

Evidence-based Practice: is *Existential-Phenomenological Therapy* a suitable psychological treatment intervention for NHS clients presenting with an affective disorder?

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Evidence-based Practice: is *Existential-Phenomenological Therapy* a suitable psychological treatment intervention for NHS clients presenting with an affective disorder?

ABSTRACT

Existential-Phenomenological Therapy (EPT) was found to be a suitable psychological treatment intervention for NHS Secondary Care clients presenting with an affective disorder, such as depression or anxiety, in comparison with Cognitive Behavioural Therapy (CBT). Both CBT and EPT were shown to be effective psychological treatment interventions producing reliable and significant clinical improvement (RSCI CORE-OM >0.5) but there was a highly significant difference found between Treatments and across Time. At Initial Assessment Sessions, clients whose choice of treatment intervention was EPT presented with more severe clinical symptoms (CORE-OM mean 2.66) than those who whose choice of treatment intervention was CBT (CORE-OM mean 2.09), according to the standard UK Clinical measure, CORE-OM. From Waiting List to Post Therapy, EPT clients showed a mean of 56% improvement on the Problem Rating Scale, and a mean of 27% increase in their of sense of Purpose in Life, but there was no change in their Direction of Interest, whether inner or outer-directed. There was a significant difference found between the ages of those in the CBT group (mean 39) and those in the EPT group (mean 46). These results have implications for guidance in treatment allocation for those more severely distressed clients (CORE-OM >2.00) who may be more suitable for EPT as an appropriate psychological treatment intervention for depression.

Key Words: Existential-Phenomenological Therapy, Psychotherapy, Evidence, Effectiveness, Cognitive-Behavioural Therapy, Meaning, Purpose in Life, Direction of Interest, Treatment Allocation, CORE-OM, Affective Disorder, Depression, Anxiety

1. INTRODUCTION

In psycho-analysis there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results.....This prospect of scientific gain has been the proudest and happiest feature of analytic work.

(Freud 1927/1986)

Throughout the history of psychotherapy and up until the present day, answering the central question of '*What works?*' still remains elusive. With regard to overall effectiveness, research has shown that a third to three-quarters of clients benefit from psychotherapy, approximately one in ten deteriorates and up to a third may recover without psychotherapy (Carr 2009: 228). Within clinical contexts, it is generally accepted that Freud's so called *Talking Cure* works or, put another way 'A typical therapy client is better off than 75% of untreated individuals' (Smith et al. 1980: 135). With over 460 different psychotherapeutic schools and research to show that 'No psychotherapy is superior to any other, although all are superior to no treatment' (Weinberger 1995: 45), there is much disagreement as to '*What works?*' At the recent UKCP Conference, Professor Fonagy said "There is still no solid evidence as to who will benefit from what type of therapy." (Fonagy 2010) The principal question '*What Works for Whom?*' (Roth and Fonagy 1996: 2005) is still open and needs answering with some urgency if the options on offer to patients within the National Health Service (NHS) are not to be restricted.

The issue of patient choice is of prime concern within the NHS as expressed in this Overview Statement:

Giving people more choice is a priority of the modern NHS. This is because research in the UK and overseas has shown that treatments are more effective if patients choose, understand and control their care.

(NHS 2010)

There are plenty of available approaches to psychotherapy that can support the idea of providing patients with a choice in their psychological treatment intervention but still a dearth of evidence-based practices suitable to be recommended for inclusion in the National Institute for Health and Clinical Excellence (NICE) Guidelines.

In 2007, the UK Government committed £173 million over three years to the innovative scheme Improving Access to Psychological Therapies (IAPT). This novel strategy was in response to a demand from clients, presenting with a range of affective disorders such as depression and anxiety, for talking treatments as opposed to medication. In order to be included as a recommended psychological treatment intervention as defined by the NICE Guidelines, evidence of effectiveness must be provided. In 2007, it seemed as if Cognitive Behavioural Therapy (CBT) was the only approach in a position to provide evidence of effectiveness and therefore, CBT gained the bulk, if not all of the funding. The consequence being that CBT now dominates the field giving the public the misleading impression that CBT is a panacea for all ills.

This situation created a public outcry within the psychotherapeutic community and led to the instigation of The Savoy Conference 2007 (NHS 2007) as an annual discussion platform for all parties with a vested interest in the development of mental health issues within the UK. The Conference was initiated by *The Association of Psychoanalytic Psychotherapists in the NHS (APP)* in collaboration with 9 partner organisations including *The British Psychological Society (BPS)*, *British Association for Counselling and Psychotherapy (BACP)*, *British Psychoanalytic Council (BPC)*, *Clinical Outcomes in Routine Evaluation System (CORE)*, *Mental Health Foundation (MHF)*, *Royal College of Psychiatrists*, *Society of Psychotherapy Research (SPRUK)*, *The Tavistock and Portman NHS Foundation Trust* and *the UK Council for Psychotherapy (UCKP)*. As an indication of the highly emotive interest in this issue, after only 2 years, it has grown to about 45 organisational members and is now re-named *The New Savoy Partnership*. The main thrust of the debate

was anger around CBT being prioritized as the only therapy recognized as suitable for inclusion in the NICE Guidelines and thereby, being given all the available funds. The 2007 Savoy Conference was where the phrase '*One size does not fit all*' originated and nobody, including CBT advocates, disagreed. As a result of the Conference discussions, a *Statement of Intent* confirming the Government's commitment to IAPT principles and including the all-important wording 'We will work towards ensuring PCTs [Primary Care Trusts] give **all patients a choice of NICE-approved psychological interventions...**' (Tyson 2008) was issued. It was recently responded to as follows:

These commitments have been welcomed by the coalition and The New Savoy Partnership, the group of leading organisations campaigning to ensure that within 5 years the NHS is able to offer a full range of evidence-based psychological therapies to everyone who needs them within 28 days of requesting referral.

(APP Website 20.07.10)

Lack of evidence for psychological approaches other than CBT is not necessarily the same as lack of effectiveness. There have been some recent encouraging developments in the 2009 NICE Guidelines with, for example, the recent inclusion of brief *Psychoanalytic Psychotherapy (DIT)* as a recommended psychological treatment intervention for depression. In response to the current political and social climate, this study aims to provide evidence of the effectiveness of *Existential-Phenomenological Therapy (EPT)* showing it is a suitable psychological treatment intervention for affective disorders, such as depression and anxiety, for use within the National Health Service. In an ideal world, rather than offering CBT as the only psychological therapy available in the NHS, a client, whose preferred treatment choice is to have psychological therapy rather than medication, would be offered a 'menu' of available therapies (Winter 2007: 78).

Evidence-based practice is not a new phenomenon as illustrated by the following statement issued in the 'NHS Strategic Review of Psychological Therapies in England' (NHS 1996).

It is unacceptable.....to continue to provide therapies which decline to subject themselves to research evaluation. Practitioners and researchers alike must accept the challenge of evidence-based practice, one result of which is that treatments which are shown to be ineffective are discontinued.

It may be more of a surprise as to why the psychotherapeutic community has taken so long to respond to this Government Directive and then, responding with such vitriol over 10 years later when a huge investment is made to evidence-based talking treatments such as CBT. One of the underlying reasons for this apparent apathy may be that some therapies are more conducive to measurement than others, or more conducive to producing the type of evidence required by government policy makers.

The term *Evidence-Based Practice* originated from the medical world of Evidence-Based Medicine where randomised-controlled trials (RCTs) are the gold standard method of producing evidence, particularly for pharmaceuticals. In this context, *Evidence-Based Practice* is understood as an umbrella term that includes research into Empirically Supported Treatments (ESTs), Empirically Validated Therapies (EVTs), Evidence-Based Treatments (EBTs), Evidence-Based Practice (EBP) and Practice-Based Evidence (PBE). The commonly accepted working definition for Evidence-Based Medicine is:

the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

(Sackett et al. 1996: 71)

Although Evidence-Based Practice originates in the medical world, many would argue that psychotherapy is not like a drug where each dose is identical, and

therefore, it cannot be delivered and measured in the same way as a pharmaceutical drug (Mollon 2009). In a critical review of the status of *Empirically Supported Therapies* (ESTs), Weston, Novotny & Thompson-Brenner (2004) argue that the assumptions in the use of RCT methodology appear to be valid for some treatments but make the important point that they are substantially violated for other treatments (Weston et al. 2004: 631). Although CBT has the same measurement issues as all other therapies, my hypothesis is that one of the reasons CBT has been so successful at providing evidence to secure government funding is that it employs a method (cognitive/behavioural) or language similar to the medical model, whereas many other therapies such as EPT (humanistic/phenomenological/psychoanalytic) do not. This means the more unstructured or contextual models of therapy that tend to follow the client, stay with unknowing or what will emerge in therapy rather than follow a prescriptive formula, appear to be speaking a different language that, at present, translates to exclusion from funding and possible future extinction in public services such as the NHS.

Existential-Phenomenological Therapy (EPT) is one of many psychological interventions currently on offer to clients at the NHS Psychological Therapies Services (PTS) at Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT) as secondary care in the Stepped Care Programme Approach (CPA). Cognitive Behavioural Therapy is the dominant therapy offered alongside Psychoanalytic Psychotherapy, Personal Construct Psychotherapy, Eye Desensitization Modification Regulatory Therapy (EMDR), Group Therapies, and Sexual and Relationship Therapy (Appendix A). The PTS *treatment as usual* currently offers patients a choice of therapies and therefore, this research study is also an acknowledgement of the same NHS 1996 Review which states that 'Valuable approaches which can demonstrate appropriate and clinically effective care should not perish for lack of funding'.

As well as the 2007 Savoy Conference discussions regarding evidence-based therapies, it is pertinent that in December 2008, Professor Rawlins, Chairman of NICE, advised that psychological treatment recommendations should draw from a broad range of evidence, writing 'Hierarchies of evidence should be replaced by accepting – indeed embracing – a diversity of approaches' (Rawlins 2008: 2159) rather than relying exclusively on RCTs. He also emphasized that '...interpretation of evidence requires judgment' (Rawlins 2008: 2159) meaning that clinical judgment should always be assumed as implicit when deciding which intervention is fit for purpose. This has always been the case according to NICE Guidelines which state 'This guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer' (NICE 2007).

The meanings, arguments and ideas around what constitutes a successful therapeutic outcome for *evidence-based practice* are neatly encapsulated in *The Great Psychotherapy Debate* (Wampold 2001) and originating in a 70-year old quotation which has become known as the *Dodo Bird Verdict* 'All have won and everyone must have prizes' (Rosenzweig 1936) because all therapies appear to have equal outcomes. Wampold (2001) argues the field is split between those who believe successful outcomes in psychotherapy are due to techniques employed (i.e. CBT or behavioural therapy) or specific ingredients, described as the 'medical' model, and those who believe a successful therapeutic outcome is dependent on non-specific effects (i.e. EPT or non-behavioural therapy) which are common across all therapies, and described as the 'contextual' model.

The medical model, according to Wampold (2001), conceptualises psychotherapy as a medical treatment, which he argued stems from Freud's background as a physician who attempted to provide a grand explanatory theory of cause and effect. Actually, although it is true Freud wished to root psychoanalysis within a scientific framework, he made it clear psychoanalysis was not a part of medicine but clearly a part of psychology (Freud 1926/1986: 67), in further support of Wampold's

argument. Nevertheless, Wampold (2001:13) defines the medical model as characterised by five factors:

1. Disorder, problem, complaint: client presents symptoms to clinician where diagnosis is identified according to *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)
2. Psychological Explanation for disorder, problem or complaint is proposed
3. Mechanism for change: CBT fixes faulty thoughts, psychoanalysis makes the unconscious conscious, etc
4. Specific Therapeutic Ingredients: techniques clearly outlined in a Manual
5. Specific Explanation: rationale for change

A medical model is one where the diagnosis, treatment and prevention of disease tends to be addressed by the use of medicine such as a drug, which is often taken by the mouth, and in contrast to treatment of an ailment requiring surgical treatment. Applying this model to psychotherapy means that the individual seeking help is viewed as a patient¹, one who is suffering from a disease and this disease can be cured and prevented by a physician who delivers the correct pill and dosage which in the case of psychotherapy, is the correct number of sessions, the correct type of therapy by the correct type of therapist, CBT, for example.

¹ Note: the terms *patient* and *client* have been used interchangeably throughout this paper, according to context. It is the author's opinion that it is appropriate to call a person presenting to the NHS, GP surgery or hospital, a 'patient', according to the Latin derivative of *il patiore* which means *the one who suffers*. (Symington 1996: xiv) It is not in any way meant as derogatory or as conferring inappropriate power.

Wampold (2001) argues that although the above are credible factors involved in psychotherapy, they only form part of the story. Psychotherapy is unlike medicine in that the inherent incidental factors, such as the therapeutic relationship, cannot be separated from the treatment itself, in comparison to medication, because both specific and non-specific factors are psychological. Although it is generally accepted that therapy works, it is still unknown exactly what it is about the *Talking Cure* that works.

A philosophical approach to the question of what is it about psychotherapy that makes it so helpful must address what all psychotherapies have in common, regardless of modality, if all have been found to be equally effective. Duncan, Miller, & Sparks (2004: 33) write ‘..because all approaches appear equal in effectiveness, there must be pantheoretical factors in operation.’ Approaches that adopt this view, such as EPT, are called the *common factors* or *contextual* approaches. The common factors have been grouped into five areas by Gencavage and Norcross (1990):

1. Client characteristics
2. Therapist qualities
3. Change processes
4. Treatment structures
5. Relationship elements

Although this common factors or contextual approach can be mapped onto the medical model as outlined above, it takes the opposite view that defines specific ingredients of individual therapies by splitting them into distinct categories for specific diagnoses. The contextual approach is more integrative and proposes that all therapies have inherent non-specific factors and it is these that are predominantly responsible for successful therapeutic outcomes rather than specific factors.

The contextual model is based on a common factors approach whereby it is acknowledged that all therapeutic models have common characteristics and it is

these non-specific, psychological and universally-present factors that account for the degree of change which occurs in therapy. This theory also provides an explanation for the equivalence of outcomes in research findings whereby all therapies are found to be equally effective, with a large mean effect size of around 0.8 (Cooper 2008: 34), regardless of modality. It also helps to illustrate how measurement of techniques is an easier way of producing evidence for policy makers' approval than the problems involved in measuring non-specific effects. One is a more factual, concrete way of working in comparison to a more ideological or philosophical way of working, and '*never the twain shall meet*' (Kipling 1892). This longstanding and seemingly unresolved dilemma, centred round definition, language and research, returns us once again to the question of '*What works?*'

Like an drug, for which it is possible to deliver in a prescribed and packaged dosage e.g. 20g Citalopram per day, therapy can be delivered in, for example, 16 weekly sessions of 50 minute duration but if, as many argue (Regents 2009; Spinelli 2007a), it is the therapeutic relationship itself which accounts for the change, it is not the delivery of the pill or the type of therapy which is helpful but a combination of the client and therapist attributes. This view suggests that it is inaccurate to include psychotherapy as a falling under the category of a medical model because therapy is not just delivered by a clinician. In psychotherapy, the clinician is an integral part of the treatment. If, as is argued, it is the non-specific factors, such as the therapeutic relationship itself that are predominantly responsible for successful positive outcomes, then it may be more accurate to describe psychotherapy as falling under a psychological model and distinct from the medical model.

There are innumerable variables in the delivery of psychotherapy; individual characteristics of the client and therapist, their co-relationship, environment, support networks, physical symptoms, diagnosis, medication, co-morbidity, etc. Some believe the very nature of therapy means it is impossible to control for confounding variables within this particular setting. In other words, maybe the very thing, the influencing factor of effective therapy, is immeasurable? (Target 2008).

The following diagram, showing just one aspect of measurement, illustrates very clearly just how problematic measuring therapeutic outcome may be:



(Richardson 2003)

One of the reasons CBT has attracted government funding is based on the premise that it can show how the application of its manualised technique produces therapeutic change in accordance with RCT methodology. CBT has its basis in the experimental method (Hawton et al. 1989: 13) and techniques such as goal-setting, formulation, agreed homework, creating diaries, grading progress are therapist-provided tasks described here as 'doing to' (meaning that the therapist does this to the client). These tasks are definable, measurable and therefore, more conducive to the production of concrete evidence. In contrast, the much more unstructured EPT characteristics of *being with*, not knowing what will emerge in therapy, attending to the phenomena in the *here and now* are not easy to measure. It should be noted that although CBT attributes its' successful outcome to techniques (maybe to secure funding?) the CBT therapist cannot help but also *be with* the client as a fundamental given.

The above points are meant to describe how research into psychotherapy is complex but not impossible. One way of approaching the current political environment would be to acknowledge that it is fortunate that research into CBT

has paved the way, overcome the complexities and managed to produce evidence of effectiveness suitable for approval by government policymakers to commit millions of pounds to providing a choice of talking therapies available on the NHS. This is a huge achievement which is often undermined by the in-fighting within the psychotherapeutic community; an economic argument (Layard 2006) was the only way ever to secure this commitment, particularly when considering the potential loss of the government's taxable income from very powerful pharmaceutical companies who have a vested interest in GPs primarily prescribing medication for anxiety or depression. During the 2010 Election campaigns, Labour, Conservative and Liberal Democrat manifestos were all fully committed to the Improving Access to Psychological Therapies (IAPT) policy and therefore, I would argue the time is ripe for psychotherapy researchers to *grasp the nettle* and attempt to produce some evidence of effectiveness for their preferred way of working. Using CBT as an established benchmark, even if we do not speak the same language, we can compare outcomes by using standard UK measures such as Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM) to provide some initial evidence of effectiveness.

This study aimed to use quantitative measures in an attempt to identify whether EPT is a suitable psychological treatment intervention for clients presenting with affective disorders, such as depression and anxiety, and, if there are any emergent properties peculiar to this particular therapy which might indicate for what and whom it may be most suitable. Therefore, our key questions are:

- ❖ Does EPT work for affective disorders?
- ❖ If so, for what and for whom is it most suitable?

It is thought that this is the first time EPT has been formally evaluated for efficacy or effectiveness (Cooper 2008: 38) as a suitable psychological treatment intervention, despite its current routine use as a treatment of choice within this particular NHS setting (PTS 2009).

Undertaking research into the effectiveness of Existential-Phenomenological Therapy as a particular therapeutic approach within our pluralistic society is also an attempt to draw attention to the distinctive identity and values of the Division of Counselling Psychology (Goldstein 2009). The characteristic values of Counselling Psychology are closely paralleled by an Existential Phenomenological approach to therapy:

	Counselling Psychology	Existential Phenomenological Therapy
Values	Philosophical basis	Philosophical underpinnings
Training and Practice	Trained in more than one therapeutic modality	Individual approach accommodating many possibilities
Subjectivity	Personal Psychotherapy	Subjective Experience
Professional Stance	Inter-subjectivity Autonomy Ethical principles Integrative	Emphasis on relationship Choice Responsibility Diverse theoretical approaches (<u>not</u> just CBT)
Research	Drawing on research to make clinical decisions – coherent integration of theory, practice and inquiry	

1.2 Aims and Objectives

1.2.1 Production of evidence within social and political climate

Some day the conscience of society will awaken and admonish it that the poor have just as much right to help for their minds as they already have to life-saving surgical help, and that neuroses threaten the health of the people no less than tuberculosis....[On that day] these treatments [*Talking Cures*] will be free of charge

Sigmund Freud, 1918, Budapest

The study aimed to measure NHS *treatment as usual* in a real world, naturalistic setting in order to gain an initial indication, some evidence, as to whether Existential-Phenomenological Therapy (EPT) is a suitable psychological treatment intervention for affective disorders, as defined in the NICE Guidelines (2009) based on the DSM-IV (APA 2000) categorisations.

This research is regarded as a preliminary study where it is hoped to instigate, construct and promote further research into the body of evidence addressing the central issue in psychotherapy of *What Works for Whom?* (Roth and Fonagy 1996; Roth and Fonagy 2005) specifically in relation to EPT. With regard to practice-based evidence, the objective is to employ a range of questionnaires including the UK standard measure, CORE-OM, with an adequately powered sample of participants in an attempt to reject the null hypothesis that is that there is no difference between Cognitive Behavioural Therapy and Existential-Phenomenological Therapy as a psychological treatment intervention for affective disorders measured at three points in time (waiting list, pre therapy and post therapy).

Existential-Phenomenological Therapy is a philosophically based modality that portrays the idea of a non-technical, non-generalizable approach. This idiographic way of working also represents a philosophical critique of the application of the medical model towards psychotherapy and could be described as more representative of the contextual model (Wampold 2001: xii).

According to the perspective of the School of Psychotherapy and Counselling Psychology (SPCP) 'The therapeutic relationship is held to be the single consistent variable identified in research as crucial to beneficial outcome in therapy.' (Regents 2009: 3). Although this is debatable (Cooper 2008: 100) with computerized therapy, self-help books, etc. proving effective in some terms, it could be argued EPT is the antithesis of CBT because it emphasizes the qualities of *being with*, *being for* or *being in relation* as the pivotal quality of the therapeutic alliance. One way of describing an Existential approach to therapy is 'A relationship which both expresses and promotes the exploration of the possibilities of being.' (Regents 2009: 4). This is suggestive of a brand new, unique relationship (Spinelli 2009) open to emerging phenomena which, because of its uniqueness, defies manualisation. According to Walsh & McElwain (2001: 267) 'From an existential perspective, every course of psychotherapy is unique. The notion of manualized psychotherapy is therefore an oxymoron.' There may be as many different types of Existential Therapies as there are Existential Therapists (Spinelli 2007b: 10).

