

A Portfolio of Research Work

**Including an investigation into motherhood
experiences using content analysis.**

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**Submitted to the University of Surrey for the partial fulfilment
of the degree of Practitioner Doctorate (PsychD) in
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Statement of Anonymity

To preserve the confidentiality and anonymity of clients, research participants and professionals, pseudonyms have been used and all identifying information has been changed or omitted through the portfolio.

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Abstract

This portfolio was submitted to the University of Surrey for the completion of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. The research dossier contains a literature review about ecopsychology and existential therapy as approaches for trauma, followed by two empirical studies using qualitative methodologies. The first study uses Interpretative Phenomenological Analysis to explore the client experience of existential therapy, while the second study explores how the existential dimensions manifest when women talk about becoming mothers for the first time. This was achieved through Content Analysis.

Introduction to the Research Dossier

The Research Dossier consists of a literature review and two pieces of qualitative research. The first report presented was a literature review which aimed to explore how ecopsychology and existential therapy could be used as approaches to trauma. Through conducting this work, it appeared that areas of knowledge appeared to be lacking substantial research. With this in mind, it was decided that it would be beneficial to focus on one such area lacking in research, and conduct an empirical study to investigate the client experience of existential therapy. My second year research project explored the clients' subjective experience of existential therapy using Interpretative Phenomenological Analysis to analyse the data. A further empirical study also took existential therapy as a focus, but this time explored the ways in which the existential dimensions appear in accounts of individuals who have experienced motherhood using qualitative Content Analysis.

Within my clinical practice, my research into existential therapy has emphasised for me a requirement to allow an individual's experience to unfold without constricting a person strictly to one model. While I was reliant on theory initially, I have found over time that I have developed a more open-minded curious stance during assessment and formulation, bringing in theory when required rather than from the outset. My research has prompted me to consider my stance on the diagnosis, and raised thoughts for me about how I can balance working within the medical model while prioritising the subjective experience of the client. I have found myself considering the existential dimensions at times when working with clients, and believe this gave me an opportunity to gain a richer insight into a client's experience. The ecopsychological concepts explored also pervade in my clinical work, and I still routinely use some of the practices outlined in my literature review both professionally and personally.

Breaking the Cycle: Could Ecopsychology and Existential Therapy be Useful Approaches to Trauma Therapy?

Lisa Corbett, Supervised by Martin Milton

Abstract

Literature has suggested that the cyclical nature of psychological trauma can cause enduring long-term effects on individuals and those around them. This review examines the effects of psychological trauma and its relationship with ecopsychology and existential therapy. Despite being relatively unexplored with regards to psychological trauma, empirical evidence is beginning to amass for these approaches. Some contributions are considered along with their limitations and empirical challenges. Speculative practical and therapeutic implications for counselling psychology are identified and relevant future research is suggested.

Keywords: ecopsychology; existential therapy; psychological trauma; posttraumatic stress disorder; nature

Breaking the Cycle: Could Ecopsychology and Existential Therapy be Useful Approaches to Trauma Therapy?

Introduction

A traumatic incident is a shocking and emotionally overwhelming situation in which an individual experiences or perceives a threat to the physical and/or psychological integrity of self or others, resulting in a reaction of intense fear, helplessness or horror (American Psychiatric Association [APA], 2000; Rothschild, 2000). It has long been evident that such experiences can cause psychological problems, with perhaps the first cataloguing of traumatic symptoms documented on Sumerian cuneiform tablets of 2100 BCE following deaths in battle (Ben Ezra, 2001, Grey 2007). More recently, acts of terrorism such as the attacks in the United States on September 11 2001 and widespread natural disasters such as the tsunami in Southeast Asia in 2004, have been increasingly formulated through the perspective of trauma by professionals and the media (Courtois & Gold, 2009). Indeed, trauma is increasingly being recognised not as a specialised area, but a fundamental aspect of human experience (Gold, 2008).

This paper begins by addressing some responses to traumatic events and the effects of traumatisation documented within the literature, before briefly outlining the key features of posttraumatic stress disorder (PTSD) and compiling some of the current therapeutic options for trauma therapy. Stolorow (2007), took a personal and philosophical reflection on the psychological and emotional impact of trauma, defining it as 'an experience of unbearable affect' in a context in which there is an 'absence of adequate attunement and responsiveness to the [individual's] painful emotional reactions' (pp.9-10). Traumatisation can be subdivided into primary, secondary, vicarious and trans-generational trauma (Lodrick, 2007). Those subjected to primary trauma are present when the traumatic incident occurs; secondary trauma can occur to those who witness the aftermath of a traumatic incident; vicarious trauma concerns people who hear about traumatic incidents; and trans-generational trauma describes the traumatic symptomatology displayed by the descendants of trauma survivors (Lodrick, 2007), as exemplified for instance by the second generation of Holocaust survivors (e.g. Solomon *et al.* 1988).

Reactions to traumatic events vary considerably, ranging from relatively mild, creating minor disruptions in the person's life, to severe and debilitating. It is common for people to experience anxiety, terror, shock, and upset, as well as emotional numbness and personal or social disconnection. Nightmares of the traumatic event are common, as is depression (ISTSS, 2003).

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (APA, 2000) outlines posttraumatic stress disorder (PTSD) as the development of characteristic symptoms of distress or impairment that are present for over one month after exposure to trauma. Banyard (1999) described its cyclical nature, outlining three main clusters of symptoms: re-experiencing phenomena, avoidance/numbing and increased arousal. The DSM-V (APA, 2013) has revised the diagnostic criteria by firstly moving PTSD from the Anxiety Disorders into a new category, Trauma and Stressor-Related Disorders, and reorganised and renamed symptom clusters. However, initial research has suggested that the revisions do not appear to adjust the prevalence of PTSD (Miller et. al, 2013) and it would appear that the diagnostic review is ongoing. Marx and Gutner (2015) report that the 11th edition of the International Classification of Diseases (ICD-11) proposes to determine a diagnosis of PTSD through a combination of PTSD symptoms falling under three categories: reexperiencing symptoms; avoidance symptoms, and symptoms of heightened threat (Maercker et al., 2013). Additionally, while diagnosis ultimately has a use and purpose, it can also be argued that this framework is also inherently limiting (Foa et al., 2008). It has been proposed that PTSD is not a neutral term, but a social construction (Maddux et al., 2004, cited in Joseph 2010) that may inadvertently pathologise normal and natural reactions to traumatic events. Joseph (2010) also states that the very diagnosis of PTSD and the medicalisation of trauma reactions essentially deny the existential nature of such responses and stifle people's ability to emotionally process their experiences in meaningful and purposive ways.

A Repetitive Cycle

'Traumatised people lead traumatic and traumatizing lives' (van der Kolk & McFarlane, 1996, p.11). Themes of repetition are central: the individual is subjected to intrusive replays of the original trauma (Lodrick, 2007). Trauma re-enactments are common and take the forms of re-victimization, self-injurious and self-harming behaviours and externalizing the trauma by victimizing others (van der Kolk & McFarlane, 1996).

Totten (2005) writes that traumatic experiences in childhood can have enduring profound effects on traumatic experiences as an adult; influencing their responses and creating patterns of hyperarousal or dissociation; together with a tendency to re-enact traumatic experiences (Perry et al., 1995; Schore, 2000). Wainrib (2006) argues that traumatic events can generate severe psychological reactions that can manifest anytime. For some, the effects last throughout their remaining lifetimes and traumatised individuals have been found to have elevated rates of psychiatric disorders including major depression and alcohol or drug dependence (Wainrib, 2006). The negative impact of trauma extends beyond psychiatric morbidity and encompasses

multiple dimensions including functioning, quality of life and physical health (ISTSS, 2004).

Approaches to therapy

The National Institute of Clinical Excellence (NICE) guidelines advocate a course of trauma-focused psychological treatment (cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]) for PTSD. While research appears to demonstrate their efficacy (e.g. Moss, 2009), demand for evidence-based-practice has focused on quantitative studies that address a finite number of parameters and struggle to examine complex interactions (Coote *et al*, 2004). Limitations such as attrition have been identified to suggest that evidence is frequently overstated or under explained (Foa *et al.*, 2008). Follette and Ruzek (2006) argued that many CBT clinicians do not have adequate training, while Courtois and Gold (2009) drew attention to a disparity between the need for professionals with expertise in psychological trauma and the availability of these services. Despite a solid base of scientific literature on trauma, this area has yet to be incorporated into the core curriculum of graduate training in psychology and other professions (Courtois, 2002). Research indicates that victims of trauma usually turn first to medical providers, yet many have apparently little or no knowledge of physical or psychological posttraumatic manifestations and often misdiagnose the symptoms or misattribute them to other causes (Courtois & Gold, 2009).

Pitchford (2009) maintains that contemporary approaches to trauma are flawed, primarily because of the narrow focus on symptom management rather than acknowledging the barriers people have to expressing their freedom in choices and will (May, 1999; Paulson & Krippner, 2007). It has been argued that using CBT for PTSD reinforces the medical model of intervention and Hemsley (2010) comments that this undermines professional autonomy within the National Health Service (NHS) and private practice, since insurance companies could demand for interventions to correlate with NICE guidelines (Fairfax, 2008). Tarrier (2010), meanwhile, argues for continual innovation, which will come from 'recognition of variability and heterogeneity and the development of new treatment strategies' (p. 140).

Trauma therapy is a complex biological, psychological and social project that unfolds in stages over time and may involve many different modalities to reach a stage of optimal recovery (Herman, 1992). However CBT assumes that the individual's inability to adequately process the experience has led to the development of symptoms (Taylor, 2007) which makes little room for inclusion of other modalities and implies that practitioners have knowledge of the client's internal world (Hemsley, 2010). This review aims to consider psychological trauma from ecopsychological and existential perspectives, not to endorse a particular approach, but to provoke questions about integration and stimulate debate pertinent to the field of counselling

psychology.

Ecopsychology

'If we do not consider ourselves connected with nature we are in a state of disconnection and this is what shattered lives are all about. If we cannot make a link with what is outside ourselves, we cannot get to know ourselves. People who are imprisoned are starved of natural light, of fresh air, of contact with the natural world. This deprivation of the natural element in our lives causes psychological damage' (Linden & Grut, 2002, p.18).

The Ecopsychology Institute (1996) defines ecopsychology as the emerging synthesis of ecology and psychology; the application of ecological insight to the practice of psychotherapy; the study of our emotional bond with the Earth; and the search for an environmentally-based standard of mental health. However, exploring ecopsychology requires more than an overview of its definition and past; but a critical look at the paths the field has evolved through; since it is a continually evolving interdisciplinary approach (e.g. Roszak *et al.*, 1995; Burns, 1998; Cohen, 2000; Scull, 2001).

Ecopsychology is a relatively new developing field. While Roszak (1992) publically defined it, many of the key concepts originated in earlier work (Roszak, 1979; Shepard 1982). Fisher (2002) proposed ecopsychology as a foundation for a critical theory of modern society, arguing that it should be a catalyst for social change. He described ecopsychology as an evolving project, rather than a discipline; identifying the dualism of outer, objective, and inner, subjective reality which has become part of mainstream psychological discourse. Similarly Adams (2005, p.270) described ecopsychology as a cultural phenomenon necessitated by our alienation from nature and identifies ecopsychology as a means of addressing this crisis, which he typifies as 'the idolatry of the supposedly separate egoic subject and its insatiable quest for security, certainty, control, and power'.

An Ecopsychological Perspective on Trauma

van Deurzen's (1997) described our relationship to the earth in a way that I found pertinent to the premise of ecopsychology: the way we interact with our physical environment should be a central concern, since it underpins the whole of one's existence, yet ecological awareness is kept on the fringes of society. According to May (1967/1982, 1992), Western culture started to dismantle for a variety of reasons, such as its loss of recognition for the classics and its depreciation of art, mythology, and historical contexts. This is identified in itself as a trauma by Glendinning's (1995, p.51) comment that society has endured a 'collective trauma ... the

systemic and systematic removal of our lives from the natural world'. The theme of a repetitive cycle from the psychological trauma literature pervades here, as Adams (2005) describes a vicious cycle of our impoverished self and ways of being; which provokes an impoverishment of nature and in turn accelerates a further impoverishment of our self and ways of being. However, literature concerning ecopsychology also addresses trauma from developmental and evolutionary perspectives.

Chawla (1998) connected our relationship with nature to a childhood perception that we had of the natural world being alive and conscious, suggesting that it plays a significant role in early development. Shaw (2000) researched childhood nature connections and trauma, observing that nature was characterised as a protector by traumatised children. For some, nature was the only place they could feel safe; for others, it acted as a kind of parent. The significance of this role reflects Khan's (1964) conceptualisation of cumulative trauma which states that trauma originates when the primary carer's protective function is frequently absent or compromised. If nature can represent such a crucial role in a traumatised child's life, it could suggest further required exploration into its therapeutic impact. Shaw makes a connection between such individuals and later conservation work undertaken, which she attributes as an attempt to resolve their trauma through restitution. Nature in this example appears to be a powerful therapeutic resource. Gatersleben (2008) describes a requirement for counselling psychologists to reinforce our understanding of the psychological components underlying the relationship between people and their natural environment; a relationship that would appear to develop at a young age. Connections such as this highlight a need for further detailed research to clarify the sphere of nature's role in our early development, identify its attributes, and explore how this could influence the way we process trauma.

Considering the therapeutic features of nature, two dominant theories draw on evolutionary perspectives. Kaplan and Kaplan's (1989) attention restoration theory focused on nature's restorative capacity in relieving stress. They suggested that natural surroundings promote healing by containing the elements that draw on involuntary attention. Ulrich (1984) proposed a genetic basis for our appreciation of nature in his Stress Recovery Theory (SRT), theorising that emotional and psychological recovery from stress was effectuated when observing scenes precipitating reactions of interest, agreeableness and calm: negative affects are replaced by positive affects; negative thoughts are obstructed. Wilson and colleagues (2008) cited evolutionary perspectives suggesting that humans respond positively to natural environments due to a genetic predisposition which once aided survival (Appleton, 1975; Orians & Heerwagen, 1992). Similarly, Lodrick (2007) illustrates evidence indicating that people instinctively respond in one (or more) of five predictable ways when threatened: 'Fight, flight and freeze' are well documented responses (Levine, 1997); plus 'friend' and 'flop' (Ogden &

Minton, 2000; Porges, 1995, 2004). For instance, Levine noted that 'freeze', aids mammals when threatened by a predator: the predator has reduced possibility of detecting immobile prey; many predatory animals will not eat meat that they consider to be dead; and if the predator kills, the freeze mechanism provides a natural analgesic (Levine, 1997). Between mammals of the same species the 'freeze' response denotes submission, with the conquering animal acknowledging their dominance and abandoning the subordinate animal. Psychological trauma occurs when these strategies continue to be adopted long after the threat has passed (Lodrick, 2007). If our trauma responses and characteristics are so inextricably linked to the natural world, then surely it should be a relevant inclusion both into the conceptualisation of trauma and therapeutic work undertaken by counselling psychologists.

Therapeutic Implications

A variety of interventions outlined by Buzzell and Chalquist (2009) exist under the ecopsychology umbrella that could be considered as approaches to psychological trauma. This review will present wilderness journeys, contemplative practices and the Natural Growth Project, along with their therapeutic and practical implications.

Wilderness Journeys

Wilderness journeys are typically group retreats with personal growth or therapeutic purposes (Friese et al. 1998). Used initially in psychotherapy under the name "psychoecology" (Greenway, 1999), they are described as a powerful countermeasure to depression, anxiety, and emptiness associated with life in modern society, with participants overwhelmingly reporting stress reduction, mental clarity, and inner calm (Hendee & Martin 1994).

Driver *et al.* (1987) created an index of measurable benefits of wilderness journeys including greater self-sufficiency (e.g. Brody *et al.*, 1988; Klint 1990; Paxton & McAvoy, 2000) and self-actualisation (Maslow, 1970); suggesting wilderness as a means of self-recovery from trauma guided by intuition, instigated by and led by the client. Skill development and challenges successfully met are reportedly perceived as empowering and proof of capability and self-worth (Johnson 2002). Indeed, Putman *et al.* (2009) reported in a survey conducted with Guatemalan aid workers that levels of personal accomplishment were inversely related to PTSD symptoms.

Johnson (2002) advised that wilderness facilitates therapeutic healing as it has limited factors that require an outward focus, thereby directing the participant's attention towards inwards self-reflection. However, research concerning the effects of wilderness therapeutically for trauma is scarce and inconsistent. Russell *et al.* (2000) reviewed wilderness therapy and reported positive

outcomes, yet the treatment focused on adolescents not exclusive to trauma, making it difficult to generalise.

Driver *et al.* (1987) reported that being in the wilderness is a physically-demanding experience, including associated health benefits set against the detrimental effects of trauma (ISTSS, 2004). A clinical resource written to facilitate primary health care providers working with survivors of war trauma and torture advised that such clients could benefit from physical challenges (Johnson, 2005). However many individuals might find themselves at a disadvantage in this situation. Tedeschi and Calhoun (1994), advocated caution to be taken with those who might have serious physical limitations, for they may have insufficient resources to benefit much from rigorous physical activity; with implications for a counselling psychologist's assessment to ensure that a client's limits and perceptions of the wilderness are accounted for.

