techniques including Socratic questioning (Frankl, 1984). It is also common for this type of existential therapy to be used in group settings.

3) Existential-Humanistic approaches (Bugental, 1978; Schneider, 2003; Schneider, 2016; Schneider and Krug, 2010; Schneider and May 1995; Yalom, 1980). This form of existential therapy focuses on the ultimate concerns or givens of life such as mortality, isolation, meaninglessness, and freedom. This existential therapy uses more interpretive techniques (Yalom, 1980).

4) The British School of Existential Therapy predominantly led by van Deurzen who set up the first training course in the UK in 1982. It also included therapists such as Spinelli (2006), Cohn (1997), and Cooper (2003). This type of existential therapy has been linked to the work of Laing

(1965) and his book on *The Divided Self* where he discussed meaning believed to be found in 'madness' and an opposing view to psychiatry and medication of distress is presented.

Though there are commonalities in the beliefs of existential therapies, each has its unique approach to working. To narrow it down, this research is going to focus on The British School of Existential Therapy as I as a researcher am more aligned to this school of thought having studied at a university started by Emmy van Deurzen. However, though there are various views on the application and conceptualization of existential therapy all approaches are in agreement over certain principles that state human difficulties are part of living and are not viewed as symptoms to be fixed but rather as tensions and paradoxes that are part of being human which we have to grapple with and explore meaning within (van Deurzen and Adams, 2016).

1.9.2 Existential Idea of Depression

Existential therapy has philosophical foundations derived from philosophers who have been concerned with what it means for each of us to live as individuals rather than a devotee of something. There is the theoretical assumption that we are always in relation to the world in a constant state of becoming grappling with the givens of the past and possibilities of the future (NSPC, 2022).

Berra (2019) discusses depression from an existential perspective in that depression may not always be a disease but can be an opportunity for a new and more authentic view of existence. They discuss the importance of differentiating between different types of depression suggesting that though they may appear at first glance as similar to other episodes of depression due to the mood being orientated in a depressive sense, they all require a different type of intervention. They discuss existential depression as originating from reflections and considerations on life producing profound discomfort which highlights how the

depressive state can in some cases represent a critical moment in existence where one starts questioning life about its meaning and having deep reflections on existence.

Existential therapy also takes into account one of the great challenges of individuality or self-reflection; this can also be seen as spirituality or living life philosophically (Van Deurzen, 2015). The emphasis of this therapy does not dismiss the importance of family life, shelter and protection, and other human rights. However, it also reflects that this is not enough and it is important to live life backward and not forwards, making choices. It is assumed that we are in a constant state of becoming and are faced with choices and freedom that this brings (Van Deurzen, 2012; Langdridge, 2011).

It is also suggested by Heidegger (1962) that we are always in relation to the world and cannot separate ourselves from this. Heidegger would also propose the idea that we are all thrown into the world. A world of cultural, moral, and political understandings that have already been constructed and are carried through language and discourse. Therefore, it could be suggested that a significant part of our reality is already defined for us through the language we learn and the cultural ideas, categories, and concepts that come with them (Hodges, 2017).

This approach does not tend to believe traits should be separated and treated in isolation; instead, the view is that the person and their world are interconnected (Heidegger, 1962, Van Deurzen, 2012). It is believed that human beings can be viewed as a whole, allowing them to communicate their experience using a phenomenological method instead of the medical model, which could be argued as limited (Van Deurzen, 1997, Hodges, 2017).

> “Existential thinkers seek to avoid restrictive models that categorise or label people. Instead, they look for the universals that can be observed cross-culturally. There is no existential personality theory that divides humanity into

types or reduces people to part components. Instead, there is a description of the different levels of experience and existence with which people are inevitably confronted." (Van Deurzen, 2022, para. 3)

Under the umbrella of existentialism, different philosophers have proposed various ideas around depression and factors that might influence this. I will explore ideas around this presented by existential philosophers. There are many existential philosophers and ideas around this subject.

The philosophers chosen for this section are all philosophers that were taught about in this doctoral program, and who are influential to the British School of Existential Therapy. Holding in mind the view that pathology can be suggested to come out of issues with living (Van Deurzen, 2012; Van Deurzen, 2015) it is also posited by Yalom (1980) that the experience of depression can arise out of experiencing existential distress through questions of existence such as the meaning of life and coping with mortality (Tillich, 1952). If we take the assumption suggested by Heidegger (1962) that we are always in the world and in relation to it, building on this, it has been proposed by Jaspers (1925) that people are especially vulnerable to experiencing such a crisis and possibly depression when they are confronted with what Jaspers (1925) refers to as 'boundary situations'. He describes these situations as moments in which an individual is faced with issues about their very existence. Existential therapies aim to help clients/patients address these questions about existence and, in turn, change the experience of depression by overcoming their existential distress (The NSPC, 2022, "What Is Existential Therapy?" section).

A layperson could view existentialism as pessimistic about the concept of human nature. However, to existentialists, the opposite is true with existential novels depicting characters as finding meaning and purpose despite living in pain and suffering around them. A philosopher that picks up this idea for freedom to choose despite a situation is Sartre (1965). He suggests that the first principle of existentialism is that man is condemned to be free. Therefore, "Man is nothing else but what he makes of himself" (Sartre (1965:15). This philosophy leaves

room for the possibility that the authentic man can come with the reality of their existence and therefore define him or herself, allowing them to create meaning for them-self and create them-self with every action. Thus, suggesting that human beings are free to, despite their difficulties, seek meaning and joy no matter their circumstances. This freedom can also be a factor in depression (Sun et al., 2022) as it is up to the individual to find their meaning. If one does not believe in a God, then life has no purpose other than one that we give it (Frankl, 1984). This lack of purpose can lead to a feeling of lostness which Camus (1955) suggests is a characteristic of depression. Camus (1955) described this experience as being a part of the human condition. He talks about human beings as meaning-seeking creatures in a world with no meaning, leaving the man in a position of absurdity, leading to depression and instability. Sartre also suggests this freedom and realisation that we are responsible for our happiness and meaning can lead human beings to want to escape if the person cannot come to terms with this painful realisation. They may do this through addiction, self-destruction, and antisocial acts (Sartre, 1965).

Other philosophers in existentialism make different contributions to this topic for example Yalom (1980) proposes that depression results from an individual's lack of acceptance of personal responsibility in life. He suggests that this sense of responsibility lies within the concept of locus of control. Those who can create meaning in their lives and use actions to create meaning have a high degree of internal locus of control. On the other hand, Yalom suggests that not being able to take responsibility is a sign of having an external locus of control and bad faith – a concept that is also important in existential philosophy. Yalom refers to the work of Victor Frankl (1963) as essential works in the existential exploration of meaning. In his work *Man's Search for Meaning* (1963), he discussed the observation that people who were unable to find meaning would rarely survive. He found that those without meaning gave up hope and displayed symptoms of depression, vegetation, and not having the strength to endure suffering.

Looking at authors who have discussed depression from an existential perspective, in his 1997 book *Existential Thought and Therapeutic Practice*, Hans Cohn does exactly this and explores the ideas of depression from an existential perspective as a specific world design and part of the structure of the client's/patient's being. Melancholia is discussed as not triggered by a single event but instead can be one way of dealing with the ambivalence in the need for absolute security and the need for adventure and being torn by the struggle. One way of dealing with it is an existential retreat which leads to either suicide or insanity.

Binswanger (1956 sighted by Karus, 2016) describes the root of melancholia in the breakdown of time with the individual clinging to the past with guilt mixed with fear of failure. In this blend of history and the future, he suggests that the present has no place. "Everything possible has already happened. A shadow of loss rules life – a loss which is not just anticipated but already fact" (Cohn, 1997: 110). Cohn goes on to explore Boss's perspective. Boss describes the melancholic state as an impairment to stand out in the openness of the world. He describes it as a change in perception and becoming so severely restricted that they "see nothing but a single significance: everything addresses them only as something to be seized and gobbled up" (Boss, 1994:218). It is further suggested that these people have lost all sense of the totality of their situation. They in this state see only themselves and the world around them related to them only in a particular way. These are some of the ideas that can be used by existential therapists to help clients/patients create alternative relationships with living and themselves (Van Deurzen 2012). Though there are many contributions to the knowledge of depression from an existential perspective, this paper will now focus on the British School of existential therapy and philosophers such as Van Deurzen (2010).

Existential therapy views depression as an experience of existence. Within the philosophy of the British School of existential therapy and the ideas of Emmy Van Deurzen, (2012; 2015) a person's relationship with life is to be explored through the four worlds as a way of being. Van Deurzen's (2010) type of existential

therapy does not offer solutions such as CBT and instead explores the complexities of human living more carefully with the client/patient. Exploring the negative pole of experiences in life in the dimensions (Van Deurzen, 2015). The four dimensions of worldly being that Van Deurzen writes about include the physical, personal, social, and spiritual dimensions, each contains aspects of existence and struggles that a client/patient might be confronted with through life.

Depression can therefore be seen as possibly needing help in gaining insight into the unavoidable paradoxes that life presents and using that experience to gain knowledge and, in turn, gain strength from that knowledge as it is believed that these moments of depression can be valuable (Van Deurzen, 2010; Jaspers, 1925). It is only in times of crisis that people can become aware of the emptiness and ignorance of their lives (Jaspers, 1925). Therefore, it provides them with an opportunity to understand life better and find meaning amid the chaos and confusion (Frankl, 1963, Sartre, 1965). Therefore, treatments for this perspective can help clients/patients to explore, understand and engage with life in a meaningful way. Existential therapists aim to help clients/patients through their depression by bringing to awareness the other positive sides of the polarities of existence through safety, acknowledgment, autonomy, and wisdom (Van Deurzen, 2010, 2012).

Therefore, in the conclusion of this chapter, we can see that there are many varying views and approaches developed over the years to understanding and treating depression.

Research Question, Aims and Objectives

This study explores the experience of the outcome of existential therapy for depression and expands on our current understanding of the qualitative experiences of depression.

This study has three aims:

1. Explore the qualitative experience of depression before therapy.

2. Explore the change that existential therapy brings to participants' experience of depression/ any change in experience after existential therapy.

3. Explore factors that contributed to any change in the participants' experience of depression, and what they learned from being in existential therapy.

The objective of this study is to help the field of counselling psychology in understanding this approach's impact on experiences of depression and what clients/patients felt influenced this change. Providing an understanding of different ways of working with depression, mechanisms of change and client/patient experiences through the journey. Increasing awareness of different approaches to treatment. The next chapter is going to build on this expanding to the rationale for the current study by exploring and reviewing the current literature in this area.

Chapter 2

2.0 Literature Review and Rationale

This chapter offers an evaluation of the primary literature around existential therapy and depression. The purpose of this literature review is to gain an understanding and explore the existing research and debates in this area as well as identify any gaps in the field. As this research is looking at the experiences of depression and existential therapy as a treatment for this condition it starts with the history of the clinical diagnosis of depression, then goes on to discuss the current diagnostic criteria versus the experience of depression. Following this, it then looks at other angles on the diagnosis of depression and the effectiveness of existential therapies on psychological outcomes and psychopathology, building a rationale for the current research.

Systematic research into outcomes of existential therapy is limited resulting in a lack of empirical findings (Cooper and McLeod, 2015; Koebbel, 2016; Schneider and Krug, 2010; Vos, Cooper and Craig, 2015; Vos et al., 2015). Fundamentally, research has dominated inclusion policy for influential organisations such as the NHS which is responsible for providing a substantial part of the psychological services in the United Kingdom. This limitation could be because the existential approach is philosophically based and therefore, opposed to an objectivist paradigm that currently dominates the industry (Lantz, 2004). A review by Walsh and McElwain (2002) explored the evidence for existential therapies, where clients/patients explore the meaning of their lived experiences. They felt that we cannot study existential therapies with conventional scientific methods (objective frame of reference), but that we need to understand a person through subjective routes and meaning (meanings of clients'/patients' problems). They also suggested that the emphasis on understanding in existential therapy and its faith in its ability to facilitate change makes existential therapy a humanistic approach.

The lack of research in this area of existential therapy and depression is especially apparent when looking at it compared to the research and evidence base for empirically supported approaches such as CBT. However, there has been a shift in this more recently with research into existential outcomes increasing (Cooper, 2008; Craig, 2010; Langdridge, 2006; LeMay and Wilson, 2008; Stephenson, 2011; Vos et al., 2015). Cooper (2008) discussed this as being out of the author's concern for the future of existential therapy.

Therefore, conducting research in this area of existential therapy and expanding the existing research base and increasing literature in an area that can offer an alternative and more individualistic approach to clients/patients, seems appropriate and timely.

2.0.1 Search Strategy

A literature review was conducted, searching a wide range of databases to investigate if there was value in exploring this area of interest and whether a worthwhile contribution could be made to research and the current knowledge base in this area. The information and research were sourced from databases including but not limited to; Medline, PEBweb, PsycARTICLES, PsycINFO, PubMed, ScienceDirect and Web of Science, Cochrane Library to explore the current research on the topic of existential therapy and depression. This was done using a combination of the search words depression, experience, treatment, existential therapy, outcome, and DSM as the initial search. The screening process for articles that were included or excluded from the literature review will be outlined in each section. A table of search terms for each section can also be found in the appendix (Appendix A). Below is a flow diagram of the process of examining the literature and deciding the subsections to be included in the literature review.

I started by searching the definition of depression that are most commonly used and form the basis of many treatments.

Defining Depression

Here the research showed different symptoms of depression that have been used to define the experience by various diagnostic manuals. This led to the understanding of the second heading.

How the DSM Does Not Capture Depression

This led to looking at the experiences of depression as some experiences were found to be left out of the diagnostic criteria.

This section then moved to looking broadly at the Current Research on the Effects of Existential Therapies on Psychological Outcomes

Then to narrow the research down I moved to looking at The Outcome of Existential Therapy on Depression Alone

Most of the research found was quantitative therefore the next section moved to looking for research on the Qualitative Experiential Outcomes of Existential Therapy

To narrow this research down further I then explored the current research on Qualitative Experiential Outcome of Existential Therapy for Depression

2.1 Defining Depression

Depression and depressive symptoms are common mental health issues that have a considerable effect on clients'/patients' lives. However, depression itself is a word that is often used to describe feeling down or being unhappy. It has become increasingly popular to speak about having depression, whether the people disclosing that they suffer from it have a psychiatric diagnosis or not. The psychiatric definition of Major Depression offered in the DSM 5 has changed little from those proposed in the DSM-III and from the original signs and symptoms presented for the Research Diagnostic Criteria (Spitzer 1978) and the Feighner Criteria (Feigner et al., 1972). These items can be traced further back to Stone and Burris (1950), who set critical criteria for Major Depression, which Cassidy et al., (1957) later cited and slightly changed. Though there have been minor changes in the diagnostic criteria among these different proposed versions, some differences exist. For example, the DSM-III did not include all the signs and symptom requirements in Cassidy et al., (1957). Cassidy et al., (1957) had criteria such as decreased libido and slowed thinking. The DSM-III, however, added other measures in place of these, such as worthlessness and poor appetite or weight gain, which were not present in earlier diagnostic formulations. Therefore, not all of the depressive symptoms that had been frequently noted in textbooks had been adopted into the DSM. Thus, the current criteria reflect a broader number of reasonable additional measures that could have been chosen and are only a subset of symptoms and signs that people with depression experience.

The current DSM-5 diagnostic criteria for major depression are limited to eight symptoms listed. Any five of these eight listed symptoms need to have been experienced by the client/patient for a minimum of three months and should have been experienced during the same two-week period. One of the symptoms must include:

1) Depressed mood or

2) loss of interest or pleasure.

The symptoms also must cause the individual clinically significant distress and impairment in functioning in social, occupational, or other areas. The symptoms must not be a result of substance abuse or a medical condition. The DSM's eight symptoms include:

1. Depressed mood most of the day or nearly every day.
2. Loss of interest or pleasure in all or almost all activities most of the day or nearly every day.
3. Significant weight loss when not dieting, or weight gain or decrease or increase in appetite nearly every day.
4. A slowing down of thought or reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down.
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate or indecisiveness nearly every day.

Recurrent thoughts of death, recurrent suicidal ideation with or without a specific plan or attempt (American Psychological Association, 2013).

2.2 How the DSM Does Not Capture Depression

Using the search strategy above 20,000 articles were found relating to the DSM criteria for diagnosis and depression. Articles were chosen based on a three-step screening process. First, I read the abstracts to see whether the studies met the search criteria of investigating whether the DSM diagnostic manual fully captured the experience of depression, then the studies were narrowed down to the ones that were looking at experiences of participants with unipolar depression using

participants without any pre-existing diagnosis or other complex presentations. The studies were not used if they were exploring other factors in addition to DSM criteria and depression. The full studies were then read to observe if the research would meet the primary aim of this section. In the retrieval for the full research papers studies were also excluded if the full document could not be accessed or if they were duplicates of others found previously.

The outcome of this search found that other symptoms of depression experienced by clients/patients may not appear in the DSM (Vos, Roberts and Davies, 2019). Kendler (2016) explored how well DSM 5 symptomatic criteria for major depression does not capture the descriptions of clinical depression. The study also examined the requirements in older diagnostic textbooks such as Cassidy et al. (1957) and Stone and Burris (1950). This study suggests that the DSM diagnostic criteria do not capture the features of major depression. Other research has echoed these findings. Kenneth et al. (2018) conducted a similar study comparing DSM criteria for major depression with other clinically selected non-DSM criteria. This was done to investigate the DSM's ability to represent the clinical features of depression. The study concluded that the DSM criteria reflects only a possible subset of a larger pool of possible depressive symptoms and signs and eliminates the uniqueness of the experience of depression. These findings were also echoed by Hodges (2017) in showing that the DSM criteria did not capture the phenomenology of depression. These same findings were further stated by much other research (Vos, Roberts and Davies, 2019; Aggen, Neale, and Kendler, 2005)

Kendler (2016) explained that this is not problematic as long as the DSM criteria are taken as an index rather than constitute psychiatric disorders. Kendler (2016) suggests that since the DSM-III, psychiatry has moved towards assuming that psychiatric disorders are just the DSM criteria and have, therefore, mistaken the index for depression itself. Other studies by Malpass, Shaw, Kessler and Sharp, (2010) explored how changes in Patient Health Questionnaire (PHQ-9) scores over time reflected clients'/patients' accounts of their experience of depression

over the same period. The study also aimed to explore the experiences of using the PHQ-9 in Primary care using a mixed-methods design. They found that PHQ-9 scores broadly reflect clients'/patients' experience of the severity of their depression over time. However, they found the PHQ-9 to be an inaccurate assessment of the intensity of the thoughts of self-harm. They found the PHQ-9 missed symptoms that are meaningful to clients/patients and the questionnaire was viewed by clients/patients as a terrible measure of their condition when used at the diagnostic primary care consultation. However, some clients/patients requested the PHQ-9 as a way to measure their recovery process and treatment response. They concluded that the therapeutic value of the PHQ-9 depends on the practitioner's willingness to discuss the results and what they mean for the client/patient.

There has also been discussion in the field of mental health treatments around the use of diagnosis and formulation and whether there is a need for formulation in addition or as an alternative to a diagnosis. A formulation is a hypothesis that draws on the best evidence and is tailored to the particular client/patient. It could be argued that having a formulation that makes sense in terms of the client's/patient's life experiences and how they have made sense of them about why they are feeling a certain way does not then need another competing hypothesis and diagnosis about why they are feeling this way, and therefore a diagnosis becomes redundant. It can also be unhelpful to test two hypotheses at a time. Furthermore, the two hypotheses are based on two different core messages. The person is experiencing an understandable reaction to life circumstances (Vos, Roberts, and Davies, 2019). The other is that what they are experiencing are symptoms of a mental illness and can give mixed messages to a client/patient (Johnstone, 2014; Johnstone, et al., 2018).

The approach practitioners take on using a diagnosis, or formulation-based approach can be defined and depends on the practitioners' perspective, experiences and training. However, when looking at symptoms through a formulation-based process, it can be seen that at some level, what a client/patient

is experiencing makes sense (Vos, Roberts, and Davies, 2019). It can also be meaningful in terms of the client's/patient's past and present circumstances and the sense they have made of them. Therefore, a therapist's role can be seen as entering into a process of ongoing collaborative sense-making with a client/patient that can then be used as a formulation (Butler, 1998).

2.3 Experiences of Depression

There has been a lot of research exploring the experiences of depression. 983,799 results were returned when using the search terms depression and experience. The results were narrowed down looking for studies that explored depression alone in adults without a specific cause, the research was also narrowed down looking at those that used a research method identifying themes in the experiences.

Ratcliffe, (2014) reviewed and published a book compiling the research he has done into the phenomenological experiences of depression over the years summarising different findings into chapters or themes found in his work (Stolorow, 2015). He writes chapters on depression and the body, loss of hope, depth, guilt and narrative, agency and free will, time, other people, and depression and empathy as themes that emerged from participants' phenomenological experiences.

Other research by Hodges (2017) used thematic analysis to identify themes in the experiences of participants with clinical and non-clinical depression and found four themes that emerged from the qualitative experiential data 1) Feeling depressed/depressed feelings, 2) Dealing with others' reactions, 3) Living with depression, 4) Making sense of depression.

Rhodes and Smith (2010) used Interpretative Phenomenological Analysis (IPA) to analyse the experience of one man with depression. They concluded "the experience of depression is so extreme that it is reported as if the person or self is dying. Onset

appears to involve the destruction of highly valued life projects of the person" Rhodes and Smith (2010, p.1). They explored themes of features of depression, masculinity and vulnerability, and the horror of depression.

There appear to be commonalities in the findings of the experiences of depression in that the experiences of depression are centred around the experience and relationship with self. This is present again in English (2018) who explored the experiences of depression in mature students using IPA. This study found three main themes: a journey through academia with depression, managing depression, and the altered self.

Miranda, Andersen, and Edwards (2013) discuss the relationship between individuals and their lives. They posit that individuals are shaped by the role those important relationships play in their lives; they also describe depression as being related to interpersonal impairment and relationship difficulties (Hammen, 2000). Therefore, the experience of depression can be overwhelming and be experienced as damage to the self (Dickson, Knussels and Flowers, 2008). Ratcliffe (2014) also discussed this loss of interpersonal connectedness in the experience of depression and describes how depression can feel like being cut off from the world.

Loss of connection has also been linked by Charmaz (1983) to chronic illness as people often change in their lives for example in functioning, abandonment in meaningful activities, increased dependence on others and social stigma, and loss of social networks. Bury (1982) describes the experience of illness as "the structures of everyday life and the forms of knowledge which underpin them are disrupted" (Bury, 1982, p.169). There are many links between chronic illness and depression as the changes that come with having a chronic illness make it difficult for the individual to maintain a familiar identity and sense of self (Bury, 1982). Erickson (1968) discussed people needing a stable sense of identity with a sense of 'self-sameness' and stability over time. He discusses how a traumatic event can interfere with an individual's sense of identity and break that sense of stability with oneself.

Dickson et al. (2008) write about how some individuals accept their new identities and adapt and replace their stable identity with a new alternative, therefore, creating a new sense of self. Whittemore (2008) stresses the importance of integration of an experience such as illness into a person's identity stating this can help with psychological adjustment and revaluation of experience in life and relationship with the inner self. Sokol and Serper (2017) suggested that people who were experiencing depression also feel alienated and dissociated from their future selves.

However, even though they found that it was common that people with depression felt pessimistic and hopeless about a future, they also noticed that this shifted when individuals could see themselves as having a recovery plan (in which they can improve from their depressive experience and return to their past self and positive chrematistics that defined them). These findings echo the work of Frankl (1959) in the belief that through suffering one can enhance oneself. Clair, Beatty and MacLean (2005) describe that there might also be a fear of being a burden to others as depression is invisible and cannot be seen by others in the individual's life.

2.3.1 Cross Cultural Experiences of Depression

Examining the research on cross cultural experiences of depression there appear to be similarities in the symptoms experienced. However, there are differences on the intensity and emphasis placed on certain features depending on culture. Yen, Robins and Lin, (2000) compared depressive symptomology among Chinese and American populations experiencing depression. Their research showed that Chinese students had lower levels of somatic depressive symptom endorsement compared to American groups. Looking at this difference they concluded that this variation in symptom reporting could be due to having depression or seeking help in China. Similar findings were expressed by Osborn, Kleinman and Weisz, (2021) looking at comparing cross cultural experiences of depression among western and Kenyan societies. It is also suggested from the literature that the current diagnostic criteria and measurement tools used for depression are based on western populations and

features of depression emphasised in non-western populations may not be captured in current diagnostic criteria or measurement tools.

Haroz. et al (2017) conducted a systemic review of the current qualitative literature on how depression is experienced around the world they also shared conclusions that the experiences of depression cross culturally shared overlap however, the frequency of expression of certain features differed culturally and may appear as associated features in the DSM but not prioritised as diagnostic criteria with those that are prioritised being based on the western expression. As pointed out by Yen, Robins and Lin (2000) the variations in societies approaches to depression and its treatment also tying in to different societies political parameters around treatments and perceptions of the condition can be partly responsible for the expression of the experience of depression itself.

There are also varying socio cultural factors that play into the understanding of depression and influence the treatment approaches provided. We can see that as societies differ so does the understanding and popularity and utilisation of treatments of this condition. There could also be much discussion here as to the cultural and political dynamic behind the current leading treatments for example in the U.K being medication and CBT, some could suggest this being based on the needs and resources of the social healthcare system. However, in this paper I chose to focus on providing an overview and understanding of the current approaches and did not feel it was relevant or necessary to go into discussion around the popularity of certain treatments or the current sociocultural or political climate resulting in the current leading treatments. I rather provide an overview of what is currently available in this area and the different understandings behind different approaches to treatment. As I believe depression can be viewed from different angles and understandings based on the training of the clinician. Some treatments can be more popular and recommended due to a higher evidence base. However, these more popular treatments may not be the best fit for all individual clients'/patients' experiences and root of depression but rather link back to the sociocultural and political climate where treatments are offered.

2.4 Current Research on the Effects of Existential Therapies on Psychological Outcomes

On the one hand, the different approaches within existential therapy are similar in that they focus on life and experience of living; however, on the other hand, they are also different in the types of existential concerns that are addressed and the way the interventions are structured with therapies such as existential-experiential therapy being more exploratory and emotion-based, making them less directive than other types of existential therapy such as logotherapy.

Using the same search strategy as above,14,489 results were found relating to existential therapy and psychological outcomes. Research in this area was vast and therefore studies were screened and narrowed down using the above and then papers were chosen based on reading the abstract to see whether the study fit:

1) Criteria looking at the impact of existential therapy on psychological outcomes without combining this with any other intervention.
2) Criteria of using adult participants.

It was decided that the best way to provide an overview of the research in this area was to start by providing a feel of the research of existential therapies on psychological outcomes.

