Engaging Activity Supporting Existence

EASE WELLBEING

Contemporary considerations, case study and outcomes

Short-term integrative counselling and psychotherapy for mild-moderate concerns in naturalistic settings

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Written and developed by EASE Wellbeing CIC

Notes:

Despair vs hope

Despair caused by isolation alienation and inhibition of service delivery at the most needed times

Hope is the possibility created by digital platforms creating access, engagement and opportunity is a very challenging environment for so many Myself and several colleagues will speak today and there will be space at the end of each section for questions or comments if you wish. Alternatively, we have worked out that there will be at least fifteen minutes at the end of what we all have to say for a broader discussion as well as comment and questions. So please feel free to write a comment in the chat or raise a hand or say anything you wish when you wish or if you would like to hear the whole presentation, there will be ample room for comments, criticisms, debate, discussion and reflections after.

In this introduction I think I will not be saying much that is new or revelationary but rather expanding on the notion of meaning as it applies to the work of EASE Wellbeing talking therapy service that operates alongside the primary care sector throughout this country. Much of what I say applies to international issues that have arisen but our work is here.

EASE Wellbeing is a community interest company that evolved out of the NHS. We were first tasked with testing a way of working in a primary care setting in 2008 when our work was less digitised and focused upon addressing concerns expressed by patients to their GPs that either did not meet the restrictive criteria for the fledgling IAPT service and/or offered a complimentary way of working.

We deliver a short-term personalised recovery oriented talking therapy that is underpinned by a rigorous process of risk assessment and monitoring and measurement of progress and outcomes.

We initially adopted the collection of data according to IAPT minimum data requirements so as to be able to compare and contrast our work. We added another measure taken from the CORE suite of measures known as the GOAL attainment form (see SEA Journal 2013).

The principles upon which this intervention are based upon utilising a phenomenological method of enquiry to capture a broad sense of experience. Thus the phenomenological reductions here expressed and addressed are:

1. To identify the nature of a person's experience

2. To identify that person's relationship to that experience

3. To identify the relationship of the person in this way of experiencing

4. And to identify the transcendental position of wished for experience.

We employed existential attitudes to consider how that which may be hidden may be paid attention to with the overarching position that a person being stuck so to speak wished to reach for a more satisfying more meaningful experience of living.

In conjunction, we were guided by a sense of the person's desire to live as well as they could using principles from humanistic psychology that asserts a person given the appropriate conditions in treatment will want to 'get better'.

After some years and success with goal attainment and a personal yet consistent way of working, we introduced a tool from constructivist psychology, the repertory grid technique which my colleague Lauren will discuss in more detail.

That remains our approach and what has become evident is in line with these hypotheses and has been tested and retested and has evolved Rayner & Vitali, 2015, 2016).

My colleagues will give examples to corroborate this but this introduction will show how this past year has challenged both more manualised approaches, suggested that people have become greatly more focused on that which they have or do attribute meaning to and has greatly challenged historic stigma around reaching out for support.

People have become more attuned to their concerns and found the need, desire and courage to face them in a way that has to a large extent been a response to having less to do, being more isolated with their concerns and finding it difficult to find distractions from that which they know is there but has been able to been shrugged off or avoided during busy social and vocational activities.

For us, from an existential perspective meaning is central to our work but not the exclusive domain as it is just as important to establish that which was or is meaningless as part of our endeavour.

This brings me to the centre of this introduction. We cannot ignore the ongoing impact of this past year either on peoples' difficulties or their interest in addressing them. While we recognise many people have carried burdens for many years, it has become clear that the pandemic has raised awareness and the urgency or people to address and re-evaluate what they do how they live their lives and what gives them a sense of meaning and purpose in a world that has been encumbered by restrictions to support, both psychological, relational, vocational and developmental.

SARS Covid-2 has acted as a magnifying glass for many challenging previously adopted ways of living and creating levels of uncertainty that have left many in despair.

At a service level, what has been most prominent is the move to a large extent towards a secure delivery of talking therapy on a secure digital platform. This has allowed so many more people to get access to our service than previously and has completely overturned the meaning of the word remote for our team. Whereas previously we were limited in meeting each other and

restricted in reaching clients, now we are a more cohesive yet diverse and spread out organisation that meets online 3 or 4 times a week to discuss clinical issues as well as professional development as well and offering our staff ongoing training and support in theoretical positions and matters relating to the wider endeavour or managing efficient pathways and treatment processes. For our clients, they are a click and a call away from help, thus we are much closer and more cohesive and involved by virtue to being remote whilst being available in both of our physical offices.

Before I hand over to my colleagues, I would like to leave you with one thought to ponder. The news has been dominated by severe reactions to the past two years and has subscribed to assigning the diagnostic label of PTSD to much of the currently or recently experienced trauma that has emerged and evolved during peoples' struggles, experiences and losses during the pandemic. I would argue that this nomenclature does not satisfactorily grasp the sense of PTSD as historically known and, furthermore, both dilutes the horrors of combat stress or historic trauma usually reserved for this diagnosis as well as giving weight to recent trauma by using this term so that many of those referring themselves for help and having been traumatised during the pandemic, now identify with PTSD and quickly begin to attribute historic issues with current symptoms. Whilst many so called symptoms do seem similar to those in the taxonomies for PTSD, I believe it would be far more helpful and allow far more people to access services like EASE Wellbeing if we could separate this into a new category that I would call PPSD = post pandemic stress disorder – this would not denigrate a person's struggles but would embrace them with a presently held focus or foci rather than propel the person into a narrative rabbit hole that reduces possibilities for recovery oriented aspirations – full write up and paper to follow but please be mindful of our psychiatric and diagnostic landscape that often traps rather than liberates people to live their lives.

Discussion, reflection, debate, criticism and questions

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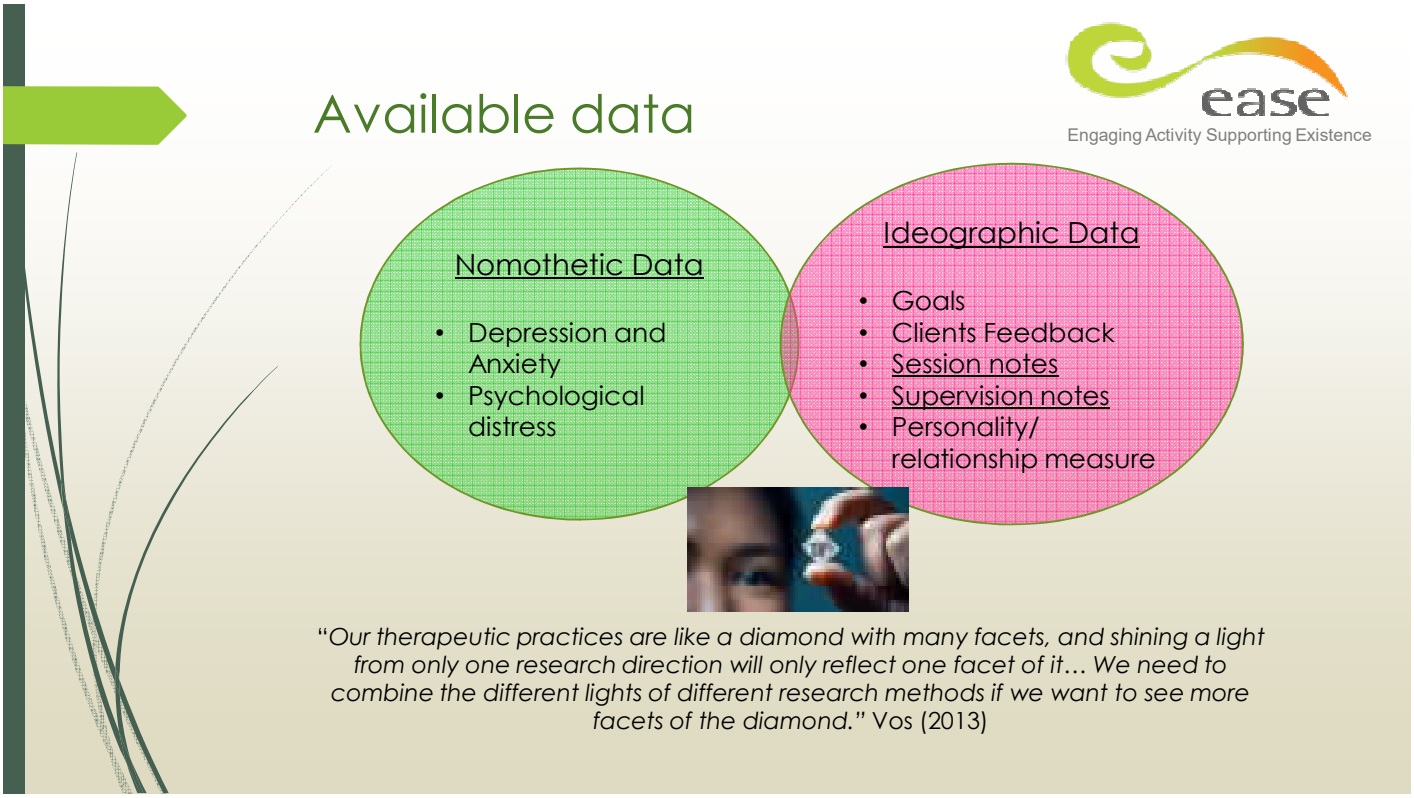
Process and Research