The Natural Growth Project

Linden and Grut described the Natural Growth Project in *The Healing Fields* (2002), which offers traumatised clients a programme of long-term rehabilitation through a combination of horticultural work and psychotherapy. This is not an isolated initiative: horticultural therapy has previously proved effective for addressing the trauma of refugee displacement and resettlement (Tristan & Nguyen-Hong-Nhiem, 1989). The book documents the first ten years of this project, in which nature is used as a medium for communication and as a source of healing, based on the premise that a person who has suffered a trauma can find relief by restoring a sense of autonomy and self-responsibility through making a connection with a natural environment. The role of nature is described not only being a place of peace but a space in which clients can process the trauma: '...using nature as a metaphor, it is possible very quickly to access deeply traumatic events and to work on the most difficult feelings, and the life cycle embodied in nature carries the promise of healing' (p.12). It is intended as a handbook for those interested in establishing something similar, providing an overview of the project, the necessary practicalities, interwoven with three cases.

Just as I found significance in Keenan's (1994) incarceration and subsequent reconnection with the natural world, I remembered that stolen glimpses of vegetation through prison walls were elements that saved him from hopelessness. The authors describe that for some clients, being outdoors is often where they have felt safe throughout their lives. For others, the outdoors is merely more containing than the closed consulting room for sharing traumatic experiences. The authors describe nature as a significant focus for traumatised clients: identification with the natural cycle plays out themes of birth, growth, decay and death, providing powerful metaphors to be worked through therapeutically. A re-connection with the natural cycle appears to be a

powerful therapeutic tool.

The medicalised approach for PTSD recommended by NICE guidelines fails to acknowledge cultural, religious and socio-economic factors (McHugh & Triesman, 2007), and despite an escalating acknowledgement that PTSD is a universal response to trauma, research overwhelmingly originates in Western nations (Foa *et al.*, 2008). However, the authors observe that since these clients come from a number of countries with diverse cultural, religious and linguistic backgrounds, their difficulty expressing themselves in words was felt to be impeding any psychotherapeutic work in a typical setting. Traumatic incidents can be difficult to articulate, yet the authors consider how nature can supply a means of communication for clients to express memories of painful experiences and their impact. The cross-cultural relevance of ecopsychology is clear: 'acknowledgement that they are inhabitants of a shared earth, rather than inhabitants of a fractured nation, or state, can create an important new healing perspective' (p.21). Such observations suggest that the natural world transcends national, ethnic, religious and racial boundaries.

The authors indicate a number of practical considerations, including the contrasting dynamics which must be managed between serving the therapeutic needs of the client and the need for the project to generate its own funding, with a risk that clients could ultimately just fulfil the needs of plant production. Boundaries are also considered: there is no ascribed therapeutic space or fixed time, requiring perhaps a more mature or experienced practitioner, plus practical issues such as confidentiality and client feedback would need to be managed outside the boundaries of the therapy room. As counselling psychologists know, the therapeutic relationship is an essential component of therapy when working with traumatised clients (Kohlenberg & Tsai, 1991). The natural world could bring another dimension into this relationship, and further work could investigate this, by considering how aspects of the natural world impinge on our consciousness. Many of our assumptions developed in early childhood result in the construction of beliefs about the self and world consistent with these experiences (Janoff-Bulman, 1989), suggesting that therapeutic work in the natural world could repair some of the cognitive damage to a trauma survivor's perception after their world-view has been fragmented.

Contemplative Practices

Adams (2005) discussed awareness practices as a powerful means of building non-dual relationships with nature. Mindfulness meditation involves the use of focused attention upon personal experiences to promote calmness and stability (Kabat-Zinn, 1990) and is thought to help achieve self-acceptance (Chodron, 2001). It typically focuses on several domains, including interactions between behaviour and the universe (Harvey, 1990), and Follette and

colleagues (2006) argue for the inclusion of mindfulness practices for those who have experienced a traumatic event. Several branches of research indicate a potential link between trauma and mindfulness-related processes: Pennebaker and O'Heeron (1984) discovered that the individual's attempt to suppress memories of trauma can increase the occurrence of intrusive thoughts (Clark et al, 1991; Wegner et al., 1990) and intensify the negative emotional experience (Cioffi & Holloway, 1993; Wegner & Zanakos, 1994). Mindfulness interventions have been integrated into behavioural treatments for trauma with promising preliminary results (Becker & Zayfert, 2000; Simpson et al., 1998).

Practical Implications

If we are so inextricably linked with the natural world, then it would suggest that a therapist's conceptualisation of clients requires expansion. A commitment to good practice, as outlined by the British Association for Counselling and Psychotherapy (2010), is to keep up-to-date with the latest knowledge. Since research has demonstrated the benefits of nature, practitioners have an ethical responsibility to explore how ecopsychology could be used to benefit clients. The pertinent considerations would therefore concern whatever adjustments counselling psychologists could make in order to look beyond the presenting problem or routine methodology and incorporate ecopsychological concepts into trauma therapy.

The assessment could be broadened to incorporate questions about a client's environment, the impact that this has on them and their perceived relationship with the natural world (Milton, 2009). Laszloffy (2009) proposed questions that explore potential associations between typical presenting problems and broader ecological planetary dynamics, allowing the therapist to consider how a client's presentation of trauma might be linked to expansive issues like consumerism, a disconnection from nature, and environmental degradation. Laszloffy (2009) also advised trainees to expand their frameworks by considering their own relationship with the natural world; identifying didactic and experiential methods which could be used. Variety appears to be significant, as the curative powers of nature are enhanced by the degree of mindfulness and mental focus one brings to these interactions (Louv 2005). Practically, van Deurzen (1997) observed that clients can be influenced strongly by the consulting room, requiring consideration around the therapeutic space created to provide an environment for consultation.

Adams (2005) commented on our requirement for rushed target-based delivery, reminiscent of the current system of managed health care and evidence-based practice, in which the requirement is to cure rather than understand (Milton, 2009). This alludes more to an appeal to change pace, in line with the client as opposed to the treatment, to see the environment in

which they function outside of their presenting problem and slow life down to a healing, natural pace; for to define is to limit, just as to manualise is to generalise. Despite NICE guidelines advocating otherwise, Hairon (2006) revealed that 93 per cent of general practitioners prescribed antidepressants due to lack of treatment options, at substantial cost, even if they did not see this as an effective approach (Halliwell, 2005). Mind (2007) estimated that in 2005, 27.7 million antidepressant prescriptions were written in England, costing the NHS £338 million. Medications used to treat PTSD include a range of antidepressants, adrenergic agents, and atypical antipsychotics (Friedman et al., 2009).

The NHS era of austerity was indicated by the Department of Health in March 2010 as it illustrated how it will actualize £4.35 billion of savings annually by 2012-13 (Laurence, 2010). Budget constraints are seemingly unavoidable, but the inclusion of ecopsychology could potentially provide a cost-effective and natural addition to existing approaches. Mind (2007) illustrated that 88 per cent of participants in an ecotherapy study reported an improvement in mood merely following a green outdoor walk, and recommend ecotherapy as an affordable treatment for mental distress. Ulrich (1984) discovered that patients following gallbladder surgery recovered faster with fewer painkillers when they had a view of trees through their hospital window than when they looked out on a brick wall. Specifically to trauma, Lefkowitz et al. (2005) proposed an animal-assisted-therapy (AAT) model for survivors of sexual abuse suffering from posttraumatic stress, anticipating decreased number of therapy sessions. This is by no means conclusive, but perhaps future research could analyse the costs and benefits: if one were to abandon a short term schedule, ecopsychology may well prove to be more cost-effective than existing options; and in the longer term, may even be a preventative measure.

Existential Therapy

'Trauma individualises us, but in a manner that manifests in an excruciating sense of singularity and solitude' Stolorow (2007, p.41).

Existential therapy is ultimately a creative, evolving process though, as Cooper (2003) notes, a diverse and difficult to define body of psychological theory, practice, and research reflecting an existential influence with the aim of exploring human reality from the perspective of the client. The answers to fundamental philosophical questions shape the theory and practice of existential therapy (Boss, 1979; Cannon, 1991; Cohn, 1984). This fundamentally began with the works of Kierkegaard (1813-1855) and Nietzsche (1844-1900), as a cultural movement that emerged in response to the growing awareness of alienation and disconnection pervading contemporary life, exploring its paradoxes to understand the dimensions of existence that underpin human dilemmas.

The therapeutic process is the experiencing of one's existence, and the client's identity is not a fixed quantity. Yalom (1980) described it as a homeless waif that did not belong anywhere, resolving the problem of definition by listing the themes relating to existence (e.g. isolation, freedom). This review follows a similar example, by considering the applicability of existential therapy to trauma. To do this, van Deurzen's existential dimensions (1997) - a development of Binswanger's (1958) framework - and Jacobsen's existential conceptualisations of crisis are considered in some depth.

Existential Dimensions: An Existential Perspective on Trauma

Quinn's (2007) description of transgenerational trauma reported it as a process that stripped people of their knowledge, spirituality, physical and emotional well-being, and most sadly, has led to the loss of community (Locust, 2000). This depiction brought to mind van Deurzen's existential dimensions documented within her book *Everyday Mysteries* (1997). The author separated the four dimensions within which existence takes place, spanned by polar opposites manifesting as paradoxes, dilemmas, contradictions and conflicts; each with connections and overlaps which prevail when considering their implications as an approach to trauma.

Physical Dimension

van Deurzen claims we are firstly regulated by physical, biological and natural forces. Throughout life the basic challenge of our physical survival remains a continuously threatened primary concern. Just as psychological trauma leads to, among other things, a heightened sense of mortality and vulnerability (Sadavoy, 1997), it is unsurprising if people wish to abstain from preoccupations with birth and death, which remind us of our humble and fragile nature.

Jacobsen (2006) conceptualises crisis, a term sometimes used interchangeably with trauma (du Plock, 2010), as identifying three dimensions: loss, adversity and the opening of existence. 'Crisis as loss' can involve direct and physical losses of a specific object or person that they subsequently miss, resulting in grief. Jacobsen observes that when something is lost, so is a part of oneself that was attached to that person or thing. Bollnow (1966, p.66) made a similar connection by discussing bereavement in which '...the bereaved does not inhabit his or her world in the same way as before. Therefore the death of a loved one is loss of existence. The individual shrinks. The death of a loved one is a piece of one's own Death'. Just as trauma heightens our sense of mortality, it potentially induces a range of physical consequences which continue to threaten it: Kendall-Tackett (2009) claimed that people who have experienced traumatic events have elevated rates of serious and life-threatening illnesses including

cardiovascular disease, diabetes, gastrointestinal disorders, and cancer.

van Deurzen equates our prioritisation of physical needs with a wholly unnatural cycle. She postulates that physical life is based upon a cycle of need: to fill an empty stomach. However, we once (as animals still do) enjoyed the process of gathering food and eating at the same time: the effort was as important as the goal. However, we have since learnt to postpone gratification, and work is perceived as depleting and exhausting. The natural cycles in which pleasure and effort are commensurate have been replaced with unnatural cycles of entitlement, comfort, instant gratification and whatever else might reinforce such views. To me, this reflects an over-simplified prioritising of quick-fix solutions for psychological trauma, while simplifying - if not negating - the core issues. Research has indicated that the long-term benefits of CBT are not quite as clear and certain as sometimes portrayed (e.g. Rufer et al., 2005, Rowe, 2007). Just as van Deurzen observes that we prefer to outsmart nature and obtain our livelihood with minimal effort, the reality is that we gain relatively little, for the journey is everything, and the 'goal' is indefinable and ever-shifting, according to the individual's perspective and the passage of time. Trauma seemingly affects us all at some point. For some, the real work on personal development begins with the awareness of the need, the lack, the black hole, the pain: not to be filled or numbed. The real work is on shaping ourselves and recreating ourselves - reconnecting with natural cycles within and without. This is an ultimately rewarding effort, the very challenge of our physical existence.

Social Dimension

Secondly, van Deurzen writes that we are social creatures, inserted into a cultural network which we internally assess, categorise and ultimately, need to connect with. The author extends this into a social commentary about the abandonment of our ancestral history; a network that could be considered therapeutically from individual's response to trauma. Denham (2008) described the varied ways people experience, construct and transmit traumatic experiences intergenerationally within American Indian families, revealing that the family's history of trauma and their related narratives appeared to function as a significant carrier of cultural and family identity. Embedded within the trauma narratives were numerous strategies for resilience, or non-pathological adaptive responses and abilities to maintain equilibrium after experiencing adversity (Bonanno, 2004; Conner, et al., 2003; Dion-Stout & Kipling, 2003; Luthar et al., 2000). Similarly, van der Hart (1983) described the tribal culture Navahos, for whom to be sick is to become fragmented, to be healed is to become whole, and to be whole one must be in harmony with family, friends and nature. This exemplifies the pervasion of the natural world into this dimension, an area also considered by McCallum and Milton (2008) who discussed the incorporation of one's ancestral human and animal history in the therapeutic environment.

Psychological trauma no doubt disturbs the social dimension, evidenced in trauma-related literature that describes our instinctive responses to threat. Our struggle for survival requires us to distinguish between those who will protect or attack, and when fearful many people trigger their social engagement system (Porges, 1995). Lodrick (2007) distinguishes *'friend'* as the earliest defensive strategy available to us, evident even in the child who smiles - or even laughs - when being scolded; and highlights the survival strategies *'fight'*, which involves the threatened individual responding with overt aggression, and *'flight'* as a means of putting space between oneself and the threat. It would seem that our way of existing within the social dimension affects our response to trauma, just as a trauma impacts upon us socially. Research (Maercker, 2008a, 2008b; Nietlisbach & Maercker, 2009, 2009b) has revealed how features of post-traumatic symptomatology and interpersonal factors may provoke an increase of social exclusion which may be an additional emotional burden for trauma victims. PTSD is often accompanied by impairment of psychosocial functioning that is not reflected within the recommendations by NICE (Hemsley, 2010); and McFarlane and Van der Folk (1996) argue that symptoms such as repression, denial and dissociation have a social as well as an individual consciousness.

The relevance of the social dimension to trauma draws attention to a central preoccupation for counselling psychology: the role of the therapeutic alliance. Existential therapy encourages clients to view their experiences of the world while acknowledging the developing therapeutic relationship (May, 1995, 1996; May et al., 1958), practically implying that clients are encouraged to become aware of their experiences, potentialities, and means of interaction with the therapist (Bugental, 1978; May, 1995; Schneider & May, 1995; Yalom, 1980). The nature of the relationship may differ from more classical kinds of therapy: for instance the existential therapist functions as a person in a meaningful encounter with another person. This is particularly pertinent to traumatised clients, as case examples have illustrated how the development of the therapeutic relationship has significantly contributed to resolution of thematic issues that defined the therapeutic work (Roth & Batson, 1993).

Psychological Dimension

van Deurzen writes that we are regulated by our personality, character and mental processes; referring to the personal space which we protect and develop in relation to our established physical and social dimensions. Just as trauma shatters the world around us, a prematurely defined self may develop, which will eventually falter and become depleted. As in the social dimension, our biological responses to threat could also relate to the psychological dimension. Lodrick (2007) described *'flop'* as occurring when muscle tension is lost and the body and mind become malleable: if impact is imminent the likelihood of surviving will be increased if the body

yields, and psychologically the situation will be more bearable if the higher brain functions are 'offline'.

The formation of self is described by van Deurzen as a constant challenge, but if physical and social well-being has been acquired at some point, a more positive experience can be drawn upon to overcome difficulties. Similarly Jacobsen's (2006) conceptualisation of 'crisis as loss' includes psychological losses of a connection with the mind or soul or existential losses of a relationship with self or other. Though the potential of trauma is consistently prevalent, so is the possibility of generating bonds of emotional attachment within which debilitating emotional pain can be held, constructed as more manageable, and ultimately integrated (Vogel, 1994). Here, the social and psychological dimensions interweave; just as Herman's (1997) commonality and reconnection theory suggests that people affected by trauma need to reconnect and rediscover themselves as well as to connect with those who have endured similar circumstances. This relational interplay suggests an inter-connection between the existential dimensions and Jacobsen's crisis conceptualisations in approaching trauma therapeutically; perhaps exemplifying the therapist's requirement to step back and question multiple possibilities.

Jacobsen's 'crisis as adversity' dimension outlines existential givens, which an individual must learn to accept or face living under false premises. Trauma can enduringly affect one's sense of being-in-the-world by altering our preconceptions: the world is unpredictable and can offer no guarantee of security or consistency (Stolorow, 2007). Such concepts epitomise the subjective conceptualisation of trauma, with therapeutic implications that listening to the subtleties of interpretation and remembrance, nuances of affect and self-experience and idiosyncratic social constructions will provide insight into the client's unique posttraumatic response (Harvey, 1996).

Spiritual Dimension

van Deurzen suggests that we are modulated by our relationship to the overall framework of meaning through which we experience the world and make sense of it on a spiritual dimension. Trauma can indeed provoke an altered philosophy of life that may include spiritual beliefs (Park et al., 1996). When exposed to trauma, the client can experience a level of death awareness that enables them to more clearly and richly experience the joys, meanings, values and life purposes (Frankl, 1969; Yalom, 1980). Jacobsen's 'crisis as loss' dimension includes loss of meaning and world-view, but his conceptualisation of 'crisis as an opening-of-existence' also resonates here. Trauma presents the therapist with an opportunity to help the client discover a paradoxical respect for life that occurs in response to the proximity of death, identified by Frankl (1969) as "finality meanings".