1) In a group therapy setting as many papers used this format of existential therapy.
2) Then to move to explore research in an individual therapy setting.

This literature review starts by looking at the effects of existential therapies on psychological outcomes in group situations. The majority of research in this area was conducted using existential therapies such as logo or meaning therapies many of which are conducted in group format (De Pont et al., 2021; Breitbart et

al., 2010; Fillion et al., 2009; Henry et al., 2010; Lee, Cohen, Edgar, Laizner and Gagnon, 2006; Starck, 1981; Zuehlke and Watkins, 1977), supportive-expressive therapies (Bordeleau et al., 2003; Classen et al., 2001, 2008; Goodwin et al., 2001; Spiegel et al., 1981, 1989; Spiegel and Glafkides, 1983; Weiss et al., 2003) and existential experiential therapy (Barren, 2005; Van der Pompe et al., 1997, 2001). Additionally, though there has been research on this topic, most of the research was carried out using participants diagnosed with a terminal or physical disease such as cancer. Nevertheless, the results showed that clients/patients appeared to benefit from meaning group therapy interventions rather than being in either a social support group or waiting list. And results of the studies further showed that clients/patients who entered into meaning therapies were able to find greater meaning and purpose in life, and symptoms of psychopathology had decreased by a small but significant extent (Vos, Craig, and Cooper, 2015).

The papers chosen were then narrowed down by screening studies looking at the effects of existential therapies on psychological outcomes using an individual therapy format, the criteria above were still used with participants needing to be adults, and there not to be a combination of interventions used to provide the outcome. Vos and Vitali (2018) conducted a meta-analysis of psychological meaning centred therapies on quality of life and psychological stress. They found that the overall analysis showed large improvements from baseline to immediate post-treatment and follow-up on the quality of life and psychological stress. They further conducted a meta-regression analysis that showed that increasing meaning in life predicted a decrease in psychological stress. However, the papers used in this meta-analysis used clients/patients with a range of individual problems. Though this study used some participants who were experiencing depression the study was not focused on this.

Another meta-analysis by Vos, Craig, and Cooper (2015) looked at 15 studies comprising of 1,792 participants. The studies included in this meta-analysis explored existential therapies and their effects on psychological outcomes. Meaning therapies used in six studies showed large effects on positive meaning in life immediately post-intervention and at follow up as well as that, meaning

therapies had moderate effects on psychopathology and self-efficacy at post-intervention. However, they showed no significant effects on self-reported physical well-being. Furthermore, looking at five supportive and expressive therapy studies, the researchers found that these had small effects on psychopathology post-treatment and at follow-up with no significant effects on self-efficacy and self-reported physical wellbeing. Two existential experiential studies and one cognitive therapy study in this meta-analysis had no significant effects. Therefore, experiential-existential, and supportive-expressive therapies had a smaller effect size compared to meaning therapies (when looking at the level of purpose and meaning the clients/patients found after therapy). However, all types of existential therapy had a significant effect on the positive meaning of life (Vos, Craig, and Cooper, 2015).

Meaning therapy was also shown to have significant effects on decreasing psychopathology, followed by supportive-expressive therapy (Vos, 2016). Again, looking at meaning therapy, this had a positive impact on self-efficacy compared with control conditions. Supportive-expressive and experiential-existential therapies were not found to have any significant effect on self-efficacy. And none of the existential therapies that were investigated showed to have any significant impact on physical well-being (Vos, 2016; Vos, Craig, and Cooper, 2015). From this study, Vos et al. (2015) 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).

Whilst these results could suggest that meaning therapies are more effective, this can also be explained in other ways. The meaning therapies above in this study were delivered in an individual format whereas other therapies were group-based. Looking at this when the meaning-based group intervention by Fillion et al. (2009) was included the effect sizes decreased significantly. Perhaps suggesting that existential therapies would be most effective in an individual format. This could also be explained by different therapies having different individual chrematistics. Vos et al. (2015) discussed how the supportive-expressive and experiential-existential

therapies were more emotions-based, exploratory and non-directive in comparison to the meaning therapies that were educational and exercise-based.

These findings also need to be considered carefully due to the small number and poor quality of many of the studies included. In particular for supportive-expressive and experiential existential therapies with unclear or incomplete reporting (Vos et al., 2015). There is also a large within-study variation which highlights the difficulty in measuring outcomes in existential therapies. Despite this, client/patient groups and goals are greatly varied. Furthermore, these results are based on quantitatively assessing the effect of existential therapies on psychological outcomes, which does not allow a full exploration of client's/patient's experiences as existential theory suggests and have not accounted for any subjective benefit clients/patients may have experienced (Vos et al., 2015). Though these studies are all valuable contributions to knowledge in this field not all of the studies were looking at the outcome of existential therapy for depression alone and mostly used quantitative methods to analyse the data. With that said they concluded that some existential therapies can be beneficial for certain populations, specifically structured- meaning-based interventions appear to be effective for reducing anxiety and depression and increasing a sense of meaning for clients/patients who are experiencing physical illness when combined with exercise, psychoeducation, and discussions around the meaning of life.

A meta-analytic review by Elliott et al., (2013) exploring the assessed outcomes for humanistic-existential therapy (HET) paints a positive picture for this type of existential therapy. In this review other sub approaches of existential therapy were also considered such as gestalt therapy, emotion-focused therapy, person-centred therapy, psychodrama, and body-oriented therapy. The approaches were chosen to be reviewed together as they all have a common emphasis on empathy; the importance of the therapeutic relationship and clients'/patients' subjective experience and they all use a phenomenological approach to understanding humans and meaning making. This meta-analysis reviewed nearly two hundred HET outcome studies; they also included some qualitative studies looking into clients'/patients'

experiences and helpful experiences from therapy. The findings showed that HET was linked to significant client/patient change pre- and post-therapy and these changes were maintained over a year later at follow-up interviews. They found that HET was helpful for a diverse range of client/patient presentations including depression, anxiety, coping with chronic medical conditions, psychosis, and substance abuse as well as relationship and interpersonal issues. This was found compared to control studies where HET showed large changes compared to client/patient groups who did not have therapy and in comparative outcome studies, HET was found to be of clinical equivalence to other therapies.

This study makes some progress in the fact that it includes some qualitative studies of client/patient experiences, and it is readier to consider this. This study does not include studies looking at other forms of Existential Therapy therefore, limiting the generalisations that can be made.

2.4.1 The Outcome of Existential Therapy on Depression Alone

The 14,489 studies found on the effects of existential therapies on psychological outcomes were reduced to 7,172 articles when screening for depression to be included. Articles were again chosen based on a three-step screening process. Firstly, I read the abstracts to see whether the studies met the criteria that were being searched for. Secondly the studies were narrowed down to the ones that were looking at experiences of participants with unipolar depression using participants without any pre-existing diagnosis or other complex presentations. who were in individual existential therapy for depression. The studies were not used if they included other factors in the treatment. Thirdly the full studies were then read to observe if the research would meet the primary aim of this section. In the retrieval for the full research papers studies were also excluded if the full document could not be accessed or if they were duplicates of others found previously. Most of the papers returned in the search were using participants with health conditions, multiple diagnoses, group therapies or a combination of

treatments. Specifically looking at the outcome of individual existential therapy for unipolar depression alone very few papers were found after removing all of the above. Discussed below are the papers found meeting these specific criteria.

Rayner and Vitali (2015) explored the effectiveness of existential therapy in primary care in the UK. The assessed clients/patients who were experiencing anxiety and depression used PHQ9 and GAD7 anxiety and depression questionnaires measures at each meeting. This was done at every meeting with the clients/patients over twelve sessions and at a six and twelve-month follow-up. They assessed participants who were referred to this type of primary care by their GP. Their results showed that this existential therapeutic approach of existential experimentation was effective in reducing the symptomatology of depression while promoting significantly low relapse rates. This study however was using participants in a short-term therapy setting where existential experimentation was the chosen model. The outcomes were also assessed using questionnaire methods which are scores based on the diagnostic criteria of symptoms of anxiety and depression. This study is a valuable contribution of knowledge in this field; however, it can be argued again that as above, the diagnostic criteria and chosen list of symptoms do not leave room for exploration of the client's/patient's lived experience of the outcome of this type of therapy for depression.

Stephenson (2011) explored the effectiveness of the British School of Existential Therapy which is commonly used to treat clients/patients with the affective disorder in secondary care settings within the NHS using a quantitative method. The data was collected and measured using the CORE-OM outcome measure to compare clients/patients receiving existential therapy for an average of 13 sessions and clients/patients receiving CBT for an average of 12 sessions. They found there to be a similar outcome for both existential therapy and CBT. However, some differences were noticed between waiting list and post-therapy and pre and post existential therapy. There was found to be a reliable change in ten participants and clinically significant for eight. Furthermore, they found that a quarter of participants in existential therapy moved from clinical to non-clinical

groups from pre- to post-therapy. These findings complement those of Rayner and Vitali (2015) looking at the effect of existential therapy in primary care. However, though this existential therapy can be valuable for some clients/patients with affective disorders it needs to be considered that this study was conducted in secondary care therefore inferences to other settings need to be made with caution. It is significant that the supervisor overseeing the intervention in Stephenson's (2011) study was Mark Rayner who developed the intervention of existential experimentation. Furthermore, the sample size used for existential therapy was significantly smaller (N=34) than the one used for CBT (N=109). Moreover, another limitation raised in the study was that participants were not randomly assigned to the interventions and due to time restraints, the second part of the study was not able to reach adequate participant numbers leaving out the possibility of investigating who existential therapy was most suited to (Stephenson, 2011). Finally, despite the studies being quantitative, there is also no manual for existential therapy threatening the internal validity of the results as it is not possible to say for certain how practitioners transfer their learnings to their practice. This being said, it is questionable whether it is ever possible to standardise a co-constructed relationship.

Stephenson and Hale (2017) also conducted research looking at the outcome of existential therapy for depression in primary care and used routine outcome measures to assess the outcomes of existential therapy for depression in this setting. It was found that there were significant differences between waiting lists and psychotherapy and a quarter of participants in the group assigned to existential therapy for depression moved from clinical to non-clinical populations after the course of therapy. Here we can see the findings for the impact of existential therapy for depression, however, these papers once again use quantitative methods, and the scoring questionnaires used are based on the DSM criteria discussed above. This leaves out the experiential outcome and the nuance and idiosyncrasies of each meaning-making and experience.

2.5 Qualitative Experiential Outcomes of Existential Therapy

When limiting the search and excluding papers based on whether they provided a qualitative and experiential review of the outcome of existential therapy rather than using quantitative measures, 2,616 results were found using the search method described above. These studies were chosen to be included or excluded based on a reading of the abstract to see whether the study was using qualitative research method. Studies were also only considered if they used individual adult participants who had attended therapy alone. Studies were eliminated from this review if they were using a form of group therapy or combined treatment types. Most of the papers returned in the search were using quantitative research methods. Specifically looking at the lived experience of the outcome of individual existential therapy alone very few papers were found using a qualitative method of analysis. After removing all of the above discussed below are the papers found meeting these specific criteria.

Here I found qualitative research on outcomes of existential therapy for presenting issues to do with physical health. Lamont (2015) explored the clients'/patients' experiential accounts of being in time-limited existential therapy at an HIV counselling service. This study used interpretive phenomenological analysis (IPA) to analyse the data collected from interviews with clients/patients. The study reported that clients/patients approached treatment experiencing a sense of profound isolation, low self-worth, and experienced time-limited existential therapy as being actively relational, affirming, and enabling; the approach was also experienced as being highly attuned to client/patient needs and objectives. The study discovered that clients reported a pivotal part of therapy was the client-therapist relationship and the development of a trusting, collaborative alliance. This study used a qualitative research method containing the richness of data and experience that can be explored when looking into existential therapy and people's interpretation of being in therapy. However, this research also used participants who had been diagnosed with a physical disease such as HIV.

Sorensen (2015) published another qualitative study looking at the lived experience of the outcomes of existential therapy in terms of learning.

He also compared these learning outcomes to CBT using IPA. He concluded from his research that psychotherapy overall helps clients/patients to enhance general learning in three major domains 1) self and life, 2) thinking, acting, feeling in relationships with others. He also suggested from the outcome of this research that 3) existential therapy helps clients/patients to enhance particular learning of authenticity and insight into self, life, and relationships with others using courage, engagement, and freedom in a personal and open approach to difficulties and life issues. This study demonstrates participants' experiential benefits of being in existential therapy.

2.6 Qualitative Experiential Outcome of Existential Therapy for Depression

This search with a combination of search words qualitative, experiential, existential therapy, and depression returned 3,834 results. The results were narrowed down by reading first the title to see whether the study was qualitatively exploring the outcome of existential therapy for depression alone, then reading the abstract. Studies were not included if they were using a group therapy model or a combination of therapeutic approaches. Studies were also eliminated if they were not using adults or using clients/patients with health conditions or complex presentations such as multiple diagnoses. Most of the papers returned in the search were using participants with health conditions, multiple diagnoses, group therapies, combination of treatments or quantitative research method. Qualitatively looking at the outcome of individual existential therapy for unipolar depression alone very few papers were found after removing all of the above. Discussed below are the papers found meeting these specific criteria.

Kauntze (2020) built on the findings by Rayner and Vitali (2015) by conducting a similar study in primary care looking at existential experimentation. Kauntze (2020) used IPA to explore clients'/patients' experiences of being in existential therapy after completion of therapy and at follow-up. They explored the experience of being in existential therapy, the experience of the work in existential therapy, and the experience of leaving existential therapy. Though this study is looking at the experience of being in existential therapy using participants who were experiencing depression it does not cover participants' experience of depression, and the change in this experience post-therapy. They did uncover themes 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/patient openness and active participation, reaching new awareness and personal meanings, towards acceptance and authentic living and short-changed by time. These themes are interesting and leave room for the curiosity of building on this to see how and if these themes impacted clients'/patients' experience of depression and if a change in the experience of depression after being in existential therapy relates to these themes.

2.7 Mechanisms of Change

We can see from the above literature review that existential therapy has a positive effect on psychological outcomes potentially down to some mechanisms of change. When searching for this using the terms mechanisms of change and existential therapy 9,992 results were returned. Studies were narrowed down by first reading the title, then the abstract to see whether they were looking at the process of change in existential therapy particularly when working with depression.

Most of the papers returned in the search were using participants with health conditions, multiple diagnoses, group therapies or a combination of treatments. Specifically looking for research on mechanisms of change with participants in

individual existential therapy for unipolar depression alone or with no complex diagnoses very few papers were found after removing all of the above. Discussed below are the papers found meeting these specific criteria.

Vos and Vatali (2018) found that increasing meaning in life predicted a decrease in psychological stress and Sorensen (2015) concluded that existential therapy helped participants develop particular learning of authenticity and insight into self, life and relationships with others using courage, engagement, and freedom in a personal and open approach to difficulties and life issues. These studies were not carried out using participants experiencing depression alone.

A study that was carried out within the British School of Existential Therapy was done by Craig (2010) and utilised a Hermeneutic Single-Case Efficacy Design as abductive reasoning (Elliott, 2002) to the effects of three different therapeutic modalities on outcomes. They were interested in whether these modalities work in everyday practice as well as understanding the interventions and how they are having their effects. They used three participants from a secondary care psychological service. One experienced CBT for 12 sessions, one experienced personal construct therapy for 16 sessions, and one experienced existential-phenomenological therapy for 16 sessions. The clients/patients in this study were seen by trainee clinical psychologists in their first year. Their researcher was also a trainee on a counselling psychology program working within the placement and was an inside researcher.

The findings of this study showed that each therapy type contributed to client/patient changes but changes in therapy were related to different forms of learning processes. Looking at factors that impacted client/patient change they found there was an interaction between client/therapist factors, relational factors, process factors, and expectancy effects. However, they discovered that whilst there were factors contributing to change what was common across modalities such as ‘feedback’ the way these common factors were delivered in each modality was specific to the type of therapy rather than the uniqueness of the factor itself.

In their uncovering of the factors and specific changes that took place within the person experiencing existential therapy, they discovered that the changes centred around the individual having increased courage to be who one felt they were. The clients/patients also experienced increased motivation, spontaneity, independence, and reported experiencing a decreased concern for what others think of their way of being. They also experienced a shift in aspects of their sense of self as well as their attitude around aspects of their sense of self and a sense of emotional control and liberation for the burdens they had discussed. This change was found to emerge through a process using “the discovery of choice and new ways of being in the presence of another causally contributed to changes in the client” (Craig, 2010, p.104).

This research by Craig (2010) is an important study to report as this study looked at effectiveness as well as mechanisms of change in existential therapy. However, it is important to note that the conclusions drawn in the study are particular to the cases reported and cannot be generalised to support wider claims about universal mechanisms of change. It is also important to note that as in the study by Stephenson (2011) the existential therapy that was delivered in this study was also supervised by Mark Rayner the developer of Existential Experimentation and therefore this the type of existential-phenomenological intervention that was being used in this study had similarities to this existential experimentation model. It is also important the therapists were trainee clinical psychologists, and their main modality was CBT therefore they were only required to deliver personal construct therapy and existential-phenomenological therapy for sixteen supervised hours before the research took place. Therefore, it is a possibility that their alignment with the CBT model would influence all of the explored experiences. Craig (2010) acknowledged, “The more cognitive stance of the therapist seems to have dominated, despite good faith efforts to work in an existential-phenomenological manner” (p.135). This was specifically acknowledged in the existential-phenomenological sessions as there were emotional processing elements of the session that were expected but not found by the researcher. Furthermore, in all three modalities, the permanence of the

changes experienced by participants was unknown without the inclusion of post-therapy follow-up interviews. Due to the study not including this element, it is also unclear how much the clients'/patients' responses in the interviews were influenced by social desirability, satisfaction bias, and other factors such as the Hawthorne effect.

Despite these limitations, this study by Craig (2010) is valuable in showing a qualitative contrast to the popular all quantitative studies on outcomes using randomised control trials. It also enables us to start to develop an understanding of the process of therapy and the ingredients of an approach as well as the mechanisms of change to bring about the reported change in outcome. Though quantitative studies can explore data on large numbers of participants pre and post-change there is also value in exploring single cases in more detail and therefore the importance of this study is clear. It goes beyond the idea of whether existential therapy is linked to positive outcomes or not; it explores the individual process for the participants and shows alternative ways of measuring outcomes of existential therapy. Another study that explored this is Sorensen (2015) mentioned above. The three major domains he uncovered and listed in the qualitative experiential outcomes section 1) self and life, 2) thinking, acting, feeling in relationships with others. 3) enhancing particular learning of authenticity and insight into self, life, and relationships with others. Using courage, engagement, and freedom in a personal and open approach to difficulties and life issues), can also be considered to be mechanisms of change.

Therefore, the rationale for my study is that existing research has left a gap in our research and knowledge base of the existential approach, particularly concerning the clients'/patients' perspectives and subjective experiences of the outcome of this type of individual therapy for depression as well as mechanisms of change related to this.

This research builds on the existing literature around existential therapy on psychological outcomes in adult client/patients, in an individual therapy setting. So

far, these results suggest that existential therapy has positive effects on outcomes (Vos and Vitali, 2018; Vos, 2016; Vos, Craig, and Cooper, 2015; Vos et al., 2015; Elliott et al., (2013). However, these as discussed above were mainly quantitative studies and did not purely focus on depression. This study also aims to build on those that explored depression alone (Rayner and Vitali, 2015; Stephenson, 2011; and Stephenson and Hale, 2017; Stephenson and Hale (2020) who found positive outcomes for the use of existential therapy for depression using quantitative methods. Therefore, this study will build on those by providing a qualitative insight into the experience of the outcome of existential therapy for depression.

This study will be focused on using adult participants who have been in individual existential therapy for depression alone using a qualitative method to capture the lived experiences of each participant that is missed by quantitative analysis. It will also address areas that were not covered by studies such as Kauntze (2020) who used IPA to explore existential therapy for depression as they did not cover the experience of depression and the change in experience post-therapy. The study will also help to build on the research and understanding of mechanisms of change (Craig, 2010; Elliott, 2002; Sorensen, 2015) as it will look at these mechanisms of change specifically about what participants felt contributed to this change in the experience of depression before and after being in existential therapy.

Therefore, in the conclusion this chapter is based on the review of current research into existential therapy and depression and the impact this has shown on psychological outcomes and pathology as well as highlighting the loss of the experience of depression by using the current medical model of diagnosis. It is necessary to, and this research will further investigate the clients'/patients' experiences of depression before and after existential therapy, not limiting the research to the diagnostic criteria or quantitative analysis as well as exploring clients'/patients' experiences of what they felt influenced that change. This research builds on the research discussed above in that it will qualitatively explore participants' experiences of what it is like to experience depression, how their experience changed after therapy as well as the factors that were important to each participant in influencing that change. It also has the potential to bring

awareness to the cross-cultural qualitative experience of depression and how this understanding can inform theory and practice of counselling psychology and the treatment of depression.

Chapter 3

Methodology and Method

This chapter will discuss the methodology and study design of the proposed research starting with the research aim and then moving through the process of how I arrived at the final study design and methodology chosen to best explore the proposed topic contributing to the existing literature.

3.1 Aims and Research Questions

This project is based on the need for a nuanced and comprehensive understanding of the lived experience of the outcome of existential therapy for depression. The principal research question is to explore participants' lived experiences of the effects of existential therapy on their depression. Essentially how people experienced depression and any change in this experience after being in existential therapy. This aim will be achieved through understanding participants' experience of depression before therapy, secondly how participating in existential therapy has influenced participants' experiences of depression/ how their experience has changed after the therapy. It will also have a third aim to explore what participants have taken from being in existential therapy and what they feel contributed to any change in experience after therapy.

The research will do this by looking at three factors and the data will be collected, analysed and reported in these sections:

1. Explore the qualitative experience of depression before therapy.

2. Explore the change that existential therapy brings to their experience of depression/ any change in experience after therapy.
3. Explore factors that contributed to change in participants' depression, and what they learned from being in existential therapy.

3.2 Ontology and Epistemology

A researcher's ontological and epistemological position can influence their general approach to acquiring knowledge and studying topics. Therefore, it is crucial to be aware of the underlying philosophical orientation behind different research methodologies. It is also vital that I reflect on my relationship with knowledge and my epistemological journey.

3.2.1 Reflections and Epistemological Stance

This section will explore how my ontological and epistemological stance as a researcher has changed throughout my education and career in this field. Initially, I began my first degree in psychology at Kingston University London. I was ontologically more aligned with structural realism, and had a constructivist epistemological approach, that is, meaning is created through the interplay between subject and object. I approached research with a more positivist view and used more quantitative methods. Moving on to an MSc in clinical psychology, this continued to remain much of my thinking about knowledge and research. Once I started working in research, I was introduced to a different way of thinking about this, given that the topics I was researching were people's experiences and perceptions of different psychological issues. Here I worked in a team to conduct and publish qualitative research exploring 'Perceived needs for support among care home staff providing end of life care for people with dementia: A qualitative study.'

During this time, I began to develop my ontological position to more bounded relativism. Epistemologically I moved to sit between constructionism and subjectivism. This led my philosophical orientation to move from positivism to post-positivism, including ideas around (social) constructivism and interpretivism. This change in ontological and epistemological position brought me to this doctorate at the New School of Psychotherapy and Counselling where I was introduced to phenomenology. The idea that the essence of the human experience of a phenomenon is only understood through the participants' understanding, with the researcher understanding how their own experiences can affect their interpretation. This will be explored further in the researcher reflexivity paragraph in this thesis.

3.3 Qualitative Versus Quantitative Research

In designing this study, I had to consider what knowledge is to be gained from this research and the purpose it is to serve. This included exploring my epistemological stance on the subject. The proposed research took form out of research and investigation into the current knowledge in this area. I initially considered quantitative analysis. The majority of research in this area is already in quantitative studies looking at measurable outcomes. Quantitative research is based on observation and review of the work of others to then contribute to the formulation of a testable hypothesis. These papers are generally concerned with reporting research results. Usually, these hypotheses are tested with experimental designs created to test a particular idea, which can answer a specific research question. Here, research is often concerned with *how* and *why* questions around a particular phenomenon. Relationships may have already been established, and the hypotheses test the significance of variables and the extent of statistical significance scientifically. Criticisms of this epistemological approach state that it is reductionist and removes a phenomenon from its environment, discouraging adventurous and creative theory (Montouri, 2016).

Looking at the body of research and digging deeper into what this study aimed to explore, as well as the gap in literature it was attempting to fill, it is evident that although a quantitative research design could gather data and test the significance of existential therapy for depression, it would be missing the descriptive, phenomenological, and, therefore, qualitative elements that this research would like to explore. Furthermore, a large degree of the existing literature as discussed above has already examined the outcome of existential therapy and depression using quantitative measures and research design. Therefore, qualitative research methods were considered. Qualitative research, in comparison, takes a different approach to exploring phenomena. Qualitative researchers believe that knowledge needs to be seen as situated within a specific context. It is subjective and cannot be free from the person who perceives it (Flick, 2009).

Here, human beings are seen as part of the world, and the researcher who chooses to use a qualitative research design aims to examine a person's worldview and meaning-making. Therefore, it can be gathered that qualitative research is concerned with understanding human experience and subjective meanings and is very different from the focus found on establishing objective facts found in a quantitative approach. Qualitative research is said to have emerged from anthropologists and sociologists such as Mead (1935) and Malinowski (1922). However, analysis using this method can be seen in psychology during an earlier period. Psychologists such as Freud (1856-1939) and Piaget (1896-1980) developed theories based on the detailed analysis of case studies. Qualitative research has grown in popularity and now includes many different branches and methods. However, despite its growth in popularity for a long time, qualitative research was criticised for rejecting a more traditional positivist scientific view to research. The advantages and disadvantages of a qualitative approach are clear in that a qualitative approach produces a thick and detailed description of participants' thoughts, feelings and experiences and interprets the meaning of their actions. It can also be argued that the qualitative approach holistically understands the human experience in different settings and interpretivism has the ability to understand different people's voices and meaning. The methods of

collecting data in qualitative research mean that the researchers interact with participants directly such as in the case of interviews. Therefore, the data is subjective and detailed. Nevertheless, there are also limitations to qualitative methods. For example, due to the subjective nature of interpretation by the researcher and the generally small sample sizes the generalisability of findings is limited. In addition, data interpretation and analysis tends to be more time consuming. Though despite this in order to fulfil the aim of this research and build on the current literature, qualitative methods were still preferred due to the richness in data that they can provide.

Choosing the appropriate sample, the sample size, the acquisition of data, and data analysis are important parts of research design and depend on what data I am looking to collect and what the research question is and designing the study accordingly. The data collection method and method of data analysis are linked. Looking at the research question of what is the experience of the outcome of existential therapy for depression, it is obvious that it would need to be a qualitative method looking at experiences. Therefore, the method of collecting the data via interviews was chosen allowing rich data on the lived experience to be obtained. Again, I needed to consider the various possibilities and what each method of qualitative analysis can offer; for example, grounded theorists investigate social processes and interactions while phenomenologists are interested in meanings of experiences and descriptions of the lifeworld. Analysing this data, I considered different qualitative possibilities and the advantages and disadvantages of each method.