If the contextual model applies to all therapies and CBT research has managed to measure and produce evidence, we can ask if EPT is comparable to CBT in terms of effectiveness? One way of producing evidence of effectiveness is to measure and compare the level of presenting symptoms pre and post therapy for those treated with CBT and EPT.

NICE Guidelines are developed independently of Government by using a complex process of evidence synthesis and consensus among clinicians, patients and managers (Barkham et al. 2010: 11). Consequently, the allocation of Government healthcare funding is influenced by the NICE Guideline Recommendations as the best available evidence for the treatment of specific diagnoses.

When Government Bodies allocate funding for healthcare, they are concerned with two things, efficacy and effectiveness. Efficacy in this context relates to whether a

treatment works or, has the potential to bring about a desired effect. (Cooper, 2008:180) For example, is psychotherapy an efficacious way to treat depression? Therefore, efficacy studies ask 'does it work?' (Basham 1986: 90) Effectiveness in this context relates to how well it works, or 'The extent to which an intervention, when used under ordinary circumstances, brings about a desired effect.' (Cooper, 2008: 180) For example, 'Is EPT as effective as CBT or an anti-depressant in treating depression?' Therefore, effectiveness studies ask 'which works best?' (Basham 1986: 90) Although there have been many studies addressing the efficacy of psychotherapy and it is generally accepted that psychotherapy is efficacious (Churchill et al. 2001; NICE 2009; Roth and Fonagy 2005; Smith and Glass 1977; Stiles et al. 2006), there is still limited evidence of effectiveness of therapies other than CBT. These two aspects are important research questions because patients and clinicians need to be confident that the recommended treatment intervention is efficacious and that, not only is the treatment itself effective but that it is cost effective for the UK NHS as well.

Depression is one of the commonest conditions seen by GPs (Scott and Freeman 1992) with an estimation that about 60-70% of adults will at some time in their lives experience this debilitating disorder to the extent that it disrupts their daily activities and approximately 18-26% of females and 8-12% males will suffer from a major depressive episode. In 1991, Kind and Sorensen (1993) estimated the annual NHS costs in England and Wales to be £417 million and the indirect costs of lost work days and premature mortality to be almost £3000 million (Churchill et al. 2001: 1). Although the drug costs in this study accounted for a relatively small proportion of the total, approximately 11.3%, there is a growing reluctance in the attitudes of patients towards taking medication. This is due to possible side-effects (drowsiness, blurred vision, constipation, urinary retention and sweating), worry about dependency, compliance and using a biochemical treatment which has, in turn, meant there has been an increase in demand for psychological therapies to treat depression (Churchill et al. 2001: 1). The considerable costs involved are related to GP consultations, hospital admissions, local authority social services, health care

nursing and medication without including the substantial input of the voluntary sector, and therefore, if talking therapies are an additional cost burden, a good economic argument has to be made for why they should be prescribed rather than medication. This is what Lord Layard proposed in his 2006 Report entitled 'The Case for Psychological Treatment Centres' which led to the national rollout of the Improving Access to Psychological Therapies (IAPT) in 2007.

Carr (2009: 18) makes a useful distinction between efficacy and effectiveness studies as representing the extremes of a continuum along which a variety of treatment outcomes fall, with efficacy studies usually conducted as a research trial, high in internal validity, and effectiveness studies drawing on routine clinical practice, high in external validity.

Efficacy studies such as 'The NIMH Treatment of Depression Collaborative Research Program' (Elkin 1994) tend to research clients with a specific diagnosis such as depression under ideal conditions according to strict RCT criteria, often in university settings. This means that the purest data may be captured in answering the question 'does it work?' but these results come at the expense of not being typical of what actually occurs in clinical practice and, RCTs are still not without their methodological problems. Although the NIMH (1994) study was a multi-site practice based trial, possibly one of the largest and most ambitious in terms of numbers involved, the results were still controversial indicating that imipramine (antidepressant drug) plus clinical management (IMI-CM), pill-placebo with clinical management (PLA-CM) was as effective as CBT and Interpersonal Psychotherapy (IPT), and CBT did very well at one site but not at another, and the same was found for IPT but the opposite way round. For the less severely distressed patients, no difference was found between all four treatment conditions (Elkin 1994: 125). Roth & Fonagy (2005: 34) cite this RCT as a real life example of a Type I error, rejecting the null hypothesis when it is true which in this case, meant findings showed that one treatment worked better than another, when, in reality, the two worked equally well. In a study comparing clinical efficacy, patient satisfaction and the costs of

three specialist treatments for depressive illness with routine care by GPs in primary care, Scott and Freeman (1992: 883) found a marked improvement in depressive symptoms in all treatment groups over 16 weeks but concluded that the additional costs associated with specialist treatment of new episodes of mild to moderate depressive illness presenting in primary care were not commensurate with their clinical superiority over routine general practitioner care. It was noted that this cost-benefit analysis did not take account of how well each treatment was in preventing further episodes of depression.

Effectiveness studies tend to draw on routine clinical practice, such as the NHS, where most clients present with co-morbid difficulties, are more heterogeneous and are not generally randomized to specific groups. This means that the data is more representative of what actually occurs in practice but the degree to which conclusions can be drawn, about whether it was the therapy which was the cause of change, is diminished.

Therefore, efficacy and effectiveness studies are both important sources for scientific information about practice which then means 'research evidence is combined with clinical consensus' (Roth and Fonagy 2005: 59).

The NICE Guidelines are developed by conducting a systematic review of the research evidence with recommendations based on a hierarchy of the best available evidence. Within this hierarchy of evidence (Sheldon et al. 1993: 33), Randomised Controlled Trials (RCTs) are regarded as the 'gold standard' because this particular scientific method, which attempts to minimize confounding variables, bias and chance findings by using controls, comparison and randomization, is the most rigorous method available to produce reliable and valid evidence and is the least susceptible to bias. Typically, patients are randomly allocated to one of two, or more, treatment conditions (CBT vs EPT) and these groups are then compared with another group of randomly allocated patients in a control condition that could either be no treatment or whilst on the waiting list. The degree of confidence with which

a study can be regarded as convincing depends on the quality of its' design and 'whether the results reported are likely to be a true reflection of the real effects of the treatment' (Sheldon et al. 1993: 39)

Reliability and validity are the cornerstones of the trustworthiness of an experimental design and consequently, these elements determine the weight of the evidence produced. Reliability in this context refers to how well the results are free from random error or in other words, the experimental conditions are designed to minimize distortion of the results by factors other than those being investigated so that conclusions can be drawn from the results with the greatest confidence. This involves the measurement tool being robust enough to produce the same results each time it is used, regardless of the rater and over time. This is often described as test-re-test. Once reliability has been established, a measure must be also shown to be valid. There are many different types of validity but in this context, validity refers to the degree to which the experiment measures what it is supposed to measure, that is, how well does CORE-OM measure the severity of symptoms of depression. These factors comprise what is known as the *internal validity* of an experiment. It is because the methods employed in RCTs are regarded as involving the highest level of internal validity that they are at the top of the hierarchy of evidence and described as 'gold standard'.

External validity, how well the results of the experiment can be generalised to a wider population, is an important consideration and often used as the main criticism of RCTs when applied to psychotherapy (Westen et al, 2004: 637). For example, in order to create an experiment that researches whether a particular therapy is effective in reducing symptoms of depression, an RCT requires that all participants have a single or pure diagnosis of depression, that therapists practise a manualised version of their therapy, the duration of therapy is standardized, they are matched for age, gender, etc. and neither clients nor therapists are aware of whether they are in the research or the control condition. An RCT design is an attempt to increase the confidence in experimental results by attempting to keep all things as

equal as possible, so that the only difference in the comparison of the groups is the therapeutic intervention. By recruiting sufficient numbers of participants based on a power analysis, employing a control group, and then subjecting the findings to statistical analysis, it is deemed that we can detect when there is a true difference among the groups being tested. It is in this way that results can be produced as reliable and valid evidence to show that, for example, it is not just down to chance that EPT works in reducing symptoms of depression and therefore, it can be stated with confidence that, for example, EPT is an efficacious psychological treatment intervention. By minimizing the confounding variables, statistical analysis can provide confidence in answering questions such as 'does it work?' whilst dispelling mythology, anecdote and confirming that if a significant difference is found, these results were not just a one-off. Due to the probabilities involved, $p < 0.5$ indicates 95% confidence or $p < 0.01$ indicates 99% confidence, we can be convinced the experimental results are not just down to random chance. The degree to which an experiment can be said to be high in *external validity* is the extent to which it can claim that the same results would be produced in other settings, or generalized consistently over time. The nature of psychotherapy with its intrinsic host of confounding variables means this is very hard to achieve.

Reliability and validity are the strengths of RCTs but the inherent structure of an experiment is that it is an artificially constructed activity and therefore, it's weakness in this context is that it does not sufficiently address what actually goes on in routine clinical practice. To select just one of the above points, rarely does a patient present in NHS Secondary Care with a single diagnosis of depression, co-morbidity is the norm (91% of those participating in this study) so immediately, the question of the relevance of the results of RCTs for depression being applicable to most patients is limited. According to Westen et al. (2004) '....single-disorder presentations are the exception rather than the rule' and, in support of the importance of practice-led research:

The average RCT for most disorders currently described as empirically supported excludes between one third and two thirds of patients who present for treatment, and the kinds of patients excluded often appear both more representative and more treatment resistant in naturalistic studies.

(Westen et al. 2004: 658)

This is irrespective of the whole ongoing debate about the definition of depression being ambiguous (Westen et al, 2004: 634). Thus, the problem of external validity is fundamental.

Although RCTs provide powerful methods for answering some questions about efficacy due to the high level of internal validity, they are less relevant when it comes to external validity and questions of effectiveness. This is where practice-led designs can fill the gaps in terms of external and ecological validity by researching what actually goes on in practice. By adopting a variation of RCT in practice, it was anticipated that a pilot study could be run as an initial investigation into whether EPT 'works', is effective, whilst redressing the criticisms levelled at the artificiality of experimental conditions. As Roth & Fonagy (2005: 26) point out, there is 'an apparent incompatibility between scientific rigor on the one hand and generalizability on the other' which indicates the need for different types of research to answer different questions. Whilst RCTs dominate in the field of evidence-based practice, there is also a need for alternative forms of evidence such as studies examining what happens in routine healthcare settings. Looking at the various forms of useful evidence, the APA (2006) defined evidence-based practice in psychology as 'the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.'

Contemporary evidence (NICE Guidelines, 2009), currently based on RCTs, recommend CBT as an effective empirically supported treatment intervention for *Mild to Moderate Depression*. Therefore, this study adopted an RCT-type design within an NHS practice setting to compare the levels of symptom reduction for

patients who were treated with CBT with those who were treated with EPT in an attempt to fill some of the gaps in knowledge left unanswered by RCTs. These were questions such as 'Does a patient who presents with a severe level of depression mixed with anxiety experience a similar reduction in symptoms in the same way when treated with CBT or EPT?', 'Is there a difference in the ages of those patients who are routinely allocated to CBT or EPT?', or 'In a naturalistic setting, do CBT and/or EPT patients experience a similar level of symptom reduction?' These effectiveness research questions are meant to complement the previous RCT research questions whereby the efficacy of psychotherapy in general has already been established (Smith & Glass, 1977, Roth & Fonagy, 2005, Norcross, 2002, NICE 2009, Stiles et al. 2006) and where the lack of external validity has been a controversial issue.

In particular, the controversy centres round CBT being unfairly regarded as the dominant paradigm to the exclusion of all other therapies that are commonly practised, such as EPT and Psychoanalytic Psychotherapy. Obviously, experienced EPT therapists who currently practise in the NHS feel unnecessarily excluded from the NICE Guidelines because they are aware of the equivalence of outcomes paradox (Stiles et al. 2006) whereby research has shown that all therapies tend to have similar successful outcomes, 'one size does not fit all' meaning that we see a lot of people who are adamant that they do not want CBT and, we also know that different people need different things at different times in their lives (Cooper and McLeod 2011). These are some of the reasons why a practice-based modification of RCTs is also useful, valid and reliable.

There is a fundamental difference between CBT and EPT with regard to their philosophical premises whereby CBT is focused on removing unwanted symptoms, such as insomnia, for example, whereas EPT is focused on an attempt to stay with the symptoms and to ask how might a client live with this symptom. Despite the various approaches, methods of intervention and the fact that the client usually comes to the NHS to ask for help with getting rid of this symptom, both CBT and

EPT have the effect of reducing the perceived severity of symptoms and therefore, this is something which can be measured and compared.

One philosophical approach to the question of what works in therapy involves an attempt to define what are the necessary and sufficient conditions required for a successful therapeutic outcome. A successful therapeutic outcome is a broad and ambiguous term, and patients and clinicians will answer in a multitude of ways. In this particular NHS healthcare setting and within the context of this study, a successful therapeutic outcome is defined as Reliable and Clinically Significant Improvement (RSCI). This is measured by the achievement of a post therapy reduction in a CORE-OM score of >0.5 reflecting the client's perception of problems, well-being, functioning and risk factors. In addition to this numeric quantification, a tentative answer might be that it is necessary for a minimum of two people, the client and therapist, to meet for a mutually agreed number of sessions and where the therapist works according to a particular set of psychological principles, for example, adopting an Existential-Phenomenological Approach; and it is an emotionally charged relationship where the client expects the therapist to be able to help him/her according to a rationale whereby the ritual or procedure requires the active participation of both. Answering what is sufficient with regard to the number of sessions is, at this stage, much more difficult. Some advocate brief therapy of six, twelve or sixteen weeks while others believe a two-year duration is too limiting. The number of sessions agreed is often quite arbitrary. However, based on a review of the current evidence-based effectiveness research such as meta-analysis, critical reviews, randomized controlled trials, treatment outcome studies, etc from PsychINFO and Medline, Carr (2009) concludes:

For common adult problems, this is 20-45 sessions and for children and adolescents it may be 10-20 sessions, but with more complex problems more sessions may be required.

(Carr 2009: 288)

Specifically in relation to depression, meta-analysis conducted by Howard et al. (1986) showed that 62% of patients improved by the 13th session, after which there were diminishing returns (Churchill et al. 2001: 2). These results support the general consensus that time-limited therapies of up to 20 sessions are effective and cost effective.

The following table sets out a summary of RCT criteria and the differences in a practice-led study that is based on an EPT argument that would emphasize the importance of client choice:

	Randomised Control Trial	Practice-led Study
Selection Process	Selected clients randomly allocated to therapy Control Group	Clients and clinician choose preferred therapy No control group – only wait list control
Diagnosis	Exclusive homogenous group	Inclusive heterogenous group
Manualised Technique	Adherence to manual	Adapted to client and clinician therapeutic experience
Validity	High internal validity	High external validity
Rationale	To measure select group of clients according to diagnosis	To measure all clients undergoing CBT and EPT psychotherapy
	Top down Researcher directed selection	Bottom up Client directed choice
	Gold Standard	Pilot Study

In summary, RCT research studies addressing efficacy and effectiveness have shown that psychotherapy is effective, that is, it works. According to 'A systematic review of trials of the effectiveness and cost-effectiveness of brief psychological treatment for depression', Churchill et al. (2001) conclude:

Comparing any variant of psychotherapy with treatment as usual or waiting lists suggested patients receiving psychotherapy were significantly more likely to improve to a degree where they were no longer regarded as being clinically depressed.

(Churchill et al. 2001: 93)

Research trials have provided an affirmative answer to the primary question of whether or not psychotherapy works but what remains to be shown is which therapy is most effective, what works best. This practice-led study is an attempt to analyse the effectiveness of EPT in comparison with CBT to see if we can discover any further answers about what and for whom EPT may be most suitable.

A related key question is '*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances?' (Paul 1967: 111) which translates in this context to 'Which clients presenting with an affective disorder, such as depression or anxiety, would benefit most from an Existential-Phenomenological Therapeutic approach?' Most clients are probably not fully aware of the differences in approach and even if they were, on what basis would they choose one over another, particularly when in distress. It is the case that 'psychological help is what thousands or even millions of patients want.' (Levenson et al. 2003 cited in Layard, 2006: 86). Both NHS and private clients expect the 'experts' to be able to recommend appropriate effective psychological treatment interventions and therefore, as reflective scientist-practitioners, we have a moral and ethical duty to respond using rigorous research methods where possible.

Therefore, additional long-term aims and objectives of this study are to produce evidence in support of Existential-Phenomenological Therapy being recommended as a suitable psychological treatment intervention in the NICE Guidelines for affective disorders, such as depression and anxiety. Current literature (Spinelli, 2007: Roth & Fonagy, 1996: Norcross, 2002: 441) has indicated the value of EPT

for some clients and therefore, formal implementation of this type of research is also an attempt to embrace *The New Savoy Declaration* reproduced here as follows:

Depression and anxiety affect millions of people in the UK, yet few receive the psychological therapies that could help with recovery. Many with the courage to seek help have to wait for many months for treatment or have to pay for it privately.

The Government has committed itself to turning this around and to implementing NICE Guidelines for depression and anxiety so that everyone can have timely access to state-of-the-art evidence-based therapies.

We congratulate the Government on this welcome initiative and call on the NHS to offer appropriate psychological therapies free at the point of delivery to all people who need them, within six years. We call for people to be given a choice of appropriate, evidence-based therapies available close to home when they need them. And we urge the government to invest in the further development and evaluation of psychological therapies to make the UK a world leader in this field.

We commit to working together to support the NHS to build up its psychological therapy provision and to ensure that the new services are safe, effective and successful.

(NHS 2008)

1.2.2 Literature Review

To gain a comprehensive view of the existing knowledge about the effectiveness of Existential-Phenomenological Therapy as a suitable psychological treatment intervention for affective disorders, such as depression and anxiety, a literature search was conducted using MEDLINE, PSYCHINFO, EMBASE and the Cochrane Library Database.

The Cochrane Library search produced two relevant results showing that in this research area, there are currently two active Cochrane Protocols including Existential Therapy under the more generic term of Humanistic Therapies. Both Protocols are recommendations in response to the lack of evidence of effectiveness for therapies other than CBT and aim to include RCTs for adults presenting with depression in primary or secondary care in the NHS. One study (Churchill et al. 2010) aims to examine the effectiveness of all humanistic therapies compared with other approaches for acute depression and the other (Davies et al. 2010) aims to examine the effectiveness of all humanistic therapies compared with treatment as usual/waiting list/attention placebo control conditions for acute depression. Both these protocols provide additional support for this research project by their focus on the importance of the production of evidence that looks at treatment as usual, waiting list and existential therapies compared with cognitive-behavioural therapies. At the time of writing, there was no further available data.

An advanced search using MEDLINE via the NHS Evidence Library with the search term *Existential* produced 33 Clinical Reviews which when refined to *Existential Therapy* (40 articles) and *Existential Psychotherapy* (52 articles) found 88 articles of which 19 included depression. None of these were specific to this project addressing evidence of effectiveness.

An advanced search using PSYCHINFO via the NHS Evidence Library with the search term *Existential* produced 619 articles which when refined to include

depression found 24 articles. One study (Langle et al. 2005) was specifically relevant with results to indicate the high effectiveness of existential therapy. Langle et al's (2005) study researched *Logotherapy* (Frankl 1966) which provided the basis for choosing the Purpose in Life Test (Crumbaugh and Maholick 1969) as part of this project. This will be discussed further under Section 1.3 Existential Phenomenological Therapy, on page 54.

One of the reasons there may be so few articles produced about existential therapy and depression may be the sensitivity around the concept of using the word depression as a diagnostic label within the world of EPT. Therefore, further searches were conducted using the terms *Existential* and *Affective Disorder*; EMBASE produced 9 results, none of which were relevant: MEDLINE produced 5 results, none of which were relevant: PSYCHINFO produced 11 articles of which 1 was relevant although this was the same paper cited above, Langle et al (2005).

According to the above literature search, there is only one study (Langle et al. 2005) found to be specifically relevant for this project researching the efficiency and attempting to provide evidence of the effectiveness of existential therapy.

1.2.3 Specific Contemporary Evidence for EPT

There is a wide, gaping abyss in the field of quantitative research into the effectiveness of Existential-Phenomenological Therapy as a suitable psychological treatment intervention and it appears that it is the most under-researched therapy currently available within the NHS. There have been papers published (Cooper 2004; Sousa 2004) in an attempt to encourage research in to this area but it is thought that, in 2011, this is the first UK research project to **quantitatively** analyse the effectiveness of EPT within the NHS.

The only specific research found was Langle et al. (2005) and whilst it provided evidence for the effectiveness of existential therapy, as tested on 248 patients in

Vienna, there is no mention of for what this treatment method is most suitable, as required by UK NICE Guidelines. The paper is written in German, published in German and Spanish but unfortunately, the only part translated into English is the Abstract so the more detailed information is currently unavailable. However, the relevance for this study is that the evidence of EPT effectiveness Langle et al., (2005) have produced is based on Logotherapy (Frankl 1966) that provides support and the background for one of the measurement tests, the Purpose in Life test, which has been employed in this research project and is discussed further in Section 1.3 Existential Phenomenological Therapy, on page 54.