Therapy timeline

Ideographic data: Goal Attainment Process
Repertory Grid Process

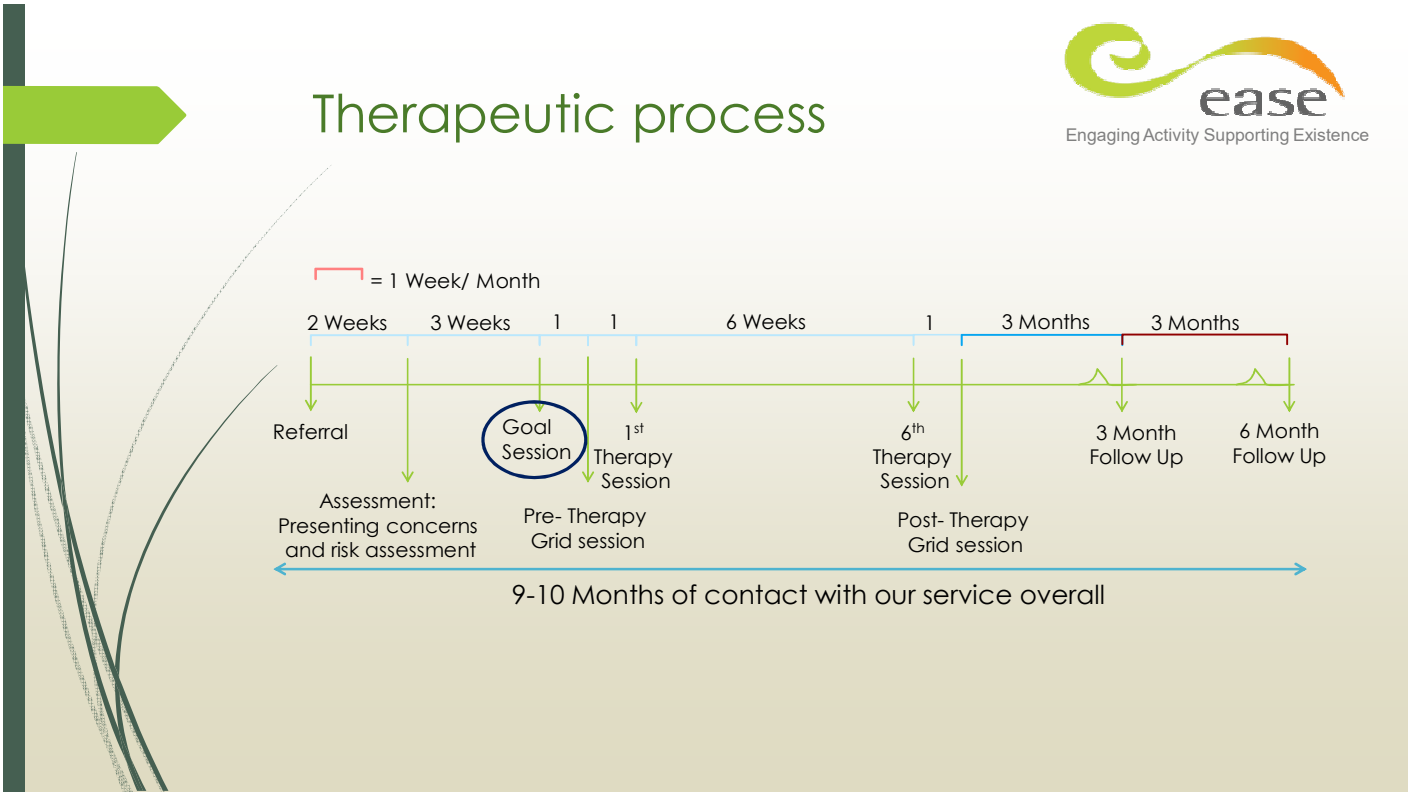
Nomothetic data: PHQ9
GAD7
CORE34



Notes:

There is a lot of information we can collect with the client throughout therapy. One thing I really want to emphasis at the start is how we 'collect the data' and our approach to it with clients. The last thing we want to do is hand a form to someone, get them to fill it out and say thanks for that, anyway how's your week been. No, It is a collaborative endeavour and the therapist shows an interest in the clients experience of completing that particular measure and what the outcomes are. When clients complete the PHQ9 questionnaire for depression we will ask them 'what was it like thinking about those questions today', 'what's changed for you this week' etc. We hope, this allows the client to use the measures as a way to monitor themselves as well. One client of mine only noticed she didn't had suicidal thoughts that week until she completed the PHQ9 questionnaire and that guided our focus in a really useful way.

We view each measure as a different yet useful way for both the therapist and the client to understand and uncover something about the clients experiences, feelings, thoughts etc, just as Joel says in his quote about shining light in a diamond at different angles reveals something different, we combine different measures to allows us to see more about a clients way of being in the world.



Notes:

So let's have a look at some of those measures. This is a summery of our therapy process and I will discuss a bit about the goal session and the pre/ post therapy. Although they are separated from the 6 therapy sessions they are all of equal importance to us.

Notes:

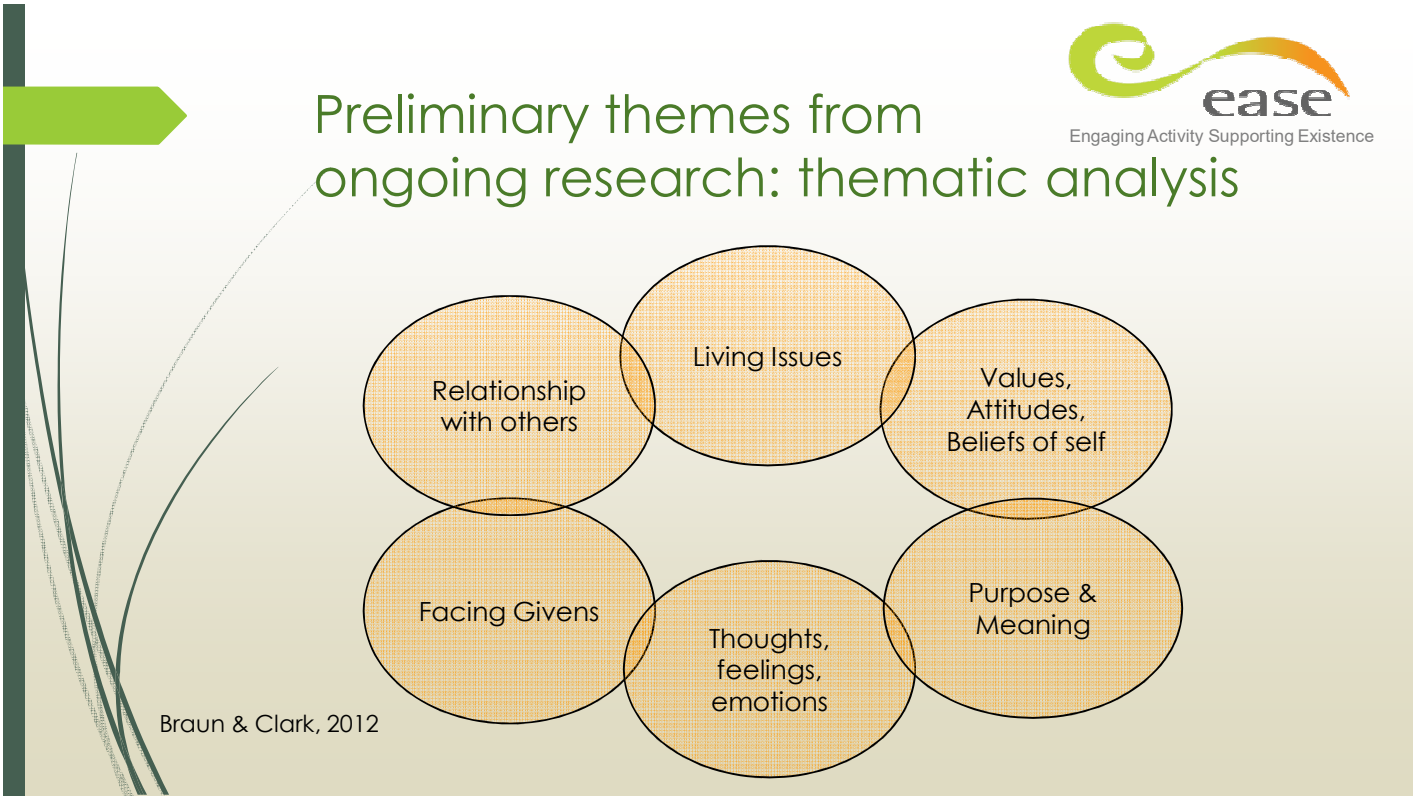
The goal session allows for both the therapist and client to better understand what they want from this experience and bring a focus to how they're going to work together in the limited time they have. Clients articulate up to 4 goals but of course there has to be a degree of flexibility, even in short-term work, for new things to come up, to revaluate the goals etc, to stay client centric.