Trauma can result in growth, inasmuch as adversity and distress can push someone to develop. Parkes (1971, p.101) characterises traumas as 'psychosocial transitions', explaining that individuals must 'restructure [their] ways of looking at the world and [their] plans for living in it'. Research suggests that a range of traumas can precipitate positive development, for example, cancer (Cordova et al., 2001; Taylor, 1983); HIV infection (Schwartzberg, 1994); rape (Ashley, 2005; Burt & Katz, 1987; Veronen & Kilpatrick, 1983); incest (Silver et al., 1983); bereavement (Schwartzberg & Janoff-Bulman, 1991; Calhoun & Tedeschi, 1989; Lehman *et al.*, 1993); heart attacks (Affleck et al., 1987) and disasters (McMillen et al., 1997). Jacobsen's (2006, p.46) describes this concept like a crack in the ground '...the crack allows the individual to look deep into something very significant. In this way, the crisis becomes existential and can become a personal turning point, a new life possibility.'

Just as trauma can disturb the existential dimensions, it would seem that they could each be considered therapeutically alongside Jacobsen's crisis dimensions. Yalom (1980) asserted that a confrontation with death and freedom could ultimately lead to existential isolation; while Heidegger used the term "thrownness" to refer to the fused affect of loneliness and helplessness: finding ourselves inserted into an existence not of our choosing.

Therapeutic Implications

In working therapeutically with a trauma, du Plock (2010) cited Jacobsen's (2006) paper suggesting that it could work as a counselling psychologist's guide: which claims that the client would need to confront and articulate losses, affording the opportunity to sense, acknowledge and express feelings, while confronting the material that was split off during the traumatic event. Ultimately, the therapist would collaborate with the client to induce meaning, implications and possible consequences.

Feelings and Moods

van Deurzen-Smith (1988) summarised the most common feelings that emerge after a trauma and regarded them, rather like the consequences of trauma are experienced as succeeding one another in a cycle (e.g. van der Kolk 1989). Each has a destructive and a constructive side, and the client needs to experience and understand the varying feelings that surface, become accustomed to them and learn something from them about one's way of life. Boss (1994) discussed moods as ways in which an individual's relationship with the world may manifest. Boss stressed the need for the individual to be able to sense their varying moods and gradually open themselves up to them, so that they are able to meet the world freely and be present to what emerges. This perhaps exemplifies the importance of the counselling psychologist's own

engagement with personal therapy, affording the therapist to have worked through their personal existential concerns, feelings and moods, since therapists may experience intense counter-transference feelings and a traumatised client's process of recovery could be extensive. I found the cyclical nature and emphasis on the individual's role a progression from the bereavement phases (Parkes 1970; Sanders 1999) which imply a degree of passivity and carry the risk of an assumption that the phases are passed through in order.

Reintegration

du Plock (2010) commented that when someone experiences a trauma, their defences are activated and some events are so horrific that the consciousness cannot contain them. Jacobsen cites Spinelli's (1994) theory of dissociated or divided consciousness, in which certain aspects of a traumatic experience are placed into one of two compartments of consciousness. The more humiliating or anxiety-ridden memories are placed in one compartment, while the more positive memories allocated to the other, with reflections of Brewin's (1996) Dual Representation Theory which depicts the traumatic memory stored in two parallel forms. The individual must gradually attempt to recall these details in therapy. This has similarities to exposure or reliving associated with CBT, which aims to update and correct trauma history on the basis that certain aspects of a trauma are omitted from recollections (e.g. Ehlers & Clark, 2000). The subtle distinction lies in the focus on recollection, not correction, as an important part of the repair process is the confrontation of the client's beliefs and assumptions that would influence the compartment that certain memories were initially assigned to, rather than identifying them as maladaptive.

Reconstruction

Jacobsen observed how therapy can naturally generate a more positive interpretation for the trauma survivor, as they re-attribute meaning to the traumatic event. This resembles but goes beyond cognitive restructuring (e.g. Ehlers & Clark, 2000), as the reconstructed meaning and orientation of one's life can be characterised by a more intense and intimate life containing features like reconciliation and acquiescence to one's existence. Jacobsen provides case examples from an interview to illustrate positive reconstructions of cancer patients, which could have been developed to include Spinelli's (1994) suggestions about the self-construct, which he proposed was maintained and validated by a remembered past that has flexible meaning and significance. In this way, as PTSD sufferers demonstrate poor autobiographical memory (Ehlers & Clark, 2000), a memory of a traumatic incident would selectively reflect the client's views about themselves.

Ecopsychology and Existential Therapy: Empirical Considerations

While doing this review I was struck by how much empirical evidence there was available to promote CBT in comparison to these approaches. While I found the discussions and presentations for ecopsychology to be compelling, many were experiential and not empirical. Gatersleben (2008) also noted that most experimental environmental psychology research concentrates on healthy young individuals and advocated future research concerning nature's role in the health and well-being of individuals suffering from longer-term psychological problems to clarify the processes which may underlie environmental preferences and the restorative effects of nature. This suggests a requirement to collaborate associations between ecopsychology and its approach to trauma before it can be considered methodologically robust enough to form solid conclusions.

While The World Health Organization's (WHO) emphasis that a holistic approach to health is defined as a state of complete physical, mental and social wellbeing (1946, 1986), ecopsychology is still an emerging field. It is difficult to define the connection and effects of nature, with all its interactions and distinctions. However, while a counter argument to ecopsychological research, this is also its biggest support: for nature also enables people to 'express the inexpressible' (Linden & Grut, 2002, p.16).

Despite methodological difficulties, qualitative and quantitative empirical evidence is beginning to amass. Doherty (2009) noted that ecopsychology has advanced through substantial clarification and theoretical and practical development, while Winter and Koger (2004) indicated how ecopsychology can be empirically validated and used in a conventional psychology framework (e.g., Johnson & Johnson-Pynn, 2008; Vakoch, 2008). Wilson et al. (2008) acknowledged the emergence of quantitative studies evidencing positive findings to suggest that the application of nature can improve and conserve mental health, with advanced national and international policy considerations and directives (WHO, 1997; Guite et al 2006; Grahn & Stigsdotter, 2003; Hansmann et al. 2007; Diette et al., 2003). They discussed studies in which symptoms associated with trauma such as self-esteem and depression (ISTSS, 2003), are significantly observed to improve (e.g. Mind, 2007., Pretty et al. 2005, Reynolds, 2002).

Tedeschi and Calhoun (1994) suggest potential physical benefits to be derived from existential work after a trauma, and while further exploration is required, this may be a promising area for investigation. For instance, Epel et al. (1998) discovered that elevations on spiritual growth and appreciation of life were related to quicker cortisol habituation to a laboratory stressor. Similarly,

Bower et al. (1998) reported that HIV sufferers were less inclined to have accelerated declines in CD4 T-cell levels if they cognitively processed their situation into something meaningful; paralleling earlier discoveries of reduced rates of mortality in heart attack victims who derived advantages from their illness (Affleck et al. 1987).

Within the existential literature, Yalom (1980), comments that as far as therapy is a deeply personal human experience, the empirical study of it will contain errors and limitations. A core epistemological theme within existentialism is concern for the uniqueness and irreducibility of human experience; unsurprisingly, scientific methods seem inadequate to the task of understanding the meaningful complexities of human experience (Boss, 1979; May & Yalom, 1995; Norcross, 1987). This relevance of scientific evidence to natural approaches has similarly been questioned (Adams, 2005; Chalquist 2009); while McCallum and Milton (2008) proposed acceptance for both empirical and representational approaches so the meaning of natural phenomena is not lost. Chalquist (2009) goes further to suggest that unrestrained empiricism is itself a version of trauma; an intellectualised resistance from experiencing the world on its own terms. EMDR has a substantial supportive empirical base, yet I realised that this was discovered in a natural setting (Shapiro, 1995). Shapiro created EMDR by chance while taking a walk in the park, noticing that while she was thinking about negative life issues and voluntarily moving her eyes back and forth, the intensity of the negative thoughts and feelings were reduced (Levine & Frederick, 1997). While research has focused on the eye movements themselves, seemingly little has been done to address the natural setting in which this took place. This is somewhat like fixating on mere finger movements in instrumental playing, without cognisance of the actual music. There may be some effect, but it is by no means necessarily the whole picture.

Conclusions: Integration and Future Research

This review examined the potential for the use of ecopsychology and existential therapy in psychological trauma. Literature has demonstrated that the cyclical nature of trauma can lead to prolonged psychological problems, while both of these evolving approaches appear to have substantial therapeutic benefits, and openings for creative integration. More detailed research would be beneficial in providing valid and useful information about the efficacy of these approaches in effecting recovery from psychological trauma, assisting in generating a conceptual framework that will guide future empirical studies, increasing practitioner awareness and providing more distinct means of integrating ecopsychology and existential therapy.

While the approaches were presented separately, they were not perceived as mutually exclusive; indeed, areas frequently overlapped. For instance, literature concerning both

approaches acknowledged the significance of a client's inter-relational presence in the world: from being-in-the-world to one's relationship with the natural world. The cyclical theme of repeated symptoms pervades psychological trauma literature and manifests in both approaches, reminiscent of van Deurzen's (1997) observation about our loss of connection with the natural cycle; the cyclical emergence of feelings in therapy, and Linden and Grut's (2002) description of the healing metaphor provided by natural themes of growth and decay. It would be interesting if future research examined this in more depth, identifying the existential components which underlie the beneficial therapeutic features of nature as an approach to psychological trauma.

Despite broad philosophical underpinnings and definitions, the issues raised by existential therapy appear to be universally perceived and basic to human experience (Yalom, 1980), suggesting that they could be integrated into almost any approach, while ecopsychology appears to transcend cultural boundaries. Cross-cultural studies could be applied to both approaches to investigate their accessibility; exploring how cultures that embrace nature respond to psychological trauma, and to ultimately address psychological trauma with a broader all-encompassing focus. Increased accessibility to the most appropriate therapeutic approach could potentially reach a wider client group, thereby preventing trauma from being simply displaced onto the next generation in yet another ever-repeating cycle.

This review is not about endorsing a new prescriptive methodology, but an integration and incorporation of other methods so that the practice of counselling psychology continues to evolve. CBT is conclusively recommended within the NICE guidelines, with a concentration on symptoms and diagnostic criteria (Hemsley, 2010), yet this fails to adequately provide a richer understanding of responses to trauma (McHugh & Treisman, 2007). Adams (2005) comments that it is typically most effective when ecopsychology operates on the outskirts of the predominate culture, working collaboratively, striving to alleviate oppressive structures, and developing possibilities for the actualisation of new experiences. People can only heal from trauma if supported as whole beings and provided a safe channel to explore their world and reconnect with themselves (Herman, 1997; Paulson & Krippner, 2007). The responsibility of counselling psychologists lies in understanding their clients' anxieties and experiences rather than coercing them into conforming to a therapeutic model.

Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology (BPS, 2005). While empirical evidence is beginning to amass for these approaches, further projects should be monitored and evaluated to reinforce existing findings and expand data. Perhaps scientific methods are inadequate to comprehend the idiosyncratic meanings we assign to trauma and the unique

relationship we have with the natural world, or maybe we are just inter-connected in ways beyond our understanding. So it is possible that more is needed, namely, a willingness to experiment and explore other approaches; to identify ways in which these approaches may be integrated; and to constantly question and debate the accepted methods as a reflective and critical practitioner.

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Appendix A

Counselling Psychology Review Notes for Contributors

Manuscript requirements:

- 1) The front page (which will be removed prior to anonymous review) should give the author(s)'s name, current professional/ training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.
- 2) Apart from the front page, the document should be free of information identifying the author(s).
- 3) Authors should follow the Society's guidelines for the use of non-sexist language and all references must be presented in the Society's style, which is similar to APA style (the Style Guide, available from the Society, or downloadable from /publications/submission-guidelines/).
- 4) For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.
- 5) Approximately five key words should be provided for each paper.
- 6) Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.
- 7) Graphs, diagrams, etc., must have titles.
- 8) Submissions should be sent as e-mail attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add 'CPR Submission' in the e-mail subject bar. Please expect an e-mail acknowledgement of your submission.
- 9) Proofs of accepted papers will be sent to authors as e-mail attachments for minor corrections only. These will need to be returned promptly.

The Client Experience of Existential Therapy

An Investigation into the Experience of Existential Therapy for a Client using Interpretative Phenomenological Analysis

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Supervised by Martin Milton

Abstract

Existential theory is a relatively emerging field and to date, the experience of a client who has undertaken existential therapy has been overlooked as a distinct research focus. This paper presents findings from a qualitative study with six participants who had all received existential therapy. Interviews were transcribed and the data was analysed using interpretative phenomenological analysis. Emerging themes focused on essential components of existential therapy; paradoxes of thinking; preconceptions and relational issues. The study could be seen as expanding the knowledge base for existential therapy, and for integrative practitioners who may wish to consider ways their own practice could potentially incorporate and adapt some of the insights.

Key words: existential therapy; client.

I didn't feel that she had any sort of clichéd approach, I think it was very individual based on what I was bringing, and there wasn't any judgement on what I was bringing

An Investigation into the Experience of Existential Therapy for a Client using Interpretative Phenomenological Analysis.

Introduction

The term 'existential therapy' is difficult to explicitly define because it has been used to refer to a number of therapeutic practices, all aiming to explore human reality from the perspective of the client (Cooper 2003). The answers to fundamental philosophical questions that underpin the way the world is perceived shape the theory and practice of existential therapy (Boss, 1979; Cannon, 1991; Cohn, 1984). Rather than pathologising the client, existential therapy 'does not seek to cure or explain, it merely seeks to explore, describe and clarify in order to try to understand the human predicament' (van Deurzen, 1997, p.3). Lantz (2004) highlights that existential psychotherapists generally believe that effective therapy is not procedurally based, but instead evolves out of the therapist's willingness to utilise the self to facilitate relationship, action and reflection to help the client work through and struggle with the ultimate issues of human life during the therapeutic process (Frankl, 1969; May, 1983; Mullan and Sangiuliano, 1964; Whitaker, 1976; Yalom, 1980). Existentially oriented therapists strive toward honest, mutually open alliances with their clients, encouraging them to consider their experiences of the world while acknowledging the developing therapeutic relationship (May, 1995, 1996; May et al., 1958).

While existential therapy is a relatively emerging field, van Deurzen (2009) notes that it is becoming a household name and there are numerous mental health and therapeutic services both in the voluntary and public sector that specialise in the approach. Despite this, existential therapy is largely understudied and existing literature focuses largely on the aims and philosophy of the approach, conveying a multitude of forms, styles and approaches (Cooper, 2003). With so much variety and definitional difficulties, one might wonder how this could translate to a client considering therapy. Little is known so far about what draws someone to choose an existential therapist and the impression that this approach leaves the client with.

Research Question

The aim of this research was to explore clients' subjective experience of existential therapy, in order to enhance practitioner awareness in this under researched area and potentially inform

those considering an existential approach. Within this, it aims to add to our understanding of individual experiences and perceptions of existential therapy and in turn help trainees and therapists reflect upon and evaluate their therapeutic style – an important focus for counselling psychology. The objective of the study was to acknowledge the subjective experiences of a range of clients who had received existential therapy. With these principles in mind, the research is guided by the question *'how do clients describe their experiences of existential therapy?'*

The Existential Client Experience

'Clients want a psychotherapist who is trustworthy, understanding and capable' (van Deurzen, 1997:189). While such assumptions have yet to be substantially investigated, some literature has speculated on the motivations a client might have for choosing existential therapy. van Deurzen (2007) observed that the approach often attracts clients who feel disinclined to trust other human beings because they perceive the existential approach as leaving them in total control, but also states that the existential approach is often misconstrued as 'intellectual'. With potential pre-conceptions held about existential therapy and specific reasons that a client might have for choosing this approach, a qualitative study could enrich our understanding about both the perception of existential therapy and the impression that it makes on a client.

The client experience could be considered from the perspective of a learning tool for practitioners and trainees, with which to evaluate their therapeutic style. van Deurzen (1997) notes that the work of existential therapists can vastly improve if they are willing to learn from clients' responses and comments. Boss(1963), Frankl (1959), Mahrer (2000), May (1983), Whitaker (1989) and Yalom (1980) have all reported that becoming a good therapist demands that psychotherapists rigorously and consistently expose themselves to the involvements, commitments, vulnerabilities and responsibilities that occur in a therapeutic relationship with a real client requesting help. In this way 'clients are our supervisors, or even therapists (van Deurzen, 1997:224). Exploring client's responses and comments regarding existential therapy could substantiate this principle by providing qualitative data to generate insight for practitioners and trainees about the impact of such an approach.

Exploring the client's experience of therapy is both appropriate and necessary for the development of the field of counselling psychology. Clients make an active contribution to the therapeutic process: the therapeutic encounter is fundamentally an interpersonal one in which therapist and client interact in an attempt to produce the conditions necessary for change (Butler & Strupp, 1986). However, most research to date has focused on the techniques, actions and competencies brought by therapists and has tended to neglect the feelings, values, attributes and skills brought by clients (Macran et al., 1999). While Macran et al (1999) acknowledge the

importance of recognising and responding to client requirements, little work has been conducted into defining these requirements and exploring clients' perspectives. The client experience is a vital area of research given the rapidly changing political and economic context in which therapy is delivered, and made even more pertinent since £70 million has been pledged to expand psychological therapies across the NHS over the next year (Lansley, 2010). While the availability of psychotherapy within the National Health Service (NHS) has always been limited, pressures increase to justify services on the basis of effectiveness and user demand (Macran et al., 1999). Investigations into the client experience of existential therapy will not only build up the research base of this so far understudied approach, but could ultimately stimulate debate and consideration regarding the development and incorporation of other approaches into existing modalities.