In line with EPT's philosophical grounding, this dearth of evidence may well be unsurprising and, as expected, there are an abundance of studies using qualitative methods such as heuristic research, single case studies, in-depth interviews, phenomenological research, and in particular, Interpretative Phenomenological Analysis (Smith 2007). There are many good reasons for this position which are discussed over the following pages but one of the main arguments is that producing evidence to show EPT works, or is effective, is contrary to the whole philosophical underpinnings of existential thinking. This project attempts to defend its' own position by arguing that all therapies have the same difficulties in producing evidence for this complex interaction we call psychotherapy and, by replicating valid and reliable experimental methods and using standard statistical analysis tools such as ANOVA, evidence of effectiveness for EPT can be produced. The contemporary position where there is an abundance of qualitative research and a dearth of quantitative research suggests that most researchers tend to avoid the quantitative studies because capturing adequate data is difficult, expensive and time-consuming. A combination of both qualitative and quantitative research is the ideal situation.

Despite anecdote and routine application of this type of therapy, there is still no good quantitative evidence to show whether EPT is an effective psychological treatment intervention for NHS clients presenting with an affective disorder such as depression or anxiety. This means our knowledge is lacking, ignorance is

highlighted and uncertainty abounds. This state of affairs reflects an existential attitude but it is not necessarily a healthy position if EPT wishes to continue to flourish and be offered as a therapeutic choice for clients within the NHS in the UK.

1.3 Existential Phenomenological Therapy

1.3.1 What is it?

The mood has already disclosed, in every case, Being-in-the-World as a whole, and makes it possible first of all to direct oneself towards something

(Heidegger, 1962; 176)

Heidegger saw the primary task of phenomenology as "ontology", which uncovers the hidden "meaning of being" by an interpretation (Greek: *hermeneuein*, interpret) of Dasein's understanding of being (see BT 58)

(Heidegger 1987/2001: 174)

Existential-Phenomenological Therapy (EPT) falls under the wide umbrella of humanistic psychology, or non-behavioural therapies, which also include person-centred, gestalt, personal construct, focusing, relational and psychodynamic therapy, for example, and where the emphasis is on human values, consciousness, subjective and individual inter-related experience. EPT's development is distinguished as being influenced by philosophers such as Kierkegaard (1813-55), Nietzsche (1844-1900), Husserl (1859-1938), Heidegger (1889-1976), Merleau-Ponty (1908-61) and Sartre (1905-80). These philosophers are linked by a fascination about what it means to be or exist as a human being, and commonly place emphasis on universal ontological issues such as anxiety, meaning, being alone, death, choice, freedom, embodiment and responsibility. It is primarily a philosophical approach to these subjects which tends to guide or inform the EPT therapist's way of working and which does not necessarily attempt to change a person's way of being but rather tries to descriptively explore and clarify how a person relates to their being in the world, and what that means to the individual. If

the words are separated into their component parts in an attempt to create a working definition, each could suggest the following:

Existential	what it means to exist as a human being; life, death, being alone, freedom, choice, anxiety, meaning, embodiment, responsibility <i>Adjective; of or relating to existence*</i>
Phenomenological	attention to what appears, as it appears in the here and now, what comes to light <i>In philosophy; an approach that concentrates on consciousness and the objects of direct experience, as distinct from the nature of being*</i>
Therapy	as attending to, being-with, being-for, an asymmetric but reciprocal relationship, use of new therapeutic relationship as echo of other relationships <i>Treatment intended to heal or relieve a disorder*</i>

** Apple Dictionary 2011*

Taken together, the above definitions are suggestive of a questioning stance towards conscious human existence whereby universal *givens* such as life, death, anxiety, choice, freedom, aloneness, embodiment and meaning manifest themselves in the way in which individuals relate to and experience themselves and others in the world. As soon as the therapeutic relationship is envisaged, a choice has been made to pay attention and reflect, and to risk being with another in a particular way. Whilst with another, this therapeutic relationship may echo other relationships in the world.

Existential phenomenologists have argued that is through this relationship itself that the client's issues are manifested or 'brought forth' for examination. In other words, the therapeutic relationship is seen to be the 'microcosm' through which the 'macrocosm' of the client's lived reality is expressed and opened to inquiry.

(Spinelli 2003: 188)

It is a strange conversation where this novel and asymmetrical space is used to explore and clarify how it is experienced and what it means, with the potential to open up possibilities. One possible interpretation of this action could be seen as the individual taking responsibility in an attempt to change or understand something even if they are unsure of what it is they want from therapy. Spinelli suggests that therapists do not have to attempt to change things because change is inevitable, if unpredictable, and has already occurred once the person has taken this decision to have therapy (2007b: 71). 'Change is a given.....it will occur inevitably because change occurs inevitably.' (Spinelli 2007c) This is discussed in more detail in relation to depression in Section 1.4 Affective Disorders on page 69.

It seems paradoxical that Existential-Phenomenological Therapy aims to get close to individual, subjective lived experience, attempts to get close to the simple jargon-free words of the layman and yet, a simple definition of this type of therapy is elusive and when introducing EPT, most clients go weak at the knees in submission on hearing those first three words.

To return to the main question *What is Existential-Phenomenological Therapy?*, another possible answer could be that experiencing, describing, exploring, clarifying, disclosing and becoming aware of relatedness in this unusual therapeutic space means;

Existential-Phenomenological Therapy is the practical application of
philosophy to everyday living

and/or

Existential therapy is a phenomenological research project for both
therapist and client

(Deurzen and Adams 2011)

Taking the words associated with the above definitions into consideration, it is apparent that unlike many other therapies, EPT is not overly concerned with the

past but tends to treat past, present and future equally. This is nicely summarized by Heidegger's (1962) description of 'Existence as rooted in the past, projects towards a future and falls into the present.' It should be noted that Heidegger is using the word Existence [*Existenz*] in a very particular way, that is the way in which human beings exist.

The EPT therapist attempts to stay with the emerging phenomena as and when it appears and, to quote Bion, 'to impose on himself a positive discipline of eschewing memory and desire' (1970: 31) so that the therapist's personal assumptions, biases, beliefs and judgements are bracketed to allow for the client's subjective meanings to be expressed and explored as fully as possible. EPT is based on Husserl's (1965) philosophy where he attempts to establish the rules of epoche (or bracketing), description and horizontalization (or equalization) as the most appropriate philosophical method for psychology and investigating conscious human experience (Spinelli 2007b: 11). This could be described as an attempt to adopt a 'not knowing' therapeutic stance whereby the client is regarded as the expert in her own life and the therapist attempts to enter into the client's worldview (Spinelli 2007b).

The difficulty expressed here in an attempt at providing a definitive answer is typical and representative of many other previous attempts. It is unexceptional and characteristic of this particular approach (and maybe all approaches when considering the multitude of variations of CBT currently available) in that there are as many possible interpretations as there are existential philosophers, therapists, and counselling psychologists for whom a definition of Existential-Phenomenological Therapy may vary. Yalom (1980) seems focused on death, Nietzsche (1961) on morality, Kierkegaard on Christian faith and possibility (1846/2001) Frankl (1946/1985) on meaning, van Deurzen on four dimensions of existence (Deurzen and Adams 2011: 16) Spinelli (2007b) on relatedness, Sartre (1943/1958) on freedom, Heidegger (1962) on Dasein, Husserl on phenomenology, Merleau-Ponty (1945/2002) on the body, so it may be more productive to describe Existential-

Phenomenological Therapy as more like a stance or attitude towards this particular therapeutic activity. (Spinelli 2007b: 9)

For the purposes of this research, the working definition of Existential-Phenomenological Therapy is based within the context of the British School and the work of Professor Ernesto Spinelli (2007b) as he has been the main influence on the researcher, her clinical supervisors, most of the therapists involved in the research project, which in turn has influenced our practice with clients in the NHS. Firstly, it must be said, this working definition is

....**a way** rather than **the way** to address and explicate its practice

(Spinelli, 2007b: 4)

And, consequently;

Existential psychotherapy takes as its primary focus the descriptive clarification of the client's currently-lived worldview. It does so in order to expose and clarify the relationally derived role and function of the client's presenting problems and disturbances as constituent expressions of, and attempts to maintain, that world-view.

(Spinelli 2007b: 86)

After addressing the huge congregation of 800 Danish Psychologists in Copenhagen 2009, Professors Spinelli and Yalom were lauded and applauded as the greatest Existential Psychologists living today. Spinelli's presentation on *Practising Existential Psychotherapy* is recalled as follows:

Relatedness

The basic premise of existential thinking turns on the foundational idea of *Relatedness or Inter-relation*. The idea that human beings are always in relation leads to an understanding that it is this inter-relatedness that creates our feelings, moods, beliefs, thoughts and actions. Even when alone, relatedness remains, even if we avoid relationships. In the same way a snowflake is individual but constructed

by the same set of conditions, humans are unique beings arising from the same set of conditions but our relatedness is what makes us stand out as individual in the world. The therapeutic relationship is one type of inter-relation.

Uncertainty

Uncertainty arises out of the conditions of relatedness with self, others and the world and because every moment of being is novel and unrepeatable, there is always uncertainty. Human relationships depend on others and therefore, I am never certain how I am going to be, nor can I be certain how others are going to be, therefore there are always possibilities, some of which I am aware and others unknown. This idea directs us towards an attempt to be mindful in allowing uncertainty to be present in the habitual. Therefore, a stance of un-knowing is adopted by the therapist.

Anxiety

As a consequence of relatedness and uncertainty, existential anxiety is always lurking and rather than viewed as pathological, its expression is welcomed as a way of indicating how one is to live an authentic or inauthentic life. The prior principles of relatedness and uncertainty lead to an experience of *being* as full of anxiety because it is open-ended and out of my control. It is a given of our existence which is not necessarily disturbing or in a clinical sense, a dysfunction, but allows me to meet life. Anxiety demands a leap of faith in choosing one possibility over many others and taking responsibility for one's actions and life. This idea originates in Kierkegaard's *Concept of Anxiety* (1844/2001) which Chamberlain and Ree elaborate as follows:

Anxiety as he understands it is quite different from fear, since fear is always a definite feeling about a known danger, whereas anxiety is a state of cloudy unknowingness, of baffled apprehensiveness about possibility in general: about everything – or rather about nothing.

(Chamberlain and Ree 2001: 178)

Existential phenomenological perspectives argue that with the ability to use language and reflect, we require meaning in a meaningless world and taken with relatedness and uncertainty, anxiety is a given. The therapeutic stance is not how to get rid of anxiety but rather, how to live with it.

Within this context, these ideas provide the backdrop to practising Existential-Phenomenological Therapy as a way of approaching lived experience where questions can be raised and assumptions challenged about how a person relates in a particular way, with the assumed knowledge that there may be a multitude of other possible ways of working. Spinelli suggests, as therapists, we adopt the roles of the idiot and the fool, asking the stupid or obvious, but possibly overlooked, questions to demonstrate that we really do not know, are genuinely curious and/or to search for the novel in the habitual. In this way, description is encouraged, elucidated and clarification emerges via this particular therapeutic relationship, allowing both client and therapist to question and challenge sedimented beliefs.

This presentation is more extensively described in Spinelli's book *Practising Existential Psychotherapy* (2007) which provides a detailed description of his interpretation of how Existential-Phenomenological Therapists work and is the closest thing we have to a manual at the current time. Whilst being reminded this is only one of many possible ways to practise, the researcher would like to acknowledge this influence on her understanding of practising Existential Psychotherapy, in particular, the ideas of:

- ❖ Relatedness
- ❖ Uncertainty
- ❖ Anxiety

For the purposes of this research, it is Spinelli's (2007b) work that is used here as a working definition and an EPT manual or guide. These ideas have also influenced

the preliminary work of Mr Mark Rayner in defining Competences for Existential-Phenomenological Therapy (Appendix B) that are currently in use at the NHS Edgware.

At the NHS Psychological Therapies Service for Adults, Existential Therapy (Appendix A) is described as follows:

Existential therapy investigates a persons' lived experience of being in the world and how they make sense of freedom and restriction from being able to make choices. Existential therapy does not necessarily focus on 'why' but rather 'how' a person structures their beliefs, values and relationships. The concept of relationship is central to existential therapy, which considers the person's own understanding of where they locate themselves in the world compared to their perception of others. These complexities are both considered in therapy and constituted in the therapeutic relationship. The therapeutic process involves both understanding and re-construing ideas and beliefs about the self and the world that have led to the person seeking therapy. Existential therapy can focus on cores issues and potentially re-construe previously fixed ideas so that new meanings may emerge.

(PTS 2009)

1.3.2 Sigmund Freud (1856-1939)

Freud resembles the wise grandfather of psychotherapy. The term *Talking Cure* was originally coined by a female patient in 1883, whilst talking to Dr Josef Breuer, to describe the therapy that relieved her of hysterical symptoms; symptoms which had no organic origin. *Talking Cure* was later adopted by Freud to describe the fundamental work of *Psychoanalysis*. This theory is still relevant today. Freud was fully aware of Nietzsche's thinking, the wise grandfather of existentialism, and it is thought his 'ideas pervade psychoanalysis..... even in Freud's literary style.' (Ellenberger 1970: 542) Frankl (1969: 12) writes that psychoanalysis is irreplaceable and thinks that the chair of Freud should be kept empty.

Many influential existential therapists were originally psychoanalysts (Binswanger 1963; Boss 1994; Ferenczi 1955; Frankl 1969) and it could be argued that once

learnt, one cannot completely remove this unusual way of thinking. Also, it is worth noting the way in which psychoanalytic ideas, such as Freudian slips, the Oedipus Complex, dreams as the royal road to our unconscious, Surrealism in art (Salvatore Dali), use of Greek mythology such as Narcissus, and in many cinema (Ingemar Bergman) and theatre (Lorca) productions, etc, are so deeply embedded within twenty-first century Western culture that many may not even realise we are using ideas which originated in Freud's work. Although EPT does not specifically align itself with psychoanalysis, there are distinct commonalities;

Time and again Freud stressed that every type of medical therapy was fundamentally rooted in such a being together, that the physician-patient relationship was the genuine basis of all forms of treatment. In fact, Freud called this the 'arena or playground' where the patient could carry out previously impaired and inaccessible possibilities of existing in 'almost total freedom' on the condition that the physician could skillfully 'handle' this human relationship.

(Boss 1994: 257)

Freud had another practical recommendation: during therapy the physician must assume a stance completely free of all intention, of all therapeutic, educational, and scientific ambition. The true art of therapy lies in paying careful attention to 'what' the patient visualizes and 'how' he conducts himself in relation to it.

(Boss 1994: 259)

For over 70 years, psychotherapy research (Smith and Glass 1977) shows there has been an ongoing debate about which type of therapy is more effective, split between behavioural forms (doing) or non-behavioural forms (being). Research has shown time and again '...virtually no difference in effectiveness was observed between the class of all behavioural therapies and the non-behavioural therapies' (Smith and Glass 1977: 752). From an EPT perspective, non-specific factors are key as the expression and promotion of being itself, in therapy *being with* is an inextricable given, regardless of modality. The question is whether *being-with* in this particular therapeutic way is sufficient.

The following is a consideration of what EPT and psychoanalytic psychotherapy, as non-behavioural methods of therapy, have in common in support of a contextual argument, that is, attention here is focused on the non-specific factors that are very difficult to measure, and which in fact, may very well be the effective influences on a successful therapeutic outcome. As much has already been written about non-specific factors such as the therapeutic relationship, emotional experiencing, therapeutic rationale (Spinelli 2007b: 93; Wampold 2001), the following are further possible non-specific factors which commonly emerge as helpful.

1.3.3 Non-Specific Factors

Psychoanalysis, in its dependence on words is, by the same token, an inquiry into what language can't do for us, into what we can't change about ourselves by re-describing ourselves.

(Phillips 2006: xiii)

The process of psychotherapy is notoriously complex and as a reminder, despite all the research, Fonagy repeats the point that 'There is still no solid evidence as to who will benefit from what type of therapy' (2010) stating that the key question has now altered from what works to how it works. This is very interesting in that EPT (like Freud) has always placed more emphasis on 'how' rather than 'what works'. The following is a general description of some possible and additional non-specific factors with supporting comments that emerged from the semi-structured post therapy interviews with EPT research participants in this study:

Acknowledgement of wanting change

The transference is activated long before a client walks in the door

(Ref ?)

Firstly, an interview with a psychotherapist is already an extraordinary experience for a potential patient, even before he has got to the doorstep. He is deeply involved, in phantasy, with the figure he believes you will turn out to be.

(Hinshelwood 1991)

It can take a long time for a person to actually pick up the phone and ask for help, unless, as is often the case, some kind of crisis has provoked this action. Most clients are probably not aware of just how much work they have already done in making the decision to seek a therapist. Motivation to engage is one of the key indicators of a successful outcome (Carr 2009: 288)

"I didn't want to continue feeling that way; my determination to get past and out the other side... and the relationship we built up over the weeks, I found myself telling him things I hadn't told anyone else, ever."

(Participant 15, 2010)

Talking Therapy

We have lingered in the chambers of the sea
By sea-girls wreathed in seaweed red and brown
Till human voices wake us
And we drown

(Eliot 1917/1969)

The final lines of TS Eliot's famous poem are meant as a reminder of just how much courage it takes to tell another. Language or dialogue is possibly the most distinctive and defining attribute of human beings and allows us to conceptualise, reflect on the past, present and future, and communicate these ideas with another.

Heidegger writes 'Language is the house of being. In its home man dwells.' (1953-59/1971: 135). Taking language as the expression of being itself and when situated within a therapeutic context, it implies the presence of another person and therefore, words take us out of ourselves and as we reach out, we extend ourselves towards possibility. It may follow that in reaching out by talking or finding the words to express ourselves, we may have moved one step away from the pain or the difficulty. Words have the ability to metamorphose the feeling. It is often overlooked but talking generally implies that one is also being listened to, so is it the talking or the listening which helps?

"I suffered from depression since my teens which is why I thought I needed Existential because CBT didn't work. They were still trying to get me to have CBT and I said 'No it doesn't work for me'. For the first time, someone actually listened to me without condoning me, without any prejudice or judgement, or them trying to impose themselves on me. Not 'You go and do this or that', but more 'How can you cope?' "

(Participant 15, 2010)

Attachment

Good therapy, like good parenting, provides the security and space within which a healing narrative can begin to emerge.

(Holmes 1993: 9)

Is the concept of Attachment (Bowlby 1969) not involved in what all therapists do to some extent? Fonagy (2010) thinks therapists need to acknowledge and invest in *Attachment* as this is how we all make a living! Bowlby criticised both Freud's drive theory and Klein's object relations theory for omitting to take the actual psychological bond between the mother and baby seriously, writing 'The young child's hunger for his mother's love and presence is as great as his hunger for food..... Attachment is a primary motivation system.' (cited in Holmes 1993: 63) His argument is based on natural science where goslings become agitated when separated from a mother who does not provide food (Lorenz 1952) and the

infamous work of Harlow (1958) which showed infant rhesus monkeys prefer a soft loving mother without food to a wire mesh food-providing mother. Ferenczi (1955) goes as far as to say 'it is the physician's love which cures the patient'. Whatever name or label we want to give it, a fundamental premise of therapy is that the client needs to feel trust and safety with this particular therapist; to walk in the door and to be able to start talking, the client needs to believe that this particular therapist can be trusted to help.

"It was the trust element..... I trusted him, to tell him..... could say how I felt, could confront my fears and it helped"

(Participant 15, 2010)

Relationship

Nothing takes place between them except that they talk to each other. 'So it is a kind of magic,' he comments: 'You talk, and blow away his ailments' 'Quite true. It would be magic if it worked rather quicker. An essential attribute of a magician is speed - one might say suddenness - of success. But analytic treatments take months and even years: magic that is so slow loses its miraculous character. And incidentally do not let us despise the word..... Words can do unspeakable good and cause terrible wounds.'

(Freud 1926/1986: 10)

It is through the willingness to contact the patient's anxieties, not to be overwhelmed by them, to work with them, that the analyst forges a working therapeutic relationship.

(Cited in Hinshelwood 1991a: 21: Jaques 1982)

Something about the belief that the therapist can help seems to facilitate change; it is a strange relationship where primarily one person tends to do more listening than the other, it is asymmetrical but reciprocal at the same time, and it highlights listening as an under-rated activity. Is listening, or being listened to, the key to how it works or how this particular relationship works?

"I've done different therapies throughout my life but this was a different one..... Helped me to think, well look, there's nothing wrong with me..... my anxiety attacks are not as frequent, or as severe.....I felt able to say anything"

(Participant 1, 2009)

Being with/being for

Dasein in itself is essentially Being-with

(Heidegger 1962)

If the analyst can survive therapy, perhaps the patient can as well

(Eigen 1998: 67)

Thinking about how dark and dismal depression can be for some people, the experience of knowing there is someone there with you and for you, may be the difference between life and death. In most cases, the client knows the therapist is trying to help. This may be an example of where a label does help; by calling a person a therapist, the client has every reason to believe the therapist can and will help which will maximise the expectancy or hope factor, and this in turn, will actually help to facilitate a positive successful outcome.