It isn't about the therapist 'leaping in' in the Heideggerian sense and saying for instance 'I've read the assessment and I think it would be useful to focus on xxx'. It is about 'leaping ahead' in so much as this is a collaborative endeavour, the therapist supports the client to articulate their own goals. I think it helps the client see their responsibility to themselves and take ownership of this therapeutic process.

Notes:

This quote from Kierkegaard summarises how we view goals. In this session we don't just focus on where they want to be at the end of therapy. We equally pay attention, through phenomenological enquiry, to where they currently are, in order to know how to achieve their goals in therapy and help them. And Veena will be speaking about her client sarah and I think she demonstrates this really nicely of how we articulate goals.

When thinking about goals and therapeutic change I think we need to understand how we view Change. For us Change is not just a decrease symptomatology, it is not just behavioural change. Change can also be how we understand ourselves better. Someone that comes to therapy who wash their hands 20 times a day, may leave therapy washing their hands 20 times a day, that doesn't mean therapy has failed, the client may have a greater understanding of what is going on for them, what purpose is this serving, what choices are they making.



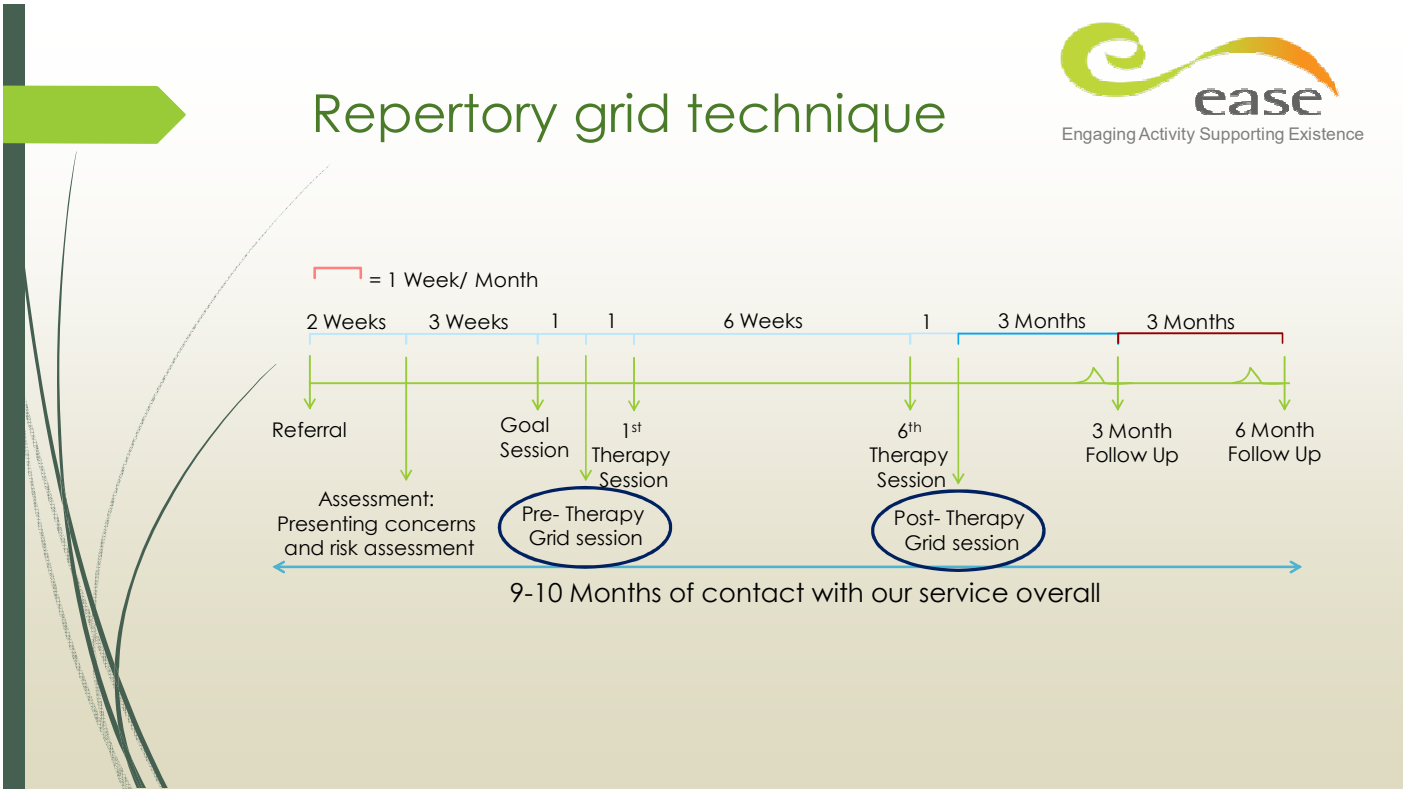
Notes:

We are currently conducting thematic analysis on goals from a cohort of 50 clients from 2019-2021. They're working titles at the moment but thought we'd present what we've got to give a flavour of what clients are coming for in therapy.

We've visually arranged the themes to be overlapping to reflect the real world that people's goals relate to one another in some way but obviously research wise the themes are distinct from one another.