3.3.1 Grounded theory

Grounded theory is a qualitative research method that involves the systematic generation of theory from systemic research, leading to the emergence of conceptual categories. This method can be used with either quantitative or qualitative data. The

processes of conducting grounded theory research are often sequential although once research begins they can also be conducted simultaneously.

Grounded theory aims to identify and integrate categories and meanings from data. It is the process of both the identification of categories and the integration of data as the method and the theory as the outcome. There is usually no preliminary literature review. There is a chosen research topic but no predetermined research problem. It provides us with the framework with which we can understand the phenomenon under investigation.

Therefore, grounded theory focuses on procedure rather than discipline and is shaped by the desire to discover new theory and evidence. It can be used for research in many different disciplines such as medicine, psychology and social work.

Ecological validity - Grounded theories usually have high ecological validity because they are similar to the data within which they were established, are context specific, and detailed.

Grounded theories are not usually tied to any pre-existing theories and therefore have the potential for new discoveries in the area that is being researched. Legitimising qualitative research as scientific inquiry.

Grounded theories aim to offer practical and simple explanations about complex phenomenon and their relationships. Grounded theory has sequential guidelines for conducting qualitative research and offers specific strategies for analysis.

However, although grounded theory has some advantages it also has its share of criticisms with the question being asked as to whether what it produces can really be called theory? What are the findings really grounded in? It has also been suggested that it allows researchers to free themselves from preconceptions in the collection and analysis of data (Oktay, 2012; Walker and Myrick, 2006).

This method of data analysis did not fit with the research question or aim of this study as the focus was on participants experiences rather than developing a new theory or evidence for a particular topic. Therefore, I considered thematic content

analysis as an option for data analysis to fulfil this research aim, as this approach is more concerned with participants experiences, and identifying themes and patterns within the data.

3.3.2 Thematic Content Analysis

Thematic analysis is an umbrella term for different approaches rather than one method alone. The different methods under this umbrella term can vary according to procedure and philosophical and conceptual assumptions. This type of qualitative analysis involves identifying and examining themes or patterns within the collected data. These are usually associated with a specific research question and are important to the description and investigation of the phenomenon being looked in to by the researcher.

Themes can be defined as patterned responses or meanings which are related to the research question that can be taken from the data. This can be on different levels where themes are identified either semantic or latent.

Thematic content analysis involves establishing meaningful patterns through six phases of coding. The first being for the researcher to familiarise themselves with the data followed by the researcher collecting initial codes and searching for themes among those codes, further reviewing themes, defining and naming themes and eventually producing the final report. This method emphasises the rich description and organisation of the data set. It uses codes to develop themes within the data by recognising and encoding important moments within the data before any interpretation has been made. This is done at a later stage by comparing how frequently a theme appears, whether themes often appear together, and noting the relationships between themes.

This qualitative data analysis method can occur in one of two ways either inductively where the themes are data driven meaning that any assumptions would be close to the data. This is similar to grouped theory in the way that the theories are grounded in the data themselves. The researcher codes the data with no pre-existing model or frame in mind.

This method has its advantages and could be the method researchers use if they are looking to identify themes in a specific area as it allows for categories to emerge from the data. This would also be a possible methodology of choice if researchers are looking to expand the study past individual experiences. Also, there is no one theory that needs to be applied this method allows the researcher to apply multiple theories along with this process. It is a good method to use if there are multiple researchers and larger data sets. However, as all methodologies, there are disadvantages that depending on the research question this may cause researchers not to choose this methodology. For example, if using multiple researchers then reliability could be a concern as the research would then consist of a wide variety of interpretations.

This method may also miss nuanced data. It does not allow researchers to make claims about language usage and maintain a sense of continuity between individual accounts. Researchers also have limited interpretive power if their analysis excludes a theoretical framework. The flexibility that allows researchers to use multiple theories can also make it difficult to concentrate on what aspects of the data needs to be focused on (Guest, MacQueen and Namey, 2011). Therefore, this method was also not suitable as it did not engage enough with participants' individual experiences and meaning making. It also did not leave enough room for the interpretation and understanding of the essence of the experience of the outcome of existential therapy for depression as perceived by participants. However, the idea of themes in the experiences of participants was one that fit with the research question and aim. Thus, I moved on to consider branches of thematic content analysis that put more importance on phenomenology and meaning making. Here I considered Interpretive Phenomenological Analysis (IPA) and Van Manen analysis. These are both based on phenomenology therefore it could be helpful to start by looking at phenomenology itself.

3.4 Phenomenology

> *"The Wonder of all wonders is Pure Ego and pure consciousness: and precisely this wonder disappears as soon as the light of phenomenology*

falls upon it and subjects it to eidetic analysis. The wonder disappears by changing into a fundamental science with a plethora of difficult scientific problems. Wonder is something inconceivable; the problem in the form of scientific problems is something conceivable, it is unconceived that in the solution of problems turns out to be conceivable and conceived for a reason" (Husserl,1980).

Here I will give a brief account of phenomenology aiming to describe how the methodology which I chose to be at the base of my research, fits both with my research questions and personal values. Edmund Husserl, at the beginning of the twentieth century, initiated the philosophy of phenomenology. The aim was to ground the foundation of knowledge and build a secure basis. Husserl decided to begin with the problem of how objects and events appear to consciousness. This is because it is believed that everything that is witnessed or spoken about comes through consciousness (Giorgi and Giorgi, 2003). He hoped to develop a scientific method that would reveal the essential structures of phenomena. This has grown over the years to emerge into a diverse epistemological and ontological position. Research into the literature has identified that phenomenology can be divided into two main strands (Finlay: 2009a, 2009b; 2011; Flood, 2010; Kakkori, 2009; Laverty, 2003; Lopez and Willis, 2004).

One is descriptive phenomenology which is based on the theories of Husserl (1980) with the other being hermeneutic or interpretive developed by Heidegger, Gadamer, and Ricoeur. Husserl's phenomenology aims to describe universal experiences which are shared by all those individuals who have a lived experience of a particular phenomenon. He also acknowledges the interpretation of perceiver consciousness and phenomenon. However, he believed that it was possible to bracket out the impact of context through different methods of reduction allowing us to return to the thing itself. Heidegger however, believed that humans are always embedded in lived experience and therefore context can never be bracketed out. Understanding for Heidegger is, therefore, not arriving at

an essential structure of lived experience but becoming aware of the interpretive influences.

Therefore, given the above various research methodologies that define themselves as phenomenological they cannot be easily separated into descriptive and hermeneutic (interpretive) but rather a continuum (Finlay, 2011). The position on the continuum determines the position of the researcher, the research method, data analysis, and the emphasis on the degree of reflexivity needed as well as the level of certainty in the final description of the phenomena being studied.

3.4.1 Van Manen Analysis

Van Manen is also a form of analysis rooted in hermeneutic phenomenology that was considered for the analysis of the data in this study as it aims to look at the meaning of experiences in the data in a pure hermeneutic perspective. The advantage and disadvantages of this method are similar to IPA however the determining factor and difference considered was that van Manen does not outline clear steps. This could be argued as being philosophically congruent with his hermeneutic philosophy (Dowling, 2007), however this can potentially add complications and leave novice researchers trying to replicate this study overwhelmed by the lack of structure and unable to follow the same steps I took in the analysis (Van Manen, 2017).

Based on the epistemological position outlined above and after evaluating the other qualitative analysis methods I have identified IPA as the most appropriate method of analysing the interview data. This method contends that to understand the lived experience requires investigating how it is experienced and what meaning is attributed to it by the individual whilst combining phenomenology, ideography and hermeneutics. It is able to sit well with the research aim and provide a clear structure to follow for the analysis.

3.5 Chosen Method: Interpretative Phenomenological Analysis (IPA)

IPA method allows participants to explore their lived experiences of a given phenomenon. This method is a philosophy and approach to inquiry that seeks the nature and quality of a phenomenon through critical and intuitive thinking about human existence (Omery 1983). An important part of IPA is that it draws on the hermeneutic tradition. This means that all description constitutes a form of interpretation (Flowers, Larkin and Smith, 2009).

IPA was chosen as a more appropriate analysis method for this study compared to Van Manen. It focuses on participants' meaning of their experience and how the experience is made sense of and interpreted. IPA aims to offer insight and close examination of how a specific person makes sense of a given phenomenon, such as significant personal experiences and life events. This method is different from other qualitative methods as it uses a combination of psychological, interpretive, and idiographic foci. It aims to develop a detailed formulation of a small group of people sharing and reflecting on common experiences. However, this is done while acknowledging the uniqueness and individuality of each individual within the group (Smith et al., 1995; Smith and Osborn 2003; Flowers, Larkin and Smith, 2009).

This method suggests that to understand the lived experience one must investigate how an individual experiences something and what meaning is placed on the occasion by the individual. It is a form of thematic analysis and involves systematic reading and re-reading of the interview scripts. This was followed by initial noting, and gradually through this process, significant themes (as interpreted by the analyst) emerged. This analysis was first done for each individual before a cross-analysis of the group of participants to search for commonalities across emergent themes and their experiences (Smith et al., 1995; Smith and Osborn 2003; Smith et al., 2009).

Moving through the stages was not a linear process, and the process is created to encourage reflective engagement with the participants' accounts. The result is always an account of how the analyst thinks the participant is thinking. Inevitably the analysis is a joint product of the participant and the analyst. Therefore, analysis is subjective, and for this reason, the researcher needed to remain reflexive throughout the process (Flowers, Larkin and Smith 2009).

The following methodological steps based on Flowers, Larkin and Smith (2009) were adhered to, though the steps were also discussed on other publications cited above:

- Reading and making notes: This process was to help me immerse myself in the data and recall the setting and atmosphere where the interview was conducted. This involved close reading of the transcript and listening to the audio recording of the interview several times. This process also included the me making notes on my observations and reflections on the discussion or any other thoughts or comments which were important, along with initial ideas and impressions in a reflexive diary.
- I then considered any comments such as how individual characteristics of the interviewer (myself) might affect rapport with the participant as these can be associated with personal reflexivity,
- Close line by line analysis of experiential understandings of each participant.
- Transforming notes into emerging themes: My notes reflected the source material. I worked more with my notes. The notes were then transformed into emerging themes by trying to formulate a concise phrase that may suggest a more psychological conceptualization. The experiential material emphasised both convergence and divergence, commonality and nuance. This analysis was first done for single cases then subsequently across multiple cases. This conceptualization was still grounded in the particular detail of the persons' accounts and emerging patterns.

- A dialogue developed between me and the coded data as well as my psychological knowledge about what it might mean for participants leading to the development of a more interpretive account.
- Seeking relationships and clustering themes: This involved looking for connections between any emerging themes and grouping them based on abstract similarities and then providing each cluster with an explanatory label. This led to some themes being dropped if they did not fit the structure or had a weak evidence base. A final list comprised of numerous subordinate themes and sub-themes. This was done for the whole transcript before looking for connections and clusters.
- The material was organised in a column format that allowed for the analysed data to be traced throughout the process through primary comments on the transcript, to initial clustering and development of themes to the final structure of the themes.
- Writing the study: Writing up the analysis involved the identified final themes being written up one by one. Each theme was described and examples were given with extracts from interviews, followed by the analytic comments of the researcher (myself). This process allowed the themes to unfold into an account that explains the important experiential elements that have been found during analysis, using interviewees' own words to demonstrate themes. This allows the reader to assess my interpretations and retain the voice of the participants' personal experiences.
- Supervision was used to help assess and cultivate coherence and plausibility of interpretation theme-by-theme supported by some form of visual guide.
- Reflection on my perceptions, concepts, and processes as I was interpreting the findings, this will be expanded upon in the researcher reflexivity section of this paper.

3.6 Study Design

The data for this study was based on a small, qualitative, idiographic sample using the phenomenological method (IPA) to guide data collection and analysis. Sampling was purposive and semi-structured interviews were conducted with eight participants.

3.7 Recruitment: (Criteria and Participants)

To fulfil the aims of this study the following criteria were set for participant recruitment:

- 8 Participants would be recruited for this study.
- Participants would need to be between the ages of 18 and 70 to participate.
- Participants would need to have experienced depression for over two months but less than one year before entering therapy.
- Participants should not have any complex presentation or multiple diagnoses.
- Participants should not be on medication or have had any other treatment for their depression, which could interfere with the experience of the outcome of existential therapy alone.
- Participants would need to have been diagnosed with depression from a psychiatrist or psychologist and self-report as having had experiences of depression before entering therapy.
- Participants should have voluntarily chosen to seek therapy.

Participants were chosen in this way to build on the existing literature discussed above by exploring the experience of the outcome of individual existential therapy for depression.

The inclusion criteria were initially set to include participants living in the UK however, this proved challenging to gain the number of participants required for this study. Therefore, the inclusion criteria was opened to include other countries around the world. This could potentially be linked back to the healthcare system in the UK and the socio cultural and political climate around popular treatments to depression,

I had conversations with participants who came forward and met the criteria to gain an understanding of the type of therapy they had and was satisfied that this was existential therapy alone as I did not have the details of the therapists themselves who conducted the treatment.

3.7.1 Participants

Participants who came forward in this study all appeared in discussion to be people with a curiosity about life and reflection. They appeared to be open to creative ideas and fluid thinking around topics. They also appeared to be willing to share information about their lives and reflections on the process openly.

3.7.2 Definition of Depression Used for Participant Selection

Participants all needed to be diagnosed with depression by a psychologist or psychiatrist. Depression is checked using psychometric tests such as PHQ9, which has a sound evidence base (Kroenke and Spitzer, 2012) as discussed in 2.2. This study only used participants' who identified with the diagnosis and self-reported experience of depression, therefore investigating what participants perceived to be

depression and depressive experiences which were addressed in the interview questions as it was explored how such questionnaires and diagnostic criteria are unable to capture the full experience of depression.

3.8 Data Collection

I began data collection after the research proposal was finalised and approved and ethical clearance was granted (Appendix B). After gaining ethical approval for this research I practiced my questions (Appendix C) several times to ensure that I felt confident and did not get distracted by the page of questions. When I felt ready for my first participant, I put out my recruitment posters (Appendix D) by therapists putting a poster/information sheet in their waiting room or on a notice board in their practice and by posting a recruitment poster on social media sites such as Facebook, Twitter and Instagram. Interested potential participants then volunteered to take part in the study by contacting me via email. For the complete research, 8 participants who were experiencing depression and chose to enter into existential therapy were recruited through this method.

If participants wished to participate and met the minimum requirements of the study (detailed in the inclusion/exclusion criteria on the poster) they were sent a participant information sheet (Appendix E) and consent form (Appendix F) to read, which gave details of the data collection process and informed participants of any potential side effects of the study, such as the possibility of experiencing negative emotions due to talking about their experience of depression. The information sheet also informed participants that interviews would be recorded, and all raw data that could identify participants would be destroyed after transcription, except for the consent form. Participants were made aware that data collection would take approximately one and a half hours. The information sheet additionally advised participants that all data collected is confidential and only anonymized data is accessed by the researcher's supervisors.

Participants were only interviewed after they finished therapy and not both before and after. They had also all chosen to seek therapy voluntarily. Participants who were still interested and arranged a time for the interview after they finished therapy with an existential therapist. I started the interview by welcoming the participant and explaining the information sheet and consent form again before the interview. I explained this consent form and information sheet to ensure that participants understood the document before signing, allowing the participants to give informed consent before taking part in the interview and asking if they had any questions about the research. Participants were then asked to sign the consent form after the chance to ask any questions (Appendix F).

Then I followed on to the research questions. Participants took part in a one-hour semi-structured interview with me exploring how they perceive their experience of depression. During the interviews, additional questions or follow-up questions varied slightly as I wanted participants to follow their own experience and journey of recalling these experiences. Some questions remained standard through all the interviews to help guide participants through the stages of exploring their experience before and after therapy. This open-ended approach is supported by Flowers, Larkin and Smith (2009) as an essential part of phenomenological research. It enables the researcher and participant to explore the phenomena freely without being defined by a predetermined process. There was then a close of interview discussion about participants thoughts and feelings after which they were sent the debrief sheet (Appendix G). Each interview was recorded, transcribed and anonymised using a pseudonym for participants. Interviews were recorded using the participants' code to maintain confidentiality and kept in a locked cupboard in the researchers' home. The data was stored on a password-protected computer. All data was then analysed using IPA to explore any changes in participants' experiences of depression after having been in existential therapy and what they felt helped any change.

3.9 Data Analysis

The IPA approach was used for this research, and data analysis was carried out using the method detailed by Flowers, Larkin and Smith (2009). This meant that the study was conducted using an interactive process that included reading and re-reading the transcripts. Three levels of coding were used to identify main themes and subordinate themes across the data.

The analysis began with each transcript being analysed individually, with me bracketing any findings or initial thoughts from previous interviews with participants. This was done in an attempt to engage with each transcripts' data separately and refrain from using themes that were identified previously in earlier cases that might colour the analysis of the subject being explored at the moment (Smith and Osborn, 2008). The data was analysed and coded in three sections using the IPA steps below before bringing the findings together to highlight any change in experience before and after being in existential therapy. The steps followed for the analysis of data for this study are also laid out in section 3.5. These steps were followed for; 1) experience of depression before therapy, 2) experience after therapy, 3) what contributed to this change.

3.10 Initial Reading

Each transcript was read following each interview. No comments were made at this stage. This reading was to make sure that I had made no errors when creating the transcript and for me to familiarise myself with the data further.

During the second reading, is when I captured any comments of first impressions of the content in my journal. This allowed me to make a note of interesting words or phrases that stood out while attempting to make meaning of what was said. This process helped create a level of familiarity with the data and helped me become aware of the described experience.

3.11 Descriptive Analysis

As the first level of coding, I read through the text again and did a line-by-line analysis focusing on any words or phrases that stood out in the text due to frequency, connotation, or perceived importance to the participant or myself. These were highlighted and included in the level of descriptive comments in line with the process described by Flowers, Larkin and Smith (2009). This process highlighted items added to the level of inquiry that began with the initial reading of the transcript and identified areas of further interest to be explored in other readings of the text (Appendix H) These notes can also be seen in the full interview transcript (Appendix I).

3.12 Linguistic Coding

The next level of coding included linguistic comments. This involved a deeper exploration of previously highlighted sections and previously repeated words or phrases. Here I focused on the word choice of the participant and looked to consider levels of linguistic meaning that exist in each word or phrase. I made notes of these in the margins of the transcript (Appendix H). I also paid attention to metaphor or other linguistic elements used to describe the experience. This allowed me to consider levels of meaning that may exist not only in each word but also in phrases both inside and outside the context of the sentence (Appendix H and Appendix I).

3.13 Conceptual Coding

The third level of coding allowed for conceptual comments, moving away from explicit claims of the participants and moving towards more conceptual interpretation. This helped to elicit deeper levels of meaning within the experience

and allowed for the identification of emergent themes, which helped capture the essence of participant experiences. These summary sentences were also written in the margin of the transcript to be referred to later (Appendix H and I).

3.14 Theme Analysis

After completing the coding and identifying themes in each transcript, I began looking for connections between the themes in both individual transcripts and themes that appeared and connected across different transcripts. As themes emerged between different transcripts, an additional table was created (Appendix J) to help visualise where these themes converged or diverged and where themes tied back to the original research question.

The data analysis was an interactive process focusing on convergent and divergent themes making meaning of the participants' experiences. Varying levels of interpretation occurred throughout the process revealing new levels of complexity and depth in both single cases as well as across experiences of all participants.

It is important to note, as this research aimed to explore the experience of the outcome of existential therapy for depression, the data analysis for this was divided into three sections as follows. All steps were followed as above for experiences of depression before therapy as one section, the second section was experience after therapy and lastly what helped. The sections were then compared to get the change in experiences among participants and what contributed to this change. This is the same three section structure that the findings section will follow in discussing the experience of the outcome for existential therapy for depression.

3.15 Ethical Considerations

The main risk identified with this study was the potential for the emotional upset caused by inviting participants to reflect on their experiences of their depression. I followed the five principles of research ethics here 1) discussing intellectual property frankly 2) being conscious of multiple roles 3) informed consent 4) respect, confidentiality and privacy and 5) using ethics resources to keep informed of my ethical obligations (Knapp, 2012; Hesse-Biber and Johnson, 2016). Therefore, comprehensive details about the study and in particular this aspect of risk was included in the information sheet that was sent to participants allowing them to make an informed decision on whether they would like to participate.

This consideration was managed by:

The participants being offered the opportunity to explore this with me immediately after the interview. If the case would have arisen that they felt extremely distressed participants would have been provided with a crisis plan. Participants were also provided with a list of agencies they could contact providing support.

Participants were asked at the beginning of the interviewing process after reading the information sheet, how they thought this interview might make them feel and how they would take care of themselves afterwards. They were also advised that there was a list of services and organizations available in the debrief sheet should they feel distressed.

Participants were also reminded that they could stop at any time, and they could also take a pause at any point during the interview. It was also at this point established between the participant and researcher how the participant would make the researcher aware that they would like them to stop asking any question.

They were also advised that they could withdraw their data at any time up to one week after their interview without giving any explanation. Furthermore, having a therapist as a researcher ensured sensitivity in managing any risk.

It is important to note as this research aimed to explore the experience of the outcome of existential therapy for depression the data analysis for this was divided into three sections. All steps were followed as above for experiences of depression before therapy as one section the second section was experience after therapy and lastly what helped. The sections were then compared to get the change in experiences among participants and what contributed to this change. This is the same three section structure that the findings section will follow in in discussing the experience of the outcome for existential therapy for depression.

3.15.1 COVID-19

Due to COVID-19, participants were mainly recruited through social media, although putting the poster in waiting rooms continued as planned as many offices were open from June 2021. Participants who preferred to have the interview face to face would have meant the research and participant would have been socially distanced by 2-metres and both be wearing masks. Interviews would have all been socially distanced to protect both parties. Hand sanitizer would have been available at the location, and disinfectant wipes would have been used to wipe door handles and seats between appointments. All participants preferred to have the interview online and met with me through Microsoft Teams. This is the most secure platform online, or other similar platforms were used if participants did not have teams. They were sent instructions to take the call in a confidential and safe place, with minimal noise and interruptions, as well as for them to ensure they have enough battery to last for 1 hour and a half.

Ethical approval for this research was requested from and granted by the university ethics board (Appendix B). The areas which were addressed for ethics were around risk to participants and the potential for participants to experience

emotional upset caused by inviting participants to reflect on their experiences of depression. This consideration was addressed by the measures discussed above.

3.16 Researcher Reflexivity

As a researcher who had a primary role in this study, I acted as a guide and interpreter of experiences for the participants during the semi-structured interviews. It is said that the research cannot be separated from the researcher (Lincoln, Lynam and Guba, 1985). Therefore, it was vital that I was keenly aware of my feelings about the topic being explored and took precautions to withhold interpretations and preconceived notions about participants' experiences or the phenomena under investigation. It is important in qualitative research for the researcher to remain reflexive throughout the process (Creswell, 2013). This process of self-reflection helped to keep the interview as authentic as possible and purely focused on the participants' experiences. This was also an important process throughout the analysis phase of the research as well, as I was the one engaging with and interpreting the participant experiences (Hesse-Biber, and Johnson, 2016). Below is reflection of my relationship with this research.

3.16.1 Background

Coming from a background of clinical psychology I was used to understanding and working with clients/patients experiencing depression through a more quantitative and CBT lens. Through my career I moved to working in the National Health Service (NHS) Improving Access to Psychological Therapies (IAPT) where I undertook additional modality training in Person-Centred Counselling for Depression (PC-CfD). This was a very different way of working and focused more on the client/patient experiences rather than processes of cognition. Working with these clients/patients I heard many stories of diverse experiences of depression and their journeys through their experience. Clients/patients discussed their

relationships with themselves, others and life. I was working with these clients/patients from an integrative but mainly humanistic and existential perspective due to my doctoral training. Through this process I was recording recovery scores for clients/patients and noticed scores improving for some clients/patients. Initially when I began this work I found myself having to be aware of when I wanted to take a more cognitive approach as I was more used to working in this way. I became interested in the existential approach to working with depression and clients'/patients' journeys through their depression. I noticed the cognitive approach didn't fit with everyone and many of the clients/patients I saw in the service were struggling with experiences of living and facts of life rather than cognitive biases and other concepts that could be worked with using CBT. Therefore, it was both interesting and helpful viewing depression as more of an experience of living and I was curious at what it was that helped clients/patients or changed in clients/patients to help them through their experience of depression, and what was behind the change in recovery scores. I began looking into the research on the outcomes of existential therapy for depression and found many quantitative studies showing these findings but found less looking at the experience of the outcomes especially when narrowing the search down to depression alone.

3.16.2 Bracketing

During the data analysis, I was also aware and carefully monitored my feelings as well as instances where I could potentially have been inserting my reality or perception into the analysis. I kept a research journal to help me with this process of reflection. The journal entries were made after each interview to help provide space and reflection to capture initial thoughts and feelings. The journal was also used for reflection alongside the readings of interview transcripts. This not only helped with understanding my thinking and feeling, but also helped to sort out initial reactions and impressions to the interview material. These reflections were later used to help inform thinking and questioning during the interactive analysis process. As I cannot separate myself and experiences from the interpretation and

engagement with this research, by being aware of these experiences or any positionings I was able to bracket them from influencing the analysis in a way they otherwise may have done (Tufford and Newman, 2012; Fischer, 2009).

3.16.3 Research

Reflecting on the research my history being slightly in favour of quantitative research but unbiased to either made me look at this topic first from a quantitative approach however in the literature review I began with an interest on what was published around the outcome of existential therapy for depression. The existing literature and gaps in the research led me to qualitatively approach the topic to expand on the limited qualitative research around existential therapy and depression. I was interested in the outcome of existential therapy for depression and therefore chose to focus on the experience of the outcome. The method of choosing to interview participants after therapy with them reflecting on their experience of depression, It is important to consider how this impacts the project. Participants' memories of their experiences may not be completely reflective of how they were feeling at that time and can be influenced by how they are feeling when they remember their experience and their relationship with that experience. There is also the form of data collection that was considered. Choosing to collect participant experiences by interviews leaves room for participants to feel they would like to give the responses they think the researcher might want to hear potentially adapting their narrative to reflect different outcomes. This can be due to the power dynamic in interviewing as a method of data collection (Durkin, Jackson, and Usher, 2020). To compensate for this possibility some important interview questions were asked more than once using different wording. This was also considered in the analysis looking at the responses and themes across all answers in each section to give a more accurate reflection of each experience. I believe it is important to be concise and research should contribute to the field therefore, I looked at the analysis and findings from the perspective of staying with participant experiences but in the discussion looked at how these fit within existing literature and the gaps it fills with the conclusion following a similar style.