"It does feel liberating, in my head.... I had a very good relationship with my therapist and as well as being very fond of him as a person, and feeling that someone could see things about yourself that you quite like without having to make too much of an effort....I dunno...just being there and being....."

(Participant 12, 2010)

Telling the story

.....so the stories that people told escaped me, for what interested me was not what they were trying to say but the manner in which they said it and the way in which this manner revealed their character or their foibles.

(Proust 1911/1992: Vol 6: 33)

In this quotation, Proust, as the great narrator in the study of human psychology via the novel, almost perfectly captures the way in which Freud advocates a psychotherapist *be with* a client to maximise the treatment of psychoanalysis. Although contemporaries, Freud and Proust never met but this is just one example of how much they had in common by capturing the Continental *Zietgeist*. In particular, both held memory as their key themes; Proust's voluntary and involuntary memory aligning with Freud's repression, repeating and working through. Proust's writing illustrates the unstructured manner of talking so typical of the strange conversation common in the therapy room, which uses words, free-association, describing dreams, fantasizing, etc. all as possible ways of accessing that of which we are unaware, or of reflecting on that which has previously remained hidden. It is thought that by paying attention to that which is normally taken for granted, change occurs or, that therapists '... enter the subjective world of the patient and attempt to find words to grasp it' (Alvarez 1992: 466).

As Sartre is famously quoted as saying 'We become who we are through the stories we tell ourselves' (Bragg 2004). This is another way of looking at therapy; maybe we change as we tell and re-tell our stories, gradually the stories we construct are moulded into such an acceptable version that we can then let go of the associated difficulties. The point being that it is not so much what people say as how they say it, how it reveals their character and through the saying of it, how the experience develops and changes.

"I've had this [*counselling*] type of experience about 6 times, or more.....but this was the best so far....it was the method.....she let me talk, then picked up on the important stuff [*non-directive*]. She was unique.... non-stereo-typical; we operated on the same wavelength.....very experienced, quietly clever.....I used to get really uptight, things making me unwell. I've become much calmer."

(Participant 18, 2010)

Strengthening the ego

Where id was, there ego shall be. It is a work of culture - not unlike the draining of the Zuider Zee

(Freud 1923/1973: 112)

What made Freud such a great analyst was that, at least at that time, he never used theoretical formulations, but made his interpretations in simple language.

(Kardiner 1977: 97)

In deference to Freud, it often occurs to me that after some time, and even from the depths of despair, the client starts to talk about feeling faith, or strength or confidence, something seems to emerge from within as helpful..... is this what we do? The sense that someone else is there who cares, is attempting to understand, or to know the client's truth, seems to have the effect of empowering the client to move or think differently.

Bearing the unbearable

Even in gone, black hole states, someone was there, clinging to life.

(Eigen 1998)

In 'The Value of Reconstruction' Brenman states that it is not enough in clinical practice, as opposed to theory, to analyse truth and resistance, if the patient does not have an object who can bear with him what is felt to be unbearable, not only in the present, but also in the past, an object that will go with the patient in an exploration.

(Brenman 2006: pxviii)

Sometimes being with someone whilst they express the most excruciating and painful experiences feels almost unbearable but very often, the client expresses immense relief during the following session which is why this idea particularly

resonates. It would be difficult to know whether it is putting the feelings into words or having someone to *bear the unbearable with* is what helps, but it is a common enough experience to note. The effect of translating the experience into words is similarly described by Hinshelwood (1992: 256) where the therapist acts '.....as a container for the patient's intolerable experiences, which, through the analytic process of putting experience into words, are thereby contained.'

"It [*the panic attacks*] was terrible. I wished, I wanted to be dead..... I came here feeling really depressedI thought 'what good can I get from talking to someone, having all this lack of energy, fear all around me, I mean, talking to someone, how can that possibly change what I'm feeling.... but then it started to happen and I think 'Wow!' Really eased my mind, you know, there is nothing physically wrong with me."

(Participant 4, 2010)

1.3.4 Does the theory support the practice?

These are some of the influences which commonly emerge as factors relevant to effective therapy, regardless of the modality, and it is clear that with such abstract and vast ideas, it seems like a monumental and limitless task to test for or measure if any one of the above was the pivotal factor or to single out one thing which was key in facilitating a positive therapeutic outcome. To elaborate, for example, if one takes a psychoanalytic view that unconscious motivations have a strong influence in driving much of our behaviour, it is no good asking a person if X helped because they a) may not know or b) are quite likely to deny it, even if true, or c) may say yes for a variety of reasons such as wishing to please the therapist who has been so helpful. This is just one point of view to illustrate the difficulties involved in research, particularly researching non-specific factors.

One major and dominating question related to the value of technique is 'How do clients withstand the fallibilities of the trainee, and still benefit?' Bearing in mind

that a great deal of the psychotherapy in the NHS is carried out by trainees with varying levels of experience and, as revealed in this research, the clients still appear to benefit. They seem to benefit whether I practice *Existential-Phenomenological Therapy* or *Psychoanalytic Psychotherapy* and when I make mistakes, according to the technique or method, the client seems to be able, not only to withstand my mistakes but appear to benefit even further. As a novice, I was clearly not practising by strictly adhering to any manualised techniques. Ruptures may be valuable experiences for several reasons such as the de-idealisation of therapist, with one idea being that once the client feels for the therapist not being able to 'do' anything to help, there is an emotive shift in the client possibly taking personal responsibility within this relationship. Spinelli writes

Leslie Farber proposed, this willingness on the part of the therapist to show their vulnerability may well provoke the client to experience 'pity' toward the therapist (Farber 2000).... it was precisely the onset of this pity that was the most reliable indicator of a likely beneficial therapeutic outcome for the client. For, in feeling pity, the client reached out to an uncertain - and hence imperfect - being. The impact of this was twofold. First, via the act of reaching out to the therapist, the client simultaneously 'broke out' of his or her self-centred, self-focused, other-excluding stance and began to recognise the existence of the present other (the therapist). Second, via the act of reaching out in pity toward the therapist, the client at the same time, 'reached in' to find and accept his or her own uncertainty.

(Spinelli 2007b: 77)

As complex as these issues are, this thesis argues they may be accommodated with an Existential-Phenomenological Therapy framework which supports the idea that there may be many different ways of working, adopting one or more theoretical approaches whilst being mindful that there are always other possibilities. The therapist's allegiance to a particular approach is important for a successful therapeutic outcome, or as Wampold writes 'One of the sacrosanct assumptions of a client is that their therapist believes in the treatment being delivered' (Wampold 2001: 159). This is difficult for EPT because although we believe therapy relieves

suffering, we do adhere to a stance of not knowing, or maybe un-knowing (Spinelli, 2007b: 64) is a better term. However, if we keep the idea of a contextual argument in mind, that is that it may be sufficient for some clients, as long as we maintain a professional therapeutic stance, to *be with* them, it may not be so important what we are *doing* in terms of techniques or 'manualised therapy'.

There are many theories about what it is that works or how therapy works and this project cannot possibly do justice to all of them. As an initial exploration into how EPT works, and as well as questioning whether it works, three research themes have been selected for their relevance to the philosophy of existential thinking. The first is a questionnaire based on the work of Frankl (1966) and centred around the importance of meaning for a flourishing life, it asks whether the clients feel their sense of purpose in life has increased after therapy. The second questionnaire asks the client to describe and then rate the level of severity of the two main problems for which they are seeking therapy. As EPT challenges assumptions, questions attitudes and beliefs, it is hypothesized that the severity rating score of the problem will decrease after therapy, regardless of whether or not the symptom has changed. The third questionnaire is an attempt to identify the type of person for whom EPT may be most suitable. It attempts to identify introverts and extraverts with the hypothesis that the therapy will not have any effect on the type of person. It is also thought that EPT may be more suitable for those whose language it speaks, therefore, introverted people are characterised as being more interested in ideas, beliefs and philosophy as opposed to extraverts being more interested in facts and figures. It is expected that introverts would be clients most suitable for EPT. These questionnaires and rationale for using them are described in more detail below:

1.3.5 Purpose in Life Test

This Purpose in Life Test (Appendix D) was developed by Crumbaugh and Maholick (1964, 1969) in an attempt to measure an individual's sense of purpose or meaning in life. It was originally based on Frankl's (1946/1985; 1969) theory named *Logotherapy*. Practising as an existential psychiatrist in Vienna, he believed that the primary motive in human beings is the 'will to meaning'. Logotherapy was developed from his own early personal experiences, which he described as 'total and ultimate nihilism' (Frankl, 1988: 166 cited in Cooper, 2003) where he suffered from an intense 'hell of despair' over the meaninglessness of life. Frankl believed that the 'will to meaning' was the primary motive in humans in contrast to Freud's 'will to pleasure' or Adler's 'will to power' (Frankl, 1969: viii, 34-36).

In 1969, Frankl believed that there was an increasing presentation of a new type of neurosis seen in clinics whereby individuals describe a lack of sense of purpose or meaning in their lives. He theorized that when meaning is not discovered, an *existential vacuum* is experienced; this is not necessarily pathological but a *given* of the human condition. An existential vacuum may be pathological if it manifests in symptoms such as boredom and a complete emptiness of purpose in life. He named this experience *noogenic neurosis* and felt that it accounted for approximately '20% of the neuroses one encounters.' (Frankl, 1969: 90). It is hypothesized that Logotherapy is suitable for those individuals experiencing symptoms of noogenic neurosis.

The Purpose in Life Test is an attitude scale designed to measure the degree to which an individual experienced a sense of *purpose in life* (Crumbaugh & Maholick, 1964). The results distinguished a significant difference between those groups who were highly motivated (non-patients) and those who were the most seriously ill (patients). It supported the existence of Frankl's *noogenic neurosis* that is, 'a breakdown due to 'existential frustration' or a lack of perceived meaning or

'purpose' in life.' (Crumbaugh & Maholick, 1964: 206) The Purpose in Life (PIL) test is an 11 question sample with a 7-point Likert rating scale whereby total scores range from 11 (low purpose) to 77 (high purpose).

With the emphasis on meaning inherent in existential philosophy, it is anticipated that those for whom this type of therapy may be effective would be clients who are experiencing a pathological lack of sense of purpose in life when entering therapy, and that, assuming the therapy has been effective, this score would increase after therapy, in other words, their sense of purpose in life would expand.

1.3.6 Problem Rating Scale

The Problem Rating Scale (Appendix E) is a self-rating questionnaire first developed by Gelder and Marks (1966) to research whether behaviour therapy is effective for agoraphobic patients. The patient is asked to identify up to two difficulties that they would like to work on in therapy. They are then asked to self-rate the severity of these two problems on a scale of 0-8 with 0 being *Not at All Severe* and 8 being *Very Severe* pre and post therapy.

It is anticipated that the score will be high (4-8 severe) before therapy and drop significantly after therapy (1-4 less severe).

This is a very simple test that was thought suitable for use in gauging how the participant perceives their difficulties. If, as EPT postulates, challenging and questioning assumptions, values and beliefs has an effect on the way someone lives their life, the same problem may be viewed very differently before and after the experience of a psychological treatment intervention such as EPT. One advantage of this test is that it does not focus on removing the symptom but asks how severely it is perceived to be at two points in time. The weakness of this test is lack of validity and reliability ratings, therefore, results can only be viewed very tentatively and at this stage, may not be generalisable to a larger population.

1.3.7 Direction of Interest Questionnaire

The Direction of Interest Questionnaire (Appendix F) was originally devised as a measure of the Jungian concept of extraversion and introversion whereby an individual's *direction of libidinal flow* is thought to be either inward or outward. It is a fourteen-item forced choice questionnaire which distinguishes between an interest in ideas, imagination, theory, religion, philosophy, unconventionality and emotional problems (inner directed) on the one hand and an interest in facts, practical problems, biochemistry, common sense, engineering, cosmetic science, personal ambition, power and action on the other (outer directed) (Caine et al. 1982). The contemporary theory being that those with an *inner direction of interest* have a preference for a psychological approach (contextual argument) whereas those with an *outer direction of interest* have a preference for a psychiatric approach (medical argument). It was posited that personal preference for a particular approach was a 'rational, systematic framework for treatment selection in the psychological and psychiatric therapies'. (Caine et al. 1981)

There has been recent research (cited in Cooper, 2008: 68) to show that personal preference for a particular style or approach is not necessarily a good indicator of a successful outcome but the use of the Direction of Interest questionnaire in this instance was thought to be appropriate in an attempt to highlight the following aspects:

- ❖ Does the extraversion or introversion remain constant pre and post therapy?
- ❖ Is there a preference by extraverts or introverts for Existential Therapy?

This great dichotomy between doing (CBT) and being (EPT) may be a vivid example of Jung's (1923) two personality types; *Extraverts* who tend to be outer-directed, pre-dominantly experiencing and making sense of the world in concrete facts and figures and *Introverts* who tend to be inner-directed, experiencing the world pre-

dominantly using symbols, metaphor and philosophical ideas. If, as hypothesized above, we are drawn to approaches which speak our language, this could provide an credible explanation for the long drawn out disagreements between those who believe in techniques and those who believe in ideas, as expressed in The Great Psychotherapy Debate (Wampold 2001).

Direction of Interest is consistently related to the general factor of 'conservatism', with the more inwardly directed subject adopting more radical attitudes with regard to a wide variety of social issues. The more inwardly directed psychiatric patients tend to express a larger number of critical attitudes towards the self and others. There is some evidence to suggest that an inner direction of interest is associated with a greater degree of empathic skill.

The questionnaire has been found to be consistently related to attitudes to psychiatric treatment in general population, medical, nursing and psychiatric patient samples. An inner direction of interest has been found to correlate with a more psychological approach to patient care and treatment. An outer direction of interest has been found to correlate with a more organic, physical, scientific approach. Direction of interest has been found to relate to treatment allocation (psychotherapy or behaviour therapy) in a number of studies and it would appear to have implications for vocational guidance. Inner and Outer-directedness was also found to be significantly related to the Direction of Interest Questionnaire in both patient and non-patient samples.

(Caine et al. 1981)

Similar ideas have been researched more recently looking at the reasons why therapists practise within different orientations in an attempt to discover whether there are distinctive trait patterns associated with different approaches. Looking at two major orientations, psychoanalytic and behavioural, it was found that 'different patterns of personality and cognitive-epistemological traits are associated with practitioners from these two orientations.' (Arthur 2000: 243) The behaviourists (medical model) tended to investigate hypotheses using physical-sensory data that are concrete, objective, observable and measurable and see themselves as rational and empirical and being active, practical, assertive, dominant and extrovert. The

psychoanalytic psychotherapists' (contextual model) tended toward intuition, having ideas, imagination and see themselves as serious, complex and having metaphysical thoughts whilst being passive, impractical, non-assertive and reactive. (Arthur 2000: 244) In this research context, existential therapists would be aligned with the psychoanalytic psychotherapists in their more unstructured or unfocused approach to therapy.

The current hypothesis being that those with an *inward direction of interest*, introverts who construe their world in terms of ideas, philosophy, meaning and unconventionality, would be clients most suitable for Existential-Phenomenological Therapy.

Existential therapists involved the study also completed the DIQ with the anticipation that they would have an *inward direction of interest* congruent with the philosophical values associated with this type of therapy and an empathic attitude.

1.3.8 Summary

This section has set out what it is that the client might find helpful and is distinctive about Existential-Phenomenological Therapy. A whole thesis could be written on any one of them but for the purposes of this project, each theory has been introduced to support a contextual, or common factors argument. We still do not know what it is exactly that helps, and because each client is asking for something individual, maybe we will never know but it is hoped to extract some initial indications using the above questionnaires.

The main thrust of this paper is that regardless of which therapy one adheres to, including CBT, all or some of the above factors may be inherent aspects of delivering therapy; as therapists, we adopt a position of *being there/being with and being for* our clients, of absorbing and surviving the onslaughts or unbearable feelings, and like a parent, there is often an emotional connection which may or may not alleviate the feeling of being alone, or the sense that 'I can't do this alone',

just enough to inspire hope or facilitate confidence for the individual to take responsibility for the direction of their life. The difficulty is trying to identify amongst all these factors what it is that helps and what it is that pre-dominates as peculiar to EPT so that evidence of its particular effectiveness can be produced. Despite not knowing, time and time again, and despite our fallibilities in addition to not knowing, we see clients repeatedly walk back in through the door as the most concrete bodily expression that somehow therapy helps.

1.4 Affective Disorders: Depression and Anxiety

Psychoanalysis promised more than it could deliver. Freud himself said that psychoanalysis was good only for "ein kleine Neurose" - a small neurosis.

(Kardiner 1977: 120)

1.4.1 What is an Affective Disorder?

'Affects' is an old psychological and psychiatric term for what the layman would term an emotion or a feeling such as love, hate, anger, greed, pleasure, disgust, happiness, joy. (Alvarez 1992: 75). These feelings are normal responses to the ups and downs of life but thought to be disordered when an individual is overwhelmed by one or several emotions to the extent that normal life is not possible: emotions take over in such a negative way that functioning and well-being cannot flourish and problems seem insurmountable. It may be that a person feels so bad, sad or low that he/she feels life is no longer worth living and the risk of self-harm and suicide is high. Depression and anxiety are the most commonly presenting affective disorders in the NHS reflecting Seligman's description of depression as 'The common cold of psychopathology, at once familiar and mysterious' (cited in Pilgrim and Bentall 1999: 265). Use of the term *Affective Disorder* was also a deliberate choice in an attempt to draw attention to the approach of existential philosophy that resists the use of unnecessary and, some would argue, possibly dangerous, labels and diagnoses, particularly when depression is an ambiguous term and may be better

regarded as 'pragmatic shorthand' for use amongst professionals.

The term *Affective Disorder* is meant to be inclusive and exclusive; inclusive of all those clients who present in NHS Secondary Care seeking psychological treatment interventions for their difficulties in living, regardless of diagnosis, and exclusive of limiting research to one diagnosis such as depression or anxiety. It is fully accepted that diagnostic labels are required for efficient communication within the medical world but an existential perspective challenges the view that diagnosis is always quite so clear-cut and to quote Wampold '... no one convenient definition of severe depression exists' (Imel and Wampold 2008: 251). The danger being that it can stigmatize people with a disease or illness by medicalising normal aspects of human nature such as sadness or misery. For the purposes of this study, the term *Affective Disorder* is used to refer to the most commonly presenting difficulties in the NHS, which are depression and anxiety, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (2000) and referred to under category headings of Mood Disorders and Anxiety Disorders respectively.

Therefore, in this study the term *Affective Disorder* was meant to express an all-encompassing interest in those adults who found they required help in coping with their moods or feelings to the extent that this was restricting their lives unacceptably.

Clinicians at the Psychological Therapies Service do not routinely diagnose patients so this term is in line with the idea of the research attempting to capture real world experience. A clinical description of depression or anxiety may be written on the client's notes but this is not regarded as an official diagnosis. Most of the research participants' main presenting difficulty was described as depression, often stating anxiety as a secondary difficulty.

1.4.2 Depression

The term *depression* was derived from the Latin verb *deprimere*, "to press down" and its use to describe subjugation or bringing down in spirits can be found dating from the 14th century. (Wikipedia 2011)

Within the UK, NHS NICE Treatment Guidelines (2009) are based on the DSM-IV Definitions of Diagnosis and recommended treatment interventions range from medication and/or psychotherapy to electroconvulsive therapy (ECT). Depression is comprehensively, if ambiguously, covered in a 75 page Section entitled Mood Disorders which states that 'this section includes disorders that have a disturbance in mood as the predominant feature' (APA 2000: 325). This Section divides Mood Disorders into Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, Bipolar Disorder Not Otherwise Specified, Mood Disorder Due to a General Medical Condition, Substance-Induced Mood Disorder, and Mood Disorder Not Otherwise Specified. In order for this project to sit within a relevant NHS context, the following definitions have been selected to provide a foundation and describe what is commonly understood by clinicians to be depression:

Depression is a broad and heterogeneous diagnosis, characterised by depressed mood and/or loss of pleasure in most activities. Severity of the disorder is determined by both the number and severity of symptoms and the degree of functional impairment.

(NICE 2009)

Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful) **Note:** In children and adolescents, can be irritable mood.
 - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
 - (4) insomnia or hypersomnia nearly every day
 - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - (6) fatigue or loss of energy nearly every day
 - (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode (see p. 343)
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

(APA 2000: 336)

Severities of depression are as follows:

Sub-threshold depressive symptoms Fewer than 5 symptoms

Mild depression	Few, if any symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment
Moderate depression	Symptoms or functional impairment are between 'mild' and 'severe'
Severe depression	Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms

Depression is described as 'chronic' if symptoms have been present more or less continuously 2 years or more.

(NICE 2009)

1.4.3 Anxiety

In the DSM-IV, anxiety is described under a Section entitled Anxiety Disorders and includes Panic Attacks, Agoraphobia, Panic Disorder without Agoraphobia, Panic Disorder with Agoraphobia, Agoraphobia Without History of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Substance-Induced Anxiety Disorder and Anxiety Disorder Not Otherwise Specified. The NICE Guidelines provide the following definition:

Generalised anxiety disorder (GAD) is a common disorder of which the central feature is excessive worry about a number of different events associated with heightened tension. It can exist in isolation but more commonly occurs with other anxiety and depressive disorders.