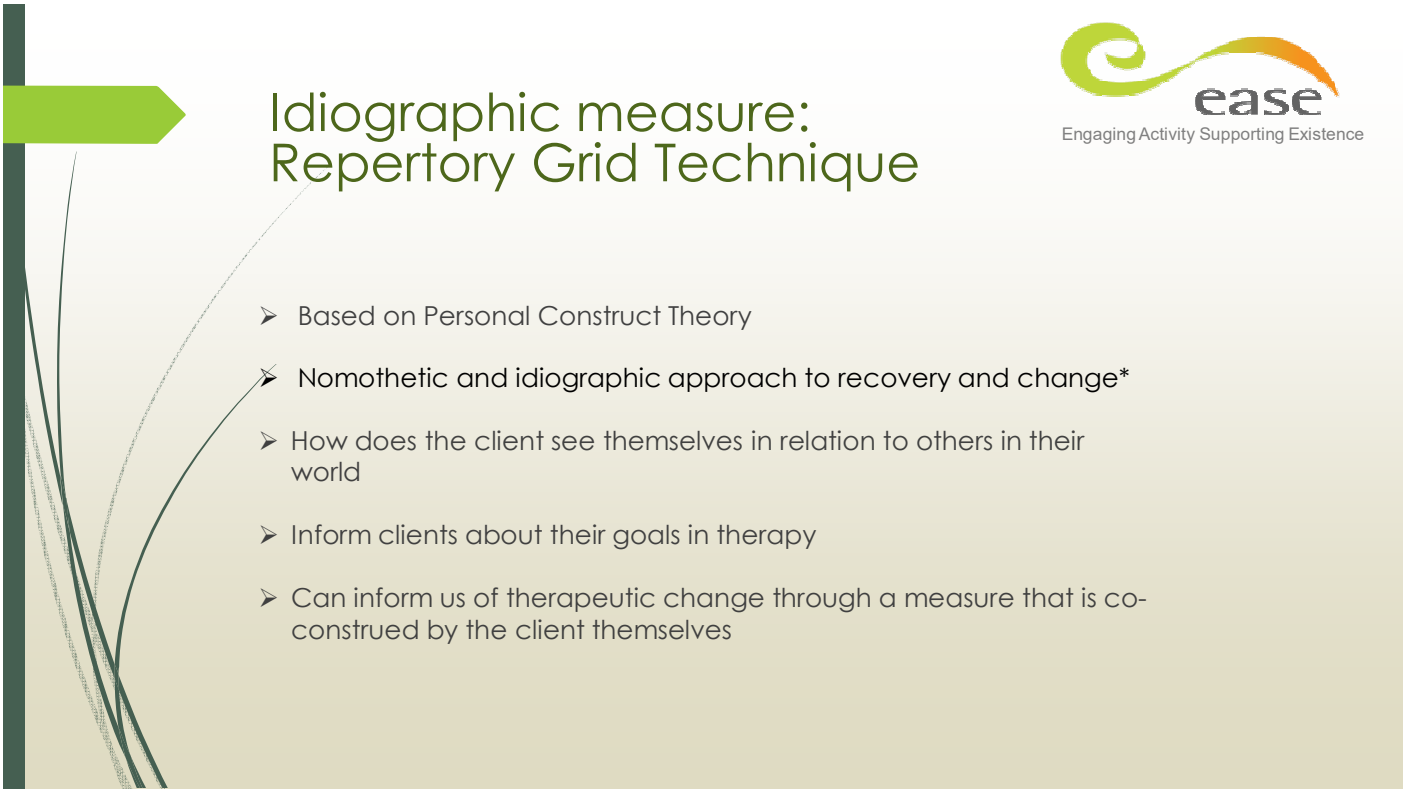
Purpose and meaning in life: this is a smaller theme compared to the others so we're thinking about this one but we noticed in this piece of research compared to the two previous goal analysis we've done in 2012 and 2015 that clients are explicitly using words like 'wanting to find purpose in my life', 'find meaning in what I do'

Facing givens: This theme captures group of goals that spoke about clients wanting to responding to life events that are not in their control, that we as humans have to face such as bereavement, upbringings, COVID



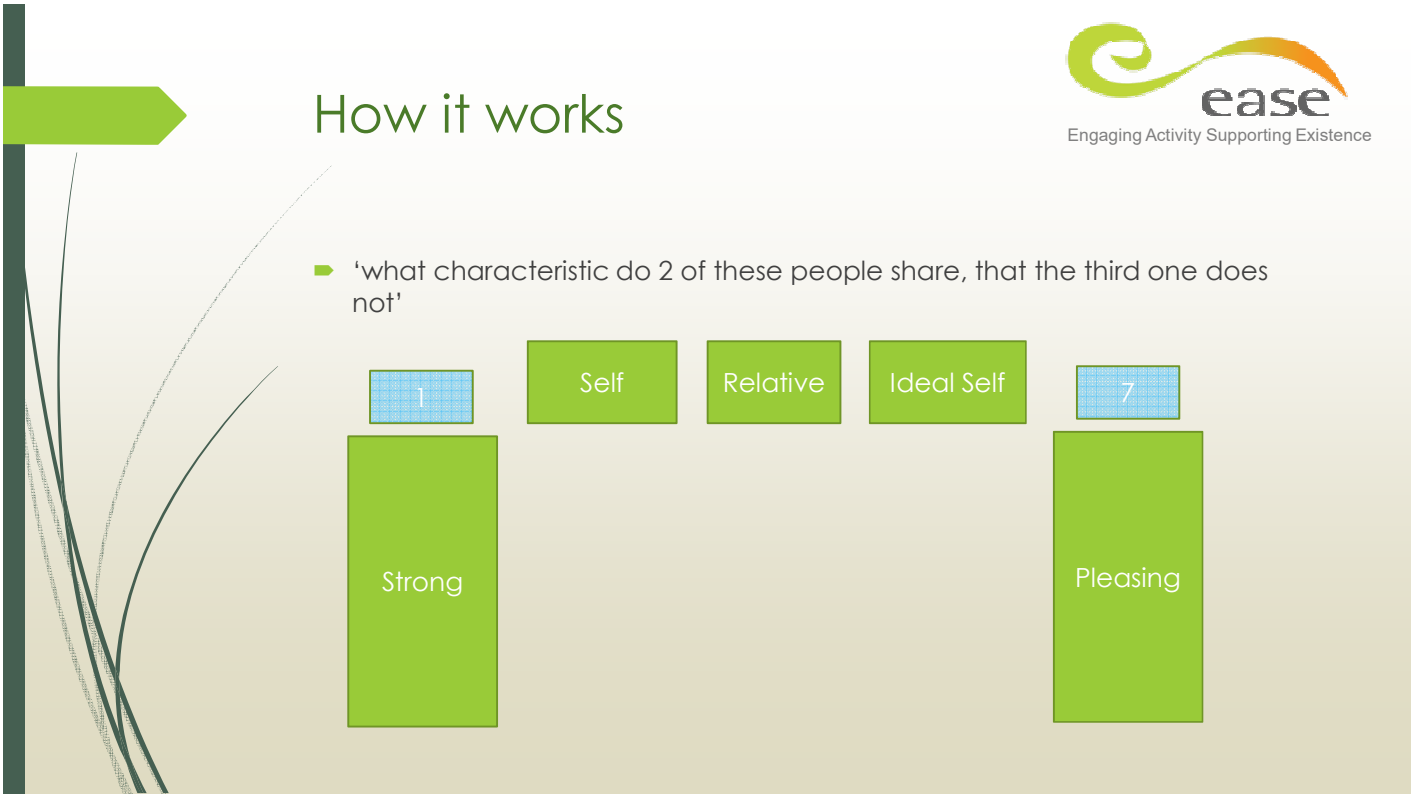
Notes:

Moving on to another measure we use is the RGT. Which is basically a similar session that is conducted before and after therapy.