3.16.4 Interviews

The interview questions (Appendix C) were designed to understand the experience of the outcome of existential therapy for depression almost a qualitative take on a quantitative study. I did a pilot interview to see how the interview questions would be received by, and felt with a participant. The participant reported positive feedback on the questions after interview and found it helpful to talk. We discussed the element of emotion that was triggered during the interview as the participant discussed experiencing feelings from the times that she was describing whilst talking about her experience. She reported feeling supported and not judged during the interview. The interview questions did not change following the pilot interview, however the order in which some questions were asked was changed to give a better flow to the interviews. Other interviews with other participants were experienced in similar ways with all participants being open to sharing their experiences with many expressing emotions during the interviews. None of the participants felt distressed afterwards and all reported finding it helpful to talk about and reflect on their experiences. All participants were people who were open to talking about their experiences and I felt I had a good and open connection with all participants. Many participants had an interest in philosophy and discussing and facing life and its challenges. I felt the interview questions were effective and generated a good depth of experiences.

3.16.5 Practitioner/Researcher

One of the reasons the participant in the pilot interview said she felt comfortable and not judged to express that level of emotion was me being the researcher. This could be related to being a clinical practitioner as well as a researcher as I have had much training in being with emotion and providing a safe and empathetic space. I am also comfortable with the expression of different types of emotions. This was helpful in participants having positive experiences of the interviews as being therapeutic but

also a factor to consider in that participants may share more information due to this or feel more comfortable to go to greater depths with the telling of their stories. This is something I was also aware of during the interviews as I am used to providing minimal encouragers to clients/patients during sessions and how this could influence participants to say more or less on a particular area. I tried to remain more neutral during interviews providing less reflection and more of an empathetic presence which was helpful in ensuring participants felt comfortable during interviews.

3.16.6 Change in approach

Through the process of conducting this research and reviewing the findings' my perspective on working with depression changed and my view of the importance of the therapeutic relationship shifted. I realised that I had perhaps underestimated the importance and the impact that this element alone had on participants' relationship with their depression, themselves, life, and so many other connections. Participants' relationship with their depression and the link this had to identity was another one that might appear obvious but can easily be overlooked or underestimated.

Being integrative and exploring the findings I can see how the experience of depression is largely about lost connections and how the relationship with self is a big part of the experience of depression. I also gained a deeper understanding of how this connection with self can be developed through therapy and the therapeutic relationship. I can also see where other approaches such as the psychodynamic approach could come in at the relationship angle to begin rebuilding connections in other areas from that perspective and how a CBT approach can come in looking at the negative thinking many clients/patients experienced about themselves and their experiences during their depression. I can also see this fitting into clients/patients wanting to withdraw with the behavioural side of things and where CBT techniques such as behavioural activation (BA) can be helpful to help clients/patients to engage in activity and build motivation. Nonetheless, I now understand depression to be a much more

meaningful experience of connections and identity and believe it to be helpful in understanding a client's/patient's personal experience of their depression before choosing a model that fits with each client's/patient's needs and element that could be most helpful to start working from. It has also chanced my approach from structuring treatment based on clinical guidelines to being with a client/patient and understanding their individual needs.

Chapter 4

Findings

This chapter is going to discuss the findings of the data analysis that was conducted using the IPA method as discussed in 3.5 to 3.17. This chapter, as also discussed in the analysis section, is going present the findings in three parts as it was analysed. 1) experience of depression before therapy, 2) change in experience after therapy and 3) what participants found contributed to this change. This is to highlight the difference and change in the lived experience of depression before and after existential therapy.

Table 1: Participant information

Name	Gender	Age	Time in Existential Therapy	Country
Sarah	Female	70	1 Year	New Zealand
Ana	Female	31	4 months	UK
Jessica	Female	35	3 years	Mexico
Anima	Female	38	2 years	UK
Richard	Male	47	3 years 6 months	UK
Julie	Female	26	4 years	Australia
Rawan	Female	29	1 year 4 months	UK
Noelle	Female	28	3 years 6 months	UK

4.1 Writing up the Findings

There were common themes that continued to appear in the transcripts of the eight participants even though they were all completely different, from different backgrounds and had never met. The participants shared a similar experience of depression, changes in experience after depression and in what they found helped or contributed to that change in experience. Each of these mentioned sections, have

themes and sub-themes which are reported in a table of main themes and sub themes that emerged from the analysis (Table 2, Table 3 and Table 4).

4.2 Experience of Depression Before Therapy

Table 2 Themes and subthemes in experiences of depression before therapy

Themes	Sub-themes
Loss of safety and connection	Identity and meaning Life Relationships
Relationship with experience	Not understanding
Not wanting help/wanting to be alone	

All participants in their experience of depression before therapy reported experiencing a sense of loss and disconnect from things they would usually feel secure in. This left participants in a place of emptiness as they felt they could not connect with points in their life that were central to their sense of safety, identity and understanding of the world.

The first theme in this section has three sub-themes, and the second and the third themes each have only one subtheme. Pseudonyms were used for participants and their identifiable personal details have been removed to keep anonymity and confidentiality.

4.2.1 Theme 1: Loss of Safety and Connection

4.2.1.1 Sub-theme: Identity and Meaning

All participants had their way in which they approached life. They also had a belief system about what is right and wrong for them. These were influenced by their environment, experiences and culture. A common experience around depression was feeling conflicted or feeling bad about going against something which they felt they should be doing or a conflict in values. This was often family related or brought about by a situation in life where they were torn between conflicting parts of self or understanding. Participant Sarah talks about the conflict she faced with needing to put her mother in a care home.

Sarah: "[...] we just couldn't cope with her. So, she went into private nursing care. And I felt terribly guilty and ashamed and all sorts of things because I was adopted. And, you know, she took me in when I needed care. And now look what I was doing." […] And I didn't realise that the things she was saying were part of the dementia. I thought she really meant them. She was a mess. It was a complete mess."

These competing choices triggered a conflict in values which participants found very difficult. Participants described situations of having to choose between things that are important to them and coping with the consequences of that choice. Participants' view of themselves was brought into question as seen below in the quote from Ana talking about how her desires are different to the expectations placed on her by her surroundings and the judgements she faced for her choices.

Ana: "However, my version of putting them first is different to other mothers. And that's okay. But there was a lot of judgement, I was very supported by my parents and my husband for my decision to do my masters. But it was like, suddenly, I was a bad mom, and a bad wife for wanting to do my masters. I didn't even put my son in nursery, actually, my mom took a year off work so she could look after my son. And that brought everything, that brought my whole existence into question. Because my identity shifted so drastically, from being a woman to being a mother. Of course, like I'm both but suddenly that mother role was at the core

of my identity, that was being called into question. So, I felt like an absolute failure towards my children. Because of the words of other people, and that would cause huge arguments between me and my husband. His arguments would make me feel like I didn't want to be there anymore."

Ana talks about her existence being brought into question, highlighting the importance or her identity as an anchor in life and the impact of that being shaken for her without other support to hold on to. Other participants described their experience of depression as a struggle to balance the different roles. Jessica below talks about how the different demands she faced and the different roles she felt the need to play took her away from the role and identity that was important to her which was being a mum.

Jessica: "Very distressed, very distressing, very, very challenging. On the one hand, I was very thrilled, I was a new mom. I was absolutely thrilled. I was happy. I was looking forward to it for a long time, because I was quite late in making my baby. And while I wanted to enjoy all of that, I really couldn't because my mother-in-law came in and just as he was turning two that became a real problem for me, a real struggle. It was family dynamics."

Both participants discussed feeling their identity was being challenged. They struggled with the space between who they saw themselves as and who others thought they should be. This could also be understood as balancing different roles as seen in the quotes from Ana, Sarah and Jessica. Anima below used the word crisis to describe how she felt about her identity expressing how destabilising this was for her.

Anima: "My, my identity, in many ways was in crisis because yes, I was a daughter, I was a wife. But for me, being a mother kind of supersedes all of those roles. And I wouldn't have wanted that to be jeopardised in any way. That identity."

> “I was so happy because there was this new existence I had brought into the world. And it was my responsibility. And also, this new person meant that I became a mother. I became a mom. Until that point, I was just me. So, I think it was identity. Yeah, it was, but it was an additional part of my identity, actually, yeah. Yeah. And I was looking forward to enjoying that. I still do, nothing will change that. But this, it felt very intrusive for me to have another person in the house that kind of took some of that away from me.”

The conflict between what a participant felt they wanted for their lives and the pressures of relationships led to a questioning of the self and a space of nothingness as expressed in the quote from Rawan.

Rawan: “I’m in a dichotomy here, you know, between what I’m told that I should do, and what I want to do. And I don’t like this, and I don’t know what to do in this space.”

Participants didn’t know how to identify or manage this, Ana’s experience adds to the theme describing the space she found herself in, the space between the two sides of her wants and the pressures of her family.

Ana: “Because I was studying for my masters. They didn’t like that. So, I started that low mood of like, the pressure of my studies and the pressure of having young children and then the additional pressure of socially what my in-laws wanted from me was different to what my husband was okay with, was different to what I wanted to do. Yeah, it was a very dark place.”

She discussed responding in ways she did not recognise:

> “I felt a huge sense of despair. I don't usually cry; I don't cry very easily. Growing up, I didn't cry very easily. I cry if I was physically hurt.”

The feeling of being connected to an identity was important for participants with those not having it searching for it. The quote from Richard below describes just this, searching for a sense of identity, belonging and wanting to be understood. We can also see from this quote a wanting to make sense of his experience.

Richard: "I didn't really have the answer to who am I and what am I and in no way sort of through that also, you know, thinking, you know, that there must be some sort of diagnostic category for me, you know, sort of as you're training, you're kind of looking at all the kind of ways that people are understood and, you know, the different character styles or even personality traits and trying to find something that sort of says, Oh, this, this is there on the money with, with my experience, never really finding it, you know."

The sense of belonging is another one that was important feeling connected to an understanding of oneself and the feeling they are accepted and belong as seen in the quote from Richard. The following quote from Noelle discusses the impact of this disconnect from a sense of self and how she felt there was nothing to guide her and help give her life direction and order.

Noelle: "I was very troubled as a person, I'll probably say that I was very disconnected from myself, I had no idea what I was doing. And I felt like there was a lot of chaos in my life, I felt like I was very fearful. And I was very much leading my life with fear."

This disconnect from identity and other aspects of life which shall be discussed later left participants in a place of nothingness and unknown. The confusion of not understanding why they were experiencing what they were contributed to the relationship they had with their experience which will also be discussed in a later section. Participants further spoke about not fitting in and the judgement they felt around that. An example of this is how some participants discussed feeling a cultural pressure to be married and what it meant for them if they weren't. Noelle discussed

the assumptions that were placed on her and how she felt she was viewed. Here again we can see a separation between what Noelle had chosen for her life and identity which was to study and what she was told to be by the society and culture around her. She discussed marriage in the quote below.

Noelle: "...if you haven't had that, then there must be something wrong with you. Or you must have been up to no good, you know, meaning fussing around and like not really making much of it anyway, which isn't true, because I've been working like a dog all this time. I'm just trying to make something of myself. And I think that there's a lot of sacrifices that you make"

4.2.1.2 Sub-theme: Life

This sub-theme highlights the experience all participants shared in finding some aspects of life overwhelming or difficult to cope with. This contributed to the feeling of depression as well as participants not feeling good enough. Jessica was trying to balance caring for her new baby and her mother-in-law. Participants found balancing different aspects of life with tasks or identity as well as conflict in values challenging.

Jessica: "During those very difficult years when my child was very, very little because he needed my attention as well. And she needed my attention too, so my husband would definitely care for her when he was around but he had to work, different shifts he travelled and so it just made it very hard for me. I was left on my own."

Participants also felt that the level of support, they received at this time was important. This theme will be explored deeper in the relationships section.

Staying with the theme of 'life' participants also felt life should be different to what it was and felt powerless in that. Participants wanted a sense of knowing and the push and pull of different aspects of life as well as needing to make choices left some

participants feeling they are not meeting their expectations of life. It was also felt that there was a sense of unfairness in the current life and that the unfolding of it was not supposed to be the way things were.

Ana: "I became very accommodative. And I think the change I was hoping for is that my mindset would change in that I wouldn't be rigid, but that I would have a mindset of yearning and growth, rather than a fixed mindset. You know, that this is how families ought to be, and this is how life ought to be."

This feeling of difference between how things should be and are was described by Noelle as contributing to the feeling of not understanding.

Noelle: "[…] is just an abyss of uncertainty, just sitting in that dichotomy, and just going? Like, what do I do and then you feel resentful, you know, you feel resentful being a woman of colour, you know, you feel so mad, because it's like, being a woman is hard enough as in school stop. I mean, it is ridiculous. You know, there's all this expectation is bullshit expectation of, you know, you gotta be educated and you've got to have a career, and then you gotta make sure that you're married and you have kids before you're 30."

Not having anything to hold on to and uncertainty in either meaning or identity meant that participants struggled with the paradoxes of life and needing to make choices, some of which went against cultural customs as described by Ana, Sarah, Jessica and Noelle. Within this there was a missing guide to help participants navigate existence. The quotes below discuss looking for those guides.

Julie: "I guess I was kind of always searching for, you know, some sort of meaning. I think, did I, I think I realised that it was a stressful situation I was in, and kind of just doing, I was just doing the best, the best I could. Yeah, but not really, not finding any kind of meaning in it."

It was also expressed that this lack of doing something meaningful was taking away from the limited time that is given in life as expressed by Richard below.

Richard: “I didn't find any inherent meaning in it. And more than that, I found that it was, it was kind of hijacking my time, and time that, while I'm alive, I need to be exploring and finding out what this is.”

“I was feeling quite lost, actually. And I moved. So, I was working, I was living and working up in Berkshire, near Reading, and I was really unhappy with my life there. And I just broke up with someone, a relationship had ended. And I was just feeling, you know, just this sort of existential angst, you know, which is always there, but it's sort of it, you know, it amplifies and then attenuates, you know, at different times in my life.”

Here again we see this participant talking about being in between places having a relationship end and not feeling satisfied with the place he was living and working. This left him without an anchor to ground himself and something to hold on to. Julie below discussed losing her job and relationships which were important to her.

Julie: “Something has happened in my family to make me feel, like, really bad, then having a tear with the person was the last thing that brought me into depression. And we have to add to that that I also lost my job in the months after that- so kind of everything just balled up together.”

Participants in this section are all expressing a loss of safety and connection with something familiar. They are experiencing a sense of lostness and disconnect without something to anchor themselves to. Here, relationships were important for participants as we see reiterated in the last quote Julie felt the tear in a close relationship was the last thing that she felt pushed her into a depression. Relationships were important for participants serving as an anchor or support in difficult times which brings us to the next theme.

4.2.1.3 Sub-theme: Relationships

All participants expressed searching for belonging and being understood. However, they also expressed wanting to be separate and have space from others. Reasons linked to this will be discussed in the section relationship with depression as this was found to be the theme that had the most impact on how participants engaged with relationships. Richard discussed moving to a different place in an aim to find somewhere he felt he fit and belonged. This can also be understood as a disconnect from a sense of belonging experienced in depression.

Richard: "I sort of upped sticks and moved to a different part of England to start again, really. But I landed in a, in a shared house, out in the countryside, with some very unstable characters in that house. And, and in the, I just felt quite a high level of anxiety. And again, it was kind of where I'd landed, it seemed better than where I'd come from, but I didn't really know anyone, and that was kind of wandering around, you know, coffee shops, just thinking, "What- what the hell is this?"

Noelle also described this sense of not belonging or being connected with others and how this made her feel lonely and isolated.

Noelle: "I'm not doing the norm. And I'm not meeting everybody's expectations. It's just incredibly exhausting and frustrating. It just makes you feel incredibly lost. Very much so. Incredibly lonely. I mean, it's very isolating, because there is no one from my background that I have come across that is doing what I'm doing. There is no one. And I haven't come across anybody like myself. It's incredibly isolating."

This sense of isolation and not belonging was perpetuated or not by the support around a participant and how accepted they felt by the relationships around them as this was also an important factor. Jessica expressed how felt she was not allowed to express negative emotions around her step mother.

Jessica: “I couldn't talk to her about my father-in-law because she would get very angry. So, on one occasion, we drove up to go and visit his grave. She was cross because I was so sad and distressed. She was very cross with me. It was almost as if I did not have a right to grieve him.”

Jessica said this led her to not share her experience. She spoke further about not having someone to share things with.

Jessica: “I didn’t. But you know, you know, when you don’t address grief, and pain, and then you get distracted with life, especially with what happened to me, the grief kind of got suppressed. Because I distracted myself, and I hadn’t actually addressed it.”

The combinations of life stressors discussed in the theme above and lack of support or close relationships made the experience more difficult for participants. Julie below discussed losing her relationship with close friends at a stressful point in her life in which she reported finding the life difficult on its own and managing the stress of her studies.

Julie: “I got into a huge fight with my best friends. And we kind of stopped talking to each other. And it was really stressful for me. And I didn't have friends and the few that I got, they kind of just talk with my best friend. And they kind of take sides and in the checking sides I kind of got lost in the middle. So, it was really stressful. It was my last year of high school, and also, I'm so bad at math. Like you can only imagine. But I have a lot of subjects that require a lot of mathematic kind of abilities that I didn't have, so for example, advanced chemistry, and physics and algebra and those kinds of subjects.”

The quote from Julie above shows that while she lost connection with her best friends, the stress was also compunded by the workload in school. Participants found changes in relationships difficult and the breakdown of friendships or romantic

relationships. Participants described finding a sense of safety in close relationships and feeling lost when that shifted.

Noelle: “I had just come out of a really, a very toxic abusive relationship. And I couldn't, and it was, I think it was like a few months, into COVID. So, it must have been, like, around June 2020, or May 2020, and a lot was going on, because I just found out my ex, I had been with him for about 13 years. And we were planning to get married, but summer, and all the arrangements and everything was set. And then all of a sudden, I found out that he had been having an affair the past few years. And I found out in May of 2020, that he got married in February of 2020. And so that meant that I was now his little side piece. I went from being the main person to the side piece. And so, I kind of sat there in shock and thought, Oh, my God, how could this have happened.”

“I think my interpretation of the situation shifted. I was very fear-led within this dichotomy of, oh my god, I have blind panic, I've left the guy, that was essentially my role.”

The loss of relationships was destabilising. What participants expressed as getting from relationships is a feeling of being understood and accepted as well as some having part of their identity in their relationships and not having this made participants feel isolated and alone as described by Julie in the quote below.

Julie: “And you do feel very isolated. Because not everybody understands on Earth, as you know. And I've had the stigma of, oh, it's gone from stigma, what the hell is this? What are you going to do with your life with this crap? And one or two, all of a sudden having the stigma of work? “And it's incredibly challenging to come across people who will have that mutual understanding. So, it's very much like a lone soldier type thing. And, yes, you can have a support network of people around you who, may have similar strengths that may be very different. And

so, we can confide in each other through that. But regardless, it's still a very isolating thing."

Participants discussed just wanting to be understood and to feel someone understands and accepts them.

Sarah: "I want to live life on my own accord and not have to get into some kind of conflict with my family members. I just want to have my family members support me for it."

Jessica expressed feeling concerned that her therapist wouldn't be able to understand her as she took a leap of faith to reach out for support.

Jessica: "[…] my one main concern was, is she (talking about her therapist) going to be able to understand my culture? Is she going to be able to address this dichotomy that I'm in?"

This need to be understood in relationships and how comfortable participants described feeling to reach out and share their experience with others appeared to be linked in itself to the participants' relationship with their own experience as well as a fear of not being understood.

Rawan: "I kind of sort of knew that I was dealing with depression. And I kind of didn't want to go with a doctor, to give me the full diagnosis just because I felt like it was too hard on myself just to admit it. And it was difficult for me, just to say it out loud, mostly because of certain stigma. And because I didn't want it to go to a psychiatrist. I wanted to deal with it myself."

In this theme we see participants wanting to be understood but fearing that reaching out would make them feel judged and even less understood leaving participants alone with their experience. How open participants were to talking about and sharing

their experience of depression appeared to be related to their own experience of their relationship with the depression.

4.2.2 Theme 2: Relationship with Experience

Participants had different relationships with the depression that they were experiencing. They all described negative associations and six out of eight participants discussed not knowing why. Sarah described her relationship with her experience as:

Sarah: "I wasn't good enough, which I'd always been brought up to believe anyway. And it impacted on that and just, just awful, just terrible. Yeah. Just Yeah. Shocking. Couldn't cope- I couldn't cope with my mother. I couldn't cope with the feelings of pushing her into a nursing home when she was so distressed."

The feeling of their experience being unacceptable was a common one among participants with many people expressing a sense of how they should be coping or what is normal. Participants also reported feeling their experiences were random and unexplained as can be seen in this quote from Julie. This will be expanded on in the next theme.

Julie: "[...] in the moment, not really, because I didn't feel like there was something major going on, maybe I was just so stressed."

"[…] really kind of brings me down. And sometimes it's not even at a moment where I feel like it should bring me down. Like sometimes I'm completely fine. Everything is okay. And then suddenly, I start to feel down."

4.2.2.1 Sub-theme: Not Understanding

Six out of eight participants described not understanding what they were experiencing and why. They expressed there being a sense of not knowing and emptiness with this, also a sense of helplessness that came with this unknown. Sarah expressed:

Sarah: "I just couldn't make sense of it."

with another adding:

Julie: "Yeah, just, it was just thinking that, okay, so I'm gonna be like this now. So, in a sense, for me, that was the answer. Like, it's just something that just happened to me. I don't know how, or I don't know why. But now I'm just stuck in this feeling."

This theme ran through participants' experiences with most describing some form of this.

Noelle: "[…] like a very kind of a confused, confused, disconnected type feeling."

Julie: "I thought that it was something that I was dealing with since I was a teenager. I remember that. One day, one specific day, I started to feel different. I started to feel kind of sad or anxious. And I remember thinking, Oh, so now I'm stuck like this. So now, this is how I'm going to feel like forever."

These experiences of not understanding led to participants feeling critical of themselves. Participants expressed different ways of coping with this experience. Most discussed dismissing the feeling and continuing. They expressed wanting to make sense of the experience.

Julie: "I guess on the surface, it was just like, well, I'm studying hard. I'm looking after mom. Of course, I'm just feeling bad. You know, it's a kind of answer that's a meaning, but it's only a kind of surface type meaning we're not really questioning or understanding why am I not enjoying things you know, you can be stressed and have a lot to do and still go out and enjoy yourself."

Richard: "[...] and not understanding, why is it that I'm unhappy where other people seem to be able to be content? And then why is it that I am, who I am? And what does that mean? "

This was also a big part for some participants as not everyone felt they could identify the reasons for how they were feeling and found the experience to be confusing.

Ana: "I was in a really, really low place at the time. And I couldn't understand why. Because on face value, I had everything good going for me. But I was really really low."

She expressed this as leading to arguments with her husband.

Ana: "Emotionally. I was crying at night; I was fighting with my husband. And I couldn't make the connection of why I just couldn't understand what was going on." It wasn't like a concrete problem that we had. I was crying endlessly and like at night, and I just cry and sat next to my husband and just cry, and it's never understood why."

This confusion and not understanding why they felt this way was tied into participants fearing others would also not understand as well as fear of the stigma. As described in the relationship section this was experienced by participants as wanting closeness and a feeling of being understood but not reaching out and wanting to be alone perpetuating the feeling of loneliness and lack of connection that was so prominent in participants' experiences of depression.

4.2.3 Theme 3: Not Wanting Help/ Wanting to Be Alone

Seven out of eight participants discussed this theme of wanting to be alone with their depression. Sarah describes her defensiveness and resistance to getting help.

Sarah: "I was closed down, I couldn't take help from anybody. […] I don't know, I don't understand, help me through this. […] when I was in a bad way, I was very defended. No, I know everything. I don't need help go away go away."

Jessica also talks about feeling a need to keep going and appear everything was alright. She did not want people to realise that she was experiencing any difficulties.

Jessica: I suspect other people might call that a breakdown. But I didn't, I didn't, because I kept going. So nothing outside broke down, just inside.

She further expressed that she didn't think to ask for help at that point and when she did she reported feeling her loved ones couldn't handle it and therefore also did not want to burden anyone with her story.

Jessica: […] It didn't occur to me to ask, so God knows who else isn't getting helped, if I don't think I can ask for help.

[…] Dear friends and loved ones had tried to hold up but no one had been able to hear it.

This was added to by Rawan in her expression of only being able to experience her emotion in private.

Rawan: I really couldn't openly express emotion like, like, I couldn't cry in front of anybody at all, I could in private.

4.3 Change in Experience After Therapy: Rebuilding Connections/ Finding Anchors

Table 3: Themes and subthemes in the Change in Experience after therapy: rebuilding connections/ finding anchors.

Themes	Subthemes
Safety and grounding/anchors	Identity and meaning Life Relationships
Relationship with experience	Being present/ the body Gratitude

In this section first theme has three sub-themes, and the second and the third themes each have only one subtheme.

4.3.1 Theme 1: Safety and Grounding/ Anchors

All participant's descriptions of their depression revolved around experiences of disconnect. They spoke of disconnect from their identity and things they used to enjoy as well as a disconnect from people and relationships around them. They also expressed confusion and not understanding what they were feeling which led to them thinking other people also would not be able to understand. This had left participants feeling alone and critical of themselves and of their experience. They wanted to escape from it but were confused and cut off from anchors and relationships in their lives that were central to their experience and relationship with life and themselves.

In this second section, looking at participants' experiences after being in existential therapy, we can see and understand that there is a rebuilding and reconnecting with these important anchors. These started for participants in different ways primarily through understanding themselves and their experiences. Through this they were able to find anchors in parts of themselves and things that were important parts of their story, relationship with life and identity. Out of this grew strength and a sense of grounding.

Participants expressed using this to reach out and create different anchor points in life that they could connect to. They began to create and find meaning in their experience which allowed them to be more understanding and therefore less distressed about where they were and what they were going through at that time. Through this making sense to them and this new relationship with their experience they were able to then start to accept connections from others and reach out to form more connections with others which made participants feel more supported. They then continued to rebuild a new relationship with life where they were more connected using these anchors above but also creating new ones. They described feeling more gratitude towards things in their life and felt more able to be in the moment. Some participants also expressed comparing themselves less to others and daring to challenge the way they saw life and were able to consider other possibilities. For these participants this helped to create and develop a new world view with roots in themselves and fundamental points in their identity and story in life.