(NICE 2011)

1.4.4 Psychological Interventions

The NICE Guidelines are based on recommendations for psychological treatment interventions based on diagnoses and therefore, this section briefly describes how Psychoanalytic Psychotherapy in the NHS, Cognitive Behavioural Therapy and Existential-Phenomenological Therapy approach depression.

According to the World Health Survey (2007),

‘Depression produces the greatest decrement in health compared with the chronic diseases angina, arthritis, asthma, and diabetes..... and is rated the fourth leading cause of disease burden in 2000 results (2007) indicate the urgency of addressing depression as a public health priority...to improve the overall health of populations’

(Moussavi et al. 2007)

Depression is twice as common in women as men (Kuehner 2003). Whilst acknowledging the critique that we may be over-medicalising ordinary human sadness, the universal distress described above and the fact that depression is the most commonly described state leading to suicide, it is taken seriously in mental health settings. Depression as an ailment has a long and complex history dating back to Hippocrates 460 BC, and this project cannot possibly address all the differing treatment methods currently available. In order to illustrate just how different psychological treatment interventions can be in the way they approach depression, and in support of a contextual argument, a brief outline of three possible perspectives are briefly outlined below.

Psychoanalytic Psychotherapy in the NHS

In Freud’s seminal paper *Mourning and Melancholia* (1917/2006: 310), he tentatively attempts ‘to cast light on the nature of melancholia [*depression*] by comparing it to the normal affect of mourning’ and, almost 100 years ago, describes the same issues we are still struggling with today:

.....we must begin our account with an admission which should warn us against overestimating our conclusions. Melancholia, the definition of which fluctuates even in descriptive psychiatry, appears in various different clinical forms; these do not seem amenable to being grouped together into a single entity, and some of them suggest somatic rather than psycho-genetic diseases.

(Freud 1917/2006: 310)

He describes how these two conditions are similar and yet, we do not consider mourning as a pathological condition even though it produces severe deviations from normal behaviour. It is expected that after a period of time, it will be overcome and therefore, interfering with this normal behaviour is considered pointless or possibly even damaging. In contrast

Melancholia is mentally characterized by profoundly painful depression, a loss of interest in the outside world, the loss of the ability to love, the inhibition of any kind of performance and a reduction in the sense of self, expressed in self-recrimination and self-directed insults, intensifying into the delusory expectation of punishment. We have a better understanding of this when we bear in mind that mourning displays the same traits, apart from one: the disorder of self-esteem is absent. In all other respects, it is the same.

(Freud 1917/2006: 310)

Freud suggests that in mourning, it is clear what has been lost and although melancholia may be in response to the loss of a loved one, often this is not the case, and then it is more confusing because one cannot clearly see what has been lost. In addition and in contrast to mourning, there is a loss of self-regard and Freud also notes that the typical symptoms of sleeplessness and loss of appetite indicate the opposite of a will to live. He identifies the flavour of morality which is often characteristic but this tends not necessarily to apply to the melancholic but rather fits someone else who he loves, has loved or should love. This leads Freud to theorize that 'the self-reproaches are reproaches against a loved object which

have been shifted away from it on to the patient's own ego' (Freud 1917/2006) and that 'Everything derogatory that they say about themselves is at bottom said about someone else.' Some kind of relationship has been lost for which the patient feels completely shattered. There is a fury and hatred for the object which seems to be turned on the ego as if it were the object 'The shadow of the object falls on the ego.' (Freud, 1917: 249 cited in Alvarez 1992: 370)

Freud's ideas were developed by Klein, Fairburn, Guntrip, Abraham and Winnicott into what is now loosely described as the Object-Relations School. This awkward term is meant to differentiate between a Freudian pleasure-seeking or instinctual drive model to a more relational model whereby the subject is primarily object or other-seeking. As much as transference is the cornerstone of psychoanalytic theory (Alvarez 1992: 369) and as practised today in the NHS, it is also based on the real relationship with the therapist. How does the client relate? What is the nature of his/her object-relating? In support of a contextual argument, this method turns on the use of the therapeutic relationship to explore and examine the client's way of relating. If it can be accepted that the main difference between mourning and melancholia, normal and abnormal, is the loss of something valued alongside an attack on oneself, and without totally re-hashing Freud's theory nor suggesting that it is the only possibility, these original ideas may be useful to bear in mind for practice today by holding this puzzling question in mind 'What is it that has been lost?' 'What is studied is a relationship, a duet, not a solo.....psychoanalysis is unique among the sciences in that the observer is also the observed' (Atwood, 1987 cited in Alvarez 1992: 202) Freud's theory is crudely summarized here to convey the importance of relatedness in *Psychoanalytic Psychotherapy in the NHS* (APP) whilst also noting that a strong predictor of a successful outcome is the strength of the therapeutic relationship (Roth and Parry 1997).

Depression in psychoanalytic terms means the loss of a loved object. It is unclear what or how that object is but the process and method of psychoanalytic psychotherapy is an attempt to make *the unconscious conscious*, in other words, to

help reveal what the client is unaware of through the use of the therapeutic relationship. '.....an unconscious conception is one of which we are not aware, but the existence of which we are nevertheless ready to admit on account of other proofs or signs.' (Freud 1912/1986: 136) Freud's work is so often taken out of context, misquoted and it is often forgotten that he continually reminds his reader these are tentative ideas and that his theories are conceptual tools. In the fifteen pages of 'Mourning and Melancholia', he reminds his reader approximately eight times to be cautious about these tentative ideas which he fully acknowledges are only based on a small number of cases. Remember, this is just an abstract theory and incomplete.

In practice, the therapist encourages the patient to talk about whatever comes to mind (everyday concerns, wishes, dreams, fantasies, free association, etc) and immerses him/herself in the experience of what it is like to be with this particular person. Whilst no attempt at change or cure is made, interpretation of the transference is used as a way of testing what is true or false for the patient and empowering their self-knowledge. Modern psychoanalytic psychotherapy does not use interpretation to impose a particular view on the patient but uses the method of *interpreting the transference* as a possible way of accessing, entering and exploring the patient's world. This attempt to always follow the patient in an unstructured way means it is the least directive method known to the author, against a background of solid framework boundaries such as time, place and duration.

Although a new object relationship is formed via this process of describing and exploring relatedness, it is hypothesized that the therapist will experience or be subjected to the patient's usual way of relating. The therapeutic relationship could be described as an echo of other relationships in the patient's world but it is different, and it may well be this novel helping relationship itself that is the facilitative factor for alleviating the symptoms of depression.

Cognitive Behavioral Therapy

Based on Beck et al.'s (1979) manual, Cognitive Behavioural Therapy is aimed at evaluating, challenging and modifying what is described as the patient's present dysfunctional beliefs and premised on the theory that these maladaptive thoughts affect current behaviour and future functioning. The treatment for depression emphasizes homework assignments and outside of the session activities whereby the therapist exerts an active influence over the interactions, topics of discussion, uses a psycho-educational approach to teach patients new ways of coping. (Cuijpers et al. 2008: 911) This is very much an approach which, although collaborative, is based on the doing aspects of therapy implying that the therapist takes the expert role in treating depression, and the client is required to comply with the directives.

Focussing mainly on external factors, CBT recommends a conscious attempt to change overly negative thoughts into positive thoughts by tackling simple healthy activities such as regular sleeping, eating well and taking exercise. These activities may seem obvious when well but can somehow seem impossible when suffering from depression. It could be that a patient needs to be told what to do in some circumstances and/or it may be possible to 'do something' like looking after oneself for someone else, the therapist for example, when it was not possible to do anything for oneself alone. The therapeutic relationship could be described as an indirect effect or by-product of this technique. With all this focused activity, it is blatantly clear to all parties that this is meant as a helping relationship that may, in itself, be the facilitative factor for a successful outcome of the therapy.

Depression in Cognitive Behavioural terms takes the view there is a fault in cognitions, and therefore, it focuses on fixing faulty thinking by attempting to do things differently. It is thought that this change in behaviour will have the effect of a more healthily balanced attitude including both positive and negative thoughts. The treatment addresses what is regarded as an imbalance towards unhealthy,

negative thoughts and feelings with the idea that consciously and deliberately changing thought patterns means that the feelings and behaviours will also change.

Existential-Phenomenological Therapy

Firstly, it should be noted that an Existential-Phenomenological Therapeutic attitude resists the use of the term depression in the medically constructed way it is meant within this context, that is, within a NHS environment where there is a demand for evidence to be provided for diagnostically specific pathologies. NICE Guidelines are produced for specific diagnoses. EPT does not adhere to the use of labels or diagnosis owing to the fact that they tend to be ambiguous, non-specific, stigmatising and do not fully describe the individual's experience mainly because they are nearly always too general. There is a resistance to diagnosis, treating a disease or pathology rather than the other way round, that is, treating a human being, and the use of a method of psychotherapy to cure a person or remove symptoms. However, being realistic about the limits of working within the NHS and not wishing to deprive clients of a choice of psychological treatment interventions, the above NICE Guidelines for depression and anxiety are accepted for the purposes of attempting to provide evidence that EPT is a suitable psychological treatment intervention for some clients presenting with affective disorders such as depression and anxiety. How else can we work within this context?

An Existential-Phenomenological Therapeutic stance views depression as a mood, attitude or relatedness a human being takes towards the world and not necessarily seen as something to be cured but rather, a way of being whereby this attitude expresses the client's being-in-the-world (Heidegger 1962: 78). According to this philosophically-based perspective, depression reveals the person's current stance towards life so, exploration of the individual's lived experience is seen more as an investigation than a cure in the sense that the client and therapist are interested in finding out 'What might this symptom be saying?' (Spinelli 2007a)

For the purposes of this study, the NICE Guideline definition of depression and anxiety is accepted and with the knowledge that there may be many other ways of applying Existential-Phenomenological Therapy, the following is an outline of a way of approaching a client presenting in the NHS with depression which is based on Spinelli's book 'Practising Existential Therapy' (2007). My interpretation is that an EPT psychological treatment intervention is based on

- ❖ Relatedness
- ❖ Uncertainty
- ❖ Anxiety

If the basic premise of EPT is **relatedness**, it follows that a client presenting with depression is expressing their being-in-the-world in this way, there is a loss of pleasure in normal activities accompanied by low mood and although the general connotations surrounding the concept of depression are negative and the reason the client has come to the NHS tends to be an attempt to get rid of this way of being, EPT does not necessarily assume this stance. EPT attempts to accept a client's description of what their depression is like and shows a particular interest in what it means but also, comes from the viewpoint that there are many other possibilities and ways of being in the world, so how is it that depression best expresses this client's current experience now. It is common for those with depression to report feeling low, stuck and as needing help to get rid of this way of life. 'I am depressed' is seen as the truth with the connotation is that this is all bad, wrong and needs fixing but adopting a philosophical approach can firstly mean challenging the assumption that it is all bad. **Uncertainty** in this context could mean questioning the 'stuckness' combined with the knowledge that the client has walked in the door asking for help with change. This new behaviour, an attempt to reach out and to form a new relationship is the most powerful indication that there is a glimmer of hope or the will for another possibility, via the therapeutic relationship, whether the client is aware of this or not.

Based on the idea that within limits, we are free to choose how we behave, and in this context to decide whether we come to therapy or not, which raises the question as to what are the pros and cons of being depressed in the world. Often clients will describe depression as being stuck in this distressing way and tend to focus on the negative aspects of their lives but as in all aspects of life, there are negatives and positives. Maybe the positives are just hidden from view at the moment, but maybe not? Whilst respecting it is rarely this simplistic, an attempt to explore this depressed mood truthfully often reveals there are some personal gains. For instance, during an investigation about what it means to be depressed, clients will often admit that it is nice not to have to get up out of bed and go to work, or to have to socialise with others or to feel relieved of normal routine responsibilities. The implicit **anxiety** around feeling this low, this disinterested, this bad provokes a valuable question about how am I to live my life. Therefore, depression is also to be regarded as a valuable embodied expression of the client's conflict around an authentic or inauthentic way of being-in-the-world and generally, this is the client's way of bringing their uncertainty to light. If viewed with the obvious connotations that depression is bad, it can also be an embodied way of saying 'something is wrong in my life, please help me to find out what that is', so another side of depression is that it points towards the client's perception of their need for change. Depression has brought the client to therapy but holding onto relatedness being linked to uncertainty, the therapist needs to explore what that means for this particular client from a position of un-knowing.

As therapists, the genuine and truthful response to what is the most suitable psychological treatment intervention for depression as classified by DSM-IV is that we do not know. What we do know is that by asking questions about individual meanings, challenging client's beliefs and assumptions, trying to understand and acknowledging possibilities, more often than not, results in a client's relatedness towards depression changing. These changes seem to result in a reduction of distressing symptoms that is perceived as helpful by the client and reflects the same discovery made by Freud almost 100 years ago, physical and mental symptoms

often seem to disappear with the *Talking Cure*. A commonly presenting paradox seems to be around a client coming to therapy that suggests they want change but their habitual behaviour (feeling low and stuck) suggests the client wants to stay the same. It is by applying an existential-phenomenological philosophy towards therapy as a psychological treatment intervention that seems to help some clients. This is based on Heidegger's (1962) idea of human beings as *Dasein*, being there, and how we can be there for our clients by *being with* and *being for*, combined with Husserl's (1969) notion of phenomenology, paying attention to what emerges in the 'here and now' in the therapy room with the therapist. This means attempting to bracket, equalise and horizontalise whatever emerges in the dialogue and to become immersed in what it is like to be with this particular human being now, and by exploring the meaning of their experience by focusing on how they are coping or not coping, for example.

The following is a very simplistic description of an imaginary EPT process:

NHS Depression EPT as a Psychological Intervention	Therapy Room as Microcosm Being With/Being For	Outside World as Macrocosm Being-in-the-World
Relatedness (negative and withdrawn from others; loss of interest, feels bad all the time) Inability to feel connection	Client: I'm depressed, feel bad all the time, please help me get rid of it. I want to be back to my old self.	Depressed but decided/motivated to seek help to change something by going to therapy
	Therapist: Not so quick, before we decide to get rid of it, tell me what its like	Permission to stay with or be with eases anxiety about having to be something else and encourages truthful dialogue. I would also argue that it gives the client the impression that the therapist understands, wishes to help which also aids the establishment of an initial connection/rapport
	Client: No energy, enthusiasm, interest	I do quite like lying in bed till midday....not having to speak with people, not having to go to work
Uncertainty (stuck and can't see any possibilities, except therapy is a possibility) Uncertainty over who I was, am and will become	Client: I want something different	
	Therapist: What do you mean?	Description facilitates a more comprehensive description
	Client: I don't know what I want. I hate my job. I'm wasting my life. It's all point- less. Therapy is the only thing I can do in the week.	I can get up to come to therapy. I do like speaking with my therapist.
Anxiety (Wasting my life, how can I live with it?) Detached from lived experience, a sort of sensory/affective dissociative experience	Client: I am interested in talking about my life project. This is the highlight of my week.	I do like speaking with my therapist but I don't like speaking with the liars and hypocrites at work
	Therapist: Tell me what it is about talking with me that you do like	Clarification opens up possibilities Attachment to therapist?

It is rarely as simple as this, in fact, it is nearly always much more complex so the above is a condensed and exaggerated version for academic purposes only with the intention of making a point about how the therapeutic relationship itself may well be the crucial tool which helps the client. It could be said that most people come to therapy for help with relationships, even if that is not how it is initially described, but it follows from this that if our relationships are good, we usually feel good and vice versa. Depression can be characterised as an attempt at withdrawal and loss of interest in any type of relating but the therapeutic relationship may be the first step in reversing the situation, whether the client is aware of this or not. This is concisely summarised by du Plock (1998)

Existential psychotherapy is not about indoctrinating the client to become an existentialist, but is encouraging the client to engage with their way of living, informed by a philosophical attitude.

(in du Plock 2002: 332)

EPT is a client-led unstructured approach that makes no attempt to change behaviour or remove symptoms but rather to clarify what it means to the individual, to explore experience truthfully and to aid understanding using the most distinctive human attribute, dialogue. It could be described as directive in that the therapist tends to encourage the client to stay with their uncomfortable feelings and explore them whilst being made aware of other possibilities and challenging current thinking and assumptions. Again, this idea is summarized in a concise way by du Plock;

For me the crucial point is what we do with experience - do we really experience our experience - in which case it becomes fully available to us - do we incorporate parts of it into our sedimented self-construct, and disregard those aspects of it which challenge this.

(in du Plock 2002: 336)

In these terms, depression means a stance, a valuable stance towards the world which can include past, present, future, internal and external aspects of life,

dreams, wishes, fantasies, etc., all of which are given equal importance with the aim of clarifying key questions such as 'What does this mean?' and 'How do I live with it?' Regardless of whatever is talked about, what also does emerge is a helping relationship and like it or not, this helping relationship is motivated by the client first expressing a need 'I wantX or Y, or don't know'. Change is a given.

Depression in terms of Existential-Phenomenological Therapy is a social construct that, by implication, means it can be deconstructed as described by van Deurzen, 'If we accept the notion that self is only a relation and not a substantive entity, then destruction is always also self-destruction and this can be a key to its resolution as well'. (2009: 93) Regardless of the validity of the medically constructed concept of depression outlined above, in EPT the meaning of depression to the individual in therapy is what is important and how that meaning manifests in the client's life, what it allows and forbids, what are its' benefits and losses, and how does one live with it. Due to the characteristic negative connotations surrounding depression, the client often presents as being stuck with this low mood, wishing change or wanting to get rid of it somehow without noticing that there are also gains to this behaviour or acknowledging that there are other possibilities of which the client has chosen to ignore or is unaware. Regardless of how low the client presents and however much the client describes she is stuck, her behaviour by walking into the therapy room shows he/she hopes and believes there are other possibilities.

1.5 Summary of Purpose

I think that the desire for knowledge exists alongside love and hate. Human beings have an urge to love, to hate, to know, and a desire to be loved, a fear of being hated and a wish to be understood.

(Britton 1998)

With such varying epistemological perspectives, it may be surprising that there is any overlap or convergence at all but according to meta-analysis comparing treatments '....it seems safe to conclude that there are few significant differences in efficacy between most major types of treatments of mild to moderate depression, including cognitive-behavioural therapy.' (Cuijpers et al. 2008: 919) Existential-Phenomenological Therapy and Psychoanalytic Psychotherapy seem to have most in common in their approach towards depression in that they are both empowering by allowing the client to lead the therapy session content, with the aim of uncovering what may be hidden or unconscious, and not making any attempt to cure or change symptoms. Whilst the existential therapist adopts a position of un-knowing, described by Spinelli as an 'attemptto remain as open as possible to that which presents itself as the client's narrative' (2007b: 64) and the psychoanalytic therapist adopts a position of not knowing 'I did not have to know myself analytically as much as I had to tolerate not knowing' (Epstein 1998: 17). The underlying premise for both being that talking therapy will facilitate a more comprehensive awareness of relatedness that results in change. Cognitive-Behavioural Therapy is much more directive in that the therapist takes the role of instructing the client in learning new ways of behaving and although collaborative, the therapist is seen as the expert teacher who directs the client's conscious activities with the aim of facilitating healthy functioning by removing negative symptoms. The underlying premise of Cognitive-Behavioural Therapy being that if the client engages in certain health-provoking activities, this behavioural change will make him/her feel better; the thoughts will affect the feelings.

Adopting the view that different people need different things at different times, it may be that a person is receptive to the language of one approach which, for example, focuses on conscious aspects of experience at one time in their lives but requires an approach which focuses on unconscious aspects of experience at another time. CBT tends to focus on aspects of experience of which we are aware, or conscious, psychoanalytic psychotherapy tends to focus on aspects of experience of which we are unaware, unconscious, and EPT gives equal weight to all aspects of experience, paying attention to phenomena as and when it emerges.

The weaknesses of each approach have not been fully described but rather implied by comparison with one another. All psychological theories are incomplete or inadequate to the task of providing a fully comprehensive explanation or description of human beings and therefore, focusing on one aspect such as what is conscious is at the expense of omitting its opposite, what is unconscious, for example. EPT aspires to be open to all possibilities available to human beings but this carries with it the criticism that as a therapy, it is too open, does not provide definitive, precise or concise answers and therefore, does not sit well within the medical world of evidence-based medicine and treatments.

The premise of this research based upon the argument that all psychotherapy treatments are equivalent in effectiveness (Smith and Glass 1977). If CBT is acknowledged as a scientifically proven evidence-based practice suitable for use in the NHS as a psychological treatment intervention, and it is the non-specific factors of the therapeutic relationship which contribute to a successful outcome, then EPT is equivalent. Therefore, if CBT and EPT are equivalent, EPT is also a suitable psychological treatment intervention for NHS clients presenting with affective disorders, such as anxiety and depression. This study aims to provide valid and reliable quantitative evidence in support of this argument with the long-term result being that NHS clients are not deprived of a choice of effective psychological treatment interventions.

Despite the wide variation of treatment recommendations for depression which originate in biological, sociological, developmental, psychological and philosophical perspectives, this paper argues for a contextual model of psychotherapy where relatedness is a key underlying common factor, and which can also support and accommodate all the above psychological theories, regardless of their technical or non-technical aspects.

Therapy is ideally a refuge where we can develop the ability to dwell with something that is initially confusing and unclear until it gradually reveals itself. This revelation usually brings physically-felt relief and enables new choices and opportunities. Each person has uniqueness that needs to be discovered gradually. Each client decides how they would like to work, but presumably including all levels - cognitive, behavioural, relational & emotional, in order to achieve lasting change.