Existential research currently suffers from a marked absence of client focused studies and is indeed one of the most under-researched approaches in counselling and psychotherapy (Cooper, 2004). Studies have addressed the experience of therapists conducting existential therapy (Wilkes & Milton, 2006), and case studies have been presented from the perspective of the therapist (e.g. du Plock, 1997; van Deurzen, 2007), yet research that reflects the client's experience is distinctly lacking. Some initial work has portrayed a client's perception of existential therapy in the form of a book by Elkin (Yalom & Elkin, 1990) who was in therapy with Yalom, but again there seems to be little availability of qualitative research to thoroughly investigate this perspective.

Other approaches have, however, been researched from a client perspective. O'Connor *et al* (1997) conducted qualitative research to investigate clients' experiences of narrative therapy, while MacCormack *et al* (2001) conducted a qualitative investigation into cancer patients' experiences of psychotherapy. Since qualitative research has already been applied to these therapeutic approaches in highlighting what is helpful / unhelpful, it could also be useful and worthwhile to quantitatively explore existential therapy from this angle.

Most existentialist claims are not subject to empirical investigation even though 'evidence based practice' increasingly requires therapies to demonstrate efficacy and efficiency (Rowland & Goss, 2000). Client experiences are captured quantitatively via feedback forms and surveys, for instance by Bende and Crossley (2000) who collected psychotherapy patients' views of treatment via questionnaire. Epistemologically, existential therapy is hindered as "the basic tenets of existential therapy are such that empirical research methods are often inapplicable or inappropriate" (Yalom, 1980, p.10). However, existential therapists generally have reservations about the use of systematic experimental research methods to generate knowledge about the practice and effectiveness of existential therapy and for many such experimental research

methods are best replaced with the process of participation (Lantz, 2004). Therapy is fundamentally a complex human endeavour, and so this study proposes to move beyond the basics of the easy to measure efficacy studies, and into a more complex realm by generating rich qualitative data that explores how participants make sense of their experience of existential therapy.

Method

Design

The emphasis of the study was to offer insights into clients' experiences of existential therapy. A qualitative research method was adopted because the project involves a detailed exploration of participants' personal experience (Willig, 2008). Qualitative studies can also be particularly appropriate to initial exploration of uncharted areas, as they aim to remain as faithful as possible to the phenomenon and context in which it appears. Another advantage of qualitative studies is that a limited number of participants allows for a more in depth analysis and can act as a baseline for larger studies of the same type (Smith et al 1997). Since the research question is concerned with the in-depth exploration of client experiences and how they perceive and make sense of that experience, a phenomenological research method is appropriate. Interpretative Phenomenological Analysis (IPA: Smith, 1996; Smith et al., 1997; Smith & Eatough, 2007) was adopted to analyse the data since it provides a systematic way of analysing qualitative data to explore participants' experiences of the world (Smith, 2008). IPA is concerned with an individual's personal perception or account of an object or event, in this instance existential therapy, as opposed to an attempt to produce an objective statement of the object or event itself, and is also appropriate to explore the phenomenology of a small sample.

Sample

This study captures the experiences of clients who have experienced therapy undertaken by a therapist who states that they work existentially. All participants had specifically sought out an therapist who had advertised themselves as practising existentially, and all were either in therapeutic training or had a psychological or therapeutic background. Suitable participants were deemed to be those who had been offered a minimum of six sessions and attended at least four sessions to ensure that they have sufficient experience to discuss the process in some depth. This promoted the likelihood of securing a relatively purposive homogeneous sample, meaning that participants shared certain basic similarities and were chosen for the purpose of the research project (Smith, Flowers & Larkin, 2009) and thereby increasing the likelihood of being able to discern commonalities of viewpoint and reported experience.

Participants were recruited by opting into the study. The study was publicised two ways - by

posters, and also electronically through website forums with an existential interest. Existential therapists were also contacted and requested to publicise the study to past clients who meet the criteria. Participants who expressed an interest were emailed an information sheet containing the title and brief description of the research. Smith and Osborn (2003) note that sample size depends on a number of factors and that there is no 'right' sample size (p.54), though 4-6 participants will ideally be sourced for the study to allow sufficient in-depth engagement with each individual case but also a detailed examination of similarity and difference, convergence and divergence. Six participants were recruited, three women and three men aged between 24 and 56. When describing their ethnicity, four participants described themselves as British, one German, and one Greek. Participants had all specifically decided upon a course of therapy with a practitioner who explicitly stated that they practise existentially, and collectively they had all received existential therapy ranging from four sessions to two and a half years. Once they agreed to participate, a consent form was signed (appendix C).

Procedure

A pilot interview was carried out, at the end of which the participant had the opportunity to give feedback about the procedure, which informed the way that subsequent interviews were conducted. Interviews took place in a quiet public place or via Skype with a webcam at a time that was convenient for the participant. All participants were re-briefed as to the purpose of the study, how the data is recorded and used and issues related to confidentiality and the disposal of recordings (appendix B). Time was allocated to answer any questions participants had. Consent forms were signed at this point (appendix C). The interviews lasted between 30 minutes and 1 hour 15 minutes. During interviews, participants were invited to interact with minimal prompting or structure and the interview style aimed to be non directive and the researcher was mindful of counselling skills as advocated by Rogers (1957). In order to remain entirely phenomenological and give the participant maximum freedom to explore their experience, just one question was asked which was "can you tell me about your experience of existential therapy" (Langdrige, 2007); the participant led the entire interview thereafter. This question was decided upon because it closely resembled the research question, and was used in the pilot interview to determine its coherence and potential to allow the participant space to explore their experience in greater depth. It was anticipated that this broad open-ended question would allow the participant to set the parameters of the topic, and prevent the researcher from imposing their understanding of the phenomenon on the participant's narrative (Smith et al., 2009). The interview was therefore more likely to be conversational in style, generating the potential for genuine rapport to be formed, and consequently more open and honest responses (Langdrige, 2007). There was no attempt to test a predetermined hypothesis, but to just allow the participant the space to flexibly explore this area in some detail. Broad prompts were employed as required which were discussed in supervision, such as "could you give an

example?” and “how do you experience that?”, but the researcher was mindful to follow the lead of the participant. Finally, participants were given the opportunity at the end to say anything further on the subject that had not been talked about and whether they had any questions for the interviewer.

Ethical Considerations

Ethical approval was obtained through the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey (appendix A) and risks and potential hazards for the participant and researcher were identified and considered (appendix E). It was possible that some clients opting into the study were still undergoing existential therapy, and potentially vulnerable, so distress was minimised by participants opting in to the study; informed consent and applying the principles of person-centred counselling including empathy, genuineness and unconditional positive regard in conducting interviews. Participants were informed that if they felt distressed during the interview they were free to withdraw at any time, and alternative support networks would have been suggested if distress was caused. After the interview participants were given the opportunity to reflect on how they felt during the interview and informed that they could still withdraw from the study until the point of data analysis without the need to provide further explanation. As a safety precaution, the researcher met participants in a quiet but public meeting place, informed someone of their whereabouts and telephoned that person after the interview.

Data Analysis

In order to analyse the data, the recorded interviews were transcribed verbatim and the data was analysed using IPA. IPA aims to explore in detail how participants make sense of their personal and social world, and how they think about the phenomenon under investigation. It focuses on how the participants experience the phenomenon, rather than whether their accounts are true or false or to what extent their perceptions correspond to an external reality (Willig, 2001). In order to explore these experiences using IPA, four recommended stages were followed (Smith & Osborne, 2003). Firstly, the transcripts were read repeatedly to enable the researcher to develop a deeper connection to the data and the participant's experience. Secondly, the researcher began to note observations, ideas and potential interpretations on the transcripts. Thirdly, emerging themes were identified, which required a higher degree of interpretation from the researcher. This was done systematically for each transcript, and the researcher considered throughout how the previous transcripts could have impacted upon the researcher's knowledge throughout the process (Smith et al., 2009). Fourthly the themes were clustered across all transcripts by strength of association to each-other and super-ordinate and subordinate themes were determined. While doing this, the researcher was aware of their own insights from being either a client or therapist, and was careful to bracket any assumptions so

that any emergent theme was based upon the participant's own account. The recordings were listened to one final time so that the researcher could reflect upon the themes identified while listening to the participants' accounts and check for coherence. The themes were placed in a table of super-ordinate and subordinate themes and the interpretations and appropriateness of the connections made between text and themes were subsequently discussed in supervision.

Evaluative Criteria

Qualitative research is embedded in a philosophy of knowledge development distinct from the positivist tradition. Whilst positivist research attempts to establish objective knowledge 'represented as regularities, even laws' (Elliott et al., 1999, p.217), qualitative research relativises the knowledge gained to the participants, the situation studied and the researcher. Therefore traditional evaluative criteria such as validity and reliability become inappropriate. This study adhered to alternative evaluation criteria suggested by Elliott et al. (1999) such as persuasiveness; owning one's perspective; situating the sample; resonance with readers; grounding in examples and providing credibility checks and audit trail coherency.

Analysis

For the following analysis, direct quotes from the interview transcripts are written in italics. Ellipses points (...) are used to indicate that a passage has been omitted from the original transcript. In order to preserve participants' anonymity, they are referred to as P1-6, and situations that might disclose personal details have been omitted and/or changed with a fictitious equivalent.

Using IPA, four super-ordinate themes across all the transcripts were identified. Each super-ordinate theme has its own set of identified subordinate themes, though only subtle differences lie between one super-ordinate theme and another and also within the subordinate internal themes. These are reported in table 1 below.

Table 1

Super-ordinate Theme	Subordinate Theme
Essential characteristics	Not being labelled
	Non judgemental acceptance
	Client responsibility
	A lack of defined structure
	Being in the present
	Difficult to Define
Paradoxes of Thinking	Intellectual yet Unknowing
Preconceptions	Decomartmentalisation leading to Connection
	Well trained

	Intellectual
	Lack of information
Relationship	Boundaries
	A shared space
	Trust
	Adult-to-adult

Due to word limitations it is not possible to elaborate each theme in detail. I therefore intend to focus on those themes that are relevant to my research question and have not been addressed in previous literature. These are: Essential components of existential therapy and Paradoxes of thinking.

Essential characteristics of existential therapy

This theme concerns the particular characteristics of existential therapy, how these came across to the participant, and what made the therapy existential. Subthemes include how participants found the therapy to be structured, labelling, acceptance, client responsibility, the focus on the present moment, and the difficulties in defining the nature of the work.

Not being labelled

Several participants highlighted the impression that they did not experience the therapy as labelling. P4, who was in psychotherapeutic training at the time of interview and had received both Cognitive Behavioural Therapy (CBT) and existential therapy respectively, talks about labelling in two terms: that the therapy itself did not fit a label of any sort, and that it similarly did not apply labels.

The thing that has appealed to me about the existential modality is its its lightness of touch in terms of needing you to be you know fitting a model err fitting a label fitting a pigeon hole or whatever, as well as the way it was seen as being quite fluid and no one really is stuck in a certain model or given a certain label. (P4)

By reflecting on an experience of CBT, P4 offered insight into the nature of existential therapy: *CBT was quite it was quite labelling and quite you know very specific and terribly sure about a + b leads to c and so on – and although that was great for me at the time um and it helped me to sort my life out a bit err there is something about it I found a little bit uncomfortable um err and I don't find that in the existential modality I find it much more freer and moulding itself around your own situation. (P4)*

P4 appears to experience the lack of labelling in therapy as liberating, by explaining that it works around him rather than the other way around. The experience of not being given a label is also described in terms of movement: 'fluid' as opposed to 'stuck'.

P6, who had received existential therapy while in psychotherapeutic training, said that his therapy was: a rejection of labelling um and that really works for me because I just think it's a very limited way of looking at the world and can buy into people's stereotypes and just expand upon people's idea of who they are and what the world is rather than opening up the world.

An example of this is: if I call myself narcissistic or another she rejects the term, not outright she just says she would rather not use those terms, better instead to ask someone 'what do you really mean by that, why do you ask me if you're narcissistic, what do you understand as narcissistic (P6)

We come into therapy with ideas about who we are, and those ideas, if I am this then I'm not the other and the other is often something else or I find myself in opposition, so I can't label myself without labelling the other two. By getting rid of the labels completely I can walk into the room and I can experience myself afresh, because labels are symbolic and if we're trying to get away from the mind and into the feeling well then to say 'why do you feel narcissistic' rather than one of the eight criteria, is a very different ball game. (P6)

P6 appears to describe the therapy as being quite dismissive of labels, and admits that he is challenged by his therapist when he applies them to himself. Once he dismisses one label, then the implication is that he would dismiss others. He offers insight into the impact that this has upon him, as being able to experience himself 'afresh' once he abandoned his usage of labels. He also comments that it has helped in terms of thinking of emotions rather than thoughts, because he has considered how it feels to be narcissistic, rather than just accepting the term as a label.

Non judgemental acceptance

Related to the concept of a lack of labelling, some quotes also describe a sense of non judgemental acceptance in existential therapy.

You know it was very kind of accepting it was incredibly accepting. (P2)

The key thing I find in existential therapy is this sense of acceptance, he doesn't know what's best for me and he never seeks to tell me such [...] he is the only therapist that I've ever worked with who doesn't question it, who totally accepts that that is the way I want it to be that is the way I choose it to be. (P4)

Whereas I've found in the past there's a particular uncertain relationship, other therapists have been very quick to say that is dysfunctional that means such and such that err you know that's a

trap you need to move on from that and so on and so forth – and I don't get that from err from an existential therapist. (P4)

P4 asserts that previous therapists have been quick to term something as dysfunctional, and also to see something in quite certain or definite terms. Whereas now he appears to feel that the therapist accepts him without question, and does not impose judgement. P4 also refers to the idea that his therapist did not 'know what's best for me', which could imply that he experiences a sense of balance in their relationship: rather than looking to a therapist for guidance, it would appear that he perceived his therapist as an equal participant in the process, working collaboratively in order to try and understand his issues.

My initial impression was um that it was very un-judgemental, and very accepting and very um supportive um and yeah the particular thing at the beginning was 'what is it to be a student, why, what is it to be, why am I doing this and I'm not doing something else' and exploring all of that was really important. (P5)

P5 also describes this sense of non judgemental acceptance which she appears to have felt from the onset of therapy and found supportive. However she also mentions that her therapist demonstrates a level of curiosity about what she does, questioning how aspects of her life are experienced.

Client responsibility

Several participants gave their impression of client responsibility in existential therapy. Some gave a sense that they found the therapy to be non directive and open, and others describe it as being very client led, giving the client a sense of ownership.

I think it allows much more freedom on behalf of the therapist to be able to listen more intently so that the focus really comes from the client and not from the therapist (P1)

I felt that she didn't sort of denigrate what I might have wanted to talk about she didn't say to me 'oh no that's not – lets go back and talk about your childhood' but we did talk about my childhood as well but it was done in a natural way – it was done in a way that I would bring a topic, and then we would look at it from all angles. (P5)

P1 explains that because the focus comes from the client, the therapist has the opportunity to really take in what the client is saying. P5 comments that her therapist did not lead the discussion, but allowed it to come from her. She appeared to perceive this as positive; as she notes that the alternative would have been to 'denigrate' what she said.

P3, a counselling psychologist in training, said that her therapist showed her that people: *are trying to do two things, the one is to forget that they are just thrown here without knowing why, and the other is to create a meaning that is going to be quite strong for their whole life uhhhh and push convince themselves that they found the meaning out there, like convince themselves that it was not there that they created it, that it was out there and they found it (P3).*

P3 went on to link this to client responsibility when she said: *so at the moment although it made me feel a bit better it still was very heavy for me to realise that it depends on me, it's kind of taking responsibility as well and err this was the reason that I wanted to be in therapy with an existential therapist. (P3)*

While P3 explains that the concept of taking responsibility underpinned her decision to take up therapy within the existential modality, she appeared to find it simultaneously reassuring and challenging, as she realised that the meanings that she creates 'depends on me'.

A lack of defined structure

Along with the experience of the direction largely emanating from the client, some quotes describe a lack of defined structure or way of working to the therapy, and a sense of an open space within which to work.

P6 describes existential therapy as 'open landscape', with no specific way of how things should be done, but also describes the unstructured way of working as a sense of possibility, and appears to find it liberating.

In existential therapy there's no set sort of idea about how it needs to be done, it's much more sort of open landscape than that. I think there's a sense of possibility that's in there, that there's no dogma that one's sort of working around, instead it's very free. (P6)

P2, who was in psychotherapeutic training with an existential focus at the time of receiving existential therapy, talked about his experience of working within a big space as a less positive experience, and reported that it felt too big and lacked focus:

... it was more just trying to get a grip on something where there were just no foot holes really, of trying to climb up a wall where you know there's just nothing to hold onto- it just felt there was nothing to hold onto that I could pull myself up on (P2)

You know there's a lot of focus on the authentic and the individual and not having manuals and not following particular practice guidelines, you know it was just somebody doing whatever they felt like at the time. (P2)

P2 explains his frustration that there was actually too much space for him in the therapy room,

which he appeared to feel did not give him something tangible to work with. For him, the space seemed to be quite unconfining. While he acknowledges that authenticity was in place and the therapy worked around the individual, it did not appear to be enough for this participant: the open nature of the therapy just seemed to feel like a form of improvisation on behalf of the therapist.

I feel that it's very open, the therapy with the existential therapist, it's everything, she will explore everything in the same way it's not that she's going in a specific direction. In the beginning it was feeling very anxiety provoking – and there were times that I was impatient 'what what are we doing here? I need to find out, to find out all the time to find out all the links like that, although now it feels that without trying things are coming up. (P3)

P3 also expresses frustration about the lack of structure, and claims to have found the experience quite anxiety provoking initially, although over time, the links that she was searching for begin to appear for themselves.