4.3.1.1 Sub-theme: Identity and Meaning

All participants described having a different relationship with things that were important to them and feeling a sense of safety in themselves and a sense of peace with life after being in existential therapy. Participants discussed finding this through having a connection with themselves which came out of having the experiences they had in life and learning to trust in the journey they were on. Learning about

themselves was something participants also discussed as being different after therapy as they were able to form a deeper relationship and level of acceptance of their own life story. The quote from Sarah below described finding a sense of strength and grounding in herself through the experiences she had.

Sarah: "[...] becoming just more and more me. Being happy there. I'm safe, and grounded. And amazed at what's happened to me. I would never have believed when I was a teenager, I'd be as I am now."

Another lady added that the feeling of safety she had developed allowed her to relax into life and feel more grounded.

Jessica: "I found my feet, I'm safe. I'm safe in the world. I've never been safe in the world before. And when I was on my course I was saying this to someone the other day I was sitting there, and I suddenly felt my toes straighten. And I realised I've been gripping the earth, most of my life, and just going through the course and the therapy and supervision just give me a grounding and a safety in the world that I've never had before."

Participants took a sense of understanding and a deeper knowing of themselves through their experiences as they unpicked their story in therapy. This understanding contributed to the sense of safety they felt in themselves and their ability to deal with events in life.

Anima: "It's a lot clearer. I thought that it was very clear to me before but in questioning them (her values), they became stronger and clearer. And now when I act, I don't have that guilt hanging at the end of it. So, the guilt is not there anymore. Because I know that the way I'm acting is in line with the values I want to live by. So I'm- I'm not questioning myself as much at all, actually, with that respect. Not anymore. And that's meant that I'm in a much, much, much happier place, emotionally, and mentally."

Anima above found that sense of grounding in her values and expressed being able to use these as a guide to help her navigate challenges in life. Ana below also described being more sure of herself which she felt helped her with the intensity of her depressive experiences.

Ana: "I think I'm more sure of who I am. I'm more sure of myself, and the actions I choose to take, for me and my family. I don't question myself as much as I used to and when I do it's short lived, it doesn't go into this deep spiral of depression anymore, with this uncontrollable crying and unable to sleep and questioning. I was exhausted then I wouldn't be able to sleep. I was questioning whether I deserved to be my children's mother. Questioning if I deserve to be my husband's wife. Umm... I was questioning all of that. I don't do that anymore. Like I'll have moments where I'm like, Oh my god, this is difficult. This is hard, but- or I heard something which upset me that impacted me. But it's very, very much short lived."

Jessica also discussed a different relationship with herself. She discussed being less critical of herself and being able to be more loving and respectful with herself which helped her feel more adequate and acceptable.

Jessica: "I feel like I'm in a better place now. I feel like I'm more loving of myself. I feel like I have found, and my therapists have given me, ways to not turn me down to treat myself with more respect and to make myself feel like more adequate when even my depression didn't feel adequate enough. And it's something like really?"

"I know it. It doesn't make sense, but I used to tell myself Oh, come on. Not even my depression looks like in the movies of not doing things right not even can I do depression the right way."

Participants even discussed developing meaning through the relationship with themselves that they gained through the experience of being in therapy and the depression.

Sarah: “And then, you know, it's a very rough ride, and then you get off the train, and then you think, Oh, I made it. I survived. Yeah, that's how it felt. You know, I survived. I survived. But it wasn't just mere survival. I think I've changed and grown in many ways. I have matured. I think there's an emotional maturity that came of that. Definitely.”

Other participants such as Anima felt a sense of safety and reassurance in there being no one fixed self an idea she discussed in therapy but rather in the idea that her identity can be fluid and therefore, having the possibility of being more than one thing allowing her to be more accepting of herself and releasing the pressure of what she felt she needs to be.

Anima: “I've got to find the real me, the one true self, where existential kind of philosophy is that, you know, we're multifaceted and multi-dimensional, and, and we're constantly- it's constantly in a state of flux as well. And, and that we are we, who we are, it is also kind of, like, it’s relational as well. So two people will, you’ll be like how I am with you now, I won’t be with anyone else, because you and I have created this relationship and kind of identity, our identities with each other through this very weird medium. So that so it’s kind of a very freeing feeling, because God you could spend your whole life trying to find out the real, you know, the real you type of thing where if you can be, except that you are different people in different situations, and you can be a daughter or a mother or grandparent or, you know. So, it’s very kind of- it’s very liberating.”

The sense of grounding and safety in the relationship with themselves also came from participants making peace with their past and their stories compared to the original position described in the chapter above of it not making sense to them or wanting things to be different to what they were.

Richard: “I think part of what I’ve learned is that, actually, this is a process, you know, there’s no end point to this. So, there's no point where I'm going to go, aha, right. You know, these are the answers to all of my questions, I need to stop searching now. That’s it. You know, so it's, it sort of helped in knowing that, you know, this, this is a process but I’m sort of more, I've got my eyes more, you know, more open, I suppose. And, and I'm not sort of searching with so much angst anymore, you know, which is, you know, the search was always full of angst. So, I can kind of search with sort of, more of a sense of delight I suppose than I used to. Yeah.”

Rawan below felt she understood herself better but also took strength from taking control over her narrative and finding control over the story she wants to tell and having her story make sense to her.

Rawan: “[...] it makes so much sense to me. And I think that might be a little bit connected with my work in the arts. So a lot of my work has been helping people find the story they want to tell as a theatre director, as a writing mentor. I think that if you can stay in the here and now when you're doing that with people, they are more likely to find a story that was relevant to them now than the one they think they ought to tell.”

Participants connected with their experiences and made sense of their lives. They looked at themselves to find answers and anchors in the themes and meanings of their narratives rather than the resistance to this that we saw in the above chapter.

Jessica: “[...]this what the experience of therapy gave me was, was a philosophy that was already part of my life as an artist, that I had no idea existed.”

Another participant Richard found a thread in his life that he could take with him and could hold on to despite what he was facing.

Richard: “[...]everything in my life had a sort of nautical connotation. Even the, you know, the sort of descriptive words or adjectives that I use quite often were either to do with water or the sea or sailing or the boat was, you know, it's very interesting to have noticed that and started to develop this kind of idea.”

“[…] this is another nautical term, it's like, everything you do is marinated, your life is a marinated life. And, and that's it, these were really sort of aha moments. And I realised that I had, you know, my dad was in the Navy, I used to sail a lot, you know, I live by the sea, it's nice to be in the sea all the time. When I look at the sort of history of my family, and the places I lived, it was all you know, the dock yards around me ship works, […]And, and so actually, that became almost like, a theme tune for me, you know, just something that I could kind of carry with me and actually in a helpful way, and not really understanding what, why, you know, why is it that my life is marinated, you know, […] that's really stayed with me it actually seems to help. It's almost like I feel more like a dolphin than a human being, you know, and feel like it came from the sea and […] even though it sounds completely bonkers it actually sort of helps me to think you know, connect, connect with something that's about being in the sea and being a loving it, but being afraid of it at the same time, you know.”

Richard found something in that theme to hold on to and gave him courage in life as he compares life to the sea and his relationship with it as “loving it but being afraid of it at the same time”.

Participants grew in their understanding and connection with themselves and realised things they did not know was important to them.

Anima: “But I do think more I went and it became weekly and open ended. I honestly feel like a sliding door here on my left made of like a beautiful

Japanese rice, paper screen, slope back. And there's this huge expanse here of world that I didn't even know existed. And there's a lake, mountain, and trees and it's crisp, and it's clear. And it is a place not of rest- recuperation may be really fresh, it's really fresh. And there's a whole world I didn't know, that I cared about."

They also described gaining an understanding of what is important to their identity.

Noelle: " [...] actually, to myself, I'm somebody who's done a lot. You know, I've experienced a lot, I've engaged in a lot. Most people knowing me would think yes, she has done a lot."

This made sense for participants in connecting with the parts of their identity they felt disconnected from during their depression. Connecting with these parts of themselves and this understanding helped participants develop into other areas. Sarah below describes this and how making peace with herself and coming to like herself gave her a sense of safety and allowed her to be more open to taking emotional risks.

Sarah: "I've always sort of been slightly outside. I never had many friends as a child, but I'd be friends, like, with the lady who lived on the corner with the cats and things that was always it. A bit different. I spent a lot of my young years wanting to be the same as everybody else. I'm very tall. I'm nearly six-foot-tall, so- and everybody else was five foot two. And it was not easy. And it's taken me a long time to reconcile that. I'm fine now. I think I'm wonderful. I think I'm lucky in being me. I'm aware. I can. I'm ready to take a risk, an emotional risk. I'm not very good at physical risk, but emotionally, and I'm very open to risk and trying giving it a go."

This new relationship with herself gave room for Sarah to have hope and take the emotional risk to create space in her life and be open to the possibility of creating something new and a new opportunity.

Sarah: “And five months ago, a new man walked into my life. I've been a widow for 40 years. And I'm not on my own anymore. It's really nice. Yeah, with no. It's the thing about clearing the space. You know, nature abhors a vacuum. And when you make a vacuum, something comes into it because my grandchildren are 15 and 13. Now- and I was thinking, What am I going to do- them getting self-sufficient? They don't need me anymore. And then John walked into my life.”

We also see here an openness and trust in life as Sarah describes clearing the space and being ready to receive what life has for her. This will be discussed further in the sub-theme below.

4.3.1.2 Sub-theme: Life

This new sense of safety in life and in themselves allowed participants to create a different way of engaging with the world and to build a new life. This theme was seen across all participants. We can also see that participants felt more at ease with where they were in life and felt less desperate to leave that place, they also felt more accepting of life’s challenges. This can also be understood through quotes from other participants.

Anima: “It means I can live a completely different life. I'm still in process, I think we all are. Perception changes all the time. So my perception changes all the time. So… yeah, it's- it's a long journey. And it continues to be. It's a journey, it's not a destination.”

This described the feeling of being more at peace with wherever they were in life and feeling less of a need to escape their current situation and experience can be understood through the quotes below. We can also see here as well the openness to the journey of life and curiosity.

Richard: “Yeah, so yeah, so that's- that's it. So it's taken- set me off on a slightly different pathway, I suppose. And I think part of that is just being okay, you know, just, you can, you can start to just be okay about being here. And you don't have to sort of keep on bashing your head against the wall over what that means. And, you know, it's still interesting, it's still important, but you also have to just you also have to live, you know, a fulfilling life, you know, so, start working on that, you know, that's, that's, that's where it got me to.”

They also expressed a curiosity and openness to what they don’t know in life and more of a willingness to be open and explore.

Jessica: “And so that sort of opening up of the don't know, side”

This allowed participants to start considering other possibilities and looking at situations differently.

Julie: “I'm a big wonder-er. And, you know, oh, I'll say Oh, look at that. There's such and such a picture, that tree looks like a certain scene, and they see what we're seeing with a different perception. Hmm, it's strange. You know.”

The curiosity and braveness that grew from the safety in themselves led to participants also describing branching out and finding new meaning through using their experiences to help others.

Noelle: “I guess, the reflection of, you know, in spite of the challenge, in spite of the difficulty of being able to support someone who needed that support. I feel very content because, you know, life I can't think of any life that will not have difficulty and challenges. Sometimes it's because of our choices, sometimes it isn't, but either way, we are going to face difficulty in life. And what I have learned is that when I'm able to use

those experiences, you know, to help someone else, it's worth it. Yeah."

Ana, the participant below, decided to go into counselling herself as a way of using her experiences to find new meaning.

Ana: "I have been working for myself and I see people from different walks of life and you know, I have so much to draw from to give because of these experiences."

Participants learnt they had a strength in them that they didn't know was there and they were able to learn about themselves and their resilience through their difficulties and depressive experience.

Sarah: "[…] we all have what we call resilience. But we don't recognise it until we are thrown into, you know, a difficulty, we're thrown into a problem into some kind of a problem that hits us. It's life's givens I think that brings this out in us. So yeah, but then I didn't know I was resilient at all."

Jessica also described a new awareness of life and herself in relation to it.

Jessica: "I guess I was just totally ignorant of, not totally ignorant of existence and its problems, but ignorant of the fact that you know, that I have what it takes in me. I think that was what I was totally ignorant of. I had what it would take for me to get through that. And to come out on the other side."

This was further linked to participants not challenging their current situation as much and experiencing more of peace or surrendering to life.

Rawan: "There is nothing I can do about it now. I have worked very hard to bring myself peace in that direction. It's the past, there is nothing I can

do about it. But I can recognise that it was just what was, we were as we were."

The less participants resisted the change, the more at ease they reported feeling with the experience and less critical of it which in turn allowed them to open up to others and share more in relationships this latter part about relationships will be discussed in the next sub-theme. Below we see Sarah talking about shifting from wanting things to stay the same to being open to change.

Sarah: "[...] my motto was always, everything changes, nothing stays the same. And I think that is a big theme of it, you know, people say, oh, I don't want to change. I like things as they are. But everything changed, our body changes. In seven years, every cell has changed, has died, regrown."

Through these experiences and exploring and connecting with themselves participants felt they were able to use their identity and anchors in themselves as a base, relate to the world more authentically and make decisions that were truer to them. They also discussed developing trust in themselves and their emotions which suggests a different relationship with how they feel and less resistance to the negative emotion and experiences.

Anima: "I can really relate to the world much more, kind of authentically. Because before I was like, didn't trust my emotions, didn't trust as always kind of trying to second guess. Just feeling, you know, awkward and painful. Where afterwards is kind of like more trusting and like, well, these are my emotions. I'm feeling unhappy now. Or I'm feeling happy now or? Yeah. A lot more in the world, and in relationships, as well."

We can see from the above this openness and curiosity to life as well as acceptance of themselves and different relationship with identity the next sub-theme will explore how these changes in experience after being in existential therapy were related to

the theme of relationships which was an important lost connection in the experience of depression.

4.3.1.3 Sub-theme: Relationships

This safety in themselves and curiosity that developed also allowed all participants to be curious about other possibilities from this they also described beginning to open up to others meaning they could start rebuilding the connections that were felt to be lost during their experience of depression discussed above.

Sarah discussed how she felt more open to connecting with people when she started opening up to the experience she was having.

Sarah: "You think it's some blinding revelation, but it's a little by little that leads up to the Eureka moment? Yeah. Yeah. The little building of things. I mean, I'm, I do a lot of Louise Hay's affirmations, because I think she is excellent. And, you know, when you start to open up, when I started to open up, I could take help from everybody. When I was closed down, I couldn't take help from anybody. It's a funny thing, the more in my experience, the more grounded I've become, the more able I am to say, I don't know, I don't understand, help me through this. Whereas when I was in a bad way, I was very defensive. No, I know everything. I don't need help go away go away."

Therefore, participants described forming new connections and improving old relationships through the change in relationship with their experience.

Julie: "I definitely learnt, learnt to be able to translate some of the more distressing stuff and, and stuff that sort of terrorised me, you know, to translate it into something that's more of a kind of, that has some joy in the exploration rather than hurt. You know, that's, I suppose that's, and

then be able to take that back into my own life and be more, more at peace and less at conflict with the stuff and the people in my life."

Relationships were important to participants and the acceptance linked to the understanding of themselves and identity and safety led to some participants acknowledging and taking responsibility and ownership over aspects of their relationships that were in their control. Here we see this participant Richard talking about taking responsibility for himself and his relationship with life.

Richard: "I wake up every morning and I'm the same person in the same world. And being in a relationship is- are really important for me. So in order to make that more stable, I should do some, you know, turn the focus on me and, and me in the world me in relationships and see if I can do some more work on that."

Richard below described realising how important relationships were to him and taking the step to communicate his experience to his partner. Attempting to deepen his connection with her and building his network of support.

Richard: "[…] in a relationship, so your partner needs to be completely on board with- with what you experience? and what doesn't help. What does help, you know, and understand what's actually going on. So, that was a big thing for me, I've never done that before."

Participants used their experience to deepen connections or find new connections with others. Sarah described how she felt more connected with others after her experience of depression and felt she gained an understanding and ability to connect from her experience.

Sarah: "I believe that I see, and I hear people's problems differently. I think that after going into my own personal process, I'm able to hear with more compassion the process of others, because I understand that

sometimes it's not easy, and I understand that sometimes it has to hurt a little."

The participant Julie below in the theme of relationships and connection with others discussed not feeling able to cry with other people and would keep any feelings to herself. Here in this quote she talks about how her therapist was patient with her and how opening up and being able to cry with her therapist then carried through to being able to develop deeper relationships and connections with other people outside of the therapeutic space.

Julie: "I was able to cry with her. So that was like a huge, huge breakthrough, absolutely huge to be able to feel that pain and sorrow with another person was just so powerful. So, so after that, and since then, I've been able to, like I've had really powerful moments, it's, you know, when, like, at funerals, or, or just, you know, where you can cry with people, or when, you know, people are grieving or you're helping, you're sort of helping a friend or a friend's upset and, you know, and just the powerful thing to be able to cry with someone and share that sorrow. And, you know, often that's the kind of powerful moving things in relationships to become close to people. So, I actually found it became so big I was able to connect and become so much closer to people."

Other participants such as Julie below echoed this opening up to relationships allowing for the formation of deeper connections with relationships around her and with her partner.

Jessica: "I have changed but my partners experience of me having changed is that I am more often more like all of me. A me that I am sharing more often, more openly and sitting with myself more simply. That's existential therapy but that is also me taking on the work of the existential therapy for the rest of my life. I think it's quite hard to do

genuine existential phenomenological work and only leave it in 50 minutes."

Participants gained new connections with people and new meanings through their experiences using their relationships and understanding of themselves.

Sarah: "[...] for me now the work that I do is a strong source of validation for myself in a way. The more I give of myself, the more I receive for myself. I absolutely love what I do. I have other sources of support now. I have a network of friends and people that walk alongside me. My child, my son, is a huge source of support now. Yeah, I have other sources of support now, as well as my own source. So I have other sources that I draw from. And I think being in therapy and studying existential therapy at the same time was a double whammy. Really really worth all the trouble for me. It gave me a new meaning to life."

Above we see Sarah talking about how through her experience she decided to go into studying existential therapy and therefore built deeper connections and networks for support. Richard below discussed how he still experiences the difficulties he previously did but how his relationship with these struggles are different as he has gained a different relationship with himself as well as being more at peace with the existential questions he had in life and how this allowed him to be more open in other relationships.

Richard: "[…] where I am right now is sort of feeling fairly grounded, but I still have a lot of the kind of difficulties I have, have always experienced, which has mostly been in relationships, actually. So, you know, and, to sort of understand myself a bit better, to be a bit more open and honest, actually about- about the difficulties I experience. I think it's set me off on a sort of a slightly different pathway. Because in a way, I was able to let go of the existential stuff enough to be able to sort of actually do some work on myself. Which I hadn't really done."

Therefore, through this section, we see that participants' relationships and connections deepened with others but also with meaning, life, and themselves.

4.3.2 Theme 2: Relationship with Experience

This section is going to discuss the master theme of relationship with experience after being in existential therapy and how participants relationship with being in the moment and importantly for many participants how they felt more connected to their body and were able to use their relationship with their physical world to connect to life differently.

4.3.2.1 Sub-theme: Being Present/The Body

All participants discussed feeling more accepting towards how they were feeling and described living more in the present. They did not have such a negative relationship with where they felt they were and therefore they expressed feeling less of an urgency to escape from the state they felt they were in. In the section above

participants also discussed feeling critical of themselves and life as it was. Here participants discussed finding a sense for release in being able to be in the present moment. Participants discuss finding different ways of being able to achieve this. For some participants, this involves using the body as their anchor in their here and now and for others linked to the sections above participants were more connected with themselves and the emotions that anchored them in the present experience rather than what could be.

Julie below discussed feeling afraid to feel happy and not being open to positive emotions in case something would go wrong. She described the change in this experience and how allowing herself to connect with what she was feeling allowed her to gain emotional freedom.

Julie: "[...] because from being able to cry with her (her therapist), I was able to cry in other situations, but I found that, because I connected to that emotion, you know, it was like being able to connect with all emotions. So, then I was able to be more present in happy times and just feel happy, just for the moment, in the moment, and get in touch with that, as well. So, it just kind of freed up my whole I don't know. Freed up all that emotional stuff."

Jessica below spoke about using her body and using this as an anchor in her life in the here and now.

Jessica: "[...] my work with my therapist always comes back to the body. He is quite hot on the philosophy too. I could distract us by talking about philosophy for hours, but he always, thankfully, brings us back to the body. And that is valuable for me. Because it's where my practice has been rooted for decades. And where I understand myself better, I mean, you know, it's, these are physical spaces, I'm talking about this, the swan, Lake and desert, they're real, they feel real. I can smell that. I didn't know that there was this material that explained that. But at the same time, my- my other background is in dance and gymnastics, and

I'm a yoga teacher, and I've practised yoga for 40 years. And so the embodied experience of the here and now. So there's a philosophical version. But there's also hear me in the room, including the Zoom Room here with you."

This is echoed in the quote below for Noelle using her body to connect to her identity and how she is feeling in the moment.

Noelle: "I think existential work, and phenomenological in particular, pays attention to hear now and to who I am, in and off my body."

Sarah also discussed using choice to bring her attention back to her body to ground her and how this intention allowed her to be more present a way of living that was positive for her before she experiences the changes in her life and experience of depression.

Sarah: "[...] through conscious choice. So I've- I've made a conscious choice to be in me more, to notice when I'm not, to come back to my breath, to my physicality, to take my other physical practises like yoga and running and swimming more seriously."

"Which is centring me in my life. Rather than having a de-centred one left in the past or one somewhere in the future, I feel in the same way that being really sick can do when we let it. I actually feel like I mostly not always but mostly tend to live, here and now. And I wasn't living like that for a very long time."

Ana like other participants Noelle, Jessica and, Sarah discussed using the body in the moment to work with how she was feeling and learning to listen to herself as a sign of what was going on for her in the here and now of her experience. These participants listened to and used their connection with their body and physical world as a sign and signal of how they were feeling giving them the keys to know what was

going on for them in the world in contrast to the experiences discussed above of shutting out these experiences.

Ana: "I think about my embodied reaction to the situation in particular. So, in that moment, where I know that they're coming, or they've booked to come, my heart starts beating really fast. And I start feeling really agitated physically. And my therapist used to tell me, just you listen to your body, what is that, whereas before I was ignoring it, and it was getting worse, worse, and worse and worse. And now, like, by stopping a little bit, and I do this thing, that if I find out this kind of news, when I'm standing, I'll sit down, and if I'm sitting, I'll stand up, and it really changes how I feel, or how my body's reacting physically, to the situation, it doesn't disappear. But it just- it brings my awareness to it more, if that makes sense. So yeah, that tip I definitely took away, and I find myself doing that in areas that are not even as provoking to me. So even if I'm just really exhausted and tired after a long day of parenting, and when I find myself on the edge. I feel like I'm able to cope with that a lot better now than I used to."

4.3.2.2 Sub-theme: Gratitude

All participants also expressed changing their relationship with what was going on for them. They discussed being grateful for things in their life and with this different relationship with life, participants took out of their lives what they could to be grateful for. Julie below discusses losing her appetite in her experience at times but looks at it in a much less lost and critical way than described above. She instead here discussed finding meaning in the things she had despite imperfection.

Julie: "[...] it was just like, I started to not get hungry. So I started skipping meals, and just trying to take the best out of what I have. And sometimes what I have is something, like, small, but very meaningful."

Participants held on to what they could form their lives as their relationship with their experience changed, they started describing, noticing, and being able to catch the gratitude and moments to be grateful for. This gave participants hope as we can see in the quote below from Noelle.

Noelle: "…When actually, if I sit there and listen to my intuition, I intuition is going. No, this wasn't really what you wanted anyway, and this is actually a relief, and you dodged the bullet, and you're actually doing pretty good. And life is actually pretty, pretty much okay, it's balanced, and you're taking care of yourself, and you're managing the stress, okay, and you're five minutes away from being qualified. I'm so world's gonna be your oyster now. But you could do whatever you want. You don't have to worry about more limitations being put on you"

Here linked together, things started shifting for participants. This theme of gratitude tied in again with the theme of life and how their relationship with existence opened up and transitioned slowly from one that was closed with many lost connections, to the possibility of openness and new creation in life. They developed a sense of safety in themselves and a deeper connection with who they were and their story as well as an openness to others and an understanding and acceptance giving room to compassion and less judgment on themselves but also less fear of judgment from others. Connections therefore deepened and participants started to build a network of more and more anchors in life whether it be in themselves, values or meaning, and eventually relationships and curiosity as well as a different approach to life. In this next chapter, we look at what these participants described as being helpful and where they were able to hold on to start rebuilding and recreating a network of connections and relationships with life. This next section discusses what these participants found helpful in changing their experience.

4.4 What Helped?

Table 4: Themes and sub-themes. What Helped?

Themes	Subthemes
Relationship with the therapist	
Relationship with self	Values
Openness/trust in life	
Connected to the philosophy	

In this section first theme has no sub-themes, the second theme has one sub-theme, the third and fourth theme have no sub-themes.

During the experience of depression, many participants reported experiencing many of the symptoms described in the DSM 5 and on widely used depression measures such as the PHQ9. In exploring this deeper to get a more qualitative and personal understanding of what this experience of depression was really like for the people who chose to take part in this study the main thing that continued to surface was the experience of loss. Loss of connectedness to who they felt they were – identity, others and support, meaning and many other personal elements that grounded participants in life and their relationship with existence. From this space and this absence of connection, when participants were asked what helped them transition

out of it to the experiences above, all participants spoke about things they could connect to. Points they could hold on to and the most common and strongest recurring theme for these participants was:

4.4.1 Theme 1: Relationship with the Therapist

This theme highlights how all participants experienced the therapist as providing a base, grounding and an anchor in the lostness and disconnect they were experiencing. One participant discussed not finding this with a previous therapist and decided to change therapist before finding someone she could have this connection and understanding with. Their therapist was someone who was with them in their experience and understood it allowing participants to feel they were not alone. This also helped participants feel accepted and therefore were more accepting of themselves.

When Anima below was asked what it was that helped, she spoke about holding on to the therapy and having that support when there was nothing else.

Anima: “I couldn't put my finger on a particular takeaway. But overall, when I look at it, I feel that it's helped me survive in the first place, rather than give up. Rather than jump out of that bus, you know, that the bus whose ride was really, really, you know, instead of jump out of it, I managed to carry on with that journey, and, you know, to kind of hold myself together until it was time for me to step out.”

This point was echoed by Jessica below who expressed feeling she was in crisis and therapy helped her hold things together.

Jessica: “I felt it was a crisis because I literally wanted to run out the door. So yeah. And then in that crisis, I think therapy was very instrumental for me, such a strong source of support and help.”

A common point for all participants was that they expressed feeling understood. This quote demonstrates that as well as the importance of the therapeutic relationship, and how Rawan felt this was also down to the connection with the therapist.