(Madison 2011)

2. METHOD

2.1 Design

This study adopted a comparison of two groups undergoing different psychological treatment interventions, Cognitive Behavioural Therapy (CBT) and Existential-Phenomenological Therapy (EPT) measured at three points in time, waiting list, pre therapy and post therapy, using the standard UK CORE-OM, Purpose in Life, Problem Rating Scale and Direction of Interest Questionnaires. It was a mixed design where comparisons were made between the means of CBT and EPT participants, and within participants by using repeated measures across time. Implementation of various measures was conducted as shown below:

	Client			Therapist	
Questionnaire Type	Waiting List	Pre Therapy	Post Therapy	Pre Therapy	Post Therapy
PART I <i>N=31</i>					
OUTCOME MEASURE					
1. CORE Outcome Measure Any symptomatic change?	✓	✓	✓		✓
PART II <i>N=14</i>					
PREDICTION MEASURE					
2. Purpose in Life Measure What?		✓	✓		
4. Problem Rating Scale What?		✓	✓		
3. Direction of Interest Who?		✓	✓	✓	
5. Interview What was helpful/unhelpful?			✓		

Figure 1: Implementation of Questionnaires

The original design was for all the above measures to be implemented across 62 client/therapist pairs but, due to unforeseen hurdles and time constraints, detailed below in Section 4.4, on page 142, only 14 full datasets from the original proposal

were ultimately available for analysis. However, routinely collected CORE-OM data from the Psychological Therapies Service (PTS) was made available and now described as Part I of the study and the 14 official research participants' data are now described as Part II of the study. Part I is a between and within participants comparison of CBT and EPT and Part II is a pre and post therapy comparison of the EPT participants only. To demarcate those in Part I and Part II for the purposes of this project, in the main the term 'Client' has been used to describe those in Part I; the routinely collected PTS CORE-OM data, and the term 'Participant' has been used to describe those who were officially invited and consented to the research study.

2.1.1 RATIONALE

The rationale for using these particular measures to answer the research question is as follows:

Evidence-based Practice: Is Existential Phenomenological Therapy
a suitable psychological treatment intervention for clients
presenting in the NHS with an affective disorder?

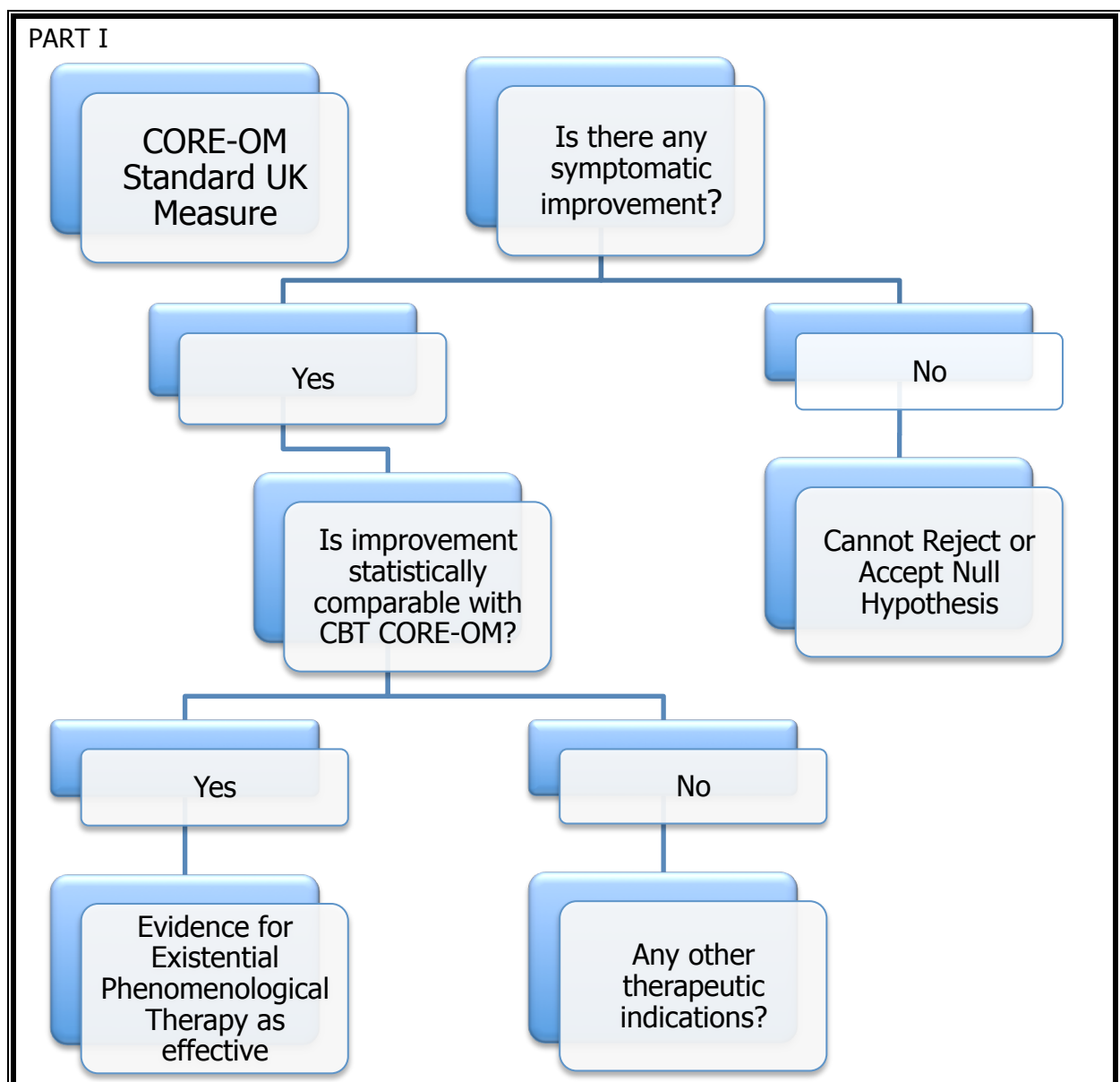


Figure 2: Rationale Part I

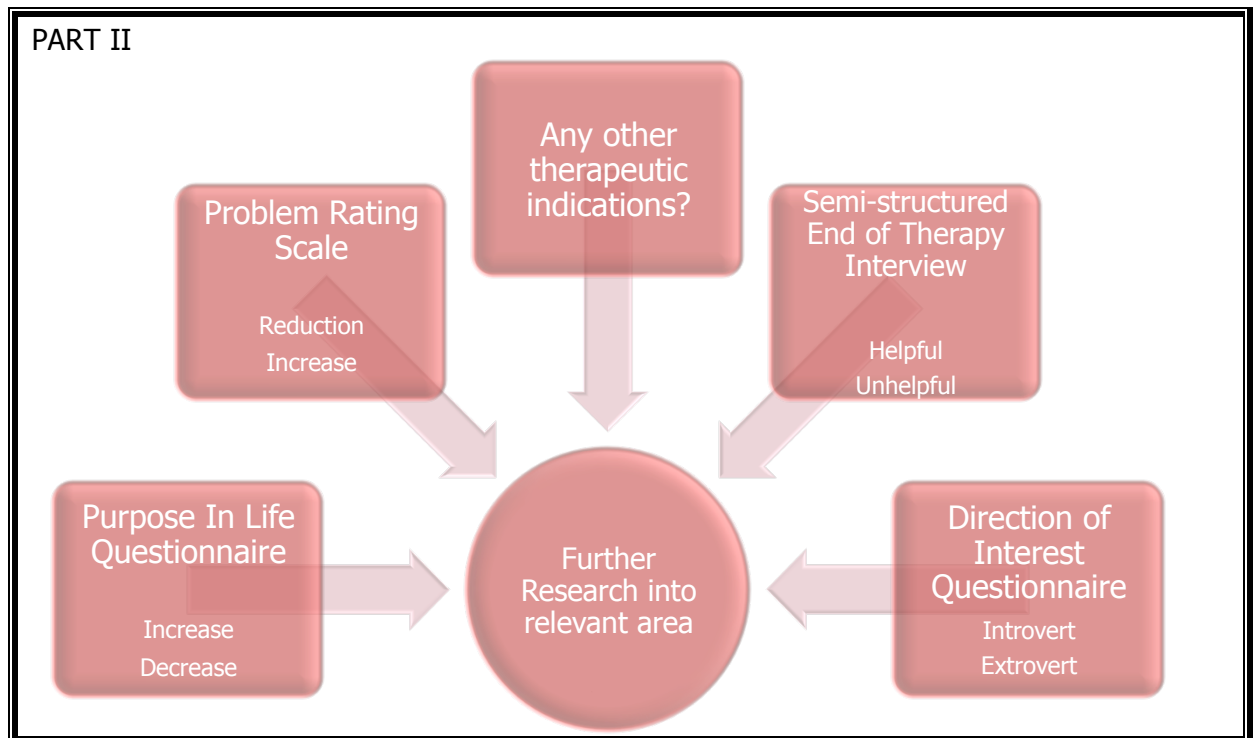


Figure 3: Rationale Part II

The research was carried out at NHS Edgware from January 2009 until September 2010 and approved by NHS Ethics Committee, 2009.

2.2 PARTICIPANTS

There were two parts to the study:

2.2.1 PART I NHS Treatment as usual

As part of current routine practice at the Psychological Therapies Service (PTS), all clients complete CORE-OM at Initial Assessment Sessions (IAS) whilst on the waiting list, before therapy commences and when therapy is complete.

The PTS was created in 2002 to reflect the growing need for a more integrated and efficient provision of psychological treatments at secondary stage of care. The mechanism for a single point of entry was via an 'initial assessment service' that acted to screen, assess, formulate and allocate all referrals to the most appropriate form of treatment. Referrals to the PTS came via the Primary Care Mental Health Teams (PCMHT), largely from GPs. Although in accordance with the Stepped Care Pathway model, some referrals already being treated in Primary Care may be escalated to the PTS through psychiatric assessment and evaluation.

A total of 62 clients were selected from the PTS CORE-OM database; 31 who had chosen and been assessed as suitable for CBT and 31 who had chosen and been assessed as suitable for EPT, as is normal practice within the PTS. Most CORE-OM forms described clients' presenting difficulties as depression or anxiety. All were adults; 14 males and 48 females equally distributed between the Groups, with an overall average age of 42. The average age for CBT participants was 39. The average age for EPT participants was 46.

During the initial period of the research study, the PTS routinely offered 12 sessions of 1:1 individual therapy that was extended to 16 sessions towards the end. The average number of therapy sessions for clients was 12 for CBT (minimum 6, maximum 20) and 13 for EPT (minimum 6, maximum 24).

All EPT therapists (8) were trainee psychologists or psychotherapists whereas approximately 50% of the CBT therapists (11) were psychology trainees and 50% fully qualified Clinical or Counselling Psychologists.

Permission was sought and granted to use this routinely collected data for analysis in this study; it is regarded as a routine Audit and therefore, additional permission from clients was not required. As none of this data was collected from clients who were officially invited to take part in a research study, it is close to replicating a randomized control trial for purity with regard to the investigation of the effectiveness of routine and currently practised psychological therapy interventions such as CBT and EPT.

2.2.2 PART II

All clients presenting to the PTS from January 2009 with an affective disorder, such as depression or anxiety, who chose and agreed to accept Existential-Phenomenological Therapy (EPT) as a suitable psychological treatment intervention, were invited to participate in the research study.

The assessing clinician described presenting difficulties for most participants, on the CORE-OM form at post therapy, as depression and/or anxiety. (Appendix G)

For Part II, there were 14 client and 8 therapist participants in the EPT Group. There were 11 female and 3 male clients ranging in age from 25 to 65, with a mean age of 46. In addition, 3 participants who consented dropped out of therapy, 2 provided feedback and 1 disappeared. There were also 3 clients who consented to participate in the research but did not commence therapy; 2 changed their minds about therapy due to the long wait and 1 was offered an alternative therapy (Personal Construct Psychotherapy) in the PTS, which he decided to take up.

Overall, 59 clients were invited to participate in this study. By September 2010, 30 clients accepted and consented, resulting in 14 completing the full set of Part II questionnaires pre and post therapy within the time limits. This represents approximately 25% of those who were initially invited.

All therapist participants were on voluntary placement at NHS Edgware practising EPT as their preferred way of working. Although a manual defining Existential-Phenomenological Therapy has not yet been developed, therapists work according to Core Competences (Appendix B) and meet every week for Group Supervision with a Senior Adult Psychotherapist who specializes in Existential Therapy. A related manual is currently being developed as a PhD study.

All participants spoke English as their first language.

All participants signed informed consent. (See Appendix J & O)

With generalisability in mind, the original intention was to select a random sample of routinely collected CBT and EPT CORE-OM data to compare with the research data as a control measure before seeking any expected explanations. This measure was intended to identify the potential bias of the results due to the phenomena whereby research participants are inclined to fare better than non-research participants due to knowledge of being observed, known as the Hawthorne Effect (McCarney et al. 2007). There may also be several other aspects that contribute in positive way: for example, the willingness to participate in research may be an indication of increased motivation in those individuals who consent to participate, in comparison to approximately 50% of those who decline. Also, the research interviews themselves may have a similar effect to therapy, or it may appear to the client that they are receiving more care with these two extra 'research' sessions pre and post therapy. However, as the research progressed, three unforeseen factors affected the original proposal:

1. The number of therapists available to participate in the research unexpectedly dropped from 6 to 2 which meant instead of a potential 18 available clients at any one time, there were now only a potential 6 available to invite at any one time. Latterly, the therapist numbers increased to 8.
2. It was decided, within the PTS, to extend the length of therapy offered from 12 to 16 sessions. Taking account of IAS sessions, holidays, etc, this meant the length of therapy took an average of 6 months instead of the originally planned 4 months.
3. Although NHS ethical approval was gained to research CBT participants, it was not possible to gain access to a CBT Supervisor willing to participate in the research project.

These were significant unforeseen hurdles and as the research was well underway, a decision was taken to conduct statistical analysis on the CORE-OM data routinely collected within the PTS as the Primary Measure of the research study (now described as Part I).

2.3 MEASURES

2.3.1 Part I Primary Measure

CORE-OM

CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measures) (Appendix C) is a client self-report questionnaire designed for administration before and after therapy. Developed as the result of a three-year collaboration between researchers and practitioners (Barkham et al., 1998) seeking to evaluate practice-based evidence, it is suitable for use by individual practitioners and large institutions alike. CORE has been in use for over 10 years in the UK and is supported on the internet www.coreims-online.co.uk with software available for analysis, reporting, benchmarking, performance development and clinical decision-making tools. It is a free paper-based system now widely accepted as a standard outcome measure for psychological therapies in the UK.

In an attempt to measure the effect of a psychological intervention on the client's distress, regardless of modality, the same 34 questions are posed at assessment, before therapy begins and repeated again at the last session. The questionnaire addresses four areas of subjective Well-being (W), Problems (P), Functioning (F) and Risk (R) (Barkham, Hardy, & Mellor-Clark, 2010: 175), a mean score which can be compared with the current level of current psychological global distress (from 'healthy' to 'severe'). Normative data has been derived from clinical and non-clinical populations showing large and highly significant differences ($p \leq 0.005$) on all the above dimensions (Mellor-Clark 2008: 14). Internal reliability in a general population sample was 0.91 (Connell, Barkham, Stiles, Twigg, & Singleton, 2007 cited in Barkham et al, 2010). Test-retest reliability was 0.88 at 1 month, 0.81 at 2 months, 0.83 at 3 months and 0.80 at 4 months (Barkham et al. 2007 cited in Barkham et al, 2010).

This study focussed on clinically significant change whereby the client has moved towards a mean score more representative of the general population than a clinical population. The original CORE System states this cut-off figure is 1.19 for males and 1.29 for females. (Mellor-Clark, 2008: 16). Later studies (Connell et al. 2007) using a larger population have produced a lower average adult cut-off score of 1.0 which is now considered the norm for a clinical population cut-off score.

As CORE-OM is widely accepted in the UK as the main standard outcome measure for psychological therapies, it is considered the primary measurement tool for this study.

2.3.2 PART II Secondary Measures

2.3.3 Purpose in Life Test

The Purpose in Life Test (Appendix D) was developed by Crumbaugh & Maholick (1966; 1964) as a method of measuring an individual's sense of purpose, or meaning in life. It uses a Likert attitude scale designed to measure the degree to which an individual experienced *purpose in life* by employing an 11-question sample with a 7-point rating scale whereby total scores range from 11 (low purpose) to 77 (high purpose) (Crumbaugh and Maholick 1969).

Result from the original research distinguished a significant difference between those groups who were highly motivated (non-patients) and those who were the most seriously ill (patients). It supported the existence of Frankl's concept of *noogenic neurosis* that is, 'a breakdown due to "existential frustration" or a lack of perceived meaning or "purpose" in life.' (Crumbaugh & Maholick, 1964: 206)

With the emphasis on meaning inherent in *Existential psychotherapy*, it was anticipated that those for whom this type of therapy may be effective would be clients who are experiencing a low sense of purpose in life when entering therapy,

and that this score would increase after therapy, in other words, their sense of purpose in life would expand.

The null hypothesis being that there is no difference in scores from pre therapy to post therapy for clients who were assessed for, chose and accepted EPT as a psychological treatment intervention.

2.2.4 Problem Rating Scale

This is a self-rating questionnaire (Appendix E) first developed by Gelder and Marks (1966) to research whether behaviour therapy is effective for agoraphobic patients. The patient is asked to identify up to two difficulties that they would like to work on in therapy. They are then asked to self-rate the severity of these two problems on a scale of 0-8 with 0 being '*Not at All Severe*' and 8 being '*Very Severe*' pre and post therapy.

It is anticipated that the score will be high (4-8 severe) before therapy and drop significantly after therapy (1-4 less severe).

With regard to reliability and validity, the original research states 'In general, the reliability of ratings is of the order usually obtained in this kind of clinical study' (Gelder & Marks, 1966: 311)

The null hypothesis being that there is no difference in scores pre therapy to post therapy for clients who were assessed for, chose and accepted EPT as a psychological treatment intervention.

2.2.5 Direction of Interest Questionnaire

The Direction of Interest Questionnaire (Appendix F) was originally devised as a measure of the Jungian concept of extraversion and introversion whereby an

individual's '*direction of libidinal flow*' is thought to be either inward or outward. It is a fourteen-item forced choice questionnaire which distinguishes between an interest in ideas, imagination, theory, religion philosophy, unconventionality and emotional problems, *inner directed*, on the one hand and an interest in facts, practical problems, biochemistry, common sense, engineering, cosmetic science, personal ambition, power and action on the other, *outer directed* (Caine et al., 1982). It is hypothesised that those with an inner direction of interest have a preference for a psychological approach (contextual argument) whereas those with an outer direction of interest have a preference for a psychiatric approach (medical argument). It was posited that personal preference for a particular approach was a 'rational, systematic framework for treatment selection in the psychological and psychiatric therapies'. (Caine, Wijesinghe, & Winter, 1981)

Existential therapists involved in the study also completed the Direction of Interest Questionnaire with the anticipation that they would have an Inward Direction of Interest congruent with the philosophical values associated with this type of therapy.

The null hypothesis is that there is no difference between clients' Direction of Interest from pre therapy and post therapy; consistent with the idea that the core interests of individuals remain the same.

Reliability & Validity

According to Caine et al. (1981: 2), the DIQ has high reliability and validity with regard to occupational groups and this inner or outer-directedness has been found to be consistently related to attitudes to psychiatric treatment in the general population, medical, nursing and psychiatric samples. This means it is also useful for both patient and non-patient samples and has been found to have implications for treatment allocation and vocational guidance, as follows:

An inner direction of interest has been found to correlate with a more psychological approach to patient care and treatment. An outer direction of interest has been found to correlate with a more organic, physical, scientific approach.

The more inwardly directed psychiatric patients tend to express a larger number of critical attitudes towards the self and others. There is some evidence to suggest that an inner direction of interest is associated with a greater degree of empathic skill.

(Caine et al. 1981: 2)

Therefore, this questionnaire has been employed with a view to an attempt at identifying whether there is a particular type of person, inner or outer directed, who may be most suitable for an EPT approach.

2.2.6 Interview

At the end of therapy, a semi-structured interview was conducted and recorded to investigate what the participant found helpful and unhelpful about their experience of Existential-Phenomenological Therapy (Appendix G). This was in the light of the points made by Kadzin (2006: 48) regarding the arbitrariness of the metric in quantitative research. Kadzin writes that significance and effect sizes say nothing about whether patients have changed in ways that make a real difference to their lives and therefore, qualitative research is also important. Kadzin (2006: 46) draws attention to the common criticism often levelled at RCTs which is whether the effects found in trials generalize to clinical practice and points out that 'A logically, empirically, and clinically prior question is whether our findings "generalize" to patient functioning.'

Each participant was invited to describe their therapeutic experience and in particular, to say what they found helpful or unhelpful about therapy so that qualitative research analysis could be conducted to complement the quantitative analysis.