Being in the present

Some participants commented that their experience of existential therapy was very much concerned with living in the present moment and the future.

P3 conveys that her therapist works very much in the present moment: *She is about being in the moment and about accepting this really and working with the here and now (P3)*

P1 who was in psychotherapeutic training with an existential focus at the time of interview, describes existential therapy as future focused: the therapist considers present issues in terms of how they impact upon the future: *The existential part of the therapy it's not grounded in the past, it's dealing with issues of now and sort of allowing me to focus on well, which way do I want to take whatever the problem's about or the issue, you know, what options are open to me and which way do I want to go with it and I select one way or the other, how is that going to impact on anything else in the future. So it's very future focused. (P1)*

P4 also discussed being in the present in some depth:

The existential stuff in therapy I've found is solely about living in the present and my attitude towards the future, yeah I mean my attitude towards the past as I carry it with me today but it's been so much more applicable to my relationships today. (P4)

I can't live in that past time, I'm aware I carry it with me you know whatever memory I have of the past is always with me but it is only a memory and my memory today might be different than it is tomorrow. The real past has gone, so this is the other thing about the existential therapy I don't live in the past so much anymore, and something err something I noticed with this

therapist that I have just now is he hardly ever even now has asked me about my family, my upbringing, simply because it wasn't material I was bringing. I found that in the existential mode there's been hardly any emphasis on that, unless I've chosen to bring something. (P4)

It is possible that P4 perceives the past as a burden that he carries with him, but he appears to attribute not living in the past so much to the existential work he has done. He comments that the therapist did not actively pursue a dialogue about his past, unless it was material that he brought to the session, which again highlights the client led element of existential therapy. P4 however is not discounting the past, but states that it is more his '*attitude towards the past as I carry it with me today*', just as May and Yalom (1995) commented that one's world includes the past events that condition one's existence, but it is these as one relates to them, as one is aware of them, moulds, and constantly reforms them, for to be aware of one's world means at the same time to be designing and constituting one's world.

Difficult to Define

While participants have offered an insight into what they conceive as the existential elements of the therapy, some participants struggled to directly see or explain what was particularly existential.

P2 questions what was existential about the therapy that he received, finding it more as a 'directionless conversation', and goes on to say that it is not clear in general what an existential therapist does.

There was nothing that actually would stand out to make this person an existential therapist, it was just a directionless conversation, there was nothing, in sharing this with you I'm thinking about this, you know this isn't some – you know - where was the existentialism in that? (P2)

I don't know actually I'm sure there's a lot of good existential therapists out there but I don't know really, I don't know I mean generally I don't think anybody really knows what they do um it's not really clear what an existential therapist does. It's very under specified in terms of the literature about what it is, I think sometimes it um you know it's just very vague, what it is and what it means. (P2)

P4 comments that it is difficult to articulate the experience and say exactly what was existential about it: *It's really hard to put it into words and explain it to you now in a way, how it was existential exactly (P4)*

P3 also comments that at times she can see that the therapy is very existential, whereas at others it could seem person-centred.

It is very very existential, so in some sessions you can see that, in others it can feel very person-centred you could not say that it's existential I guess you know it can be it depends on what I bring (P3)

Perhaps this reflects a bigger issue, in that existential therapy is hard for people to define. However it also perhaps exemplifies the significant personal nature of this experience; that can be ultimately hard to put into words.

Paradoxes of Thinking

The super-ordinate theme 'Paradoxes of Thinking' refers to a collection of paradoxes which emerged during the analysis of the transcripts and is inclusive of themes intellectual but unknowing, and unconnected but connected.

Intellectual but Unknowing

Some quotes referred to intellectual discussions and philosophical debate, while others maintained that things were not over intellectualised.

P6 initially raises the importance of the philosophy to him, the prevalence of philosophical discussions during his therapy sessions, and appeared to feel that this underpinned his reasons for choosing this kind of therapy.

I think the philosophy's critical. I mean I have existential ideas of my own to begin with which is why I took that route, and I'd already done some philosophy so those ideas I suppose travel into the room with me and they are of course part of her approach. But it is quite a philosophical process I think for sure because I find myself speculating a lot in there and she's up for the speculating: what is meaning, where is the meaning held, who has the meaning, that sort of thing. (P6)

P1 also talks about the philosophy as an aspect of the therapy that she liked. She discusses working with the existential dimensions in therapy which she thought the approach highlighted:

I really like that the therapy involves philosophy, I think if you look at different dimensions in life you know we're all affected by physical social spiritual personal dimensions really and events and things that happen in your lives and I think this is the first approach, existentialism is the first approach that really highlights these four areas. (P1)

P6 goes on to highlight a risk of the therapy becoming a debate, of existing too much in the mind, and underlines the importance in his opinion that the therapist is aware of this also, so as

not to lose sight of the encounter within the room:

I believe that there's a danger for somebody like me who lives in my head an awful lot and is fairly verbose as you can hear, to find myself in the room with somebody who is existential and is interested in the philosophy, sometimes we can both end up debating and so much can be in the mind. I would say built into the approach is a risk that for those that are quite in their head or mechanical in their thinking or or edit and filter things via their mind, then with the wrong existential therapist I'm sure you could get into a real rats nest of hours of debate. But I think most properly trained existential therapist it very much comes back to the quality of the encounter and what's actually happening in the room in its totality – not just an exchange of ideas. (P6)

P5 acknowledges that intellectual discussions take place, but they only go so far before coming back to how this relates to her in real terms. P4 appears to support this view as he describes discussions about philosophers but maintains that they go beyond an intellectual discussion, as the therapist uses it in relevance to where they are at the time.

What's interesting is yeah we do have sort of quite a lot of if you like almost some intellectual discussions sometimes, and we don't pretend that isn't happening, but it won't be very long before we come back into why is that important for you to think or feel like that, how does that relate to your relationship with your husband (laughs) do you see what I mean? (P5)

Well we err when we're chatting he'll make reference that Sartre would say this and Heidegger would say that... but he's not sitting there talking purely about Sartre and Merleau-Ponty you know he is dragging on all sorts of stuff and bringing it into where we are (P4)

While there is a place for intellectual discussion and some participants found it helpful, there is also discourse around the use of working within the unknowing. For instance, though talking about philosophical discussions within therapy, P5 also mentions her therapist's focus on staying with the unknowing, and challenges her need to know everything.

No it's just sometimes we might talk about the philosophy, so she might say 'oh in existentialism we think like this'. She might do that, not really often, but she might say for example 'in existentialism it's very important to stay with unknowing, you know, do you have to know everything'. (P5)

P3 also discusses this in terms of an acceptance of how you feel at the moment, and adds that by accepting there is no real or right way, the explanation paradoxically manifests.

And another thing it's the acceptance it's like calling you, inviting you to accept how you feel at the moment, without judging it too much and without explaining too much at the moment, and then paradoxically the explanation comes itself, after that, which has been very helpful for me,

that I don't have to find why this is happening now, it's less focused on intellectualising it's not intellectualising. (P3)

Therefore this theme perhaps conveys the significance of the underlying philosophy of existential therapy and the intellectual nature of the work, but also paradoxically a acknowledgement that there is value in working without the answers, abandoning the explanations, and allowing a solution to present itself through an acceptance of the present moment.

Decompartmentalisation leading to Connection

P5, a counselling psychologist in training, revealed a different paradox of sorts, by referring to a sense of connection that she began to find for herself in therapy, after the therapist had decompartmentalised her life in other ways. It appeared that as a result of the therapist decompartmentalising aspects of her life in therapy, it allowed her to independently begin to make connections and see things holistically for herself.

First, she explains that something important about existential therapy is that it does not compartmentalise you, but unifies your different roles across varying time spans.

But what I want to hold this thought as it's something I think is important about existential therapy, is that what it tries to do is it doesn't try to break you down into all these component parts as far as I, well my therapy isn't put it that way, I feel it provides not only a thread across time but also a thread across my different roles, and how I am able to be in the world. (P5)

However, as she goes on to explain in the second quote, it does this by acknowledging her different roles yet also inviting her to consider how something that affected her in one role also impacted on her in another role.

So all the things that I probably came to therapy thinking that this is my sort of self as a mother this is my sort of self as a somebody's work force, I couldn't really see the connection always between them, and I think what therapy's done is allow me to see myself within all those different roles. So she will sort of try to shine a light on, so I'm talking about work and she will say so how did that affect your life outside work. If I'm talking about my studying she'll say how did that affect... so she sort of sees me as the same person across everything, which has helped me reflect back and see myself as the same person across everything as well. (P5)

There is this idea of a thread of you across everything, rather than having to be different things in different compartments of your life. It decompartmentalises things as far as I'm concerned, it sort of makes everything connected, and me within it connected. (P5)

She's seen all these different compartments but also a thread through my development, and

that's been helpful, to see things holistically (P5)

For this participant, it appears that segregating her roles in life has helped her to acknowledge a more constant thread that intertwines them. In this way she found that the therapy decompartmentalised her life, and yet paradoxically appeared to give her a sense of being very centred and connected.

Discussion

This study provided a qualitative analysis of the client experience of existential therapy. The six participants have disclosed some of the aspects of therapy that had stood out to them and revealed some interesting paradoxes of thinking, which could be useful implications for counselling psychology and future research.

IPA was considered suitable because of its potential to generate insights into the subjective experience of existential therapy. There was no hypothesis or prior assumptions, and the research question was open-ended, making it difficult to categorically state whether it was answered; yet key features emerged and all themes were supported by multiple examples. IPA is an idiographic mode of inquiry: while inferences were drawn for this sample, interpretations for the wider population could only be made with great caution (Smith, Jarman and Osborn, 1999). It should be noted that all participants had received some form of therapeutic training, which could have impacted upon their experience. The subjective nature of IPA also raises questions over reliability and validity (Golsworthy and Coyle, 2001), which perhaps could have been strengthened by having analysis independently checked and interpretations validated, to ensure the credibility of the final account (Osborn and Smith, 1998). While this research identifies areas for further exploration, perhaps the findings may have benefited from a larger sample size while retaining its idiosyncratic focus, and may have been more relevant if the minimum number of sessions required for participants had been increased, since a thorough existential approach is most appropriate in long-term therapy (May & Yalom, 2005).

One challenge that stood out in analysis was that while participants highlighted areas of the therapy that they felt were particularly existential, it appeared to be difficult to define exactly what existential therapy was. Apparently when discussing the essential components of this, and perhaps any type of therapy, there is something deeply personal about the experience that is hard to put into words. Some initial insights into areas that appeared to be significant to participants have been uncovered, but a more detailed exploration of what was particularly helpful and why could be useful to practitioners. Perhaps future research could select some of the areas that participants appeared to find significant, and question what exactly is the added

value of discussing philosophy with clients (for example), what philosophical insights have been helpful to the client, and in what way does this influence the therapy.

It was also found that themes overlapped, for instance the client-led nature of the therapy re-appeared when discussing the concept of working within an unstructured space, suggesting that the therapy was not governed by distinct concepts, but rather a fusion of elements. In this way perhaps the impact of therapists role is left unclear, in that rather than having a rigid perceived way of working, it is more reflective of Yalom's (1980) perception of the therapist as a "fellow traveller" through life, who uses empathy and support to elicit insight and choices. While they may overlap, it is perhaps important to elicit these themes, in order to attune a practitioner's awareness to the impact they can have upon a client. Some aspects such as the lack of defined structure did not appear to benefit all participants, perhaps illustrating the premise that existential therapy does not suit everyone, or maybe highlighting a requirement for more information to be available about the therapy for potential clients. Perhaps the disparity, overlap and lack of clarity is to be expected, since existential psychotherapy is not a specific technique or set of techniques. Indeed, van Deurzen (2010) notes that existential therapists are reluctant to say: 'This is how you do existential therapy' because one of the central principles of existential therapy is that each therapist has to create his or her own personal way of working. Rather, she comments that existential therapy is an enquiry into meaning based on the same broad structures that underpin phenomenological research, with characteristic structures, actions, disciplined interventions and specific skills to guide this enquiry and the task of existential therapists is to make these their own.

Several participants gave the impression that they did not experience the therapy as labelling. This perhaps reflects what Cooper (2009) refers to as understanding clients as 'trans-diagnostic' beings, which looks beyond a label or category, and considers how a diagnostic label can create distance between client and therapist. Fletcher (2012) comments that the diagnosis system can be frustrating, unsatisfactory and restricting in practice, since many of his clients have reported that no single diagnosis or combination of diagnoses entirely captured their situation. He asserts that the challenge for practitioners is to consider how to work within the diagnostic way of working, and cultivate a therapeutic relationship that is less characterised by the stereotypes of the diagnostic system, but 'more focused on creating a genuine dialogue that recognises the autonomy and uniqueness of the other and can be used to acknowledge and explore limitations and possibilities for wider choice and change (Spinelli, 1989)' (cited within Fletcher, 2012, p.7). Some participants indeed appeared to support such views, by describing the rejection of labelling and dismissal of stereotypes as a liberating experience. Implications for counselling psychologists could be to consider this dimension of existential therapy and explore how to work with diagnosis, but without ignoring the individual characteristics and requirements of their

clients. The therapist's aim is perhaps ultimately to consider the client's issues from an open stance, for once the client realises that the therapist does not automatically assume understanding, they are free to investigate their assumptions more carefully (van Deurzen 2002).

Several participants discussed the client led nature of the therapy and the sense of responsibility that they experienced, although, the emphasis that existential therapy places on self reflection and understanding appeared to lead to certain challenges. Some participants appeared to find this way of working frustrating at times, and this sense of self-responsibility could legitimately be perceived as a challenge by those who wish to rely on the therapist more. Dryden (2007) notes that there is also an argument that the existential approach attracts clients who perceive the therapy as leaving them in total control, and points out that such limitations can only be overcome by a therapist who neither fights the need nor leaves it unchallenged, but who assists the client in turning such self-reliance into a positive end. Therefore potential implications for practitioners are to neither encourage the client to regress to a deep level of dependency nor attempt to become a significant other in the client's life, becoming more of a consultant who is there to provide systematic support and allow the client to relate to themselves more than the therapist (Dryden, 2007).

A theme that appeared to overlap with client responsibility was the sense of working within an unstructured space, which also appeared to have its challenges for some. However, one participant (P3) commented that once her initial anxieties were overcome of working in this way, and realised the extent of her responsibility in the process, the links that she was searching for began to appear for themselves. Perhaps this reflects Sartre's (1956) equation of responsibility to authorship: to be responsible means to be the author of one's own life design. Facing this concept of responsibility indeed could be integral to the work, since Yalom (1980) wrote that acceptance of it enables an individual to achieve autonomy and their full potential. May and Yalom (2005) highlight the need for the existential therapist to focus upon each client's responsibility for his or her own distress, and help clients recognise that they themselves, not the therapist, must generate and choose among options. While this could be anxiety provoking and challenging at times, it could also be liberating and empowering. The client process of taking on responsibility can represent vital moments of therapeutic change as Anderson (1997) notes, since when a client begins to work collaboratively with the therapist, they slowly achieve self-agency and a sense of freedom and hope. This does not mean that the therapist abdicates responsibility, but when the therapist adopts a reflective philosophical stance 'the dualism and hierarchy between a client and therapist collapse and responsibility and accountability are shared' (Anderson, 1997, p.105). Participants in this study revealed insights into their experiences of taking responsibility in therapy, at times conveying that this was both reassuring

and challenging. Perhaps this suggests a requirement for the therapeutic space to be deemed safe enough for the client to feel sufficiently empowered and supported while managing this responsibility, with implications for counselling psychologists to consider how their clients are given space to achieve this sense of responsibility in their clinical work, how they are supported in doing so, and how this process might be experienced and managed collaboratively.

Some participants discussed how existential therapy was focused on the present moment, and less about the past. It could be relevant for future research to capture what was helpful to clients about defining and discovering meaning in the present and the future, since this temporal orientation is another major distinction of the existential approach (May & Yalom, 1995). A more in depth exploration could discover how it feels for a client to work in the present tense, and to understand themselves from the perspective of what Yalom and May (1995) describe as a here-and-now cross-section, as opposed to the perspective of a historical longitudinal section. This could also have pertinence for counselling psychologists in terms of how existential therapy and mindfulness practice could be used together, since this also focuses on the present moment and the two practices have many parallels (Nanda, 2010).

A paradox of thinking was observed within the transcripts, with some participants finding the therapy quite intellectual, containing philosophical discussion, while also getting a sense of being able to work with the unknowing. This paradox could be useful for counselling psychologists to have an awareness of, since existential therapy is commonly perceived as an intellectual approach (van Deurzen 2007), and yet as one participant noted, the answers manifest for themselves when working within the unknowing and accepting that there is no real or right way. Additionally, Dryden (2007) notes that some clients are attracted to the approach with the hope of avoiding senses, feelings and intuition, and therefore a therapist should heed all these different levels of experience, as full self-understanding can only be achieved through openness to all different aspects of being. Ultimately, perhaps working within the unknowing, with the backdrop of intellectual and philosophical discussion, is particularly effective for existential clients.

Conclusion

This study aimed to capture the client experience of existential therapy. Analysis revealed some emerging themes that appeared to have significance for the participants, which offers insights into how existential therapy is experienced from a client perspective and may generate ideas for future research and implications for counselling psychologists.