Rawan: "I remember feeling very understood. First, I think, possibly for the first time in therapy, apart from one I had one therapist, who was actually an art therapist a few years before, but I had, I had to end that therapy when I moved so but I did feel really understood. With it almost sort of unspoken understood, you know, I mean, the therapist, female therapist, a bit older than me, I suppose, maybe. But that was how I didn't know her age. But yeah, I think she must have been older than me and just very wise, as you know, and just, you know, accepting, but understanding I got lots of sort of, you know, knowing sort of looks and smiles and nods and so sort of, I felt quite validated in a lot of the stuff that I was bringing, you know, I felt quite validated."

Here we see this participant Richard talking about how he felt he was not alone in what he was experiencing.

Richard: "[...] it was having someone who seemed to understand and seem to get it and almost normalise it for me, you know, that I'm not on my own with, with, you know, this this sort of quest and this kind of angst you know, that this person, you know."

"So I have to have a therapist that sort of understood that and understood where I was coming from, and understood my angst, you know, that was, yeah, that that was really, almost sort of normalised it for me, certainly took me away from this place of thinking, it's just me, you know, I don't really seem to be able to find people that resonate with this stuff, you know? Yeah. So that was it, just did just that was in itself helpful."

Participants were able to feel accepted and make a connection with their therapist. This was the beginning for many participants to start branching out and making a lot of the changes that were seen in the above chapters. They discussed the relationship with themselves changing, with others and with life.

4.4.2 Theme 2: Relationship with Self

4.4.2.1 Sub-theme: Values

Using the base of the therapeutic relationship and feeling understood participants engaged in discussion with their therapist deepening their relationship and feeling of being understood. This allowed all participants to explore themselves and their situations. This led to the other factor that six out of eight participants reported as being helpful in transitioning them out of their depression, this was the connection with their values. We saw in the chapter above that participants expressed feeling that there was a change in their connection and relationship with themselves. Here we see values played an important part in this for participants as they discussed being able to use this again as another anchor to help ground them in decision making and the lostness they were experiencing at that time. Participants also drew strength from their values and what was meaningful for them.

The participant below talks about how important her role as a mother is for her and how that gave her the strength to keep pushing through. This can also be understood as meaning to keep fighting for.

Jessica: “I just did not know what resilience was, or that I was resilient. You know, I just kept pushing through and pushing through and pushing through because I knew I had to. And I guess, one of the main reasons why I began to do that, even looking back at the time when it first started, was because I wanted to be the mother for my child. If I allow

this, to distress me to a point where I would lose my ability to, you know, play my role as a mother, then, for me, that would be utterly worthless, I would be worthless if I allowed that to happen to myself. And so, I guess I developed that in myself, I knew I had it in me that I could find that."

Anima expressed developing resilience from her values. She also discussed learning about how resilient she was after going through the experience and having a deeper relationship with herself and her beliefs.

Anima: "I had to be extremely resilient, I had to develop that resilience, that mental resilience, to face up to the challenge, and to walk through it, and to change it to grow from it. So, there was a lot of my own resilience and determination. And, of course, therapy was very useful for me. And I think my own values as well, my values as a person, you know, my values, my beliefs, as a person went a long way in helping me become resilient, because I don't think I was, or I guess, I didn't even know I was resilient. Before I faced this experience. I guess you don't know until you know, you're in a crisis. Don't know what your real strength and skills are. Until you, you know, walk through a crisis. That's, that's what it was for me."

Here we see in the quote below from Ana that for her it was not only a matter of knowing oneself better or knowing what one's values are but actually using these in daily life and putting these into practice as a point of reference and as a guide.

Ana: "I guess, exploring, knowing my values, exploring it, and then actually bringing it in to practice really, you know, otherwise, your value is just left on the shelf. It's like just an old book, gathering dust, I had to actually bring it in into my real life and use that."

In this section, we see participants found it helpful to connect with themselves and what was important to them in life. Through the relationship with their therapist

described above participants were able to be open and explore themselves, and their values helped them to develop safety and connection and form a new relationship with existence.

4.4.3 Theme 3: Trust/ Openness to Life

Seven out eight participants reported finding it helpful to trust in life. As seen in the chapter above people took a much more open approach to existence and the challenges they face with it. This is expressed in the quote below from Rawan.

Rawan: "I've learned to expect it and take it when it does come and you know, embrace, embrace life's different situations and learn from it. Because if we don't, then we are going to end up in a very conflicting situation in our heads."

We also see it was helpful when participants reframed their relationship with their experience of life and were grateful for life as well as having a more grounded relationship with themselves and being. The also contributed to this relationship with existence. Sarah below talks about this relationship with her experiences in life and how these for her allowed her to develop strength and her relationship with herself to go forward and continue being open to and facing life.

Sarah: "I just think I've been incredibly fortunate. My life. It hasn't always been easy, but what happens is grist to the mill. And its that therapists are like the grit in an oyster to make the pearl they rub and rub and the beautiful pearl forms because they they don't make things easy. They're confronting and but it's a very funny thing, isn't it? It's, it's confronting, but it's gentle. Well, gentle, not always gentle. It can be quite harsh. I've been in therapy and so Oh, I'm really scared sitting here and not having the wherewithal to say to the therapist, you're really scaring me. Which is a shame because we could have gone a

long way. Now. I will say to my therapist, I don't like what you're doing. That's not who I am. You know, I'm prepared to stand up for myself."

Sarah above used her experience and built strength in herself making her less afraid of life and possibilities within it. Richard below also discusses how he connected with the themes in his life in which he discovered in therapy and how he found comfort in this and in turn his relationship with life- both being in it, living it but being afraid of it at the same time and that feeling less uncomfortable as he found this nautical theme in his story to hold on to.

Richard: "[…] something will come from the depths and devour me. Again, it is a nautical, this is water, this is being in the sea. And, and so actually, that became almost like, a theme tune for me, you know, just something that I could kind of carry with me and actually in a helpful way, and not really understanding what, why, you know, why is it that my life is marinated, you know, but this is, this is something that that the therapist you know, began and developed with me that's really stayed with me it actually seems to help. It's almost like I feel more like a dolphin than a human being, you know, and feel like it came from the sea and that that sort of, even though it sounds like sounds completely bonkers it actually sort of helps me to think you know, connect, connect with something that's about being in the sea and loving it, but being afraid of it at the same time, you know"

Sarah in the quote below speaks further about her experiences of challenges in life and her approach to them she discusses looking at life and suffering like it will pass which she takes strength from there is also an openness to the idea that she is in life and many different experiences can happen.

Sarah: "[,,,] its not the first time I have been through difficult things. […] And so yeah I am reminding myself that that was hard but it passed and this is

also hard but it will also pass. You know what is useful to think about… the experience of giving birth it hurts a lot, it's terrible for a few hours and then the baby is born and you forget all the pain and after a while you can say yeah it was painful but you can't reproduce how it felt, the pain. And so I have taken that experience now and said I am sure I will forget after and I would be able to describe what it felt like but I won't feel anything. […] You know some days I do have times where I say fuck all experience, I am fed up I just want it to stop I have had enough. You know some people go through one or two difficult periods and I have the feeling of oh no why me. But that's again the wrong, you it's not helpful to ask why me so I don't. I remember one time I told my brother why me and he said why not, why not you. And it's true you know an accident can happen to anyone and an illness you know it's around the corner for any one too and you know it's good luck this time and you have to recognise many things that are good like in life and I have to focus on those too and yeah."

Therefore, in this section this theme that participants developed a new relationship with life, themselves and their own philosophy to living out of that whether it be through the experiences themselves, or their relationship with themselves and their ability to cope, also combined with gratitude participants found this openness and new approach to life helpful in moving through depression.

4.4.4 Theme 4: Connected to the Philosophy

Six out of eight participants also found it helpful connecting to the existential philosophy that their therapists had discussed with them in sessions whilst working with their depression. This also helped ground participants and give them something to hold on to furthermore seeing concepts of life that they were struggling with written down and spoken about validated their experiences and further helped participants feel understood. Below we see Richard talk about finding grounding in the philosophy.

Richard: "[…] because through the therapy, also, I kind of started to get a bit more understanding about, about, like, existential theory and, and it was, then I came across Martin Heidegger's work, and that really, you know, that was like kind of reading, oh, crap, this, you know, this, this […] idea of philosophy sort of missing the point of exploring what being is before the being of being, you know […] so that that really, that really kind of helped,"

Ana discussed reading more about existential philosophy and feeling it is something she can always go to as well as being able to re-access the therapeutic relationship with her therapist. This in itself for Ana was a form of connection and being understood through the writings of existential literature.

Ana: "I think I've definitely started like reading more things on, like, being, you know, being existential, like, I didn't really know what existential therapy was before. And so, I'm like, I'm interested, I'll read a few blogs and stuff. I'm not a big reader. So they'll just, like, be really basic stuff. I'm sure it's nothing philosophical, but it really helps like, ground me. And also, that- knowing that I can go back if I need to, it feels like a safety net. I haven't felt that, that I do need to go back. But if I do, that feels good, that I know that I can access it again."

Therefore, in the conclusion of this chapter, we can see that participants experienced a loss of connectedness to themselves and other markers in their lives. This tied in with their relationship with the experience which led to the loss of connection in relationships and a more profound sense of lack of connection and isolation.

Experiences after therapy expressed a different relationship with their experience of depression and life as well as new connections with relationships and self. Participants discussed using the relationship with their therapist as a starting point to begin developing these new connections with life and themselves. The next chapter is going to discuss these findings within the context of the existing literature, the importance of these findings, limitations, and recommendations for future research.

Chapter 5

Discussion

This research set out to explore the experience of the outcome of being in existential therapy for depression. The aims and research objectives were divided into three sections.

1. Explore the qualitative experience of depression before therapy.
2. Explore the change in experience of depression after being in existential therapy.
3. Explore what participants felt contributed to this change and if they took anything from therapy.

The interview questions were also divided into three parts to reflect the objective aims of the study. These three sections in the above order will be discussed under the first two divisions of the discussion 1) Interpretations: What do the findings mean? Which will discuss the main conclusions of each section based on the data analysed for this paper. 2) Implications: Why do the findings matter? Which will look at situating each above section within the current literature.

The first research objective was identified as exploring the experiences of depression before therapy. This will be discussed here not to elaborate on the literature on the phenomenology of depression in-depth, as much work and research has already been done on this. Nor was it to discuss findings in relation to the existing literature on the phenomenological experience of depression but rather to establish a baseline and highlight the experience of these individuals and the uniqueness in the second objective, change of experience as reported by participants. However, the findings will of course be linked back to the existing literature to ground them in the current research base.

The second objective and set of interview questions were laid out to allow for the exploration of the change in participants' experiences after therapy as expressed by

participants themselves. This objective allowed for the findings of this section of the study to be placed within existing literature on the outcomes of existential therapy for depression as discussed in the literature review of this thesis. It also allowed me to elaborate on the existing quantitative research in this area giving depth and experience to the findings on outcomes of this type of therapy for depression. The findings also build on the qualitative research in this area as not all the studies used client/patient experiences of the outcome of existential therapy alone or used the objectives and questions chosen for data collection for this research. These questions allow for an understanding of in-depth experiential accounts of the change in experience and qualitative outcome of participants choosing to be in individual existential therapy for depression alone.

The third and final objective and set of interview questions were there to gain an understanding of what participants felt contributed to the change in experience and if they had taken anything from therapy that helped.

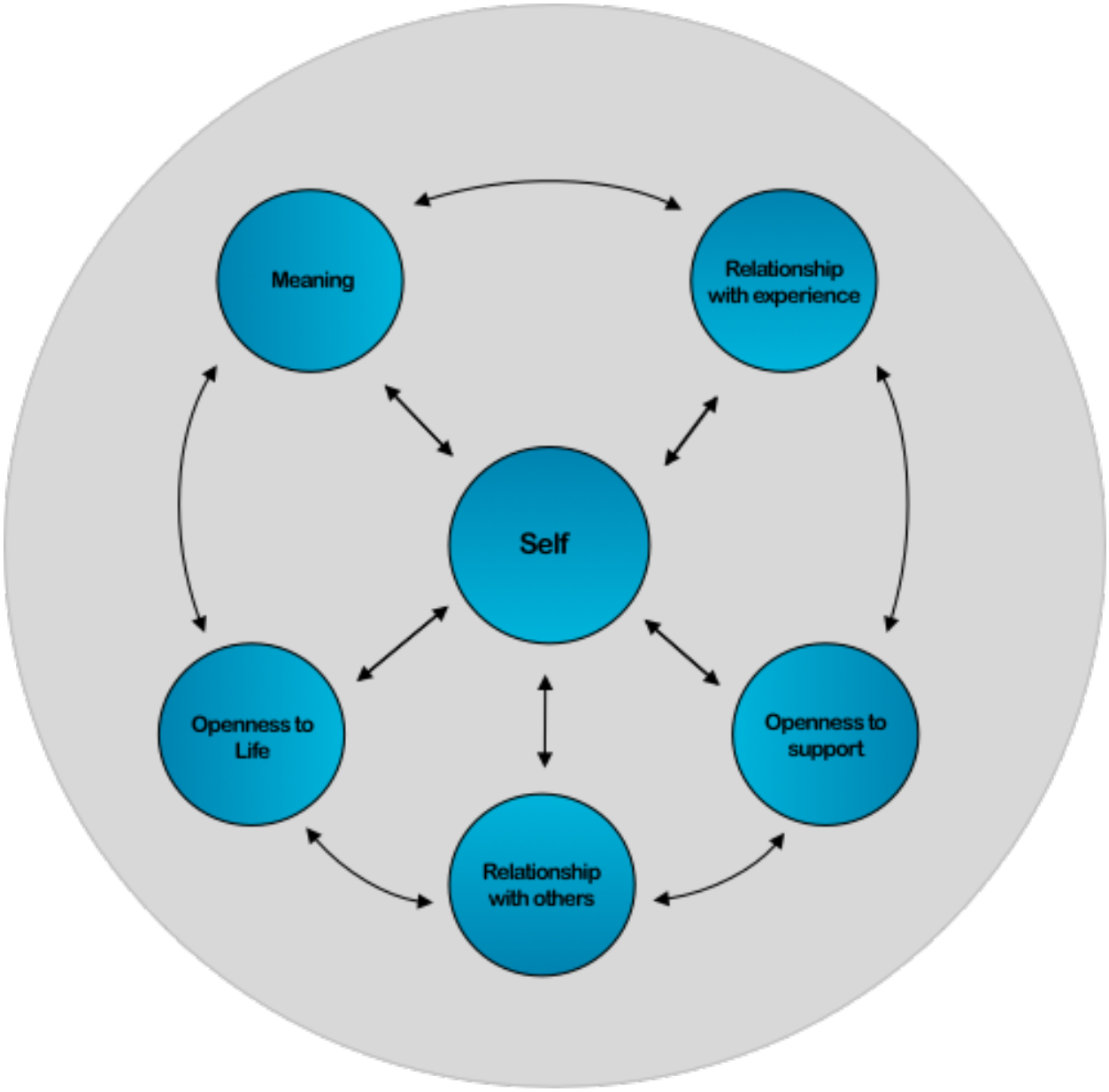
The discussion section will start by giving an overview of the findings broken down into three sections by research objective; experience of depression before therapy, change in experience after therapy and what helped.

The sections will be explored under the heading interpretations: what do the findings mean? This will be repeated under the headings what the findings tell us and why the findings matter and how they fit within the current research in the field. The discussion will then look at limitations of the current research and recommendations for future studies wishing to expand the literature and understanding in this field.

After the two sections that were discussed above (Interpretations: What do the findings mean? And Implications: Why do the findings matter?), the remaining sections of the discussion will look at:

1) Practical implications of the findings within the field.
2) Limitations: What the findings can't tell us.
3) Recommendations: What practical actions or scientific studies should follow.

Diagram 1: Experience of Depression/ connections



The above diagram was created from analysing the themes that emerged from this study and aims to explain and demonstrate the connections lost during the experience of depression and that were rebuilt in the experiences after therapy. Findings from this study suggest that the positive change in depressive experience started from the therapeutic relationship being the main factor providing a base to facilitate a change in relationship with self and relationship with depression which

allowed participants to make meaning of their experience leading them to be more open to support and relationship with others and in turn more openness to life.

Looking at this diagram and situating it within the field of counselling psychology using a lens of NICE approved and recommended treatments for depression employed in front line primary care NHS services in the U.K., it can show how the different treatments offered in the NHS approach treating depression with a range of modalities with different elements of the depressive experience as a core focus:

1) CBT working to disrupt the network of these experiences through the challenging of negative thinking patterns and behaviors that are often present around each of the areas of self, relationships, support, life, meaning.

2) Interpersonal Therapy (IPT) working on changing depressive experience from the relationship angle looking at improving interpersonal relationships in the present working towards more support and connection.

3) Dynamic Interpersonal Therapy (DIT) again working form the relationship angle and

4) Person-Centered Counselling for Depression (PC-CfD) using a Rogerian approach and the core conditions of the therapeutic relationship to help clients/patients integrate aspects of self.

The findings of this research suggest that no matter the school of thought and initial approach taken, the relationship between client/patient and therapist is essential to the change in depressive experience and relationship with self. Furthermore, from this it could be suggested that building on a PC-CfD approach to working with depression, existential therapy can bring the added feature of the philosophy behind it which participants found helpful to further use to anchor in and provide a new understanding and meaning making around self and experience which then led to openness to support, the change in relationships with others and therefore openness to life and break the cycle of depressive experience.

5.1 Interpretations: What do the Findings Mean?

This section will give an overview of the findings of this research divided by research aim.

5.1.1 Experience of Depression Before Therapy

The findings of this research suggest that the experience of depression is about a loss of connection and furthermore stability in the relationship with life that was familiar to the individual before the depressive experience. It can be understood that the loss of connection in different areas of life are linked and have impacts on each other building to form the experience of depression reported by the participants. Areas that were impacted were reported under three master themes - 1) loss of safety and connection – identity and meaning, life, and relationships, 2) relationship with experience – not understanding. This was linked to the loss of safety and connection theme above in that participants' relationship with their own experience of depression and understanding of their experience was related to openness with others and willingness to access support. This brings us to the sub-theme of relationships – participants felt disconnected from others and lonely however not wanting to connect and wanting to be alone participants discussed this in 3) theme not wanting help/wanting to be alone, as participants felt people won't be able to understand their experience if they themselves are not able to. This led to some participants experiencing wanting it to end as they could not see a way out of their experience.

5.1.2 Change in Experience After Therapy: Rebuilding Connections/ Finding Anchors

The experience of depression described above changed for participants and can be seen reflected in themes from the data collected from the experience after therapy. Participants' main theme changed here from loss of safety and connection to a master theme of safety and grounding/ anchors – they discussed reconnecting with identity and meaning, having a different relationship and openness to life, rebuilding connections with others and being more open to reaching out for support. The theme of relationship with experience changed from not understanding to being present and having gratitude. Therefore, participants found a new way of engaging with life and reconnecting with existence and aspects of life that were important to them.

5.1.3 What Helped

These changes in themes and experiences can be understood by looking at what participants reported as taking from therapy or what they found helpful in moving out of their depression to the experience reported after therapy. Here participants discussed areas that are grouped into three main themes – Relationship with the therapist, relationship with self, and openness and trust in life. What they reported as being helpful in achieving that change in relationship with themselves was mainly the relationship with the therapist. This allowed them to feel understood and in turn understand themselves and explore their values. Many participants discussed using the relationship with the therapist as an anchor for them to ground themselves. Out of this we can see a spread of reconnection in other areas and development of openness to life.

This can mean that the therapeutic relationship or the qualities of it are helpful and one's relationship with themselves is key in overcoming depression. It can also mean that having supportive relationships where one is able to understand themselves and not feel judged is an essential part of the process.

5.2 Implications: Why do The Findings Matter?

Adding a more personal lens and understanding to the current research on outcomes of existential therapy for depression by exploring the meaning of the experiences of depression before therapy we can see themes of loss. Loss of connection with things that were important and anchoring for participants in life with elements of this being in their relationship with themselves as well as participants' relationships with others, with this leading into a different experience of their relationship with life and therefore experience of depression.

Participants' relationships with themselves and identity was a central theme of their depressive experience as well as participants' relationship with their depression itself. This relationship with experience also appeared to be an important factor playing a role in the maintenance of participants' depressive experiences. A main feature preventing participants from reaching out for support and connecting in relationships was not understanding what was going on for them and why they were feeling this way, this led to self-criticism and feeling if they could not understand others would not be able to understand either. In the change of experience after therapy we can see a rebuilding of connections and participants finding new ways of anchoring themselves in the world and engaging more with support and relationships and developing a more open approach to life.

Many participants discussed values and using this as a theme of self and identity and how their depression can be understood through a conflict in values, others understanding their depression through relationships allowing them to make meaning of their experience.

This understanding and therefore change in relationship with experience was largely found to be down to the relationship with their therapist allowing participants to feel understood and safe to then engage differently with their own experience, having more compassion and understanding for themselves, exploring values and conflicts.

In this section I will situate the findings of this research in the current literature sectioned divided by research aim.

5.2.1 Experience of Depression Before Therapy

Participants shared experiences of depression under the master theme of safety and connection. They discussed experiencing a loss of identity and meaning which was linked to the experience of life becoming overwhelming and not feeling good enough. Participants reported feeling embarrassed and not understanding what was happening. Through this not understanding and not feeling good enough they withdrew from relationships around them leaving them feeling isolated with their feelings and not being able to see a way out. This led to some participants wanting the experience to end even if this meant ending their life.

This section will discuss the findings as they sit within the current literature starting with the experience of depression expressed by participants in this study.

Participants reported experiencing a loss of identity and meaning and not understanding what was happening and why there were feeling depressed. This finding supports the work of Erickson (1968) where he discussed people needing a stable sense of identity and sense of 'self-sameness' over time. He also spoke about events that can interfere with an individual's sense of identity breaking that sense of stability in one's self. This also links to the findings in that all the participants were experiencing a life change or questioning at the time of their reported depressive experience. Rhodes and Smith's (2010) conclusion adds depth to this describing the experience of depression as being so extreme that it is reported as if the person or self is dying. This links to the experiences of participants and findings of this section loss of safety and connection – Identity and meaning, as participants experienced a disconnect from things they used to enjoy. These were things these participants felt were central to their sense of self and how they identified. This also echo's the findings of Rhodes and Smith (2010) in that they discuss the onset of depression as involving the destruction of highly valued projects of the person. The concept and theme of the altered self was also discussed in a study looking at the experiences of depression by Burey (1982), and also raised by Charmaz (1983) and English (2018).

The findings of this study found that participants' experience of life was associated with their reported experiences of not understanding what they were going through or why they were experiencing it. This was discussed in the theme relationship with experience – not understanding. This theme echoes that of Ratcliffe (2014) where he discusses guilt and narrative and how people make sense of their depression. Hodges (2017) also discusses this theme in the experience of depression.

Participants' relationship with life changed during their depressive period as they reported feeling that aspects of life were too overwhelming to cope with contributing to them feeling not good enough. Dickson, Knussels and Flowers, (2008) talk about how the experience of depression can itself be overwhelming which echoes findings and they add how this can be experienced by participants as damaging to the self. We can also see this in the data collected here as participants felt negatively about themselves for not being able to cope in the way they once could and being in the experience. Dickson, Knussels and Flowers, (2008) add that this is also emphasised by relationship difficulties experienced in depression.

The theme of their relationship with life and their experience of depression was also found to have an impact on their relationships with others as participants described not wanting help and wanting to be alone. Many believed others would not be able to understand if they themselves could not understand what was happening. Here we can see this also being linked to their relationship with the experience. Some participants did not feel they had supportive people around them or were afraid to be a burden or had fear of the judgements of others. Clair, Beatty and MacLean (2005) describe this saying that the experience of depression can also include a fear of being a burden as depression is invisible and cannot be seen by others in the individual's life. This theme of relationships and its role in the experience of depression supports research by Miranda, Anderson and Edwards (2013) where they suggest that individuals are shaped by the role those important individuals play in their lives. They add that depression is related to interpersonal impairment and relationship difficulties. Whether relationship difficulties were present before the onset of depression or depression led to relationship difficulties. Participants in this

study described both, supporting this relationship between depression and interpersonal relationships (Hammen, 2000).

The aspect of experience where participants described ‘wanting it to end’ links to research by Sokol and Serper (2017) who suggested that people experiencing depression feel alienated from their future self. This could explain why participants found it difficult to see a way out of their experience as participants also expressed feeling stuck in this new state, they had found themselves in. We will now explore the change in this experience as reported by participants after therapy.

5.2.2 Experience After Therapy: Rebuilding Connections/Finding Anchors

The first main theme that was found in this section was different to the above in that the theme changed from loss of connection and safety to safety and grounding/anchors. Participants reported having new connections with their identity and meaning. Looking at the experience above and links to other research, it can be seen that the connection with a stable identity is important for participants. Looking at this shift Dickson, Knussen and Flowers (2008) write about how some individuals accept their identities and are able to adapt and replace the former identity which is no longer stable with a new alternative and creating a new sense of self. Whittemore and Dixon (2008) stresses the importance of this integration of experience into identity. He suggests that this integration can help with psychological adjustment in life and relationship with the inner self, perhaps partly explaining this change in experience. These findings also echo the work of Frankl (1959) in the belief that through suffering one can enhance themselves. The idea of clients/patients developing greater meaning/purpose after being in existential therapy and therefore reduced symptoms of pathology have been reported by (De Pont et al., 2021; Breitbart et al., 2010; Fillion et al., 2009; Henry et al., 2010; Lee et al., 2006; Starck, 1981; Zuehlke and Watkins, 1977), supportive-expressive therapies (Bordeleau et al., 2003; Classen et al., 2001, 2008; Goodwin et al., 2001; Spiegel et al., 1981, 1989; Spiegel and Glafkides, 1983; Weiss et al., 2003) and existential experiential

therapy have shown similar results (Barren, 2005; Van der Pompe et al., 1997, 2001) also echoed in the meta-analysis by Vos, Craig and Cooper (2015). However, though these findings of clients/patients developing greater meaning/purpose after being in the above therapies and therefore reducing symptoms of pathology are similar, the research above sharing these findings were either using meaning group therapies, quantitative research methods or not looking at this phenomenon in the experience of depression alone.