2.2.7 Summary of Method

EPT patients were asked to complete CORE-OM (Barkham et al., 1998), the Purpose in Life Test (Crumbaugh 1966; Crumbaugh and Maholick 1969) and the Direction of Interest Questionnaire (Caine et al. 1982) as repeated measures at three stages: whilst on the waiting list and pre-therapy to serve as their own control measure, and post therapy (Appendix B, C, D, E and F) to measure any change. A semi-structured interview was conducted at the end of therapy asking the participant to describe their experience and in particular, what was found to be helpful or unhelpful (Appendix S).

2.4 PROCEDURE

2.4.1 PART I

All CORE-OM data from January 2009–August 2010 was extracted from the Psychological Therapies Service (PTS) database. All names were removed and replaced with a number to protect anonymity.

There were 114 complete sets of CORE-OM data for CBT clients, this being the main therapy on offer at the PTS, and 31 complete sets of CORE-OM data for EPT clients. All the available EPT datasets were used.

In an attempt to match CBT and EPT therapists for experience, and because all EPT clients were seen by trainees, all the CBT clients who had had therapy with trainees were selected first (15 sets). Then, starting from the top of this list of 114, the remaining 16 participants were selected as the first 16 with complete datasets available for whom depression and anxiety was the main presenting difficulty. There is a methodological flaw in that the data for the CBT Group has a larger proportion of fully qualified clinicians involved than the EPT Group.

Data from the full 114 CBT datasets was used as a comparison measure throughout the study as and when required.

2.4.2 PART II

Participants were recruited by being sent a letter (Appendix H) inviting them to attend a meeting to discuss the research whilst they were on the Waiting List for Existential-Phenomenological Therapy. The invitation letter was followed up about one week later by a telephone call asking if they had received the letter, would be willing to discuss further and if so, to arrange a suitable time for this initial research consent interview.

At this meeting, the client was given an Information Sheet (Appendix I) that the researcher read through together with the client, answering any questions, explaining how the data may be used in published research journals, and then asking if the client would be willing to participate. If the client agreed, he/she was then asked to sign a Consent Form (Appendix J) and then given each questionnaire to complete. These questionnaires were CORE-OM (Appendix C), Purpose in Life (Appendix D), Problem Rating Scale (Appendix E), and Direction of Interest (Appendix F). This meeting took approximately one hour.

Once completed, the researcher informed the patient that when their course of therapy had finished, they would be contacted again and asked to attend another research meeting to complete the same questionnaires again.

After the first interview, a letter (Appendix K) was sent to thank them for their time and contribution to the project. A letter was also sent to their General Practitioner (Appendix L) informing the doctor that their patient had agreed to participate in the research. A copy of the Consent Agreement and the letter to the GP was enclosed with the thank you letter to the participant.

Once therapy was complete, the researcher contacted the participant by telephone to arrange a suitable time for completion of the post-therapy questionnaires and interview. The questionnaires were completed. The researcher informed the participant that they would be sent a summary of the results of the research when it was finished. This meeting took approximately 90 minutes. After the end of therapy meeting, the researcher sent a letter (Appendix M) thanking the participant for their time and contribution to the project.

2.4.3 Timing

Initially the study was proposed as a two-way comparative project; delivering Part I and II to all EPT and CBT clients and therapists but due to the time constraints, it was only possible to deliver the full batch of questionnaires to EPT participants. It was envisaged the study would be complete by September 2010.

2.4.4 Limitations

As an initial benchmark, it was envisaged that by conducting ANOVA on the standard CORE-OM for EPT and comparing this data with the same CORE-OM measures for an accepted, evidence-based NICE recommended therapy, CBT, reliable and valid results could be produced. Auditing routinely collected data means this method is close to replicating the requirements of a randomized control trial (RCT) because all participants were blind to their participation in any research condition. However, whilst being practice-led was its' strength, Part I does not provide any **additional** information about what or for whom EPT may be most suitable, focusing solely on symptom reduction as a measure of outcome.

Clearly, Part II of this research was not RCT comparable because clients self-selected by accepting an invitation to participate in the research project rather than be randomly allocated to treatment groups. However, it is ecologically valid as it aimed to extract data from clients who have been assessed as suitable for Existential-Phenomenological Therapy and this not only reflects the clients' choice of psychological treatment intervention, but also attempts to elucidate *treatment as*

usual. Therefore, analysis should provide an initial indication of the routine and current effectiveness for motivated EPT clients.

Although this study may provide an initial indication regarding the effectiveness of EPT, in comparison with CBT, in terms of the immediate outcomes post therapy, more research is needed into its' longer term effectiveness. This would mean investigating aspects such as how stable recovery was for the client after 6 or 12 months, for example.

2.5 Ethics

The research project was granted a favourable ethical opinion by the NHS National Research Ethics Service Barnet, Enfield & Haringey Local Research Ethics Committee on 18th August 2008.

The project adhered to the Caldicott Principles (Appendix N) as an ethical framework with regard to confidentiality. As is routine practice within the National Health Service (NHS), The British Psychological Society (BPS) and the UK Council for Psychotherapy (UCKP) Code of Ethics, participants were asked for consent to inform their GP, Mental Health Team, or other professionals if the researcher had serious concerns for the participant's safety or, if other people were at risk. Participants were informed that their participation in the project was voluntary and they were free to withdraw at any time without giving any reason, without medical care or legal rights being affected.

There is an ethical issue regarding the vulnerability of the participants as the questionnaires may arouse unexpected emotional feelings and therefore, the services of a fully qualified supervisor as a support for anyone who felt they needed additional help as a result of completing the questionnaires. Debriefing and the services of a qualified supervisor were offered and explained fully on the Client Information Sheet (Appendix I). Consent to participate in the research was also sought from therapist participants in order to ensure the highest standards of care; their agreement was confirmed by signing a Consent Form (Appendix O).

2.6 Power

Essentially, we have a 2×2 ANOVA which at its simplest is a test of equality of sample means drawn from the same population.

We have a two-tailed test because we are uncertain about the directionality of the outcome [which treatment will be more / less effective?].

NICE recommends an effect size, γ , of 0.5 standardised units [conventionally, an intermediate size of effect].

Let us then set $\gamma = 0.5$; set α [Type I error] at conventional probability of 0.5.

Set power $[1 - \beta]$ at 0.80 which is also a convention using cautious assumptions. Then number per group becomes:-

$$n = \left(\frac{\delta}{\gamma} \right)^2$$

where δ can be derived from a Table of values of power as a function of δ and significance level (α).

Hence

$$n = \left(\frac{2.8}{0.5} \right)^2$$

which means that $n = 31.4$ for this study.

Note: This was prepared by Dr Ralph Goldstein (Glenberg 1988). Originally the study was 2×2 reflected in this calculation and according to subsequent calculations, 2×3 makes little difference to the numbers required.

3. RESULTS

There were two parts to the study:

3.1.1 PART I

The design was a two-factor 2 (CBT vs EPT) x 3 (waiting list vs. pre therapy vs. post therapy) ANOVA analysis with repeated measures on the second factor. The first factor has two levels of Treatment, CBT and EPT, and the second factor called Time has three levels, waiting list, pre therapy and post therapy. The dependent variable was the severity of symptoms according to CORE-OM.

Factor 1 Treatment 2 levels Between Participants	Factor 2 Time 3 levels Within Participants			
	Therapy <i>N=62</i>	Waiting List	Pre Therapy	Post Therapy
	Cognitive Behavioural Therapy <i>n=31</i>	CORE-OM	CORE-OM	CORE-OM
	Existential Phenomenological Therapy <i>n=31</i>	CORE-OM	CORE-OM	CORE-OM

Initially, ANOVA was employed to test whether the research hypothesis is true or false: taking the means of the variances of the CBT and EPT groups into account, ANOVA tests whether there is a difference in the variances within and between the groups. This is based on measuring the severity of affective disorders at three junctures, using CORE-OM, and then by comparing the variances of values within the groups with the variances of values between the groups.

The null hypothesis is that there is no difference between CBT and EPT as a psychological treatment intervention for affective disorders measured at three points in time.

Therefore $h_0: \mu_1 = \mu_2 = \mu_3$

or The null is false and therefore, can be rejected

If we cannot reject the null hypothesis, that there is no difference between the effect of psychological treatment interventions, CBT and EPT, on the affective disorder, depression and anxiety, measured at three different junctures, waiting list, pre and post therapy, these results would indicate that EPT is a comparable psychological treatment intervention to CBT which is accepted as an evidence-based treatment for depression and anxiety. Therefore, accepting the null hypothesis would mean that EPT is an appropriate psychological treatment intervention for use in the NHS. If we reject the null hypothesis, this raises the possibility that EPT is either a more or less effective treatment intervention for affective disorders than CBT. As CBT is an accepted evidence-based psychological treatment intervention, it can be used as a benchmark as a comparison for EPT which may indicate a positive or negative effect.

The majority of clients presenting to NHS Psychological Therapies Service (PTS) with an affective disorder such as depression or anxiety, made reliable and clinically significant improvement (RSCI) in the reduction of their symptoms according to CORE-OM (>0.5), with an average of 12 weeks of therapy, regardless of whether the psychological treatment intervention was CBT or EPT, shown in Table 1 as follows:

Table 1: Summary numbers of Improved CBT and EPT clients

From WL to Post Therapy	Improved (RSCI >0.50 CORE-OM) (RSCI <0.50 CORE-OM)		
	YES	NO	Number
CBT	26	5	31
EPT	27	4	31
TOTAL	53	9	62

According to Barkham et al, (2010), a difference in the CORE-OM score of >0.50 is expected from pre to post therapy in order to be confident of a client having made reliable and significant clinical improvement (RSCI). The average change in CORE-OM scores for CBT clients was -0.66 and for EPT clients -0.74 which means that we

can deduce reliable and significant clinical improvement for the average client presenting at Secondary Care at the PTS in Barnet, Enfield and Haringey NHS Trust.

A summary of overall mean CORE-OM scores is presented below in Table 2:

Table 2: Summary of Overall Mean CORE-OM Scores

Summary of Mean CORE-OM Scores									
N=62	<i>Waiting List</i>	<i>Pre Therapy</i>	<i>Post Therapy</i>	<i>Standard Deviation</i>	<i>Standard Error</i>	<i>Effect Size</i>	<i>Grand Mean</i>	<i>Mean difference from pre to post therapy</i>	<i>Mean difference from Waiting List to Post Therapy</i>
CBT <i>n=31</i>	2.08	2.13	1.49	0.83	0.08	0.71	1.90	-0.66	-0.59
EPT <i>n=31</i>	2.65	2.55	1.81	0.79	0.08	1.05	2.34	-0.74	-0.84
ALL				0.85	0.06		2.12		

ANOVA results are presented in the following Table 3:

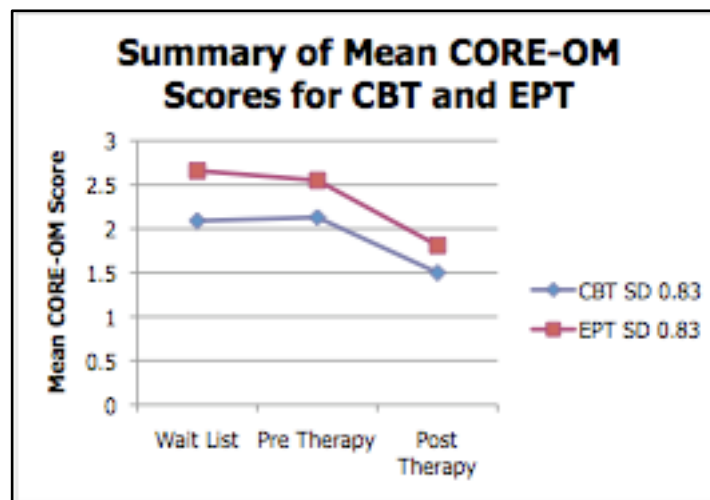
Table 3: ANOVA Results

ANOVA Results						
<i>Source of Variation</i>	<i>Sum of Squares</i>	<i>Degrees of Freedom</i>	<i>Mean Sum of Squares</i>	<i>F</i>	<i>p-level</i>	<i>F crit</i>
<i>Factor 1 (Therapy)</i>	8.93652	1	8.93652	15.43282	0.00012	5.50955
<i>Factor 2 (Time)</i>	20.38771	2	10.19386	17.60415	0.00001	3.99829
<i>Factor 1 + 2 (Therapy x Time)</i>	0.48678	2	0.24339	0.42032	0.65748	3.99829
<i>Within Groups</i>	104.23074	180	0.57906			
<i>Total</i>	134.04174	185	0.72455			

The first point of interest is that initial ANOVA results (AnalystSoft 2009) showed there were highly significant differences between CBT and EPT on both main factors; the main effect of Treatment ($p<0.001$) was highly significant, the main effect across Time ($p<0.001$) was highly significant, and there was no interaction

($p>0.1$) between the Treatment and Time Factors, as summarized in Graph 1 below:

Graph 1: Summary of Mean CORE-OM Scores for CBT and EPT



Therefore, we can reject the null hypothesis and conclude that there is a significant difference within and between CBT and EPT treatment groups across time. Both treatments show a significant difference when comparing scores at three points in time with a decrease in symptoms from pre to post therapy. The parallel lines on Graph 1 above, dropping from pre to post therapy, supports the argument that they are both reliable psychological treatment interventions because both decrease by more than 0.50, the CORE benchmark for RSCI.

TREATMENT

A difference within the groups was found between the treatments where the level of severity in scores at each juncture was significant for CBT (average 1.9) and EPT (average 2.33). In terms of the level of severity of symptoms, according to CORE-OM, the CBT average <2.0 is defined as *Mild to Moderate* and the EPT average >2.0 is defined as *Moderate to Severe*.

The ANOVA result ($p<0.001$) for the main effect of treatment was highly significant which means we can say with the utmost confidence that there is a difference

between the means of the treatment groups and therefore, the null hypothesis is rejected. These results provide evidence to indicate that there is almost no chance that the finding that there is a difference between those in the CBT Group and those the EPT Group across three different points in time, is due to random error.

TIME

The ANOVA result ($p < 0.001$) for the main effect of time was highly significant which means we can say with utmost confidence that there is a difference in the means of the participants' scores when measured at three points in time, waiting list, pre and post therapy, and therefore, the null hypothesis is rejected. These results provide evidence to indicate that it is highly unlikely that the finding that there is a difference across time within each group is due to random error.

Table 4: Comparison of All Participants within Groups for Factor 2 Time Scheffe Test Results

Comparisons for All Participants Factor 2 - Time					
<i>Scheffe contrasts among pairs of means</i>					
<i>Group vs Group (Contrast)</i>	<i>Difference</i>	<i>98% Confidence Interval</i>		<i>Test Statistics</i>	<i>p-level</i>
Post Therapy vs Pre Therapy	-0.68855	-1.07496	-0.30213	12.69046	0.00001
Post Therapy vs Waiting List	-0.71532	-1.10174	-0.32891	13.69658	0.00001
Pre Therapy vs Waiting List	-0.02677	-0.41319	0.35964	0.01919	0.981

Using the Scheffe test to compare the groups overall from waiting list to pre therapy, the mean CORE-OM scores (CBT -0.11, EPT +0.04, $p > 0.05$), showed that the difference was not significant between each group at this stage of analysis. The CBT group had mean scores that increased from waiting list (2.08) to pre therapy (2.13) in contrast to the EPT Group decreasing from waiting list (2.66) to post therapy (2.55). This waiting list to pre therapy element of the study meant each client also acted as a their own control measure providing support to the theory that the major difference from beginning to end, or from waiting list to post therapy,

was the preferred psychological treatment intervention of CBT or EPT for each individual participant.

Using the the Scheffe test compare groups overall from pre therapy to post therapy, there was a highly significant difference found between the CBT and EPT groups ($p<0.001$) and from waiting list to post therapy, there was a highly significant difference between the groups ($p<0.001$).

With the treatment intervention from pre therapy to post therapy, there was a reduction in mean CORE-OM scores (CBT -0.66, EPT -0.74, $p<0.001$) shown by the lines on the Graph 1, dropping in parallel and indicating reliable and significant clinical improvement (RSCI>0.50) in both groups. These results produced a medium effect size of 0.71 for CBT and and a large effect size of 1.05 for EPT, according to Cohen's d (1988: 22). This means that there is a medium difference (0.71) in the average variation of symptoms from wait list, pre to post therapy in the CBT group and a large difference (1.05) in the average variation of symptoms from wait list, pre to post therapy in the EPT group.

INTERACTION

Table 5: ANOVA Interaction Results

	<i>Sum of Squares</i>	<i>Degrees of Freedom</i>	<i>Mean of Sum of Squares</i>	<i>F</i>	<i>P-level</i>
Treatment Time	0.487	2	0.243	0.4203	0.6574814

There was no significant interaction between Treatment and Time factors $F(2,120)=0.4203$, $p=>0.1$

The ANOVA result ($p>0.1$) for the interaction of treatment and time is important for the research findings because it means that the differences between the treatment groups are the same at all levels of time (waiting list, pre and post therapy) which also means the treatments do not differ at one point but not at another. The treatments differ in the same way at each level of time; both treatments differ between wait list, pre and post therapy in the same direction, as expected according to the literature (Cuijpers et al. 2008; Rosenzweig 1936; Wampold 2001).

Interaction tests for the way in which they are different i.e do the treatments differ at one point but not at another?

For each pair of factors, there is one possible interaction, in total three possible interactions for which ANOVA tests, as follows:

1. Does the difference between CBT and EPT vary at waiting list in the same way as at pre therapy?
2. Does the difference between CBT and EPT vary at waiting list in the same way as at post therapy?
3. Does the difference between CBT and EPT vary at pre therapy in the same way as at post therapy?

The null hypothesis could not be rejected as there was no significant difference found in any of the three possible levels of interaction, graphically illustrated by the CBT and EPT lines running parallel with no crossover.

Assumptions of ANOVA Testing

ANOVA is a procedure for testing whether there are any significant differences among two or more means; CBT and EPT, wait list, pre and post therapy, by analysing the individual effects and then investigating whether there are any interacting effects of the variables (Howell 2002: 319). As ANOVA relies on three major assumptions; *Normality*, *Homogeneity of Variance* and *Independence of Observations*, a Flowchart for selecting the appropriate statistical tests for group comparison studies (Cone and Foster 1993: 180) was employed and accordingly, a Shapiro-Wilk Normality test was run as follows:

Normality Testing

Table 6: Normality F-Test

Normality Test			
All CORE Scores			
<i>Sample size</i>	186	<i>Mean</i>	2.12425
<i>Standard Deviation</i>	0.85121	<i>Median</i>	2.18
<i>Skewness</i>	-0.34131	<i>Kurtosis</i>	2.58981
<i>Alternative Skewness (Fisher's)</i>	-0.34409	<i>Alternative Kurtosis (Fisher's)</i>	-0.38847
	Test Statistics	p-level	Conclusion: (2%)
<i>Shapiro-Wilk W</i>	0.97869	0.0061	<i>Reject Normality</i>

Although the results of this test indicate that there is a significant difference ($p < 0.01$) in the range of scores which means that the distribution of scores is not normal, it is assumed that by having conducted a power analysis to determine the numbers used, the sample population ($n=31$) in each group is robust enough to sufficiently outweigh this violation. With regard to normal distribution assumptions associated with ANOVA testing, Pallant writes 'With large enough sample sizes (e.g. 30+), the violation of this assumption should not cause any major problems.' (Pallant 2010: 206)

It is quite common for practice-led samples not to have a normal distribution of scores. According to Barkham et al. (2008), the non-normal distribution of scores is a standard feature of practice-led studies in comparison with RCT's where 'selection procedures systematically narrowed the pre-treatment distribution of scores' and this was 'mainly attributable to the systematically smaller pre-treatment SD [Standard Deviation] among the selected clients in the randomized trials as compared with the unselected clients in the practice-based studies' (Barkham et al. 2008: 412). However, it is of interest that when the same test is run at three junctures, normality is accepted and the following results are interpreted as further support for sample being large enough to outweigh this violation:

Table 7: Normality F-Test Results Waiting List

Normality Test Waiting List			
<i>Sample size</i>	62	<i>Mean</i>	2.37161
<i>Standard Deviation</i>	0.69613	<i>Median</i>	2.43
<i>Skewness</i>	-0.42318	<i>Kurtosis</i>	3.00748
<i>Alternative Skewness (Fisher's)</i>	-0.43375	<i>Alternative Kurtosis (Fisher's)</i>	0.11151
	Test Statistics	p-level	Conclusion: (2%)
<i>Shapiro-Wilk W</i>	0.98163	0.47851	Accept Normality

Table 8: Normality F-Test Pre Therapy

Normality Test Pre Therapy			
<i>Sample size</i>	62	<i>Mean</i>	2.34484
<i>Standard Deviation</i>	0.72765	<i>Median</i>	2.375
<i>Skewness</i>	-0.13237	<i>Kurtosis</i>	3.05794
<i>Alternative Skewness (Fisher's)</i>	-0.13568	<i>Alternative Kurtosis (Fisher's)</i>	0.16629
	Test Statistics	p-level	Conclusion: (2%)
<i>Shapiro-Wilk W</i>	0.98681	0.74571	Accept Normality

Table 9: Normality F-Test Post Therapy

Normality Test Post Therapy			
<i>Sample size</i>	62	<i>Mean</i>	1.65629
<i>Standard Deviation</i>	0.92147	<i>Median</i>	1.73
<i>Skewness</i>	0.14868	<i>Kurtosis</i>	2.05886
<i>Alternative Skewness (Fisher's)</i>	0.15239	<i>Alternative Kurtosis (Fisher's)</i>	-0.91831
	Test Statistics	p-level	Conclusion: (2%)
<i>Shapiro-Wilk W</i>	0.96767	0.10129	Accept Normality

The Shapiro-Wilk Normality Test showed that the overall distribution of scores is not normal but having employed a power analysis to determine the sample size, and

having conducted normality analysis at the different points in time, means the total numbers are sufficient and robust enough to avoid any misleading conclusions.