Existential psychotherapy perceives the client as an existing, immediate person (May & Yalom,

2005) and so it is hoped that counselling psychologists and indeed all psychological therapists may find it useful to acknowledge the various subjective client experiences of existential therapy, which could inform their work with a client if they are working existentially, or consider ways their own practice could potentially incorporate and adapt some of the insights. Therefore having knowledge of these themes, challenges, and areas of confusion, may help a practitioner to tune into the client's perception of working in this way, reinforce the requirement to routinely elicit clarification, and potentially help to quickly identify ruptures within the therapeutic alliance. Future research may determine how the themes identified vary across wider populations, with implications that counselling psychologists may need to identify various subjective interpretations; recognise their therapeutic value, and be willing to support a client to explore these meanings.

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Table of Appendices

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- E. Risk Assessment
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Appendix A: Ethical Approval Form

ETHICAL APPROVAL FORM	
1.	<p>Title of Proposed Research:</p> <p><i>An Investigation into the Experience of Existential Therapy for a Client using Interpretative Phenomenological Analysis</i></p>
2.	<p>Name of Investigator:</p> <p><i>Lisa Corbett</i></p>
3.	<p>Organisation in which the research will be conducted:</p> <p><i>University of Surrey.....</i></p>
4.	<p>Do you need permission from the organisation in which the research will be conducted and how do you intend to secure this?</p> <p><i>None</i></p>
5.	<p>Do you need to gain consent from an Ethical Committee within the organisation or external to the organisation?</p>

University of Surrey approval

6. How are you going to recruit your participants?

The participants will opt in to the study by means of a poster campaign and online publicity through forums with an existential interest

7. How will you ensure that your participants are able to give their informed consent to participate in your study?

A participant information sheet, including risk assessment, will be provided in advance of the study.

8. What opportunities will your participants have to withdraw at any time from the study and how will you inform them of these?

The participant will be informed in advance via the participant information sheet (including an informed participant risk assessment) that they can withdraw at any time from the study. At the interview they will be advised that they can withdraw from the interview at point without reason.

9. What data gathering procedures are you intending to use in your study?

Participant semi-structured interviews

10. Could any aspect of your study cause distress, anxiety, guilt, offence or pain to your participants?

Yes

11. If yes, how do you justify this and what may be done to minimise these consequences?

This research is justified by increasing the knowledge and understanding of the client experience of existential therapy. Distress will be minimised by participants opting in to the study; informed consent including risk assessment and applying the principles of person-centred counselling including empathy, genuineness and unconditional positive regard in

conducting interviews.

12. Is there any deception involved in your study? If yes, how do you justify this?

No

13. What feedback will you give to your participants and when?

A summary of results of the study will be offered to participants on submission of the study to the University of Surrey PsychD Programme.

14. How will you ensure confidentiality of the information you obtain during your study?

Transcripts will be made anonymous, and all reasonable steps will be taken to safeguard the security of interview audio-tapes until the end of the data analysis procedure at which point they will be destroyed

15. Do you foresee any other ethical problems and how will you address these?

None

—

This sector to be completed by Research Supervisor and a copy retained in the trainee's personal file:

I foresee no ethical problems with this research

Signed Date

I advise that this trainee should seek ethical approval from the Faculty Ethics Committee (and, where necessary, another relevant ethics committee) (in the event of potential difficulties)

Signed Date

Appendix B

Participant Information Sheet



University of
Surrey
Guildford
GU2 7XH

Title of Research Project:

The Client Experience of Existential Therapy

Brief description of the Research:

My name is Lisa Corbett and I am a second year student on the PsychD Counselling Psychology doctoral programme at Surrey University.

This study is designed to explore the ways in which clients have experienced existential therapy. There are a number of studies which have looked at existential therapy; however these studies have focused on the therapists' experience. This research proposes to explore how clients experience this therapeutic approach.

It is hoped that the information which is gathered from interviewing a small number of participants will provide a client-led perspective to emerge within the existential literature and may provide insights into the perception of existential therapy.

Thank you for expressing an interest in participating in this research. If you do decide to participate in this study the following information will inform you of what the process will involve. This study has received a favourable ethical opinion from the Ethics Committee of the Faculty of Arts and Human Sciences at the University of Surrey.

What will be expected from you as a research participant?

Participation in this research will involve meeting with the researcher for a semi-structured interview, at a time and place convenient for you.

The interview will normally last somewhere between 30 minutes and one hour – and will be audio recorded. This recording will be deleted once the interview has been analysed,

You have the right to withdraw from the study at any time without giving a reason up until the point of data analysis. All data will be handled in accordance with the Data Protection Act (1988).

Your confidentiality will be maintained provided the information you provide falls within the British Psychological Society's (BPS) and the Health Professions Council's (HPC) ethical guidelines.

The interview will be transcribed and your name and any other identifying information will be removed. You will be given the opportunity to read the transcript and to alter any information which you feel is inaccurate.

You will be required to sign consent forms before the interviews; you will be given copies of these.

What will be covered in the interview:

- 1) You will be invited to give a general account of your experience of existential therapy.
- 2) You will be invited to contribute any other information which you think is relevant to this research.

Risks

Since you will be discussing your therapeutic experience, there is a risk that you could talk about sensitive material. If this is the case, you can stop the interview at any time, request a break, and have the opportunity for a full de-briefing following the interview.

If you need any further clarification or have additional questions, please do not hesitate to contact me.

Yours sincerely,

Lisa Corbett (Trainee Counselling Psychologist, University of Surrey)

Researcher contact details:

Lisa Corbett

Trainee Counselling Psychologist

University of Surrey

Guildford

GU2 7XH

Email: l.corbett@surrey.ac.uk

If you are unhappy with any aspect of how you have been treated in the research, please contact my supervisor:

Dr Martin Milton

University of Surrey

Guildford

GU2 7XH, Email: m.milton@surrey.ac.uk

Appendix C

The Client Experience of Existential Therapy



Consent Form

1) I the undersigned voluntarily agree to take part in the study on the Client Experience of Existential Therapy

2) have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

3) I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being.

4) I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

5) I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

6) I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS)

Signed

Date

Name of researcher/person taking consent (BLOCK CAPITALS)

Signed

Date

Researcher contact details:

Lisa Corbett

Trainee Counselling Psychologist

University of Surrey

Guildford

GU2 7XH

Email: l.corbett@surrey.ac.uk

Appendix D: Interview Prompts

Could you give an example?

Could you elaborate on that?

How do you experience that?

Why was that?

What are your thoughts on that?

Participants were given the opportunity at the end to say anything further on the subject that had not been talked about and whether they had any questions for the interviewer.

Appendix E

Risk Assessment – The Client Experience of Existential Therapy

Risks and potential hazards for the participants and the researcher.

- Every attempt will be made to provide a safe environment for all involved in the research project.
- The research data collection will either take place in a public centre or in a place agreed by both parties.
- In the event that the research is carried out in a public centre the researcher will check the health and safety credentials of that centre before undertaking meetings with participants and to make adequate checks of rooms in which the data collection is to take place in order to minimize any risk or hazard to both parties.
- In the event that the research is carried out in another place this will be the home of the participants. Prior arrangements will be made by the researcher for a reliable person who will act as a contact in the event of an emergency; this nominated person will be contacted before and after entering and leaving the premises by mobile phone which will be adequately charged.
- The participant will be informed before the data collection that it is a matter of university protocol to log the time of arrival and departure from any address.
- Should sensitive material arise, the participant will be given the opportunity for a debriefing after the interview data collection in order to minimize any risks or hazards to the well being of the participant.

Appendix F: Web Request

I am a doctoral student on the PsychD programme at Surrey University seeking participants for my research project titled:

The Client Experience of Existential Therapy.

This research proposes to explore how clients experience an existential therapeutic approach. Have you received personal therapy for from a therapist who practises existentially and would you be willing to talk about your experience?

Participation in this research will involve meeting for an interview, at a time and place convenient for you or a conversation on skype with a webcam if this is more convenient. Your confidentiality will be maintained and all data will be handled in accordance with the Data Protection Act (1988).

If you are interested in participating, or in learning more about the research, please contact me at l.corbett@surrey.ac.uk.

The final chapter in the book of growing up: a content analysis of motherhood experiences

Lisa Corbett

Supervised by Dora Brown

Abstract

This study explored the ways in which the existential dimensions appear in accounts of individuals who have experienced motherhood for the first time. The research is guided by the question 'how do the existential dimensions manifest when women talk about becoming mothers for the first time?' Sixteen participants were interviewed, and data was analysed using Content Analysis (CA). It was discovered that data with the highest frequencies was attributed to the physical, social, psychological and then spiritual dimensions respectively. Categories emerged within these domains, which are presented and discussed. Speculative practical and therapeutic implications for counselling psychology are identified and relevant future research is suggested.

Key words: motherhood; existential dimensions

The final chapter in the book of growing up: a content analysis of motherhood experiences

Introduction

Motherhood undoubtedly represents a crucial transition for women, since a number of significant personal, social and biological changes coincide (Smith, 1999), making pregnancy, childbirth and motherhood times of enormous upheaval (Blehar, 2006; Dennerstein, Astbury, & Morse, 1993). Indeed, motherhood has been identified in the literature as a critical life event that can bring about many challenges (Barclay et al., 1997; Weaver and Usher, 1997; Nicolson, 1998; Nelson, 2003).

Several studies have documented the stressful aspects of initial motherhood, including parental fatigue (e.g. Petch & Halford, 2008), increased role-overload (e.g. Perry-Jenkins et al., 2007) and sudden declines in relationship satisfaction (e.g. Doss et al., 2009). However, Darvill and colleagues (2008) acknowledge that while a much of the literature depicts particular aspects of childbirth, there is comparatively less work relating to the transition to motherhood from the woman's perspective (Barlow and Cairns, 1997). Of these, Nelson (2003) conducted an amalgamation of nine qualitative studies concerned with the maternal transition, and recommended that the primary processes to emerge were 'engagement', or being actively involved and experiencing the presence of the baby (Noblit and Hare, 1988) and 'growth and transformation'. Another finding was that women were broadly unprepared to handle motherhood: the initial postpartum months are described as physically and mentally exhausting; a time of uncertainty and emotional flux for the mother (Nelson, 2003). A grounded theory study by Barclay and colleagues (1997) also noticed this theme, and described mothers' overwhelming feelings, both physically and emotionally, in the early postpartum weeks and months. Another qualitative study observed that the mothers in the study felt socially isolated after childbirth (Sethi 1995), while Weaver and Usher (1997) used discourse analysis to consider aspects of motherhood, and noticed that while the women felt overwhelming love for their babies, they also found the reality of motherhood significantly different from their expectations, were overcome by the tedium of caring for infants, and felt that they had sacrificed part of their identity.

Motherhood: a time of growth and transformation

Darvill and colleagues (2008) identified work on the transition of motherhood that discussed the time as a period of maturational growth. The parenthood transition has been described in some psychoanalytical literature as a means of providing an opportunity for growth (Parens, 1975), and Rubin (1961, 1967, 1984) described the cultivation of a mother's identity as a part of the maturational process of developing a female identity. Additionally the findings of Pancer et al. (2000) recorded a growth in complexity of thinking before and after birth and suggested that parental transition was a time of maturational growth for both parents. Darvill and colleagues (2008) used grounded theory to explore the transition of motherhood, and identified three main themes (control, support and forming a family) which all contributed to the core category: 'changes in the woman's self-concept'. Women in their study felt that they had lost some control over their lives in the early stages of pregnancy and after the birth. The unfamiliar process of early motherhood created a need to seek out others to help guide them and to normalise their feelings and experiences. Finally, the women acknowledged having their first baby fundamentally transformed them and their partners from individuals or a couple into founding members of a new family.

Existential Research and the Existential Dimensions

Existential research is one of the most under-researched approaches in counselling and psychotherapy (Cooper, 2004). However a small amount of research has been done to explore motherhood from an existential perspective. Adams and colleagues (2006) applied key concepts from existentialism as a theoretical framework to address sexual intimacy for new mothers and considered the issue from natural, personal, social, and spiritual dimensions of being. This study will also consider these dimensions in order to explore the experience of first time mothers.

van Deurzen's developed her existential dimensions (1997) based on Binswanger's (1958) work, and they offer a framework for conceptualising clients. van Deurzen (1997) claimed that 'as human beings we are complex bio-socio-psycho-spiritual organisms, joined to the world around us in everything we are and do' (p.94). Essentially, the author describes a four-dimensional forcefield that we are constantly concerned with: physical, social, psychological and spiritual. The dimensions begin with the relationship between ourselves as a physical body and the natural environment: the biological forces that regulate us within the physical dimension. Secondly, the author describes the social dimension: our social and cultural network through which we relate to others. We are thirdly modulated by the psychological dimension which concerns our personality, character and mental processes, and finally by our relationship to the framework of meaning through which we experience and conceive the world on a spiritual dimension (van Deurzen, 1997). The four dimensions within which existence takes place span polar opposites manifesting as paradoxes, dilemmas, contradictions and conflicts; each with

connections and overlaps which may prevail when considering their implications in relation to experiences of motherhood.

While the impact of motherhood has been of great interest among researchers, limitations have been noticed. Smith (1999) highlighted reviews of research on the psychology of motherhood (e.g. Entwisle & Doering, 1981; Ussher, 1989; Scott & Niven, 1996) which revealed that most followed prescriptive or obvious routes defined by the parameters of particular subject disciplines. Smith (1999) observed that typically the pathological is stressed, at the expense of the 'normal' so that typical studies concentrate on 'maladaptation' to mothering, with an emphasis on illness or pathology, neglecting the range of possible experiences undergone by first time mothers. This study explores experiences of motherhood, not in relation to any underlying pathology or psychological difficulty, but in order to discover how this life change might affect a mother in terms of the existential dimensions.

Research Question

This study explores how women talk about their experience of motherhood in terms of the existential dimensions, in order to enhance practitioner awareness in this under researched area and potentially inform those considering an existential approach. Such an exploration could challenge assumptions and add to our understanding of individual experiences and perceptions of motherhood. This could in turn help trainees and therapists reflect upon and evaluate their therapeutic style when they have a client who has experienced motherhood – an important focus for counselling psychology. With these principles in mind, the research was guided by the question 'How do the existential dimensions manifest when women talk about becoming mothers for the first time?'

Method

Sample

Sixteen participants in total opted into the study, all of whom had experienced childbirth within the last three years. By limiting the sample this way, it was hoped that the experience would be relatively fresh in their mind and hopefully ensuring that they will be able discuss the experience in some depth, promoting the likelihood of securing a relatively homogeneous sample and thereby increasing the likelihood of being able to discern commonalities of viewpoint and reported experience. The participants babies' ranged in age from 2 weeks to 2 years and 9 months, and the average age of the babies across all participants was 17 months.

The study was publicised in two ways - by posters placed in postnatal class venues and on website forums that held an interest for new mothers (appendix A). Postnatal groups were also

contacted and requested to publicise the study. Participants who expressed an interest were given an information sheet containing the title and brief description of the research (appendix B). If they agreed to participate, a consent form was signed (appendix C).

Data Collection

Interviews followed a semi-structured schedule designed to elicit different aspects of participants' experiences of motherhood. The interview schedule consisted of a set of questions which were initially generated from the literature describing the existential dimensions (van Deurzen, 1997) and discussed in supervision to ensure the likelihood that they represented the relevant dimensions without enforcing any assumptions and allowing the participant room for interpretation. These are presented below in Table 1.

Table 1: Sample interview questions

- 1- How did you find becoming a mother in terms of your body?
- 2- How did you find looking after your first baby in the initial weeks?
- 3- How did you look after yourself and attend to your needs after having your first baby? (if at all?)
- 4- How was the experience of becoming a mother on your social life (if so, how?)
- 5- Were your close relationships / family affected when you became a mother (if so, how?)
- 6- After becoming a mother yourself, how did you relate to other mums?
- 7- How did you see yourself after becoming a mother?
- 8- How does this compare with how you saw yourself before becoming a mother?
- 9- How do you see yourself in the future?
- 10- Would you say that becoming a mother plays a role on your outlook on life (if so, how?)
- 11- on your beliefs (if so, how?)
- 12- on your values in any way (if so, how?)

The questions themselves were designed to focus on the physical, social, psychological and spiritual dimensions, and each dimension was assigned three related interview questions although analysis explored if and how these themes present themselves across all the questions. . The questions were non directive and avoided assumptions, and were discussed in supervision to ensure they were checked for fairness and open-endedness. Participants were informed that they did not have to answer any questions if they did not feel that they related to them. Interviews lasted approximately twenty minutes. At the beginning of sessions, it was explained to participants that the research was confidential and that they could end the interview at any time should they wish. Participants were advised that they did not have to answer a question if they did not feel it was relevant to them. Each interview took place in a quiet meeting

place at a time and place convenient for the participant, digitally-recorded with consent and then transcribed verbatim. The recordings were then deleted. Since Prior (2003) had argued that any form of written material could be used in research to investigate and understand ideas which influence human behaviour, participants were also given the option of completing the questions electronically, hopefully to facilitate the process for first time mothers who might struggle for time otherwise. In such instances, the interview questions were emailed to participants so that they could complete them at a convenient time and return them to the researcher.

Data Analysis

The emphasis of the study was to offer insights into experiences of first time motherhood and therefore a qualitative research method is adopted. CA was selected as the favoured method to analyse the interview transcripts and written material. CA has been described as a systematic, replicable method that allows the analysis of larger quantities of text to be compressed into content categories based on explicit rules of coding (Holsti, 1969; Krippendorff, 1980; Weber, 1990). Holsti (1969) has provided an overall definition of CA as “any technique for making inferences by objectively and systematically identifying specified characteristics of messages” (p.21). The premise is that words, phrases and sentences (coding units) that reappear frequently in the material are those reflecting important concerns in every communication (Weber, 1990).