These findings also support work for Vos and Vitali (2018) who suggested that participants found an increase in meaning in life after being in existential meaning centred therapy and this increase in meaning predicted a decrease in psychological stress. Vos, Craig and Cooper, (2015) also found that meaning therapies had large effects on positive meaning in life immediately post intervention and at follow up their findings also showed that this had a moderate effect on psychopathology. They found that different types of existential therapies had different effect sizes on psychological outcomes suggesting that this might play a role in the effectiveness of the outcome of existential therapy. Meaning therapies here were found to have the highest effect size on symptoms of psychopathology though all existential therapies were found to have a significant effect on positive meaning of life (Vos, 2016). However, looking at other research Vos, Craig and Cooper (2015) concluded that the positive outcomes of existential therapy might be similar to other humanistic, relational and positive psychological therapies. Therefore, comparing the findings above to the findings of this study it could be suggested that not only the type of therapy has an impact but also the meaning therapies in the above studies that were shown to have a greater effect size on psychological outcomes. However, they were also the only studies to be examined using an individual format perhaps suggesting that existential therapies would be more effective using this method of delivery. The individual format was also the method of delivery of therapy used in this research. However, the studies above also used quantitative methods and not all research was solely looking at participants experiencing depression therefore, the current research expands on these findings showing clients/patients developing greater meaning/purpose after being in existential therapy and therefore reduced symptoms and pathology giving depth to the outcome data suggesting that this outcome might

also be applicable for individual existential therapy for depression. This study also adds flesh to the bones of the findings shown by a review done by Elliott et al. (2013) showing that humanistic existential therapy (HET) was helpful for a range of client/patient presentations including depression. However, HET was also found to be of clinical equivalence to other therapies. This could suggest that the findings of the current study could be due to the therapeutic dynamic and not existential therapy itself though existential therapy does show to have a positive effect on increasing meaning in life expressed to be a change in experience by participants.

Existential therapies were also found to have positive effects on reducing symptomology of depression by Rayner and Vitali (2015), Vitali (2015), Stephenson (2011) and Stephenson and Hale (2017), as well as Stephenson and Hale (2020). However, again the current research expands on these findings by adding depth of personal experience by using qualitative methods.

Participants also described a different relationship with life, and closer relationships with others where they felt more comfortable to reach out for help. This was a learning outcome identified by Sorensen (2015) who found that some of the outcomes of existential therapy was that participants were able to develop a new relationship with self and life as well as a different way of thinking, acting and feeling in relationships others. He further suggested that existential therapy helps clients/patients to enhance a particular learning of authenticity and insight into self, life and relationships with others. He also highlighted the use of courage, engagement and freedom in a personal and open approach to difficulties and life issues. This is reflected in this study's findings of the experienced openness to life and relationship with their depressive experience. This could be linked to the theme of relationship with identity and their relationship with depression as through understanding themselves and having a space to be themselves, they were able to understand their experience better which was the other main theme experience and not understanding. This changed to being present and having gratitude. Kuntze (2020) built on the findings of Rayner and Vitali (2015) by conducting a qualitative IPA study into the experiences of existential therapy for depression Kuntze (2020) found themes of leaving behind the mask, in search of how to be, reaching new

awareness and personal meanings, towards acceptance and authentic living. This could again be tied back to the relationship with self and identity discussed earlier allowing participants to form a new relationship with themselves and their experience of depression.

These finding of Kuntze (2020) and now this study could suggest that in the case of depression, it might not be about individuals accepting a new identity or replacing their identity with a new alternative as suggested by Dickson et al. (2008), but rather connecting with their core identity and values leading to a different experience with life and relationship with inner self, again supporting the work of Frankl, (1959). This of course depends on the type or cause of depression experienced by the client/patient as the findings and suggestion of Dickenson et al. (2008) was supported by separate findings by Whittemore (2008) and previous work by Charmaz (1983), stressing the importance of the integration and sensemaking of a life changing experience, such as illness, into a person's identity or part in creating a new identity incorporating this new factor of the client's/patient's life.

5.2.3 What Helped?

Participants reported that the things that helped them with the change in their experience and moving out of their depression were understood in three main themes: relationship with the therapist, relationship with self - values, and openness/trust in life.

The theme relationship with the therapist is one that has appeared in much previous research. Participants in the findings of this study discussed feeling they were not judged and feeling comfortable to be themselves. This finding can sit alongside that of Clair, Beatty and Maclean, (2005) in that they suggested that a limitation to relationships and a reason for loss of connection in relationships could be related to a fear of being a burden to others as depression is invisible and cannot be seen. Dickson, Knussels and Flowers (2008) discuss this loss of interpersonal

connectedness experienced in depression. Participants in this study discussed the therapist having a sense of knowing and understanding allowing them to feel comfortable and not judged and therefore being able to be open and explore their experience, this created an understanding and different relationship with their depression. This was also discussed by participants as having a starting point where they can feel understood. They then discussed using this feeling to be able to reach out to others and expand their network of support (Miranda, Andersen and Edwards, 2013; Hammen, 2000). Thinking, feeling, and acting in relationships with others was also a learning outcome that participants reported taking away from existential therapy in Sorensens' (2015) study. Lamont's (2015) study looking at clients'/patients' experiential accounts of being in existential therapy, found that participants also reported the pivotal part of therapy as being the client-therapist relationship and the development of a trusting collaborative alliance, all of which they found to be relational, affirming, and enabling. Kauntze (2020) also found the theme of the value of a personalised approach which could again suggest the client-therapist relationship.

Craig (2010) looking at factors that influenced client/patient change discovered that there were common factors that were reported as contributing to change across modalities such as existential therapy and CBT such as feedback. There were specific factors that influenced change within the person experiencing existential therapy. They discovered that for these clients/patients the changes centred around an individual having increased courage to be who they felt they are. Clients/patients also expressed having increased motivation, spontaneity, independence and reported experiencing a decreased concern for what others think about their way of being. They also experienced changes in their sense of self and emotional control and liberation from the boundaries they discussed. They concluded from this study that change emerged out of "the discovery of choice and new ways of being in the presence of another" (Craig, 2010, p104).

Craig's (2010) findings can be related to findings in this study with participants discussing using their relationship with the therapist to gain a better understanding of themselves and being a place where they can be without judgment. These

experiences and gaining an understanding of themselves and their story can be linked to the change and development of meaning and relationship with identity that participants experienced after therapy (Vos and Vatali, 2008; Vos, Craig, and Cooper, 2015; Vos, 2016). This links to the next theme of relationship with self where participants reported feeling a better understanding and grounding in themselves, identity and story. Participants also reported finding this through exploring and understanding their values in therapy as they discussed using these as an anchor or guide in making difficult decisions as well as feeling able to trust and listen to themselves more. This ties in with participants' reported experiences of finding it helpful to be in the moment more as well as practising gratitude for what they have. All contributing to this new relationship and in turn openness and trust in life.

5.2.4 Practical Implications of The Findings Within the Field

The findings highlighted that the theme that made the most difference in change in depressive experience was the client/patient relationship with their experience itself. The factor that helped achieve this the most and therefore helped participants the most out of their depressive experience was the relationship with the therapist. The therapeutic alliance helped participants understand their experience of depression therefore, enabling clients/patients to make meaning of their situation and experiences, changing their relationship with this experience as well as helping participants connect to their values as part of sense of self leading to a more open approach to life.

The findings support the current research showing the positive impact of existential therapy on depression and depressive experiences, it also reflects common themes in the research around depression. It can be taken from this that though there are commonalities in themes reported to be experienced during depression each person's relationship with the experience is unique and could develop from the persons relationship to different aspects of their life and self. Therefore, it could be

suggested that though there is a large evidence base for treatments such as CBT targeting negative thinking and behaviours, this is only one element of the experience, and incorporating a humanistic element alongside various theory or modes of practice can provide clients/patients with the support and explanation or sensemaking they can hold on to in a way that can be tailored to them. The biggest factor that stood out in perpetuating the experience of depression was the relationship participants had with their experience. Therefore, a humanistic base to treatment can provide this supportive space for clients/patients to start changing their relationship with their experience as many felt they did not understand and were critical of themselves for it. Therefore, a suggested approach could be combining this person centered element with relevant theory and practice depending on the base of the depression experienced by the individual. The identification of this would depend on the skill and orientation of the therapist and their understanding of depression linking to the angle and approach in which they may start treatment. However, the relationship with the therapist and the therapeutic alliance can be helpful in giving the client/patient something to hold on to and a first base to start feeling accepted and in turn become more accepting of themselves to then begin building connections out of their experience. It could further be suggested that existential therapy could be helpful in providing comfort to clients/patients experiencing challenges where they are faced with dilemmas in living or where the is no obvious solution, as existential philosophy discusses many of the concepts of these challenges, allowing clients/patients to feel not alone in their experience of living.

In the current climate in working with depression the conceptualisation of depression can be helpful in providing an understanding of the experience for the client/patient however, the findings suggest treatments should be based on an individual formulation rather than standardised treatment protocol based on a diagnosis as this may not best fit all client/patient experiences, though may be able to provide some support and help with the experience. This is a challenge that is faced in how to categorise and treat the condition of depression on a large scale whilst still providing individual and personalised care and what this means for outcomes. Furthermore, in support of a personalised approach clients/patients in treatments in line with their preferences have better therapeutic alliance linking to the findings of this study and

changes in experience of depression as well as better outcomes (Cooper et al., 2017; Cooper, Van Rijn, Chryssafidou, and Stiles, 2021).

5.3 Limitations: What Can't the Findings Tell Us?

Though this study supports findings of previous research it builds on the areas which were limited within this topic, the findings elaborate on the quantitative studies giving insight into the experience of participants being in existential therapy for depression alone and the change in experience after therapy. The study is not without its limitations and therefore findings and conclusions should be read with this awareness. The study has a small sample size limiting the generalisability of findings. To this factor there was also no set type of existential therapy which participants enrolled in with no set number of sessions making each participant's experience unique. Participants had also all chosen to enter into existential therapy as a treatment for their depression. Research has shown that treatments that were chosen and clients/patients that were allocated to treatments in line with their preferences have a better therapeutic alliance, participation, and outcomes (Cooper et al., 2017; Cooper, Van Rijn, Chryssafidou, and Stiles, 2021). There were also many more female than male participants, again limiting the generalisability of the findings. However, this being said the analysis and themes were viewed as experiences of living rather than being sex or gender specific.

5.4 Recommendations: What Practical Actions or Scientific Studies Should Follow?

Future research could focus on exploring the different themes present in this study such as the theme of gratitude in depression as well as themes in other studies and understanding them through existential literature. Future research can also replicate this study in different settings with different numbers of sessions as well on specific types of existential therapies to expand research and understanding of the different effects on the experiential outcomes of existential therapy for depression. There

were also many studies looking at this topic within IAPT services it could also be of value to replicate these studies using qualitative rather than quantitative methods.

Chapter 6

Conclusion

In conclusion we can see that participants and their experiences of depression discussed in this study fit with many of the diagnostic criteria present in the DSM 5, however, adding more phenomenological depth and detail exploring the experiences of depression before therapy we can see themes of loss. Loss of connection with things that were important and anchoring for participants in life with elements of this being in their relationship with themselves as well as participants' relationships with others, with this leading into a different experience of their relationship with life and therefore depression.

The findings of this study 1) expand our understanding of the experience of the outcome of existential therapy for depression 2) build upon the current literature on using existential therapy to work with depression and increases awareness of other alternative treatments to the most utilised treatments of medication and CBT as well as 3) give a qualitative insight to what participants felt helped this change in depressive experience.

The findings suggest that clients/patients being in existential therapy for clinical depression had a positive impact on the individuals experience of their depression as found previously by the many quantitative studies discussed in the literature review. This study built on these findings by adding a qualitative phenomenological element and depth to this understanding participants and some helpful insight for clinicians working with this presentation with what helped facilitate this change.

Where this study added to the existing literature is on the finding that being in existential therapy for depression helped participants (and therefore can help clients/patients) to have a better understanding of themselves and what was going on for them through the relationship with their therapist as the main contributing factor for this change allowing participants to feel understood and safe to then

engage differently with their own experience, having more compassion and make meaning and understanding for themselves. Participants used this base of the therapeutic relationship to explore themselves and understand where they were facing internal conflicts in self and values which was also a central theme in the experience of depression contributing to the sense of loss. Participants also described being able to relate to and use the writings in existential philosophy that their therapists discussed to not feel alone in their experiences and provide a further sense of normalization, understanding and meaning making leading to a different experience of their relationship with their depression and self. This in turn allowed the participants (and therefore clients/patients) to be more open to sharing with people around them in their lives as one of the key themes leading to a felt need to isolate and disconnect was not understanding and feeling that if they did not understand what was going on others will not be able to either. Therefore, this base of the therapeutic relationship and change of relationship with experience gave an opening for participants to then reach out establishing and reconnecting with their support network and building supportive connections. Furthermore, with more support and meaning making of their experience participants also experienced more openness and trust in life enabling them to step out further and engage in new experiences.

These insights were uncovered through interviewing eight participants with three interview sections focusing on participants' and therefore client/patient experiences of 1) depression before therapy, 2) experience after existential therapy and 3) what helped any change in experience. The analysis was done comparing experiences and changes in experience from data collected in interview section one and two experience before and after therapy to assess change and then looking at data from interview section three what helped this change.

The findings suggest that the experience and perception of self is central to many participants and therefore client's/patient's depressive experiences. With existential ideas and philosophy existing around this concept of self, identity and values it could be suggested that potentially incorporating existential ideas into a humanistic and person-centered way of working can be helpful in changing the negative experiences

of depression through supporting clients/patients in understanding the existential conflicts surrounding sense of self, identity and life. These central themes of self and relationship with experience also appeared to be an important factor in maintaining depressive experiences through loss of connection with things that were important and anchoring for participants in life. In the change of experience after therapy a rebuilding of connections and participants finding new ways of anchoring themselves in the world can be seen partly in the new openness to life and new understanding of depressive experience and self.

The findings of this research suggest that no matter the school of thought and initial approach taken, the relationship between client/patient and therapist is essential to the change in depressive experience. It could further be argued that in addition to the use of a humanistic/ person-centered base it is also important at assessment or conceptualization to explore the individual themes that are central to the clients'/patients' depressive experience allowing clinicians to know how to tailor treatment for each individual client/patient and the core feature of each client's experience and therefore the best modality and approach with which to start treatment.

Existential therapy being a humanistic modality incorporates this essential element of the therapeutic relationship when working with depression whilst also bringing the philosophical teachings and literature behind it. With a potential focus on meaning in life and values it could be considered that this additional element of existential literature and philosophy could bring an added feature to classic person-centered counselling for depression and provide further reinforcement to the acceptance, understanding and meaning making of experience by discussing conflicts of self/values through existential teachings and philosophy.

This research can be valuable to clients/patients interested in seeking therapy, those interested in existential therapy, people who believe they are experiencing or are diagnosed with depression and those who are currently in existential therapy especially for depression. It can further be of value to health care professionals

affiliated with therapy or depression who may have not considered this approach to working with clinical or perceived depression.

7. Appendices

7.1 Appendix A: Table of Search Terms

Table of Search Terms

Section	Search Terms
How the DSM doesn't capture depression	Depression, experience, treatment, existential therapy, outcome, and DSM
Experiences of Depression	Depression Experiences
Current Research on the Effects of Existential Therapies on Psychological Outcomes	Existential therapy, psychological outcomes
The Outcome of Existential Therapy on Depression Alone	Existential therapy, psychological outcomes, depression
Qualitative Experiential Outcomes of Existential Therapy	Existential therapy, psychological outcomes, depression, qualitative, experiences
Qualitative Experiential Outcome of Existential Therapy for Depression	Qualitative, experiential, existential therapy
Mechanisms of Change	Mechanisms of change and existential therapy

7.2 Appendix B: Ethics Letter

NEW SCHOOL OF PSYCHOTHERAPY AND COUNSELLING
NSPC Limited
Existential Academy
61–63 Fortune Green Road
London NW6 1DR

23rd February 2022

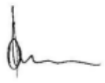
Dear Catherine

Re: Ethics Approval

This letter confirms that your application for ethical approval was reviewed and approved on 25th February 2020.

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



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7.3 Appendix C: Interview questions

Areas to be explored in the interview:

- Presenting issues and experience.
- Outcome/ change in experience

Interview questions:

Welcome and introduction

I introduce myself and ask the participant if they have read the information sheet and interview questions. I will give participants another information sheet and ask if they have any questions before we begin. Participants will also be given a consent form to sign. Participants will be reminded that they can pause or stop the interview at any point.

High-level information:

- Can we begin by just clarifying some details with you?
- Can you confirm for me when you had the counselling and how many weeks you attended for?

Presenting issues/experience:

- Can you tell me something about what brought you to counselling?
- How did you experience that issue before counselling?
- What was that like?
- When did that start?
- Can you describe your depression to me?
- What did having depression mean to you?
- How have you changed since you started experiencing this?
- What changes did you notice?

- How was it to experience this?

Outcome/ change in experience:

- How do you experience life now after therapy? What if anything has changed for you?
- What does depression mean to you now?
- Can you describe what your experiences are like now after therapy?
- How have you changed since being in therapy?
- What if anything has changed in your daily life?
- What if anything has changed in your experiences of the world?

Future: What was taken from therapy

- What if anything have you taken from therapy that has been helpful?
- Is there anything that has stayed with you from the therapy?
- Is there anything that you feel you would remember from therapy for future situations?

Closing of interview:

Thank the participant, ask them to reflect on the experience of the interview, how do they feel, ask if they have any questions for me. Participants will be given a debrief sheet with a list of numbers they can contact should they feel distressed.

7.4 Appendix D: Recruitment Poster

Existential therapy for depression

Would you like to take part in new exciting research?

To investigate the outcome of existential therapy for depression.

Are you:

- Between the ages of 18 and 70 to participate.
- Experienced what you consider to be depression or low mood for over two months but less than one year before entering therapy.
- Been in existential therapy as a form of treatment for depression.
- Not on medication for depression or had any other form of treatment for depression.
- Not have multiple or complex diagnosis.
- Been diagnosed with depression from a psychiatrist or psychologist and self-report as having had experiences of depression before entering therapy.
- Participants should have voluntarily chosen to seek therapy.

If you are interested in sharing your experiences of being in existential therapy or would like more information on this research please contact the researcher:

Catherine Barnes. CB1179@live.mdx.ac.uk 07463888191

The NSPC Ethics sub-Committee have reviewed and approved this proposal.

Thank you for taking the time to consider taking part in this study.

7.5 Appendix E: Participant Information Sheet

Middlesex University School of Science and Technology
Psychology Department

Title of study: What is the meaning and essence of the lived experience of the outcome of existential therapy for depression?

Researcher's name: Catherine Barnes CB1179@live.mdx.ac.uk

Supervisor's name and email: Pamela James: office@nspc.org.uk

Dear participant,

I would like to invite you to take part in research that is being conducted based on the need for a nuanced and comprehensive understanding of the outcome of existential therapy for depression. Before you decide to participate I would like you to understand why the research is being done and exactly what it would involve for you. Take time to read the following information carefully and ask questions if anything is not clear or you would like more information before considering whether or not to take part.

What is the purpose of the research?

This study is going to explore your lived experiences of the outcome of being in existential therapy for depression. This will allow for an exploration of the ways in which participating in this type of therapy has influenced your experiences of depression. It will also allow for an exploration of the ways in which your participation in existential therapy for depression has influenced your experience of life and existence.

Why have I been chosen?

You have been chosen because you are between the ages of 18 and 70 and have voluntarily been in existential therapy for depression. You can share your valuable experience of what your experience of depression before and after was like for you and how anything if at all has changed.

Do I have to take part?

Taking part in this study is entirely voluntary and you are under no obligation to consent to taking part. You can also withdraw your consent at any time up to one week after completing the interview without having to explain your reasons for doing so.

What will happen to me if I take part?

You will be contacted by me to make sure that you meet the criteria for participation and to arrange a suitable time and place for the interview to take place. You will be given a consent form to sign saying that you agree to take part in this study which I will go through with you to make sure you fully understand the aims of the research and your participation in it before signing. You would also agree with me a way to signal if you are becoming distressed and wish to pause or stop the interview. We will then begin the audio-recorded semi structured interview. I will ask you questions about what brought you to therapy and your experience of depression before and after being in existential therapy. After the interview you will be given the opportunity to discuss any feelings that have come up for you during the interview with me. I will answer any questions you have about the study and I will re-explain the intentions of the study, what will happen to the data and findings and restate your right to withdraw. You will then be given a debrief form thanking you for your participation and explaining the reason for the study and giving details of services and organisations which you can contact if you are feeling distressed or need to talk after the interview. You will also be given my and my supervisor's contact details.

What are the possible disadvantages to taking part?

The main disadvantage is the potential for emotional upset caused by reflecting on your experiences of depression which may trigger negative emotions and memories. If this happens you are free to pause or stop the interview at any time and can withdraw from the study without having to explain your reasons for doing so. Further, a list of services and organisations will be provided and the researcher will also be able to call NHS emergency services should you feel at immediate risk.

What are the possible advantages of taking part?

The information we get from the study will help to increase current research and understanding of how existential therapy impacts on the experience of depression. You will therefore be able to contribute to new research in the field of psychotherapy. Although there is no direct benefit to you in contributing in this way, you may find having the opportunity to talk about your experiences has a therapeutic effect.

If a non-academic version of findings is written than I would be more than happy to send you a copy as this may be more useful for you than the academic version.

Consent

You will be asked to sign a consent form which I will go through with you to make sure you have understood the details of the research and what your participation will involve before signing it.

What will happen to the data?

Your data will be anonymized by using a pseudonym and any raw data that could identify you will be stored securely and separately to your anonymized data. Original recordings will be destroyed immediately upon transcription and held on an encrypted USB stick. Paper copies of anonymized data will be held in a locked cabinet in the researcher's own home. The anonymized data would also only ever be accessed by the researcher and her supervisors. All anonymized data will be kept for 10 years after which time it will be confidentially destroyed.

Who has reviewed the study?

All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed.

The NSPC Ethics sub-Committee has reviewed and approved this proposal.

Thank you for taking the time to consider taking part in this study.

7.6 Appendix F: Written Informed Consent

Middlesex University School of Science and Technology
Psychology Department

Title of study and academic year: What is the meaning and essence of the lived experience of the outcome of existential therapy for depression?

Researcher's name: Catherine Barnes CB1179@live.mdx.uk

Supervisor's name and email: Pamela James: office@nspc.org.uk

Academic year: 2020/2021

- I have been fully informed and 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.

- I have been given contact details for the researcher in the information sheet to keep.

- I understand that my participation is entirely voluntary, that all reasonable steps will be taken to ensure my data will not be identifiable and I have the right to withdraw from participating in the project at any time without any obligation to explain my reasons for doing so.

- I have been informed that I can ask for my data to be withdrawn from the project until data analysis begins one week after the date of interview.

- I also further understand and give consent that the data I provide may be used for analysis and subsequent publication, including in doctoral theses,

research papers, journal articles, books and teaching materials, as well as conferences and seminars.

- I agree to the audio-recording of the interview and the storage of my data for 10 years on an encrypted memory stick or in a locked cabinet in the researcher's own home.

_____ _____

Print name Sign Name

date: _____

To the participant: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Science and Technology 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: _____

7.7 Appendix G: Debriefing Form

The New School of Psychotherapy and Counselling (NSPC) and the Psychology Department, Middlesex University, School of Science and Technology

Title of study:	What is the meaning and essence of the lived experience of the outcome of existential therapy for depression?
Researcher:	Catherine Barnes: CB1179@live.mdx.ac.uk
Academic Supervisor:	Pamela James: office@nspc.org.uk

Thank you for taking the time to participate in this research study exploring the outcome of existential therapy for depression, and making a valuable contribution to research in this area. The findings will allow for an exploration of the ways in which participation in therapy has influenced clients' subjective experiences of depression, rather than limiting them to current clinical diagnostic definitions which attempt to define and dictate the experience. It will also allow for an exploration of the ways in which participation in existential therapy for depression has influenced the client's experience of their existence.

I hope you have understood the overall aim and purpose of this study and enjoyed your participation in it. Please be aware that now your interview has been conducted, if you have any queries or concerns you can contact me or my supervisor using the contact details at the top of the page.

I would like to take this time to ask you how you found the interview and if you would like to ask any questions, or require any further understanding of the research and your participation in it?

Your data will now be transcribed by me, coded, anonymized and stored on an encrypted USB. The original recording will then be deleted. Paper copies will be stored in a locked cabinet in my own home and only myself and my supervisor will have access to it. Any identifying data will be held separately to your anonymized data and all data will be held for a period of 10 years, after which time it will be confidentially destroyed. Any verbatim quotes from your data may be published in my final thesis but your name and any other identifying details will not be used.

You have a right to access your personal data by making a request to the researcher. You can also choose to withdraw your data before the data analysis takes place one week from the date of this interview. Furthermore, if you would like a copy of the findings when the research is complete, I am happy to do so, please send a request for the findings to my email address at the top of the page.

Below is a list of resources and organisations should you wish to explore any issues that have arisen for you as a result of participation in this research. You can also contact your GP, the Mental Health Support Line (0800 028 8000 Mon-Fri, 5pm-9am; Sat, Sun & Bank Holiday, 24 hours) and the NHS (111 Mon-Fri, 6.30pm to 8am, and 24 hours at weekends and during bank holidays).