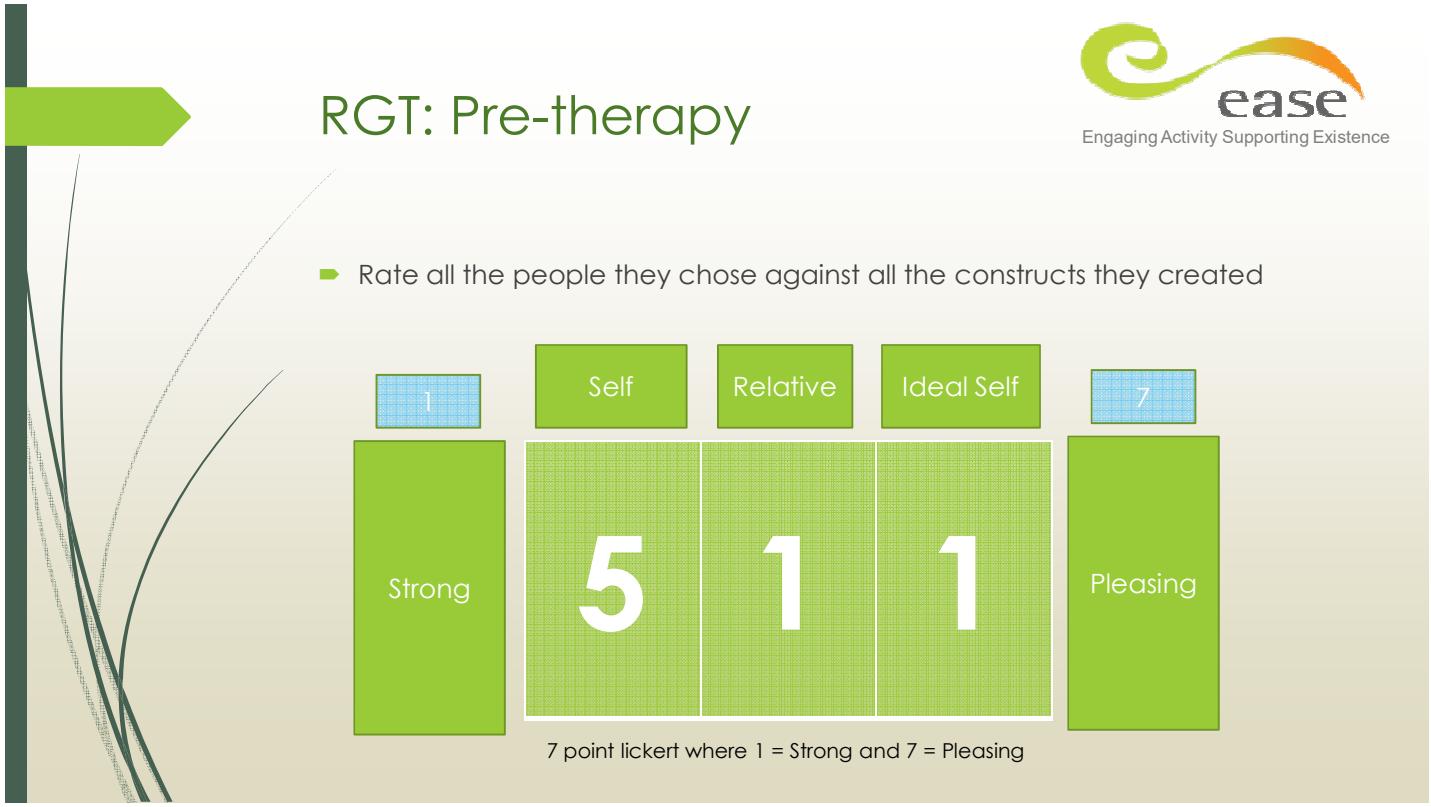
Notes:

We have adopted this sophisticated measure, which is a semi-structured interview, as a way to measure therapeutic change in a more personalised manner (compared to questionnaires like PHQ9/ CORE34) because the outcome of this (a matrix on excel) is subjective and unique to the client. Ultimately this measure helps the client to explore how they view themselves in relation to other people in their life and this can also be used to inform the goals and focus of STT.



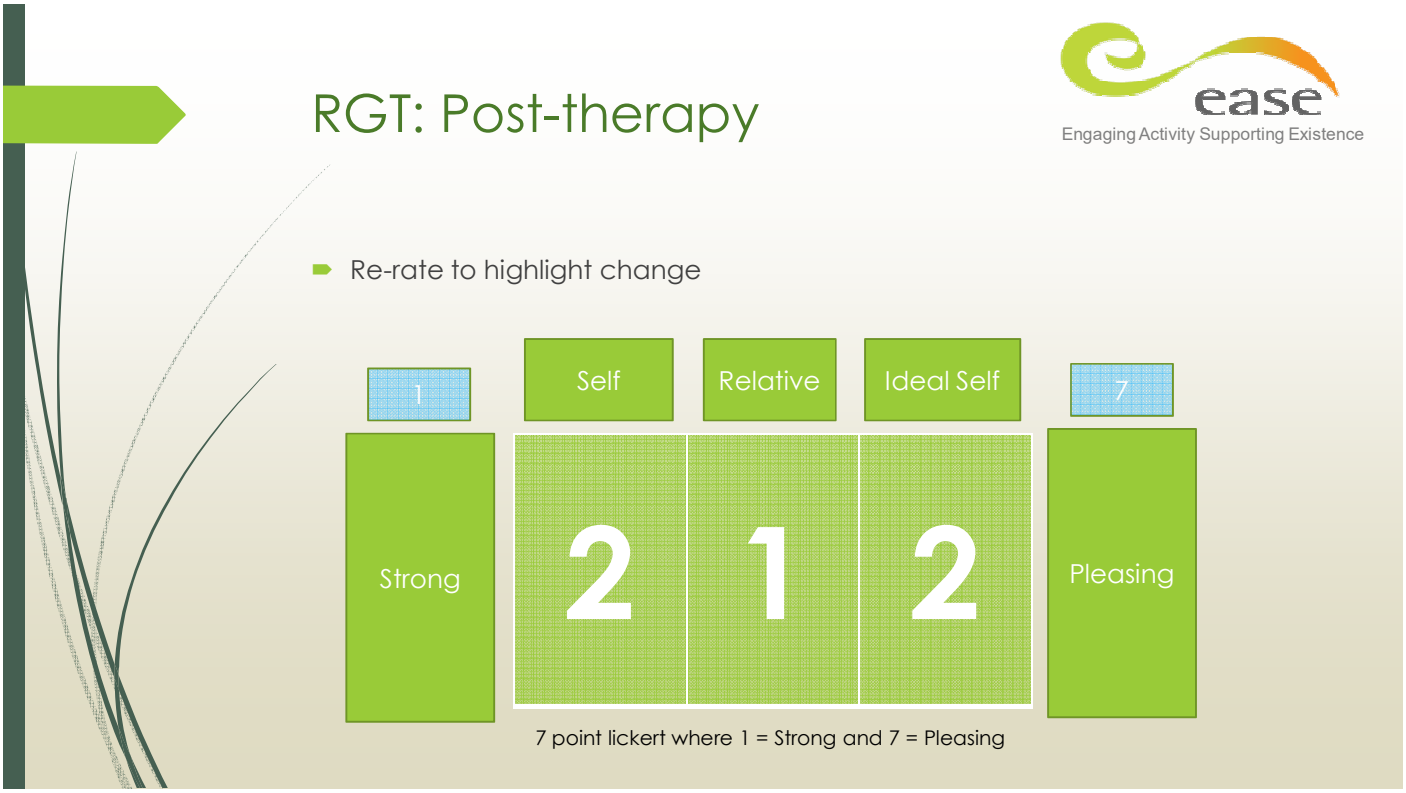
Notes:

So just to briefly describe this session: There are 10 people clients think about in relation to themselves and they choose some of those people such as a friend, a relative, person they like and dislike. By looking at 3 people at a time, they are asked what one characteristic do 2 of these people share that the third one does not'. So in this example they may say my relative and ideal self are strong and I am different from strong because I am pleasing. They essentially create the constructs by which they measure themselves by at the start and end of therapy.



Notes:

Clients are then asked to rate everyone they spoken about in the session against all the characteristics they articulated in the session. This is done on a scale of 1-7. You can see the client has chose to rate their auntie and ideal self at 1, meaning strong and themselves as 5, which is more towards pleasing. We will always leave space at the end of the session for the client to reflect on this experience and think about how this relates to why they came to therapy and the goals they established in the previous session.



Notes:

In the post therapy session, we get clients to re-rate how they view everyone, including themselves in relation to the characteristics they articulated. If therapy is working in helping clients to find ways to change themselves so that they can resemble more to what they would like to be then we should see that in our data, by looking at the self-ideal self ratings pre and post therapy. Change might be reflected in 2 ways: in how they see themselves but ALSO in how they define each construct. And again we see this in veena's case study so I'll leave it there for now.