The method of using CA for this study was informed by Brown and colleagues (2009). Using CA typically requires a frequency count, and the technique relies on categorisation and coding of data so initially the unit of analysis had to be defined. A category is understood to be a group of words with similar meaning and coding units are generally words, sentences or paragraphs (Weber, 1990). Categories in this study were not mutually exclusive or exhaustive, and coding units were notional sentences in that they represented a thought or expression of an idea.

Coding was done by repeatedly reading through the data sources and assigning coding units to a category. Primary categories were already pre-established as the existential dimensions (physical, social, psychological and spiritual), but additionally sub-ordinate categories were generated from the data. The organising principle in the selection of themes was that of counting frequencies. Prior to analysis, to promote consistency of coding, emerging coding was carried out to explore and identify sub-ordinate themes and to verify inter-rater reliability. In the first instance, the principal researcher and supervisor reviewed and independently coded two randomly selected transcripts. The researchers then compared notes, discussed differences and reached agreement on initial category and domain assignment. They then repeated the process with another transcript. An inter-rater reliability of 0.93 was achieved which is above the 0.90 level recommended by Miles and Huberman (1994). The researcher then analysed the

remaining data sources accordingly and further categories were developed, which were shared with the supervisor to check for credibility and consistency throughout. During this time the researcher was careful to bracket any personal thoughts or assumptions about the data in order to mindfully create space so that the participants' experience could be highlighted.

Evaluative Criteria

Qualitative research is embedded in a philosophy of knowledge development distinct from the positivist tradition. Whilst positivist research attempts to establish objective knowledge 'represented as regularities, even laws' (Elliott et al., 1999, p.217), qualitative research relativises the knowledge gained to the participants, the situation studied and the researcher. Therefore traditional evaluative criteria such as validity and reliability become inappropriate. However, measures were taken to address inter-rater reliability, and the study adhered to the inter-rater reliability level recommended by Miles and Huberman (1994).

Ethical Issues

Ethical issues were unequivocally considered throughout this study. Participants opted into the study, and the questions posed were unlikely to cause distress. Therefore the project was not submitted for academic ethical approval, in line with the guidelines of the ethics flowchart (appendix D). Participants' welfare was considered: participants were told they could withdraw from the sessions for any reason whatsoever, and copies of the written report and transcripts were available to any participant who requested them. Participants were told they could withdraw from the research up until the point of data analysis. Pseudonyms have been adopted to preserve participants' anonymity and situations that might disclose personal details were omitted and/or changed with a fictitious equivalent.

Results

Key findings are reported here from the fourteen categories which had the highest frequencies within each domain. These are supported by verbatim quotes to illustrate statements that support the identified category. The total frequencies for each are reported in Table 2.

Table 2. Domains, categories and frequencies

Domain	Total Frequencies	Categories	Frequencies
Physical	479		
		Body Image	81
		Body Responsibility	36
		Recovery	115
		Sleep / Tiredness	58
Social	376		
		Change	74
		Connection / Disconnection	80
		Impact	96
		Support Networks	76
Psychological	296		
		Emotions	116
		Personality	51
		Identity	75
Spiritual	102		
		Prioritisation	35
		Outlook	34
		Hierarchy	17

While many areas were discussed by the participants, due to space limitations, the study will outline and give examples from key categories within each domain that had higher frequencies. In many cases the categories could easily have applied to more than one domain, but they have been allotted to the domain that appeared to be immediately paramount to the researcher.

Physical Dimension

The highest frequencies from the data sources appeared to resign within the physical dimension (459). Within this domain, twelve categories were developed including physical safety, breastfeeding and sex lives. The categories that emerged with the highest frequencies concerned body image, body responsibility, recovery and sleep. These are presented here:

Body image

Thirteen participants talked about a change in body image after childbirth, including weight gain, stretch marks, and changes to the appearance of their breasts. These changes appeared to be both perceived as positive and negative.

“Pregnancy and childbirth has ruined it, I have skin I don’t think I will ever get rid of” (Annalise)

“I was surprised how much it changed my body, I think it’s better after having Ben. I’m slimmer

and generally in better shape.”(Lucy)

Two participants disclosed that their new body image had not concerned them at the time, because the functionality of their body had taken precedence:

“There was no time to think about appearance, just function” (Mina).

Body Responsibility

Three participants talked about their body in terms of its function and responsibility. One example highlighted here by Fiona was how she was both intrigued by the way her body was working for her, but also let down by her body after she had struggled with labour and breastfeeding:

“I was fascinated by how my body was looking after my baby for me” (Fiona)

“I felt hugely disappointed that my body had failed me when I really needed it as well as at myself for not having been better able to cope with the labour emotionally too” (Fiona)

In this example, Fiona has described her body as if it is a different entity. Likewise, three participants admitted a sense that they felt their body was no longer their own:

“During the later months of my pregnancy my body seemed to cease to be my own. Rather a vessel to house and maintain another. In the early weeks this feeling continued and the sole purpose of my body seemed to be to nourish and care for another.” (Janet)

Recovery

Nine participants talked about their initial recovery, and discussed pain or discomfort in terms of the sensations initially after childbirth:

“I’m in bits, my body is so sore. I’m on painkillers but I had second degree tearing and stitches so it’s hard to walk.” (Zoe)

Five participants talked about neglecting their body to an extent, because there were other priorities:

“I didn’t feel I neglected my needs as such, just that it wasn’t the right time to have any” (Melissa)

"I wasn't eating properly – just shovelling food into my mouth now and again to keep going because everything was about looking after Jessica" (Mina)

However ten participants talked about taking measures to look after their body just after childbirth:

"I used sleep times well. I didn't sleep when Tobias slept but I did things like have a nice bath, paint my nails. Looking after myself like that was important" (Lola)

Sleep/Tiredness

Twelve participants talked about lack of sleep, tiredness or exhaustion:

"The lack of sleep or disturbed sleep was a real shock to the system which took a while to adjust to... but you do" (Molly)

"Your body runs on adrenaline, and although my body was physically exhausted, to some extent the sleep deprivation wasn't even noticed" (Frances)

Four participants talked about their babies' early sleep patterns:

"He sleeps through the night has done since he was 11 weeks" (Helen)

Social Dimension

The second largest number of frequencies was located within the social domain (376). Seven categories were developed, including areas such as the adaption of social lives, work lives and support networks. The categories with the highest frequencies related to the change experienced to social lives, a sense of connection and disconnection to friends, support networks, and the impact of motherhood on close relationships. These are presented here.

Change

Eleven participants talked about a complete social change following the birth of their first child, all of whom revealed that their social lives had diminished:

"It definitely changed my social life, I don't have one now" (Helen)

On the other hand, three participants described how their social life adapted when they were mothers:

"We still meet friends, but the event has to be adapted" (Annalise)

"Instead of going out for cocktails we go to kid friendly places" (Dirona)

Three participants talked about required planning and lack of spontaneity:

"It does however, now mean I can't be spontaneous. I have had to say no to a lot of things, but planning in advance is the key and a cheap babysitter!" (Frances)

Connection/Disconnection

Ten participants talked about a connection with other mothers, some in a new found empathy for other mothers, while others talked about more immediate intimacy with other mothers in terms of conversations and disclosures:

"So if there's a baby crying in a coffee shop, you look at the mum and know what's going on for her. Before I would have just been a bit annoyed probably" (Claire)

"I found myself having intimate discussions about chapped nipples and the energy to have sex and all sorts of personal things with girls I didn't know all that long, and the friendships became real in a way they weren't before" (Fiona)

However, seven participants also described a sense of disconnection from friends of theirs who did not have children in that they saw them less or felt as if they did not understand them in the same way now:

"Everybody says I don't have time for them now" (Dirona)

"I have lost some close friends who don't have children" (Sam)

Impact

Seven participants talked about the impact that motherhood had on their family relationships and commented that it had progressed the relationship in some way:

"I've always got on well with my inlaws but it was a polite and friendly relationship. Now we have moved things up a gear since having a baby." (Fiona)

Six participants also described how motherhood had developed their relationship with their own mother, in terms of increased understanding or mutual respect:

"Having a child has strengthened the bond with my own mother even more, because I understand what she went through. (Annalise)

Nine participants talked about their relationship with their partner. Of these some described a stronger bond after they had their first baby, some talked about a sense of becoming a team or unit now they had become parents, while others described deterioration in the relationship:

"I now have an even closer relationship with my husband" (Sam)

"My relationship with my husband has changed. We're now less lovebirds, in fact barely love birds at all, and more "team baby" (Tess)

"Daniel and I split up as a result, he left when Tobias was 8 weeks old, I think we realised more than ever when we became parents that we were never going to make it work" (Lola).

"I think I became very focussed on Stuart and this meant I neglected him and our relationship. (Bryony)

Support networks:

Eight participants talked about the support they had received from friends and family as a valuable resource:

"When Adam went to work I made sure my mum came round to help me. Looking back this was probably vital emotional support as well" (Annalise)

However four participants described this support as a hindrance at times, in terms of conflicting advice and interference:

"I was given conflicting advice – some told me I should let him sleep. others said I should wake him" (Bryony)

"I also feel a bit overwhelmed at times with everyone giving advice or opinions on how I should and shouldn't do things for my child" (Michelle)

Five participants talked about new support networks in the form of other mothers that they had discovered since becoming a mother:

"My NCT group of other mums made an amazing difference to me. We became and still are a close group of friends and that was invaluable." (Fiona).

Psychological Dimension

Ten categories were developed, including aspirations for the future, expectations, and a new found sense of responsibility or vulnerability. Categories which had the highest frequencies emerged relating to the range of emotions experienced by first time mothers, perceived changes in personality for new mothers, and perceptions regarding identity. These are presented here.

Emotions

All sixteen participants described their emotions on becoming a mother. Of these, nine participants described motherhood as generally an emotional time:

"it was a tough time emotionally to adjust to all that as well as the new experience of being pregnant and expecting a new baby" (Michelle)

Some participants talked about specific emotions, for instance six participants talked specifically about feelings of worry or anxiety, four participants described feelings of anger, five participants talked about feelings of happiness or contentment, and two participants mentioned feelings of guilt:

"I'm so worried – I have to keep checking him to see if he's ok – I'm always alert" (Zoe)

"After becoming a mother I think I have become a bit more irritable with others" (Michelle)

"As a mother I am much happier and more content now" (Bryony)

"These feelings of guilt stayed with me for months after the birth, although after the first week or two it was put to the background a bit as dealing with a new baby took over." (Fiona)

Personality

Twelve participants talked about how becoming a mother had impacted upon their personality in some ways. In particular, seven participants talked about the impact of motherhood on their confidence both in terms of gains and losses:

"I fell off a cliff in terms of both the day to day stress of making decisions way outside my

comfort zone and on my lack of confidence with the simplest tasks (changing, going out in pram etc)” (Melissa)

“I have grown in confidence as I can’t believe I have managed to be a mum without falling at the first hurdle!” (Molly)

“I think my confidence has grown – it’s either that or I’ve stopped caring so much about what people think of me” (Claire)

Additionally, three participants described themselves as being less selfish since becoming a mother, while three participants talked about becoming more patient since becoming a mother:

“I have become more aware of what others are going through, and therefore maybe more patient. Patient with myself and others” (Frances)

“I’m much more patient and am learning to enjoy the immediate rather than being impatient for what’s next” (Bryony).

Identity

Ten participants talked about their identity as a mother. Some accepted their new found identity readily, whereas others describe this as more of an adjustment. Some also mentioned identity in terms of how motherhood defined them:

“When I am with my child I am see myself as a mother only and nothing else. When I am at work or out without my child then I am myself with a mother overlay” (Janet).

“It took a while before I started to think of myself as a mum, it was almost a struggle in a way because it didn’t like the implication that I was just a mum and nothing else.” (Claire)

“Becoming a mother seemed a death sentence to all the things I identified with and to some extent it was because my definition of who I thought I was was pretty narrow.” (Tess)

Seven participants particularly talked about their identity in terms of the transition from being a woman without children to becoming a mother. Some talked about being perceived differently by other people, and others noticed that they were noticeably looked at less in terms of desirability.

“It’s like the way strangers look at you, maybe once you could walk into a room and people would check you out, or look at what you were wearing, or something like that, but now you get

two different looks. They either look at you in that “ohhh how lovely a mum and a cute baby” look, or they give you the “oh god not another mum and a screaming baby” look” (Claire)

“When I bent over to pick something up in public I would hope my bum might look vaguely nice in case anyone might notice it. Nowadays I buy high waist jeans, belts and extremely long vest tops because I spend a disproportionate amount of my time bending over and while I don’t imagine for a second that anyone might notice my behind, I don’t want to take someone’s eye out with my builders bum” (Fiona)

While talking about identity, six participants acknowledged that this was difficult to articulate and put into words:

“I’m just getting used to that- being a mummy. It’s going to take time to get used to and I’m not sure I can put it even into words” (Zoe)

“It’s hard to say, I think the way I see myself is still changing” (Tess)

Spiritual Dimension

The least number of frequencies were assigned within the spiritual dimension (102). Seven categories arose including values, beliefs and a sense of the unknown. Categories with the highest number of frequencies were a sense of prioritisation and hierarchy, and a new outlook for first time mothers. These are presented here.

Prioritisation

10 participants talked about a sense of prioritisation in their lives now as a result of motherhood:

“The needs of the baby came first.” (Sam)

“Before having maisie all my energy went in to keeping my husband happy and keeping on top of work but now maisie comes first and having to splash kisses and affection on two people now is something they don’t teach you at ante-natal classes!” (Molly)

“Finn is just 2, so he can have whatever he needs from me, and Nick can have what’s left over. The rest can wait, including the housework.” (Fiona)

Hierarchy

6 participants talked in terms of a perceived hierarchy, identifying the place they took in this new

hierarchical order.

"Initially though, the baby was my priority to take care of, and I was his priority to take care of, and he did it well" (Fiona)

"My daughter came first, then my business, then my husband, then me" (Molly)

"All I remember is that no one was asking how I was anymore, they were coming in to check on my baby. I had suddenly gone from being a priority to being what felt like last in the pecking order" (Claire)

Outlook

4 participants described a change in their outlook since becoming a mother, and 2 participants talked about their new outlook in terms of how they saw the world around them now:

"How I look at life going forward will be different for sure now with her" (Michelle)

"I get slightly more anxious about the world's future e.g. when I read or see things about war/terrorism and the environment/global warming and wonder if there is more I could do" (Annalise)

"I see the world as a big place for my children to navigate, but I don't think I'm cynical or negative or feeling threatened by any of it for them". (Fiona)

3 participants described this shift in outlook in terms of seeing a bigger picture, or completing a piece in a jigsaw:

"I guess before having Amanda I didn't realise something was missing but now I feel complete." (Molly)

"I suppose on one level it feels a bit like my life has been working towards this somehow." (Claire)

5 participants talked about a new appreciation of the simple things in life:

"The small things have become much more important" (Bryony)

"You also appreciate the simpler things. A nice day becomes a big deal because you see it through the eyes of your child and also because you're not freezing at the playground. In a

weird symmetry, things that seemed very important such as work related things, become less important” (Tess)

Summary of Results:

- Notional sentences from the data sources could be assigned to each of the existential dimensions
- In many cases there was overlap, and a degree of interpretation was required in order to select which dimension was the most appropriate category
- The domain with the highest frequencies was the physical dimension, followed by the social, then the psychological and then the spiritual dimension
- Within each domain, key categories were also identified. Some of these will now be considered further in the discussion.

Discussion

The goal of CA is “to provide knowledge and understanding of the phenomenon under study” (Downe-Wamboldt, 1992, p.314), and this study aimed to explore the experiences of first time mothers to see how the existential dimensions manifested. CA of sixteen participant transcripts revealed domains and categories that could fall within the existential dimensions. The highest frequency recorded in this study was for the first domain: the physical dimension, which suggested that participants felt that motherhood affected them primarily on a physical level. This was followed by the second domain which was the social dimension, and then the psychological and spiritual dimension respectively. This appeared to reflect the order the dimensions are presented (e.g. van Deurzen, 1997). Indeed, van Deurzen (2002) notes that therapeutically there is no point in working with a client on the other dimensions unless they can come to terms with a basic sense of being able to manage their physical existence, which suggests that one can begin exploring the physical dimension, and work inwards through the remaining domains.

Word limitations prevent a detailed consideration of all results, but aspects from each dimension will now be discussed, limitations to the study will be presented, and implications for practitioners and counselling psychology will be considered.

Participants discussed a range of physical demands and in particular the impact that becoming a mother had on their body. Some described the change as a destruction of their former body, some experienced the changes positively, and others expressed a fascination with the function

of their body. Three participants talked about their body in terms of its function and responsibility, but perhaps strikingly, they appeared to be describing a sense of body ownership without necessarily a sense of agency. While these participants appeared to acknowledge that their body was working for them, they did not seem to have a sense of agency for what their body does e.g. *"I was fascinated by how my body was looking after my baby for me"* (Fiona). Perhaps this illustrates a diminishing impression of bodily control, disconnection or reduced sense of agency for some new mothers (see Gallagher, 2000a, 2000b; Marcel, 2003). Walsh (2009) discussed childbirth in terms of Cartesian Dualism (Davis and Walker, 2008), with the body becoming the object of dissection and examination. He pointed out that an effect of this was that the understanding of childbirth became reductionist with women's bodies becoming comparable to a machine (Garcia et al. 1990), reflective in diagnostic terms such as "failure to progress". Perhaps such reductionism extends to the experiences and perceptions of new mothers, in some of their attempts to make sense of what is happening to their body while managing some of the overwhelming feelings and changes during this critical time.