- The Samaritans – National
  Tel: 08457 90 90 90
  Email: jo@samaritans.org (responses within 12 hours)
  Letter: Chris, P.O. Box 90 90, Stirling, FK8 2SA

- The Samaritans - Putney
  14 Princeton Court, 53-55 Felsham Road, Putney SW15 1AZ

Tel:116123
Face to face: Open to receive callers at the door 10am-7pm (by appointment only)

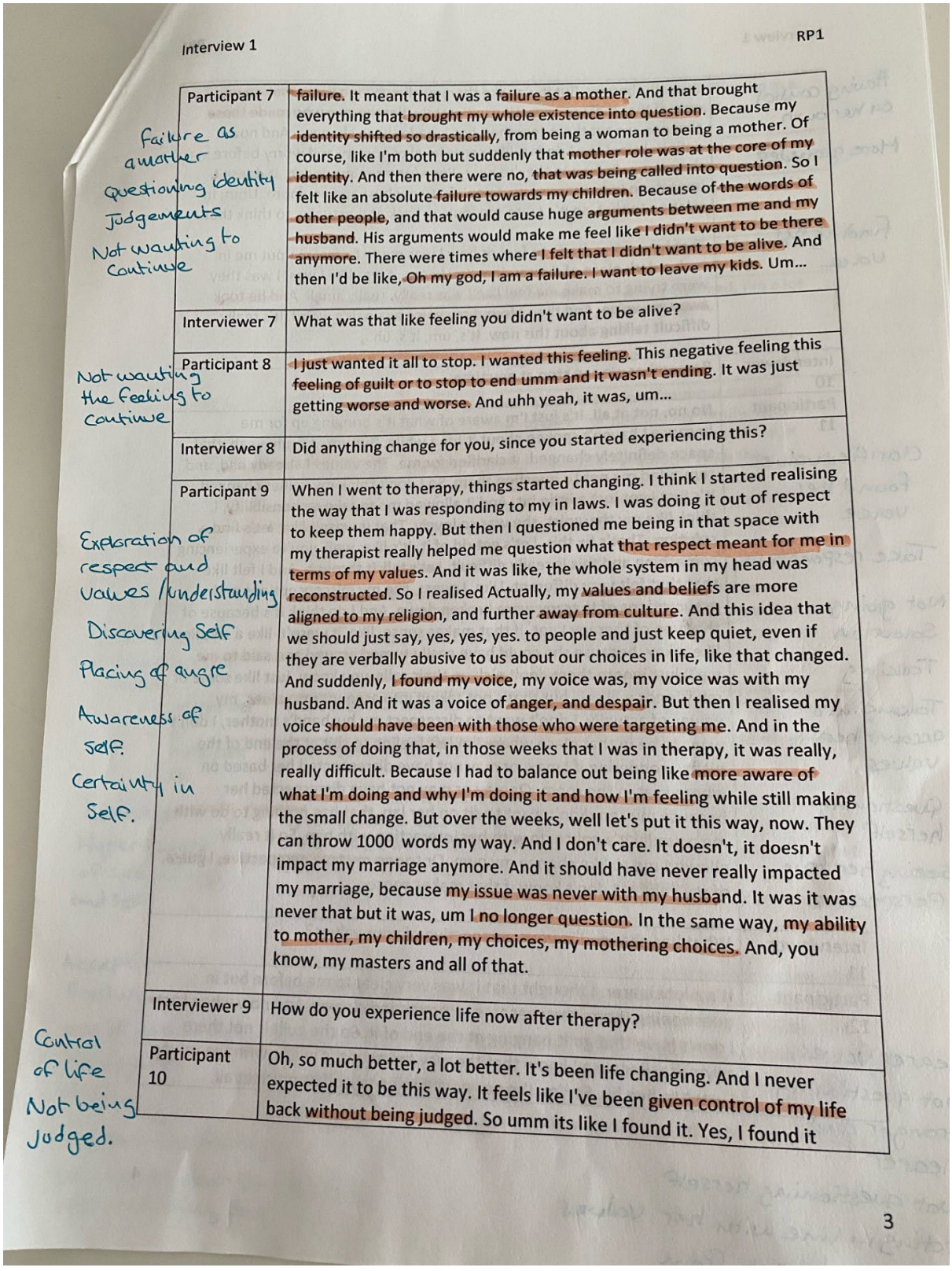
- Saneline
  Tel: 0845 767 8000 (Every Evening, 6pm – 11pm) Email support: www.sane.org Support forum: www.sane.org

If you would like to talk about your personal experiences further with a trained professional, you can contact the following counselling and psychotherapy organisations for access to local therapy.

UKCP Psychotherapy Register - http://members.psychotherapy.org.uk/find-a-therapist/

BACP Psychotherapy Register - https://www.bacp.co.uk/about-therapy/how-to-find-a-therapist/

7.8 Appendix H: Image of transcript and Comments



Interview 1 RP1

Participant 7	failure. It meant that I was a failure as a mother. And that brought everything that brought my whole existence into question. Because my identity shifted so drastically, from being a woman to being a mother. Of course, like I'm both but suddenly that mother role was at the core of my identity. And then there were no, that was being called into question. So I felt like an absolute failure towards my children. Because of the words of other people, and that would cause huge arguments between me and my husband. His arguments would make me feel like I didn't want to be there anymore. There were times where I felt that I didn't want to be alive. And then I'd be like, Oh my god, I am a failure. I want to leave my kids. Um...
Interviewer 7	What was that like feeling you didn't want to be alive?
Participant 8	I just wanted it all to stop. I wanted this feeling. This negative feeling this feeling of guilt or to stop to end umm and it wasn't ending. It was just getting worse and worse. And uhh yeah, it was, um...
Interviewer 8	Did anything change for you, since you started experiencing this?
Participant 9	When I went to therapy, things started changing. I think I started realising the way that I was responding to my in laws. I was doing it out of respect to keep them happy. But then I questioned me being in that space with my therapist really helped me question what that respect meant for me in terms of my values. And it was like, the whole system in my head was reconstructed. So I realised Actually, my values and beliefs are more aligned to my religion, and further away from culture. And this idea that we should just say, yes, yes, yes. to people and just keep quiet, even if they are verbally abusive to us about our choices in life, like that changed. And suddenly, I found my voice, my voice was, my voice was with my husband. And it was a voice of anger, and despair. But then I realised my voice should have been with those who were targeting me. And in the process of doing that, in those weeks that I was in therapy, it was really, really difficult. Because I had to balance out being like more aware of what I'm doing and why I'm doing it and how I'm feeling while still making the small change. But over the weeks, well let's put it this way, now. They can throw 1000 words my way. And I don't care. It doesn't, it doesn't impact my marriage anymore. And it should have never really impacted my marriage, because my issue was never with my husband. It was it was never that but it was, um I no longer question. In the same way, my ability to mother, my children, my choices, my mothering choices. And, you know, my masters and all of that.
Interviewer 9	How do you experience life now after therapy?
Participant 10	Oh, so much better, a lot better. It's been life changing. And I never expected it to be this way. It feels like I've been given control of my life back without being judged. So umm its like I found it. Yes, I found it

Failure as a mother
Questioning identity
Judgements
Not wanting to continue

Not wanting the feelings to continue

Exploration of respect and values / understanding
Discovering Self
Placing of anger
Awareness of self.
Certainty in Self.

Control of life
Not being judged.

3

7.9 Appendix I: Example of Full Interview Transcript

Initial impressions		Emerging themes
	R1: So can I start by just clarifying with you? What brought you to counselling?	
	P1: Well, I think the catalyst was my mother had to go into a nursing home. And it was all pretty horrendous. And I went to my doctor, and he said, Oh, well, we've got a doctor who just trained in CBT. And we can give you like six sessions. And I had six sessions with her. And I thought, yeah, this radically changed the way I was able to be with my mother, but I knew it didn't get to where I lived. And I just found a local counsellor, and she happened to be existential, just luck.	
	R2: And what was going on for you at the time of going into counselling? So you said it was something to do with your mum?	
	P2: Yes, um, she had become more what I now recognised as suffering from dementia of one sort or another. And we just couldn't cope with her. So she went into private nursing care. And I felt terribly guilty and ashamed and all sorts of things because I was adopted. And, you know, she took me in when I need to care. And now look what I was doing. And, yeah, just a bad place.	
	R3: Sitting with the guilt and the shame of that. What did that mean for you? What did that experience mean for you at that time?	
	P3: I wasn't good enough. which I'd always been brought up to believe anyway. And it impacted on that and just, just awful, just terrible. Yeah. Just Yeah. Shocking. couldn't cope I couldn't cope with my mother. I couldn't cope with the feelings of pushing her into a nursing home when she was so distressed. And I didn't realise that the things she was saying were part of the dementia. I thought she really meant them. She was a mess. It was a complete mess.	
	R4: And what was it like going into existential therapy with all of this?	
	P4: it just felt like coming home. The moment I was with the existential therapist, it felt safe. I felt	

	comfortable. It felt where I needed to be I I knew she could help me find a path. And she actually suggested that I become a counsellor. And I thought oh me. And I thought, well, she's an existential therapist. So I thought I'll go and investigate that and I started the course it was just like coming home. It was just wonderful. Yeah. So working with her was easy. It was just it flowed, rolled along and there was I felt no embarrassment. No, nothing. I couldn't say she was a good counsellor. She, I mean, it probably wouldn't have mattered what type of care model she followed. She was just good. Yeah.	
	R5: And has anything changed for you at all?	
	P5: If I could see me now from then I wouldn't recognise me I have changed so much. It's unbelievable. I found my feet I'm safe. I'm safe in the world. I've never been safe in the world before. And when I was on my course I was saying this to someone the other day I was sitting there, and I suddenly felt my toes straighten. And I realised I've been gripping the earth, most of my life, and just going through the course and the therapy and supervision or just give me a grounding and a safety in the world that I've never had before. I had some superb counsellors. I had a superb counsellor while I was on my course. And before and afterwards.	
	R6: What do you think helped get you from that place to this place?	
	P6: Um, Damn hard work on my part. I've worked very hard. Um, it's that existential thing of being believed and accepted. I think that's very much the platform of existential therapy, is believing what the client says, and going with it not saying oh, well, I thought that was possible, or bla bla bla, just being accepted. This is what you've experienced what you're saying in this moment. And I believe you. Yeah. And I'm with you.	
	R7: Yeah. What does that experience? Looking back on it? That's a place where you were what does that mean to you now?	

	P7: It means I can live a completely different life. I'm still in process, I think we all are. Perception changes all the time. So my perception changes all the time. So… yeah, it's it's a long journey. And it continues to be. It's it's a journey, it's not a destination. I think that's all I want to say. But at the moment, it's lovely.	
	R8: And how did you? How did you come to that shift? Sort of from the destination to the journey?	
	P8: Well, it's what Popa says, isn't it. You think it's a some blinding revelation, but it's a little be little that leads up to the Eureka moment? Yeah. Yeah. The little building of things. I mean, I'm, I do a lot of Louise Hays affirmation, because I think she is excellent. And, you know, when you start to open up, when I started to open up, I could take help from everybody. When I was closed down, I couldn't take help from anybody. It's a funny thing, the more in my experience, the more grounded and me I've become, the more able I am to say, I don't know, I don't understand, help me through this. Whereas when I was in a bad way, I was very defended. No, I know everything. I don't need help go away go away. Look, it's quite remarkable, quite remarkable.	
	R9: Has anything changed for you with the guilt that you were saying about your mom?	
	P9: Um, I regret very much. We didn't have a happy relationship. There is nothing I can do about it now. I have worked very hard to bring myself peace in that direction. It's the past there is nothing I can do about it. But I can recognise that it was just what was we were as we were, and I didn't get? Well, I did actually, at the end, I had the CBT. And it just gave me enough enough tools to reconcile. Really? Yeah. Yes. So although that wasn't, I wasn't seeing an existential therapist at that time. It helped me a lot. Yeah. R10: Thinking about existential therapy. Is there anything that you've taken from that?	
	P10: From the existential therapy? Well, it's funny, even before I met existentialism, my motto was	

	always everything changes, nothing stays the same. And I think that is a big theme of it, you know, people say, Oh, I don't want to change. I like things as they are. But everything changed, our body changes. In seven years, every cell has changed has died regrown. Unfortunately, at the age when it dies, instead of going back to being young. But yeah, except I don't know if for me, it's becoming just more and more me. Being happy there. I'm safe, and grounded. And amazed at what's happened to me. I would never have believed when I was a teenager, I'd be as I am now.	
	R11: You say, more grounded, what's contributed to that sense of grounding?	
	P11: All sorts of things I had. I was married for 40 years and very happy. I had two daughters have two daughters. They taught me probably more than anybody. Seeing and being with them as children, and growing up was just a revelation to me, because I knew I couldn't bring my children up as I was brought up. I knew there was a better way. And I found a better way. And it it was amazing. We have the most wonderful loving relationship. And my sons in laws and my grandchildren. It's I live in a world of love, actually. And five months ago, a new man walked into my life. I've been a widow for 40 years. And I'm not on my own anymore. It's really nice. Yeah, with no. It's the thing about clearing the space. You know, nature abhors a vacuum. And when you make a vacuum, something comes into it because my grandchildren are 15 and 13. Now and I was thinking, What am I going to do them getting self-sufficient? They don't need me anymore. And then john walked into my life. So far I've had a tough time. But I've been so fortunate. And I think I'm lucky in being me. I'm aware. I can. I'm ready to take a risk, an emotional risk. I'm not very good at physical risk, but emotionally, and I'm very open to risk and trying giving it a go. R12: Have you always felt that way?	
	P12: I think so. Yes. Yes. I've always sort of been slightly outside. I never had many friends as a child, but I'd be friends like with the lady who lived on the corner with the cats and things that was always it. A	

	bit different. I spent a lot of my young years wanting to be the same as everybody else. I'm very tall. I'm nearly six foot tall, so, and everybody else was five foot two. And it was not easy. And it's taken me a long time to reconcile that, sir. I'm fine now. I think I'm wonderful. Someone said to me, what, what's, what's your relationship? Like? I said, Well, we've got a lot in common. He thinks I'm wonderful. I think I'm wonderful. I think its taken me 10 years to find my feet. Really. It's because everything, I didn't know how to make a phone call. I didn't know what the codes were, you know, and everything was wiped away. My husband died and my daughter's marriage a kiwi bloke. And she said, Well, why don't you come and live with out here with us? We're not with them. But I've always got a therapist. Now I don't have regular therapy. I've got always got someone I can bring up and say, Oh, can I have an appointment? And I'll do two or three seconds and sort out what's bothering me. Some ways I quite like to be in regular therapy all the time, because there's always something to do. But on the whole, I don't need to be there. Yeah, very accommodating. They're quite happy to just see me on an up. You know. I have a very, very good therapist at the moment. But I've been pretty lucky with the therapist. And the supervisors. I've come up against Yeah.	
	R13: And how was it for you sort of moving to New Zealand? Do you say everything was your husband died? Everything was wiped clean?	
	P13: Yeah, it was. Some ways it was great, because I was back with my daughter. And if I hadn't moved here, I'd never have seen my grandchildren because I left my younger daughter and her husband in England. And I said, I'll leave you and she said, Look, if you don't move, you'll never see your grandchildren. So that was the final benediction on the on the move. But it was it was tough. I mean, I knew nobody. Luckily, everyone, like my son in law's family were very kind and helped me through. And one day, I went into a coffee shop in the town. And I was just sitting there and the lady sitting. Next day, we'll sit alone started chatting. She said, Oh,	

	hello we have a coffee group here this morning. Every week. Would you like to come and join us? So I instantly had ten friends. I mean, it was just these coincidences are amazing. Yeah. Because I couldn't work as a counsellor. I was too emotionally beyond it. I you know, I'd set everything up and I joined the association and I was all ready to go. And the counsellor I was seeing at the time said, No, you're burnt out. You need not to be doing it at the moment and I've never picked it up again, as too long now I haven't worked for 11 or 12 years, and I'd have to redo this and redo that. I just don't want to. I do I miss it. I miss it so much. But I've stopped trying to counsel all my friends now it takes a long time. Because it's me, you know, it's not a job. It's me. Yeah. It's um, it gives me a nice place to be with people. Yeah.	
	R14: you say having a new sort of a new group, has anything else helped with that sort of meaning of, losing everything and moving?	
	P14: Well, yes, having my daughter had her daughter when I came over here. And then she had a son since and we brought the children. I mean, he's got a husband that he was always working, we brought them up together. It was great. They never knew which one of us to call mom. Because we're very likely we sound alike. And we don't look too dissimilar. So that's very nice. She's very, she includes me and everything takes me everywhere.	
	R15: Is there anything from the therapy that helped? Or didn't help?	
	P15: Well, yes, because just it's having someone to talk to privately, and that it's confidential. And I could say what I needed to say, even though sometimes wasn't the nicest things. And just some in a land where I knew nobody. It was someone on my side. The defiantly, it helped a lot. Yeah.	
	R16: Someone to sort of walk alongside you?	
	P16: Which is what it is all about. She can't change me, only I can change me, but she can show me where the change might be. And just, you know, hearing myself say, x, y and Zed. I'm thinking, Oh, yes. Well, that's right. I'm not	

	AB and C. Maybe there's an X y&z that I am also, and that's a nicer place to be.	
	R17: Is there anything that stuck with you? Or that you remember for future situations?	
	P17: I am a terrible rescuer. I have to work. I used to have to work so hard as in now as just as a person, I want to make everything better. I don't want people to suffer. And I'm constantly trying to leave space so that people can experience themselves without me jumping in and spoiling everything. Yeah. And that's an ongoing struggle for me. Yes, accepting and just being. Yeah.	
	R18: Is there anything else that you feel has shifted for you you've taken from the therapy or will change from you experience before after?	
	P18: Well, it's a funny thing, isn't it that the therapy opened up my world. So at one time, I was seeing an Alexander Technique guy, and I was saying, Oh, I'm so tall and he said, Oh, enjoy glory in it. And he helped change my perspective. But I was only seeing him because I had the confidence from the therapy to go out and meant more help, you know. Learning to accept myself I think is the biggest thing learning to love myself that's taken a lot of years, but all of a sudden it clicked. And in this new relationship with john, I'm presenting myself as lovable, attractive, worthwhile person, which is unbelievable for me, would have been when I was a teenager. And just just being on my side, I thought for a long time, I was never on my side, I was always on the side of the people that ran me down. Yo, yes, you're right on this, you know. And now I'm not I'm on my side. And I take care of myself and defend myself and won't let people what have you. It's turned inside out upside down. I travelled across the world, and I'm upside down. But also, my life journey is like that. It's remarkable. And I'm sure I wouldn't have done it without the therapy. I'm sure these it was the just as acceptance, there was something about I was in the right place with the right sorts of therapists, because I saw a couple of therapists before one was what they called, like a Freudian, you know? Yeah, yeah. And I couldn't cope with that at all. But I saw um, you're okay. I'm okay. And she was excellent. But again, that's on very existential lines. I thought that was a bit	

	difficult. They went a bit far, trying to describe it. But yeah, I think that's a really good. I was saying to my tutor at a college, if I weren't existential, that's probably what I want to be. And she said, Yes, funnily enough, I would do it. It's a good thing. And I ended up actually teaching counselling at the college where I studied, he thought it was good. So it led me into I mean, they want me to do so that was all part of the growth the change that finally my feet. Yeah. Which counselling had given me. But I have to be fair, I had a wonderful husband who supported me every inch of the way and always wanted me to succeed and up and up and up. Yeah.	
	R19: You say something clicked. I would, I wouldn't have supported myself in this way. Before. When was that? What clicked? What was that shift? During your relationship with yourself?	
	P19: I think it was as recent as well, since I've been here. I think I think it's been the step by step by step. And it's just that this counsellor I'm with now was the one I was with when the revelation came. It wasn't altogether to do with her, but she just happened to be there when reached that point.	
	R20: What helps with that revelation?	
	P20: I don't know. It just it was off sorts of things had an input Like I say, I like Louise Hay, I do her stuff. I in England, I had, I went to her conferences, because I had my own business or businessman's business people's conference. And I sat next to this lady, and it turned out she was a crystal healer. And then brown died and she helped me enormously giving me healing. And I was always very anti anything to do with the Spirit. And she changed. I'm still not sure it's not a lot of rubbish, but I'm not quite as adamant as I was. My late husband finds me parking spaces. It's quite uncanny. And I, I've been I did six sessions with a group quite recently last year. And I was saying, it's just a lot of nonsense and we work through it. And it's actually not it's who knows, who knows, actually, but it gives me comfort and it keeps me in contact with them. And so that sort of opening up of the don't know, side. I can't know, nobody can know. There are people who say, yes, there is a God, definitely for sure that nobody can know. And perhaps until you're dead, you you don't know whether there's an afterlife,	

	but some people sincerely believe there is, um, I don't know, I'm a big don't knower. I'm a big wonder. And, you know, oh, I'll say Oh, look at that. There's such and such a picture in that trees looks like a certain set, and they go what we're seeing with a different perception. Hmm, it's strange. You know, in New Zealand, we had Maori people in the indigenous population, and they have something called mana, which is your presence, they call it your mana. An Omari lady said to me one day, you've got such Mana. And I thought, Oh, that's amazing. That's so yes. Oh, yes. And, john, the one I'm with now is very clever and very willing to explore. So it's really nice. We have a lot of arguments and singing out the house, and coming back again. But yes, I don't let him walk all over me. Which once upon a time… Yeah. Yeah. It's lovely.	
	R21: So connecting with yourself in that way, but what shifted? I'm just wondering what shifted, you say? I wouldn't have let him do that before? Sorry. You wouldn't let them do that now? But I would have let them do that before was shifted. Why?	
	P21: Well, there's never an answer to why as you know that. It's again, this popa thing that little by little by little, I change. And then one day, I was a different person. Really? Yes. I can't put my finger on when I can't. No, I can't. It's just I suppose. It was seeing with different eyes. I've spent a lot time saying there are so many people who love me, and I can't accept that I'm lovable. And I said it's so unfair, because they're sending me all this love and get away. You don't know me? You know, I'm not lovable. And I was, I've worked very hard on they can see lovableness in me, so why can't I? And I don't know, all of a sudden. I know, I am lovable. And I love me. But I couldn't pinpoint it. I couldn't say it happened one day, or it's the popa up little by little. Until one day you think Eureka, but it's not Eureka. It's just a build up of all the tiny steps. Is there anything else you think? Um, I just I just think I've been incredibly fortunate. My life. It hasn't always been easy, but what happens is grist to the mill. And its that therapists are like the grit in an oyster to make the pearl they rub and rub and the beautiful pearl forms because they they don't make things easy. They're confronting and but it's a very funny thing, isn't it?	

	It's, it's confronting, but it's gentle. Well, gentle, not always gentle. It can be quite harsh. I've been in therapy and so Oh, I'm really scared sitting here and not having the wherewithal to say to the therapist, you're really scaring me. Which is a shame because we could have gone a long way. Now. I will say to my therapist, I don't like what you're doing. I that's not what I am. You know, I'm prepared to stand up for myself. When it happened. It's happened really since I've been to New Zealand the most. Why that should be I don't know. But as new beginning.	
	R22: Okay, thank you. How did you find talking about this?	
	P22: Oh, great. It's lovely. It's a great experience. I miss it a lot. Yeah, makes me think about what's happened.	

7.10 Appendix J: Themes Table

Experience of depression before therapy

Theme	Subtheme
Loss of safety	Identity **LIFE**
	• INTERVIEW A • Losing self • **CONFLICT IN VALUES** • INTERVIEW RB • Paradoxes • **IDENTITY** • No support • INTERVIEW MO • **NO ANCHOR/CONNECTEDNESS** • Wanting to be understood/belonging. • **INTERVIEW D**

	• Not feeling good enough • Loss of safety • **INTERVIEW S** • Wanting to be understood • Losing identity • **INTERVIEW C** • Disconnection from self • No safety • Dichotomy • Wanting autonomy • Safe world crumbled. • Not finding her place existentially. • INTERVIEW T • Not questioning • Paradoxes
	Relationships
	• INTERVIEW RB **LOSS OF CONNECTEDNESS** • INTERVIEW MO **NO ANCHOR/CONNECTEDNESS** • Wanting to belong

	• INTERVIEW D **LOSING RELATIONSHIPS** • INTERVIEW C **HIDING** • Isolated • Not understood. • Not fitting in/ belonging. • INTERVIEW T • Isolated • Feeling disconnected • Lack of support **PHQ CRITERIA** • INTERVIEW D • Not having interest • Lost meaning • Appetite • INTERVIEW S • Not enjoying things, she used to. • INTERVIEW T • Not enjoying what she used to.

Not wanting help/ wanting to be alone	• INTERVIEW A • Being defensive not wanting help. • INTERVIEW D • Not wanting help wanting to be alone. • INTERVIEW S • Not showing pain/ not asking for help. • Not wanting to burden others. • Wanting to be understood. • INTERVIEW T • Not showing it.
Relationship with their experience	• INTERVIEW A • **GUILT AND SHAME** • INTERVIEW RB • Confusion • INTERVIEW D • Not knowing if it is normal. • Stuckness • INTERVIEW C • Being different • INTERVIEW T • Confused

CHANGE IN EXPERIENCE/ AFTER

Theme	Subthemes
Safety and grounding	Identity and certainty
	• INTERVIEW A • Identity and certainty • INTERVIEW RB • Connection with self. • INTERVIEW MO • Relationship with himself. • Relationship with emotions. • Relationship with life • Connection with values and self • Responsibility • INTERVIEW D • Listening to depression • Relationship with herself • Body • INTERVIEW S • Identity • Her story making her narrative • Finding rest • Body • Relationship with herself • Authenticity • INTERVIEW C • Strength in values • Relationship with self • Challenging self

	• Body • INTERVIEW T • Connecting with emotions • Listening to self • Relationship with self
	Life
	• INTERVIEW A • Acceptance and trust in life • Meaning in experiences/ using negative experiences • INTERVIEW RB • Trust in life • Gaining from experiences • Meaning from different experiences. • Accepting difficulty • INTERVIEW MO • Trusting in life • Acceptance of emotions • Living with • INTERVIEW D • Accepting • INTERVIEW S • Meaning • Acceptance/allowing • Using experience/value in experience. • INTERVIEW C

	• Living with • Using the experience • Accepting • INTERVIEW T • Connecting with life • Meaning • Accepting • Trusting
Gratitude	INTERVIEW A
	Relationships
	• INTERVIEW D • **CONNECTING WITH OTHERS** • INTERVIEW S • Connected to the philosophy. • INTERVIEW T • Vulnerability with others.
Being present	• INTERVIEW S • Here and now • INTERVIEW T • Being in the moment

WHAT HELPED

Themes	Subthemes
Relationship with therapist	• INTERVIEW RB • **RELATIONSHIP WITH THERAPIST.** • Therapist as an anchor. • INTERVIEW MO • Relationship with therapist/ empathy • Therapist as an anchor. • INTERVIEW D • Therapeutic relationship/ feeling safe • INTERVIEW S • Relationship with therapist. • Therapist being brave. • Therapist self-disclosure. • INTERVIEW C • Relationship with therapist/ not judged/ safe space. • INTERVIEW T • Relationship with therapist.
Openness to life/ trust in life	• INTERVIEW A • Learning from experiences- using them to build a relationship with self/meaning • INTERVIEW RB • Meaning in negative experiences/ using experiences.

	• INTERVIEW S • Creativity • INTERVIEW T • Accepting • INTERVIEW C • INTERVIEW D • INTERVIEW MO
Support	• INTERVIEW A **BEING HEARD** • INTERVIEW RB **BEING LISTENED TO** • Having a witness • INTERVIEW D • Having support • INTERVIEW S • Feeling heard • Having space
Self	Values
	• INTERVIEW R.B • Connection with self through values or job. • INTERVIEW MO • Being in touch with values. • Relationship with self and story

	• Connecting to own anchors. • INTERVIEW D • Relationship with herself. • Understanding • Values • INTERVIEW S • Confronting fears • Being brave/ having courage • Connection with body. • Authenticity • INTERVIEW C • Wanting change • Meaning and values • Making meaning • INTERVIEW T • Relationship with self • Relationship with body
Gratitude	• INTERVIEW D • Gratitude • INTERVIEW A • Gratitude • INTERVIEW C • Gratitude
Being present	• IINTERVIEW S • Being present

Philosophy	• INTERVIEW T • Here and now • INTERVIEW T • INTERVIEW C • INTERVIEW MO • INTERVIEW S • INTERVIEW A • INTERVIEW D

EXPERIENCE OF DEPRESSION

- Main themes: Loss of safety: relationships, experience of life, identity, not wanting help/wanting to be alone, feeling about depression.

CHANGE IN EXPERIENCE/ AFTER

- Main themes: Safety and grounding, identity, life, gratitude, relationships, feeling about depression (making meaning out of the experience)

WHAT HELPED

- Main themes: Relationship with therapist, openness and trust in life, support, relationship with self, gratitude, being present.

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