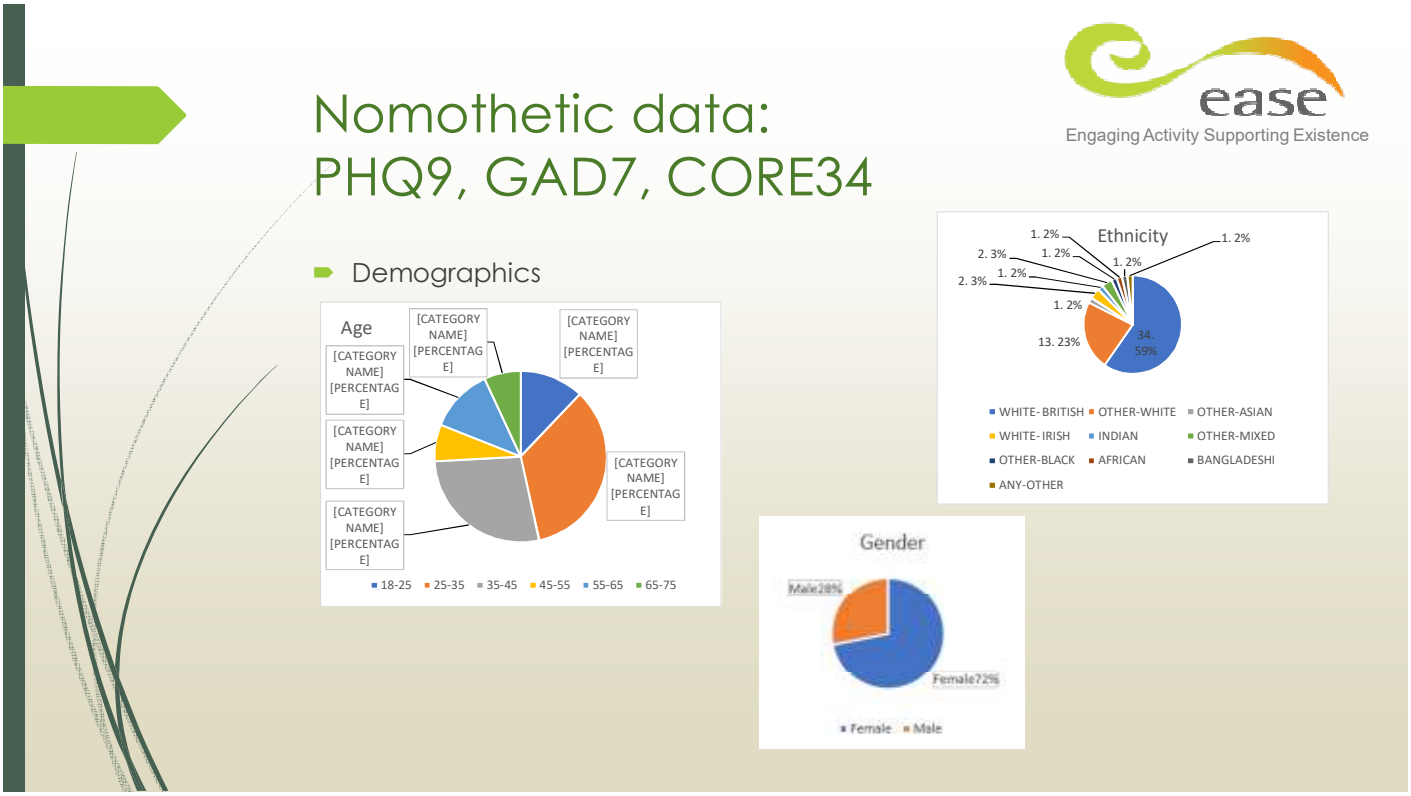
Notes:

We did some research in 2018 looking at how clients rated themselves and their ideal self before and after therapy and we saw that after therapy clients rated themselves more similar to their ideal self, suggesting therapy has helped the client to move to more wished for position in their world. And when clients ratings between their current and ideal self were similar, their scores on the PHQ9 questionnaire for depression decreased. Suggesting to us the RGT is a valid and yet personalized measure to capture change in therapy.

Note to presenter:

There is no correlation between self and ideal-self distance and depressive symptomatology at baseline ($r = -0.01$ $p = 0.936$ at baseline.

A linear model testing whether a pre-post improvement in self-ideal self distance (pre-post change in distance scores) predicted lower symptomatology level at the end of therapy, $F = 6.05$, NA, $p = 0.02$, NA.



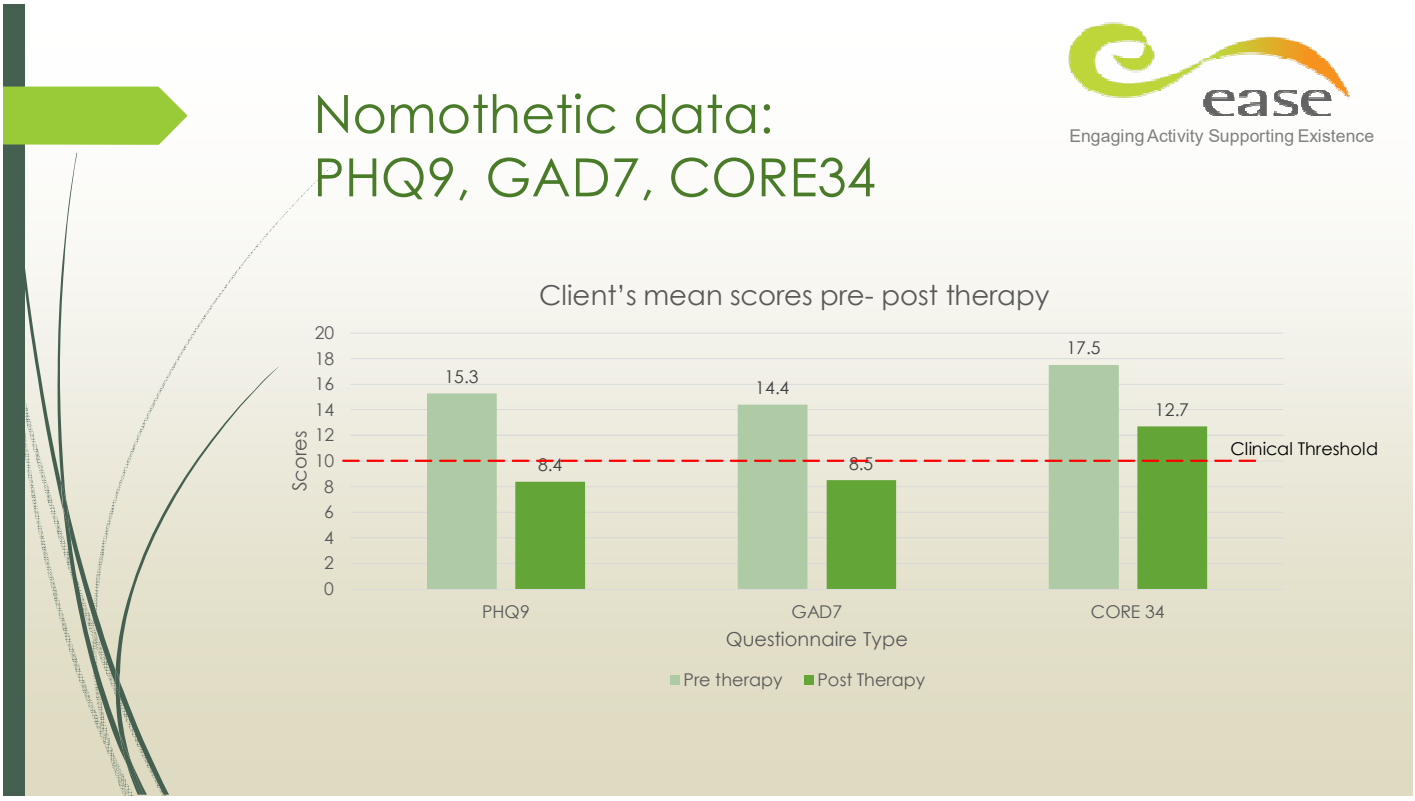
Notes:

Some interesting observations pre/post covid:

Age: mainly 20-35 (younger demographic post-covid maybe due to how we reach referrals now – online self referrals rather than through the GP)

Ethnicity: White

Gender: we are seeing more males than pre-covid



Notes:

Core 34 is given at the start and end of therapy, phq9/gad7 is every week- clients are sent them 20 minutes before the session (enough time to fill them out but close enough to the session so if any feelings come up from doing the questionnaires they can be explored and supported in the session soon after completion of the questionnaires)

EW has integrated these into the process to compare results to the 'national standard' of IAPT

It is not to say we think they accurately reflect change or recovery and this is why we also use the CORE goal attainment form and also the RGT.