Participants also discussed physical pain, and again at times the body was seemingly described as a separate entity: e.g. *"I'm in bits, my body is so sore"* (Zoe). Akrich and Pasveer (2004) observed that some women dissociated from their physical experience of pain during childbirth, and such experiences were perceived both positively and as negatively alienating. Walsh (2009) argued that this illustrates how agency can mean embracing physicality which paradoxically can be giving in to the body's primal power (Anderson, 2000) or dissociating as a way of coping with labour pain. Feelings of alienation however negates agency leaving the new mother in limbo until she can ground herself with a more meaningful subjective experience (Walsh, 2009). Not all mothers in this study experienced this alienation or lack of agency, but perhaps for some this disconnection could reflect potential disorientating feelings that arise after childbirth for new mothers, and a need for some to find something to re-centre or re-connect with oneself as soon as possible. When considering therapeutic techniques that might be adopted by counselling psychologists, mindfulness meditation could be explored, where conscious attention and awareness are actively cultivated (Brown & Ryan, 2003). Mindfulness involves the use of focused attention to promote calmness and stability and the first foundation is attention to the body (Kabat-Zinn, 1990). Such techniques could potentially help a new mother re-centre herself after childbirth, while possibly also alleviating physical pain, since mindfulness techniques are recommended as positive pain management techniques in pregnancy and labour (Hughes et al., 2009).

Within categories that were identified residing within the social dimension, women described big changes to their social lives, in terms of friends drifting away and new relationships forming. One emerging category addressed this: disconnection from some friends and a new found

connection with others. van Deurzen (1997) writes that we learn to relate to others as a hierarchy: one way we divide others into categories is by generation and position relative to oneself, so when adults have children of their own, they find themselves inserted into a new class of parents, and thus the social dimension is affected. Some participants spoke of the importance of new support networks experienced after becoming a mother, perhaps in part because they reinforce this social adjustment and potentially give a new mother a space to discover their new place within this new hierarchy.

Smith (1999) described the movement from the public to a more personal world and suggested a shift in focus from the wider circle to the immediate family. Similarly, emphasis for some participants appears to shift from broader circles of friends to a more intimate world, although the individuals that make up that personal world vary for each person. Some describe turning to their partner for support, while others discover a new found bond with family members, or other mothers (also evidenced in studies by Phoenix (1991) and McLaughlin (1993)). Some participants described a renewed bond with their own mother, also observed by a Mitchell and Green (2002) study in which over half of the participants highlighted that becoming a mother had cemented mother/daughter relations.

Bailey (1999) observed that new mothers described entering into a new network or community of mothers, and hypothesised that perhaps the process of individuation that dominates womens' lives recedes to an extent with the onset of motherhood. She notes, however that these changes were not reported invariably or necessarily described as desirable. Similarly participants in this study sometimes found their new found support networks a hindrance and an imposition at times. It could be useful for a therapist to consider the shifting social dynamics impacting clients, since the changes may reflect more than just an increase or decrease in social support, but an adjustment to a new role and a new place in one's social surroundings, which may bring with it a range of associated challenges for a new mother to manage. This is possibly a new balance that a first time mother must learn to manage: acclimatising and integrating herself within new social networks while creating the necessary space around her new family.

Williamson (2004) wrote "when a woman gives birth, two are born: a baby is born from the womb of its mother, and a woman is born from the womb of her former existence" (p.235).

Ten participants talked about their identity as a mother, and for some motherhood appeared to increase their sense of what defined them as a person, while others described a struggle in adjusting to their identity as a mother. The literature also appears to acknowledge the impact motherhood can have on a woman's identity. Raphael (1976) described "matrescence": the period of change in which a new mother takes on the full responsibility of mothering in the face

of numerous changes to her identity and various adjustments in her changing sense of self. Spier (2001) also discussed the struggles a new mother can face when confronting their new identity, particularly in terms of work, since her perception of herself as an employed individual receiving acknowledgement and recognition in the world may be temporarily sacrificed to the demands of a needy baby on a 24-hour schedule. Some participants talked about their transition from being a woman without children to a mother, and appeared to believe this equated to being less desirable. Spier (2001) also commented on a new mother's sexual identity as a woman, commenting that there is a dampening effect on feeling sexy and aroused when children can be heard in the next room.

van Deurzen (1997) writes that out of our experiences on the physical and social dimensions, we gradually draw a circle around ourselves to protect ourselves as an entity in our own right. This personal self concept is initially "not well articulated, but it is out of an increasing self-reflection and definition that we begin to create a private space in our inner world, where a more circumscribed notion of self can be cultivated" (p.118). Some participants also disclosed that it was difficult to find the words to describe the change to their identity. Perhaps this reflects the evolving nature of this period, or illustrates the deeply personal nature of something so individualised, that is connected with the ongoing developments and challenges within the physical and social dimensions. Perhaps this suggests an opportunity for therapists to consider the implications that motherhood could have on their clients' perceived role or sense of identity. In this way part of the work may be bringing about an awareness of the impact parenthood may have on an individual's sense of self, or integration, so that a new mother does not need to sacrifice one part of their identity while embracing another all-encompassing one.

van Deurzen (1997) writes that it is on the spiritual dimension "we really come into the true complexity of being human, as we organise our overall views on the world, physical, social and personal and generate or are inserted into an overall philosophy of life" (p.123). Few participants mentioned religious beliefs, and those that did advised that they remained unchanged. But van Deurzen (1997) notes that this dimension is broadly determined by the dominant ideology in society, which may or not mean religion: "as we encounter different beliefs and broaden our minds, we find some of our original convictions to be flawed and begin to alter our views, adding new beliefs and values to the old ones" (p.123).

Participants discussed a shift in outlook, and five in particular described a new found appreciation of simplicity. When talking about the spiritual dimension, van Deurzen (1997) commented that many crave a new sense of meaning that extends beyond the enjoyment of commodities and the pursuit of health, wealth and self. Likewise, one participant described an appreciation of the simplest things like a nice day, and accordingly the things that were once

important seem less so. Some participants talked about a sense of prioritisation: as their outlook had shifted, their perception of what seemed important had changed, suggesting that motherhood does indeed provoke an altered philosophy of life for some. The participants in this study had all recently become mothers within the last three years, but perhaps it could be beneficial to also interview mothers some time after the birth of their child, as maybe such shifts in views occur over a longer period of time and may take longer to become apparent.

As well as prioritisation, participants talked about their place in a perceived hierarchy. The themes of prioritisation and hierarchy bore perceived resemblances to the hierarchy of human needs outlined by Maslow (1943,1954): a perspective that considers biological, psychological, social and environmental domains, proposing that human needs are arranged in a hierarchy beginning with physiological needs and culminating in self actualisation. Koltko-Rivera (2006) cited that Maslow (1969) amended his model, placing self-transcendence as a motivational step beyond self-actualisation, and commented that such individuals seek a benefit beyond the purely personal and seek communion with the transcendent, perhaps through transpersonal experiences. Koltko-Rivera (2006) discussed the implications of this further hierarchy: at the level of self-actualisation, the individual works to actualise their potential, whereas at the level of self-transcendence, the individual's own needs are put aside in favour of service to others or to some higher force or cause conceived as being outside the personal self. Perhaps this is reflective of the experience of becoming a parent: the dimensions working together in the sense of a hierarchy, with the physical needs of most immediate importance culminating in a more spiritual awakening for some co-inciding with the displacement of their own personal needs as they care for their child.

While the dimensions have been presented independently for the purpose of analysis, they work together and have connections and overlaps. It was noted that there was overlap during analysis, for instance aspects concerning identity that were seen initially as psychological, could also be seen to reside in the social dimension, though this may not be surprising since as humans we are "complex bio-social-psycho-spiritual organisms" (van Deurzen, 1997 p.94). Additionally Smith (1999) asserts that it is the change in interpersonal contact that can lead to a change in the conception of self as related to others: that we are inextricably linked to our social relationships. In this way a new mother's increased social contact with significant others helps to facilitate an increased awareness of their sense of personal identity, which underlines the interrelation between these dimensions. Furthermore, each dimension contains paradoxes and tensions, for instance within the physical dimension there is both life and death, and within the social dimension there is both a sense of belonging and isolation (van Deurzen, 1997). Similarly, paradoxes were observed within the experiences of first time mothers. For instance, participants talked about a new sense of belonging to a new network of mothers, while describing alienation

from other circles of friends; or talked about experiencing a new sense of confidence in their role as well as overwhelming doubt. These paradoxes and overlaps may have implications for practitioners working therapeutically with new mothers, by potentially suggesting a requirement for a therapist to engage the client with these complexities and understand where contradictions exist and how they are negotiated, while considering how paradoxes are tolerated. The dimensions provide a framework in order to conceptualise where a client is experiencing difficulty, yet as van Duerzen (1988) notes, it is vital to maintain tentative portrayals of a client's world, and not be drawn into reductionistic models of the mind or person. It also suggests a need for practitioners to consider how the dimensions relate to them, and how they struggle with their own paradoxes, since van Duerzen (1988) writes that there are no short cuts for understanding clients: practitioners have to be able to allow themselves and their clients to be exposed at times, and know how to make them safe again.

There are some limitations to this study. Firstly, any generalisation to other groups of mothers needs to be used with caution, since this study is based on a small sample of new mothers. Though the demographic information revealed that participants from different ethnicities took part, there was also a level of homogeneity in that all participants were heterosexual, had become mothers within the last three years, and the age range across all participants was ten years. This could further limit the generalisability of the findings, though future research with a wider sample could reveal similar themes across multiple contexts. Only women were sampled in this study, thereby limiting the study to one gender. It could be interesting to apply the same questions to new fathers and consider how (if at all) the existential dimensions manifest in their accounts of parenthood and how these potentially differ from their female counterparts. This could potentially reveal subtle differences in the experiences of childbirth which would add richness and depth to the results already outlined.

Qualitative CA is a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Hsieh & Shannon, 2005). Therefore this is ultimately the researcher's impression of the findings and any inferences drawn should note this limitation. Also the researcher's own bias could have affected analysis, since the researcher has read about the existential dimensions and potentially formed assumptions. There was an attempt to minimise this limitation with supervision during the analysis, which offered an alternative perspective of the analysis of transcripts.

Since within western society motherhood is frequently romanticised and idealised as the ultimate physical and emotional achievement (Phoenix and Woollett, 1991), it is always possible that, in conducting research interviews, there was an element of social desirability in the ways that women talked about becoming a mother. Furthermore, some of the participants recruited

were from the researchers social network, which could have elicited a degree of compliance in interviews or discouraged a participant from sharing openly. Finally, while participants were given the option of a face to face interview, the majority preferred the option of electronic completion of the questions. While CA can be used effectively with more than one data source (White & Marsh, 2006) this did mean that there was a degree of inconsistency in the way the data was collected. On one hand this enabled some participants, particularly those who were new to motherhood and could not set aside time for an interview, to take part. However, these instances lacked the verbal exchange of an interview, and the opportunities to pause or probe further as required.

These limitations aside, this study aimed to explore how the existential dimensions manifested in accounts of new motherhood, to provoke questions and generate further understanding that could benefit the field of counselling psychology. Motherhood appears to be an experience unique to each woman, with a range of associated changes, feelings and issues which could be considered in physical, social, psychological and spiritual terms. While discussions around motherhood may not be uncommon for practitioners, counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional psychology (BPS, 2005). It is hoped that presenting the experience of motherhood in terms of the existential dimensions could deepen the existing understanding of a practitioner working with a client who has recently become a mother, and potentially add a richer layer to conceptualisation and formulation.

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Appendix list

Appendix A

Poster

Appendix B

Information sheet

Appendix C

Consent Form

Appendix D

Ethics Flowchart

Appendix A – Poster

I am a doctoral student on the PsychD programme at Surrey University seeking participants for my research project titled:

When women talk about motherhood: a content analysis of experiences

This research proposes to explore how individuals experience motherhood. Have you recently become a mother and would you be willing to talk about your experience?

Participation in this research will involve meeting for an interview, at a time and place convenient for you or electronic completion of questions if this is more convenient. Your confidentiality will be maintained and all data will be handled in accordance with the Data Protection Act (1988).

If you are interested in participating, or in learning more about the research, please contact me at l.corbett@surrey.ac.uk

Appendix B – Participant Information Sheet

Participant Information Sheet



University of
Surrey
Guildford
GU2 7XH

Title of Research Project:

When women talk about motherhood: a content analysis of experiences

Brief description of the Research:

My name is Lisa Corbett and I am a third year student on the PsychD Counselling Psychology doctoral programme at Surrey University.

Thank you for expressing an interest in participating in this research. If you do decide to participate in this study the following information will inform you of what the process will involve.

This study is designed to explore the ways in which individuals experience becoming a mother for the first time from an existential perspective.

It is hoped that the information which is gathered from interviewing participants will provide an insight into how motherhood affects people existentially.

What will be expected from you as a research participant?

Participation in this research will involve either meeting with the researcher for a semi-structured interview, at a time and place convenient for you, or completing some questions electronically.

The interview will normally last around 30 minutes and will be audio recorded. This recording will be deleted once the interview has been analysed,

You have the right to withdraw from the study at any time without giving a reason up until the point of data analysis. All data will be handled in accordance with the Data Protection Act (1988).

Your confidentiality will be maintained provided the information you provide falls within the British Psychological Society's (BPS) and the Health Professions Council's (HPC) ethical guidelines.

The interview will be transcribed and your name and any other identifying information will be

removed. You will be given the opportunity to read the transcript and to alter any information which you feel is inaccurate.

You will be required to sign consent forms before the interviews; you will be given copies of these.

What will be covered in the interview:

- You will be invited to give a general account of your experience of motherhood.
- You will be invited to contribute any other information which you think is relevant to this research.

If you need any further clarification or have additional questions, please do not hesitate to contact me.

Yours sincerely,

Lisa Corbett (Trainee Counselling Psychologist, University of Surrey)

Researcher contact details:

Lisa Corbett

Trainee Counselling Psychologist

University of Surrey

Guildford

GU2 7XH

Email: l.corbett@surrey.ac.uk

If you are unhappy with any aspect of how you have been treated in the research, please contact my supervisor:

Dr Dora Brown

University of Surrey

Guildford

GU2 7XH

Email: d.brown@surrey.ac.uk



Consent Form

- I the undersigned voluntarily agree to take part in the study on the Existential Experience of Motherhood
- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.
- I agree to comply with any instruction given to me during the study and to co-operate fully with the investigators. I shall inform them immediately if I suffer any deterioration of any kind in my health or well-being.
- I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).
- I understand that I am free to withdraw from the study at any time up until the point of data analysis without needing to justify my decision and without prejudice.
- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS)

Signed

Date

Name of researcher/person taking consent (BLOCK CAPITALS)

Signed

Date

Researcher contact details:

Lisa Corbett

Trainee Counselling Psychologist

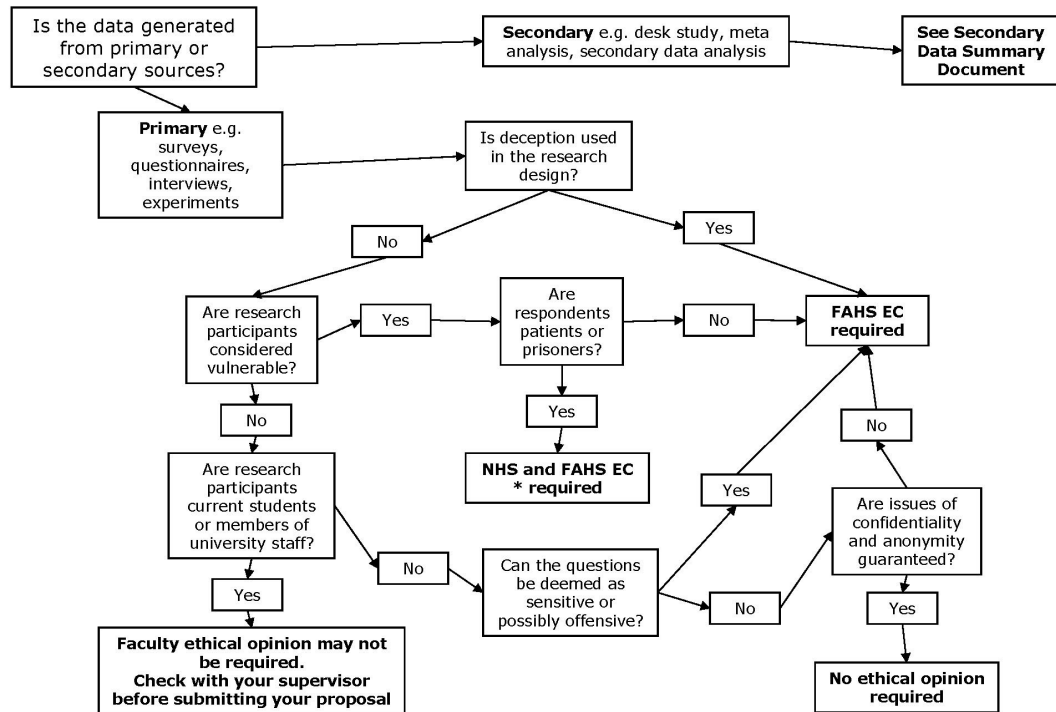
University of Surrey

Guildford

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Email: l.corbett@surrey.ac.uk

Appendix D - Ethics Flowchart



* Chair of FAHS will expedite approved LREC and COREC Submissions. This is necessary for University insurance cover