T- tests on all measures shows the pre-post differences are statistically significant

Reliable Improvement & Clinically significant Change

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Questionnaire	Improvement of RCI	Clinically Sig' Change
PHQ9 (n=46)	63.03%	43.48%
GAD7 (n=40)	65%	57.5%
CORE 34 (n=56)	37.5%	12.5%

Criteria according to Jacobson & Truax (1991)

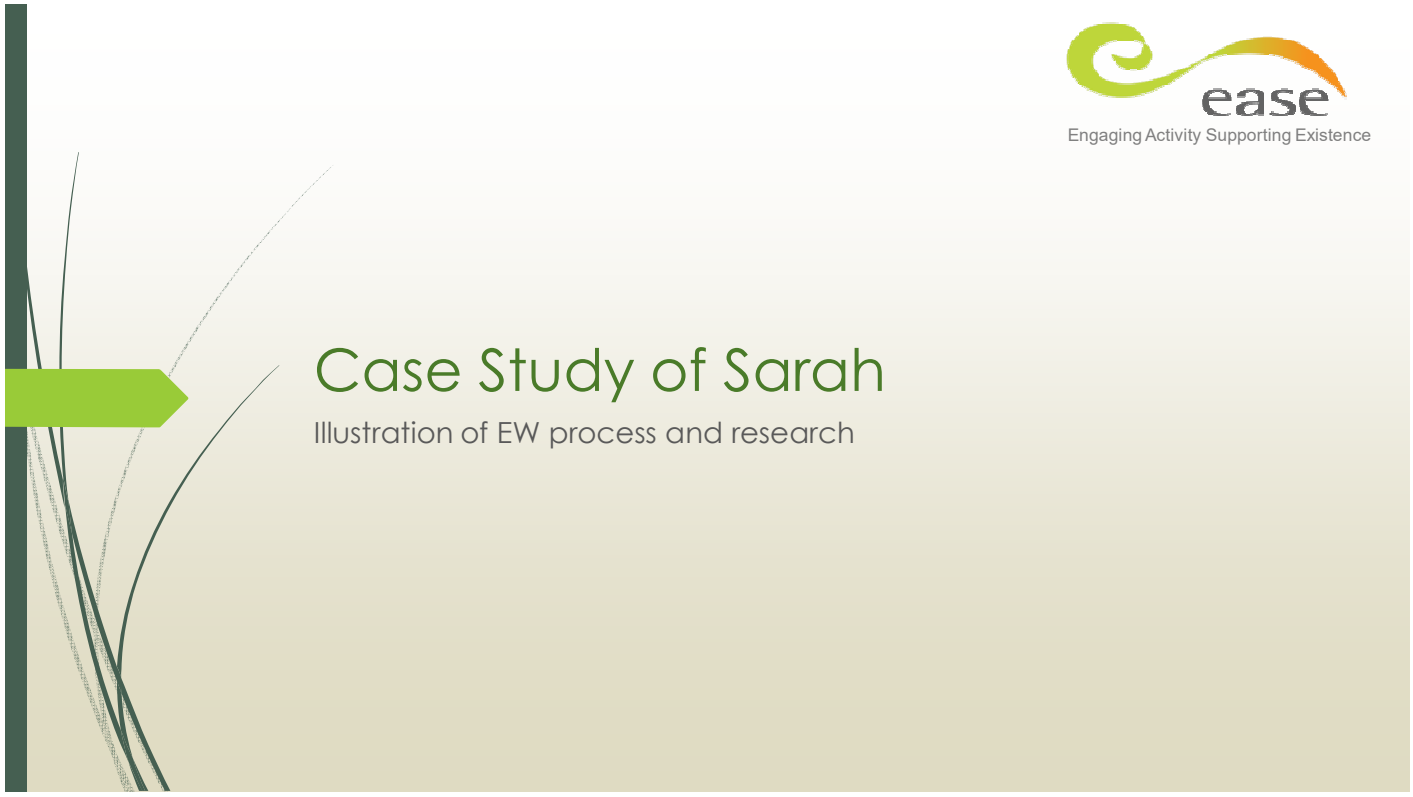
Notes:

Following recommendations by Jacobson and Truax (1991).

Why do we consider RCSI as well as statistical change? to ensure our data can be understood in a clinical framework/ setting.

In this table you can see that many of the clients achieved a reliable clinically significant change or at least showed reliable improvement for PHQ9 and GAD7 and some clients did with respect to CORE34. (for us to hold in mind) It is assumed that clients had achieved RCSI if they started the treatment in a dysfunctional state and left treatment in a normal state, and they had improved reliably. We considered reliable improvement to be a pre-post difference that, when divided by the standard error of the difference, was 1.96 or greater. We calculated reliable change indexes for each of the outcome-scales, on the basis of

Guided by stats not driven by them, but we have to be griunded by the stats (NICE guidelines also state that clinical judgement takes precedent over the states here)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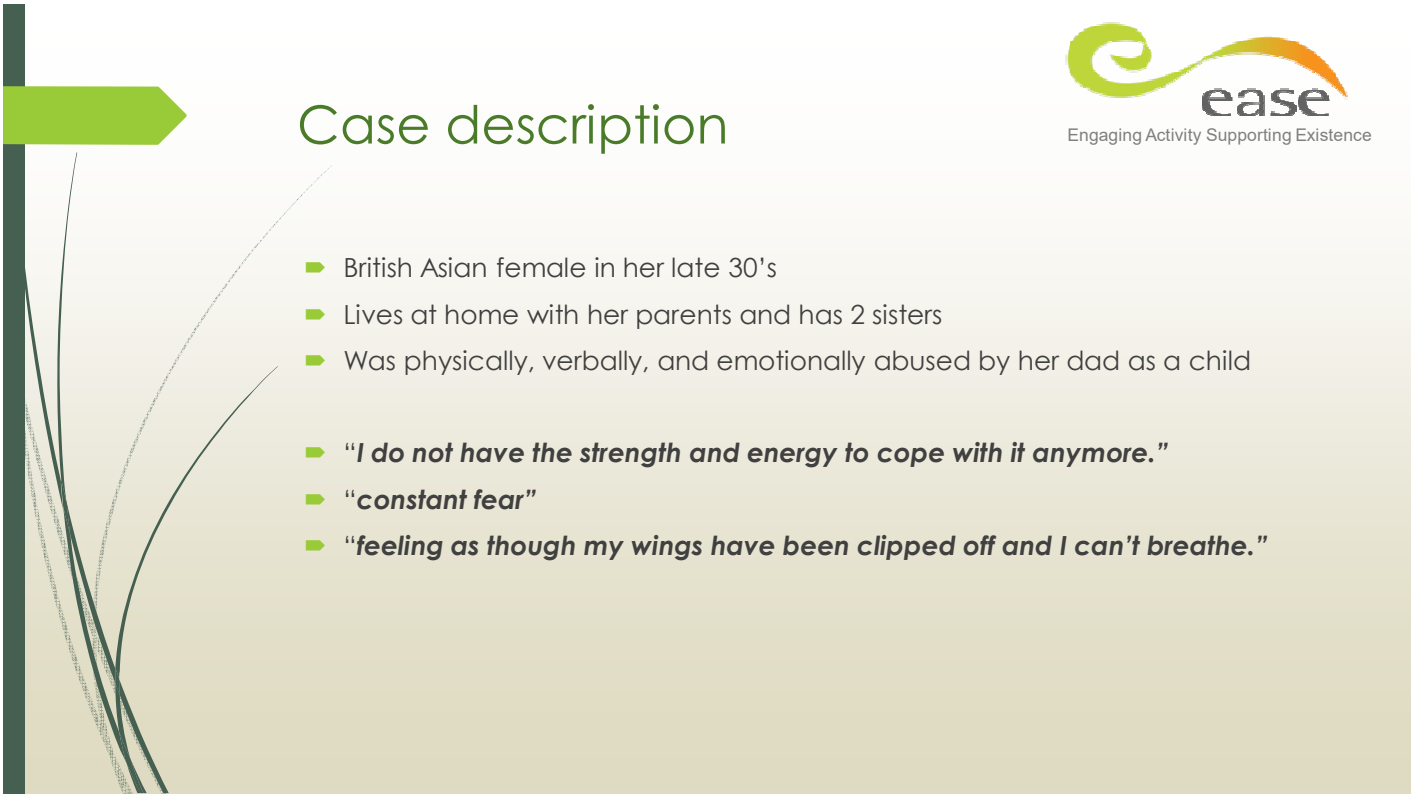
Case Study of Sarah
Illustration of EW process and research



Notes:

Today, I would like to present Sarah to you. For the purpose of the case study, the content I will present has been anonymised and some information has been altered in order to protect the identity of S and she has consented for us to present her as a case study. S is a client I assessed myself and took on for therapy. The assessment and therapy session took place via Zoom and should be noted that S did not turn her camera on during any of the sessions.

S is British Asian female in her late 30's who has a PhD in the Medical field and is starting her own business. S lives at home with her parents and has 2 sisters and both of S's sisters have moved out of home and living with their respective partners. As a child, S was physically, verbally, and emotionally abused by her dad. S mentioned her dad does sometimes shout at her. We discussed her safety and confidentiality during assessment and S felt she was not in immediate risk and is aware of who to contact if she felt like she was immediately at risk. Having experienced abuse throughout her lifetime, S explained to me that the main reason which triggered her to seek therapy were the suicidal ideations she was having. S explained she "I do not have the strength and energy to cope with it anymore." S described herself to be living in "constant fear" as her dad would always be watching her around the house, stand outside her bedroom and calling her when she goes out. When asked what this was like for S, she described it as "feeling as though my wings have been clipped off and I can't breathe." S described having panic attacks, anxiety, and depression, these are generic psychological concepts. We explored what they meant for her in the goals session.

Notes:

During the goal setting session following the assessment, I worked collaboratively with S to create goals which she wished to address throughout the course of therapy. I explained to S the rationale of goal setting as Lauren spoke about earlier. As the therapist in the goals session, my aim was to gauge an understanding of what the client would like to explore in therapy and the function of these goals for me, was to use these goals as a guidance throughout the course of therapy if needed. A brief outline of the four goals the client outlined for therapy were the following:

1) Exploring how to manage panic attacks

2) Increase self-esteem and confidence

3) Being more assertive with people and realising my time is valuable- re-evaluating my relationships with others.

4) Exploring my own worldview and how this has an impact of how I view life.

My approach as the therapist after S had identified these four goals was to explore each one a little bit further by trying to gain an understand of the phenomena mentioned. For example, asking S what it would look like for her to 'manage her panic attacks', and what this would involve. Regarding 'increasing my self-esteem and confidence', I thought it would be valuable to first explore what is means to S to be confident and for S, being confident means being able to articulate herself to others and not being driven by her anxiety and fear. Through supervision at EASE, I began to learn a different way to approach the goals formulated by the client whereby in addition to the questions I asked, it would also be useful to ask S where she feels like the lack of self-esteem, confidence and assertiveness is. By being able to understand the lack of these concepts, allows us to stay phenomenological and gain a better understanding of where she is in her life now and therefore, where she wants to get to.

Notes:

S managed to complete the Grids with some ease although at times found it difficult to come up with characteristics for the various people she had chosen. When I asked S about this difficulty, she said she noticed she was overthinking the relationship she had with each person whilst trying to generate a characteristic for them. During the process of completing the grid, S identified she couldn't assign the two extreme ends of the numbers (1 and 7) to some of the characteristics because she thought there was more to the meaning of that characteristic. When asked what S meant by this, she gave the example of the characteristic 'successful' which she used to describe her future self. S explained she did not want to reach the ultimate point of success where there is no room for anything and to keep working. I was surprised when S was explaining this as she already had a basic awareness of an 'and' position, rather than an 'either or' position.

Through S's description, she recognised that it isn't a case of 'I can be successful or unsuccessful' but more a position becoming successful whilst maintaining her being-in-the-world and described there being a 'multifaceted nature to things".

After completing the grid, I asked S if there was anything that surprised or struck her upon reflection. S said completing the grid made her "realise the complexity of people". I asked S if there was a particular person within the grid that related to this, and S spoke of her father. S reflected on the characteristic of "selfish" which she had assigned to her father and acknowledged that although she thought her dad was selfish, it Is difficult to say it as she is aware of the difficulties, he endured himself when he first moved to England. S was able to recognise she felt empathy towards her dad despite how he has treated her but that it does not give him an excuse for his behaviour.

There were 3 themes which stood out throughout the course of therapy which I will present to you today:

Notes:

1) Exploring 'panic attacks' and fear

During the first session of therapy, I asked S if she had any reflections over the last week following the pre-therapy session and S explained she had begun to realise her way of being with others. She recognised she 'live in a state of fear' and because of that she would always put others ahead of herself as a way of managing that fear. S said, "everything I do is a way to survive". For example, even though she was busy when her sister asked her to pick up her children, she still did. I recognised the fear experienced by S that was initially instilled by her father had extended into other relationships and her way of relating to others. My approach towards exploring the panic attacks was to gain an understanding of how S experiences these 'panic attacks'. S described some physical symptoms she experiences, such as heart palpitations as well describing the panic attacks to feel 'dark and gloomy'. S mentioned she experiences fear when she has panic attacks, and it resembles the kind of fear she experienced as a child when she thought she was about to be hit and would run away to try and stay safe. Although S's childhood plays an important role now in her life, we explored her current panic and fears where she explained the anticipation of the day ahead and uncertainty of what the day will bring.

Notes:

2) Relating Fear to Being-in-the-world

Through this exploration, a link emerged between the association of fear, assertiveness, and S's way of being-in-the-world. Whilst conversing about fear, S spoke about how whilst growing up, she was always told what to do by other people and her role was to 'to serve others' because that is what would make her a 'good girl'. S then acknowledged she was always told how to behave, what her role was within the family but deep down she knew something did not feel right. I asked S what stopped her from voicing how she truly felt, and S explained because she grew up in a violent household where the consequences of not listening would be being shouted, sworn at, or being hit.

Therefore, to avoid this, she would always do what she was told even if it was at her expense. I highlighted to S the conflict of knowing she has a sense of responsibility towards herself and her own way of living in the world but also experiencing fear that comes with being assertive. The dilemma here is for S to ask herself what position she would like to be in. Is she willing to be more assertive in her life, for instance voicing her needs and being honest with others about what she does and doesn't want to do, knowing the feelings of fear and anxiety will be provoked along with consequences such as confrontation? Or would S remain how she is and endure the difficulties she is experiencing?

Notes:

3) Experimenting with a new way of relating to self and other

By the fourth session, S said she felt as though she was becoming more able to articulate her thoughts and feelings along with feeling she is more of a priority to herself. I approached this in the session by inviting S to explore where she previously felt like there has been a lack of priority towards herself. When asked this S said the following "I felt overwhelmed by people being in my space and constantly being told what to do." Sara's lack of prioritising herself was expressed though being unable to articulate to others and making them aware of this and instead putting others before herself. It was not just the

other people in S's life she was being controlled by, but also the fear that comes with the possibility of S putting her needs first. Perhaps more significantly, S spoke about not being 'afraid' of her dad anymore and had 'extra space in her lungs to breathe'. I questioned S as to what had changed and led her not to feel afraid of her dad at this point in her life and S explained she came to realisation that she "did not come into this world handcuffed to my dad' and that she does not owe him anything. S mentioned this realisation felt like a 'weight being lifted off my shoulders' and that she no longer has to 'carry it'. I asked S what she is referring to what she says 'carrying it' and she explained the 'it' is the fear her dad had instilled in her and the pain of what he did to her. I asked S if it was more important for others to acknowledge what she had been through or if it was more important that she herself acknowledged it and over the remaining sessions we had, S revealed it is more important for her to acknowledge what she has been through in order to move forward.

Notes:

Whilst completing the grids again in the post-therapy session, S identified quite early on she found it more difficult to complete the grid compared to last time. I explored this with S and she recognised her understanding and meaning of the characteristics has changed over the course of therapy. S explained some of the positive characteristics such as 'relaxed', 'confident' and 'care-free' were abstract words to her at the start of therapy as she did not know what it meant to be all these things. However, through the process of therapy, she feels more attached to these words as she has started to realise what they mean to her. A comparison of the grids completed pre and post therapy demonstrate the gap between her current and future self has bridged. I asked S if there were any particular relationship or people which stood out for her from the grid and S said she has been able to acknowledge she has been treated badly by other people and how much she had put others ahead of herself. With this realisation, S said she has started to change the way she behaves with these people by putting boundaries in place and have the capacity to tolerate the anxiety and fear that comes with this.

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Conclusion/Discussion/Questions

- Thank you – EASE Wellbeing Team

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