Homogeneity of Variance Test

Treatment comparison is robust to violation of the underlying assumptions of ANOVA testing but time comparison is not, therefore, the data needs to be examined for variances in homogeneity. As there is non-normal distribution of overall scores within the samples, an F-test (Fisher and Yates 1953) is run to establish whether the standard deviations in each of the groups are sufficiently equal. The null hypothesis is that there is no difference between the two groups, CBT and EPT, in the data collected across all times.

Table 10: Homogeneity of Variance F-Test Results

F-Test Two-Sample for Variances Homogeneity of Variance				
	CBT	EPT		
<i>Sample size</i>	93	93		
<i>Mean</i>	1.90505	2.34344		
<i>Variance</i>	0.72259	0.63725		
<i>Standard Deviation</i>	0.85005	0.79828		
<i>Mean Standard Error</i>	0.08815	0.08278		
Summary				
<i>F</i>	1.13391	<i>F Critical value (2%)</i>	1.53887	
<i>p-level 1-tailed</i>	0.27396	<i>p-level 2-tailed</i>	0.54791	
<i>H0 (2%)?</i>	<i>Accepted</i>			

According to the F-test (Fisher and Yates 1953), the null hypothesis is accepted, that is, the variances between the two groups, CBT and EPT, are sufficiently equal so that they do not violate the assumption of homogeneity of variance required for ANOVA testing.

Independence of Observations

This assumption is fully adhered to and complied with in that the data collected from all participants was completely independent and none of the participants were

involved in any type of interaction with one another that might have influenced the results.

Summary of Results

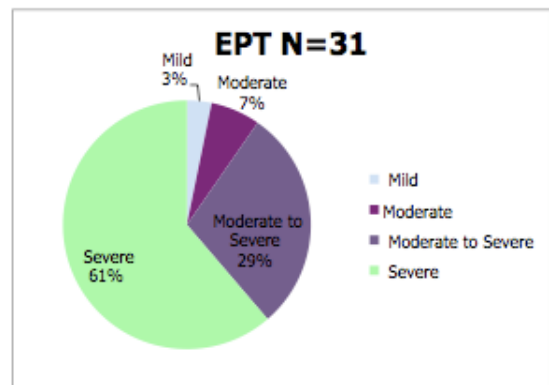
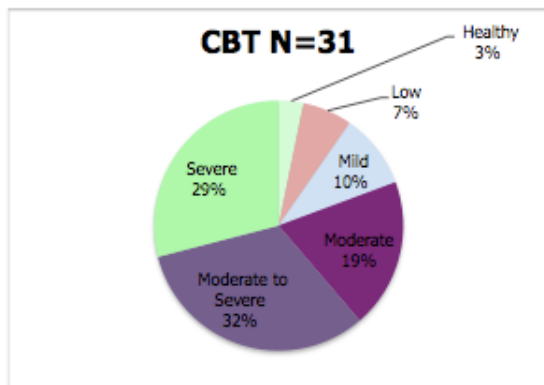
As is clearly shown in Graph 1 on page 101 above, in this sample, EPT clients presented with more severe symptoms of depression and anxiety, according to CORE-OM (Average at wait list: CBT 2.09, EPT 2.66). The pre-post treatment effect size for CBT being 0.71 (medium) compared with EPT being 1.05 (large). Normative data derived from Secondary Care settings with clients ($N=224$) receiving a range of therapies produced a pre-post effect size of 0.87 (Barkham et al. 2001), and from a study combining Primary and Secondary Care ($N=1309$) producing an effect size of 1.36. This research suggests smaller effect sizes are to be expected in Secondary Care overall. The CBT effect size of 0.71 is smaller than the national Secondary Care average as it is less than 0.87 (Barkham et al, 2001). However, the EPT effect size of 1.05 is very close to the average 1.11 across both of these settings that provides further support to the recommendation of EPT as a suitable psychological treatment intervention for depression and anxiety.

3.1.2 Severity

In terms of baseline severity of individual participants, the raw data clearly revealed a difference in the numbers of those presenting with *moderate* difficulties being treated with CBT in comparison to those with more *severe* difficulties being treated with EPT, as shown below:

Table 11: Numbers of Clients in each CORE-OM score category at Waiting List

Numbers of Clients in each CORE-OM score category at Waiting List	1 Healthy 0.03-0.59	2 Low 0.60-0.97	3 Mild 1.00-1.47	4 Moderate 1.50-1.97	5 Moderate to Severe 2.00-2.47	6 Severe 2.50-4.00	N= Mean of CORE-OM Score
CBT	1	2	3	6	10	9	31 1.90
EPT	0	0	1	2	9	19	31 2.33
Grand Mean of CORE-OM Score							62 2.11



(Source: Barkham et al. 2006b)

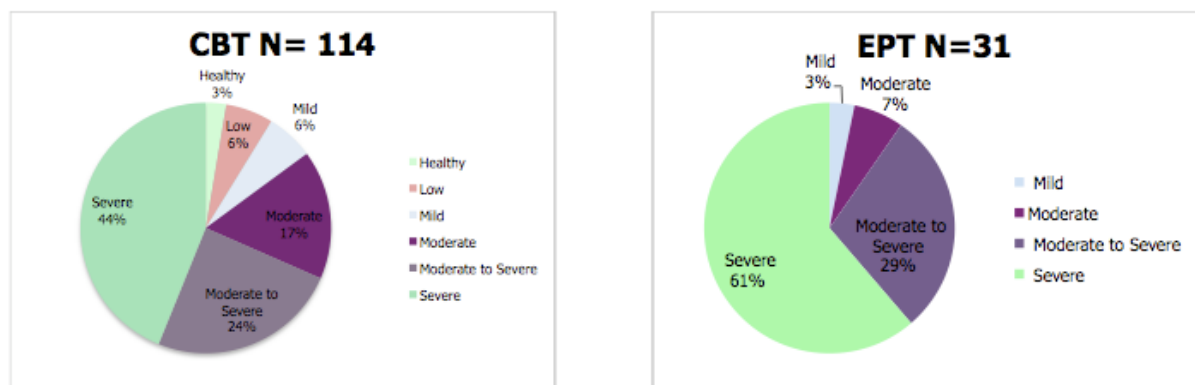
When broadened out and compared to larger sample of clients (CBT=114, EPT=31), the distribution of severity of diagnoses shows a larger percentage of Severe CBT (44%) clients but this is still much lower than the percentage of Severe EPT clients (61%). These results indicate that trainee EPT therapist are producing at least

equivalent treatment outcomes to those of fully qualified CBT therapists, regardless of severity.

Table 12: Severity Score CORE-OM according to Client

Severity Score CORE-OM according to Client	1 Healthy 0.03- 0.59	2 Low 0.60- 0.97	3 Mild 1.00-1.47	4 Moderate 1.50- 1.97	5 Moderate to Severe 2.00- 2.47	6 Severe 2.50- 4.00	N=
CBT	3	7	7	19	28	50	114
EPT	0	0	1	2	9	19	31

The full range of available datasets for all clients (CBT N=114, EPT N=31) presenting at the PTS is illustrated in the following pie chart where it can be clearly seen that the ratio of the more severe clients is weighted towards treatment allocation being for EPT.



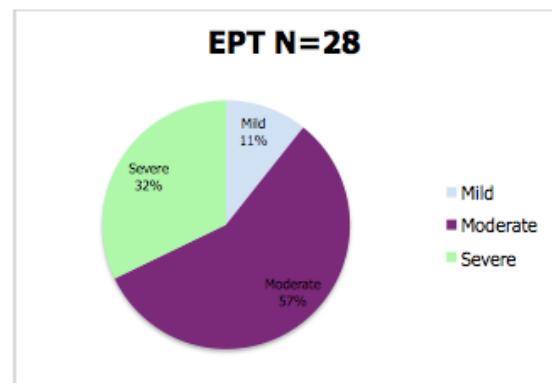
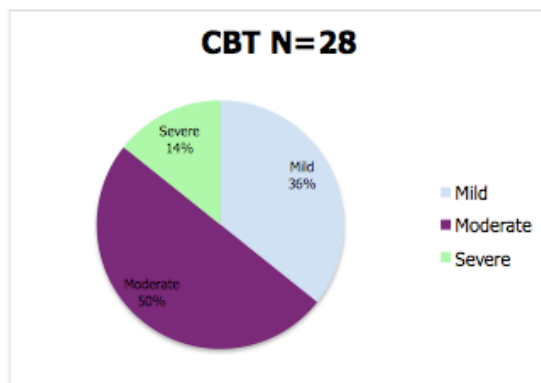
(Source: Barkham et al. 2006b)

This distribution illustrated in the above graphs suggests a difference in the preference of routine Treatment Allocation for CBT or EPT, according to the *Severity* of the affective disorder, whereby CBT clients and therapists were allocated those less severely diagnosed than those of EPT clients and therapists. The following CORE-OM severity data was retrieved for 28 clients, as perceived by therapists and shows a slightly different picture:

Table 13: Severity Rating CORE-OM according to Therapists Results

Severity Rating CORE-OM according to Therapists	0 No Data	1 Mild	2 Moderate	3 Severe	
CBT	3	10	14	4	31
EPT	3	3	16	9	31

As illustrated in the following pie chart, severity rating by therapists shows CBT therapists perceived 36% of their clients' difficulties as Mild, 50% as Moderate and 14% as Severe, in comparison with EPT therapists perceiving 11% as Mild, 57% Moderate and 32% as Severe. Although this differs slightly from the clients' perceptions, the overall picture is still similar with EPT being the treatment of choice for the majority of those presenting with more severe symptoms of distress (CBT 14%, EPT 32%).



(Source: Barkham et al. 2006b)

3.1.3 AGE

An independent-samples T-test was run to ascertain whether there was a difference between the ages of those in the CBT or EPT group as this may have played a part in the differences found between the groups. The results are present in the following Table 14:

Table 14: Summary of Ages in CBT and EPT Group Results

AGE			
Comparing Means T-test assuming equal variances (homoscedastic)			
<i>Treatment Variable</i>	<i>Sample size</i>	<i>Mean</i>	<i>Variance</i>
CBT	31	38.90323	72.89032
EPT	31	45.58065	87.45161
Summary			
<i>Degrees Of Freedom</i>	60	<i>Hypothesized Mean Difference</i>	0.E+0
<i>Test Statistics</i>	2.93607	<i>Pooled Variance</i>	80.17097
Two-tailed distribution			
<i>p-level</i>	0.00471	<i>t Critical Value (5%)</i>	2.0003

There was a significant difference ($p < 0.05$) in ages for those in the CBT group ($M = 38.9$) and those in the EPT group ($M = 45.5$). The clients presenting for therapy in the CBT group were significantly younger than those in the EPT group that may have implications for routine treatment allocation.

3.1.3 PART II

The second part of the study is a within-participants analysis of EPT clients' presenting difficulties using questionnaires identified as useful measures which represent the philosophical basis of this particular EPT approach, that is, a focus on meaning, assumptions and purpose in life. All three questionnaires were analysed using either the Wilcoxon Signed Ranks Test or a Paired Samples T-Test.

Repeated Measures Within Participants		
Therapy <i>N</i> =14	Pre Therapy	Post Therapy
Existential Phenomenological Therapy	Purpose in Life Test Problem Rating Scale Direction of Interest Questionnaire	Purpose in Life Test Problem Rating Scale Direction of Interest Questionnaire

Although Part I of the study focused on whether EPT had the effect of reducing symptoms according to CORE-OM because this measure is the most widely employed measure used in the NHS nationally, symptom reduction is not a primary concern for EPT but it is rather more focused on an exploration of attributed meanings and how to live with symptoms. Also, research recommendations (Churchill et al., 2001: 96) commonly advise the use of a broad range of outcome measures and therefore, in addition to the UK Standard CORE as a standard benchmarking tool, the Purpose in Life Test, Problem Rating Scale and Direction of Interest Questionnaire were used in an attempt to identify any particular trends within this EPT group. In particular, does EPT as a psychological treatment intervention have an effect on the client's perception of

1. Sense of purpose or meaning in life
2. Magnitude of their problems

And/or does the research provide any indication of:

3. The type of person for whom EPT may be most suitable

3.2.4 Purpose in Life

To ascertain whether there is a difference in participants' scores from pre therapy to post therapy, and due to the small numbers in this sample, a non-parametric Wilcoxon Signed Rank Test produced the following results:

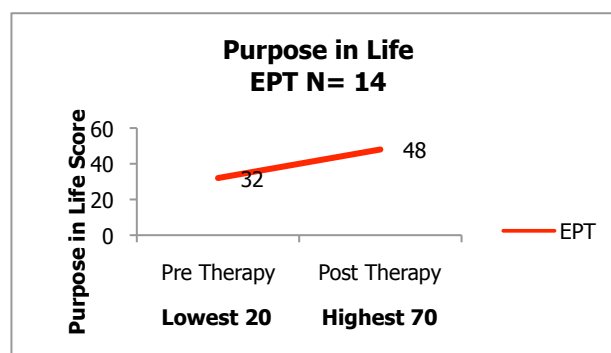
Table 15: Purpose in Life Wilcoxon Test Results

Wilcoxon Matched Pairs Test					
<i>N</i>	14	<i>T</i>	7.	<i>Z</i>	2.85633
<i>p-level</i>	0.00429				
Sign Test					
<i>N</i>	14	<i>Z</i>	1.87083	<i>p-level</i>	0.06137

P value <0.05, T statistic 7.0

This difference is statistically significant at a *p value*<0.05, *T statistic 7.0* which means that in this sample, participants' sense of purpose or meaning in life increased from pre to post therapy and it is highly unlikely that this difference was down to random chance.

The average scores for participants' sense of purpose in life pre therapy (mean 32) and post therapy (mean 48) are illustrated in the following Graph 2:



Graph 2: Purpose in Life Average Score Results

3.2.5 Problem Rating Scale

To ascertain whether there is a difference in clients' scores from pre therapy to post therapy, and because all participants each identified two problems that provided higher numbers for analysis, a Paired-Samples T-test was employed. The results are shown below in Table 15:

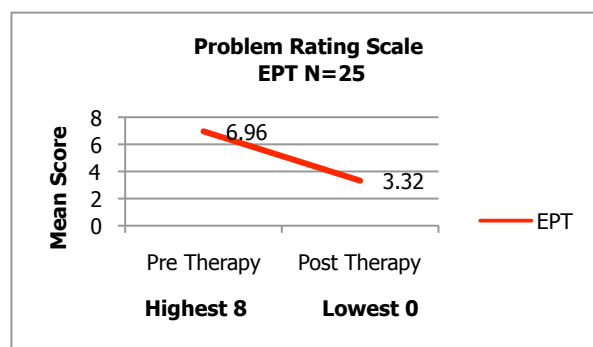
Table 16: Problems Rating Scale T-test Results

	N	Mean	Standard Deviation	Minimum	Maximum
Pre Therapy	25	6.96	1.06	4.0	8.0
Post Therapy	25	3.32	2.155	0.00	8.0

P value <0.001, T statistic 8.51

The difference is statistically significant at a p value of <0.001 which means that in this sample, it is highly unlikely that the decrease in participants' perception of their problems from pre to post therapy is due to random chance.

The average scores for participants' self-rating of their presenting problems pre therapy (6.96) and post therapy (3.32) are illustrated in the following Graph 3:



Graph 3: Problem Rating Scale Results

3.2.6 Direction of Interest

To ascertain whether there was a difference in the participants' perception of their Direction of Interest, whether inner or outer directed, from pre therapy to post therapy, a non-parametric Wilcoxon Signed Rank Test was run, and this produced the following results, as shown below in Table 16:

Table 17: Direction of Interest Wilcoxon Signed Rank Test Results

Wilcoxon Matched Pairs Test					
<i>N</i>	14	<i>T</i>	23.	<i>Z</i>	0.88911
<i>p-level</i>	0.37394				
Sign Test					
<i>N</i>	11	<i>Z</i>	0.E+0	<i>p-level</i>	1.

The difference is not statistically significant at a *p-level* of >0.05 , *Z statistic* 0.889 which means that participants' Direction of Interest, whether inner or outer directed, did not change from pre therapy to post therapy that suggests the psychological treatment intervention did not have an effect on the type of person, introverted or extraverted, as defined by the Direction of Interest Questionnaire.

4. DISCUSSION

The desire to know, the drive of the intellect, is subtly intertwined in its roots with the desire to be, the drive of the whole person.

(Macquarrie 1972: 192)

The results reported here show both CBT and EPT are appropriately effective treatments for the common presentation of affective disorders, such as depression and anxiety, that are generally seen in a Secondary Care NHS setting. As a short-term therapy (12-16 weeks) and based on current routine NHS Secondary Care practice, it was found that both psychological treatment interventions, CBT and EPT, produced reliable and significant clinical improvement (RSCI) from pre to post-therapy (CORE-OM >0.50), as defined by CORE-OM UK Standard Benchmarking protocols. EPT is as effective as the NICE Guideline Recommended Treatment Intervention, Cognitive Behavioural Therapy (CBT) as employed within this National Health Service Setting. With regard to Treatment Allocation, it emerged from the study that EPT may be the treatment of choice by clinicians for clients who are more severely distressed (CORE-OM >2.00 *Moderate to Severe and Severe*). In this sample, the rate of improvement for more severe cases using EPT was the same as the rate of improvement in less severe cases using CBT.

Despite the ongoing difficulties around measuring *What Works for Whom*, the principal aim of this project was an attempt to answer specifically whether Existential-Phenomenological Therapy '*works*' as an effective psychological treatment intervention for affective disorders within the context of evidence-based psychotherapy research. Evidence is based on a hierarchy that places RCTs at the highest level due to the confidence provided by the internal validity of the results. (Rawlins 2008: 2152) Many RCTs have provided evidence for the efficacy and effectiveness of Cognitive Behavioural Therapy (CBT) for many affective disorders, including depression (Churchill et al. 2001: 93). One way to find support for the efficacy of a non-supported treatment such as EPT is to compare it with an already

Well-Established Treatment (Chambless et al. 1998) such as CBT. As a pragmatic starting point, this study attempted to establish whether EPT was 'Equivalent to an already established treatment in experiments with adequate sample sizes.' (Chambless et al. 1998) Reflecting real world practice by analysing routine outcome data, EPT showed equivalent effectiveness when compared with CBT, as expected (Smith and Glass 1977; Stiles et al. 2006; Wampold 2001: 216).

The results are consistent with previous research findings showing psychotherapy is efficacious, regardless of modality (Cuijpers et al. 2008: 752; Smith and Glass 1977) and although these results were not unexpected, it is thought this is the first time EPT has been formally evaluated in the UK NHS in this way (Cooper 2008: 38). The unexpected finding was that in NHS routine practice, EPT is the preferred treatment choice for clients presenting with more severe symptoms of depression mixed with anxiety (CORE-OM >2.0). This research study was designed and proposed as an initial exploration or pilot study to find out whether EPT is effective and if further research into this particular type of therapy is worthwhile.

4.1.1 Primary hypothesis

The primary research hypothesis was that there is no difference between the effectiveness of CBT and EPT as a psychological treatment intervention for affective disorders in this particular sample. Although it was found that there was no difference in overall effectiveness in answer to the question 'which works best?', there was a difference in the means of the treatment groups.

Comparison of the CBT and EPT groups, by analysing the variance of means (ANOVA) of the CORE-OM scores, showed there was a highly significant difference between each treatment group: the grand mean was 1.90 (SD 0.83, SE 0.08) for CBT (Effect size 0.71) and 2.34 (SD 0.79, SE 0.08) for EPT (Effect size 1.05).

As clearly illustrated on Graph 1 on page 101, the treatment difference is displayed in the level of severity of symptoms between each group, where the EPT group has

higher, or more distressing, symptom scores than the CBT group. According to CORE-OM (Barkham et al. 2006b), the CBT average of 1.9 is less than 2.00 and therefore, defined as *Mild to Moderate*, and the EPT average of 2.33 is greater than 2.00 and therefore, defined as *Moderate to Severe*. The implications of these findings are discussed below in Section 4.1.4, on page 125.

Previous research findings state 'theoretically different approaches tend to have equivalent outcomes.' (Stiles et al. 2006: 555) and this appears to be supported in this sample where the level of reduction of symptoms in both CBT and EPT groups, regardless of severity, was similar. Outcome in this study was defined according to CORE-OM where Reliable and Significant Clinical Improvement (RSCI) is measured as >0.5 . The scores from waiting list to pre therapy were used as a control measure to compare with the scores from pre to post therapy. As is clearly displayed on Graph 1 on page 101, the lines for each group run parallel showing almost no change before therapy and an equivalent dramatic drop for each group from pre to post therapy.

Consideration of statistical power ($N=62$) and pre-post therapy effect sizes (CBT 0.71, EPT 1.05) means these results provide strong support for the argument that EPT is a suitable psychological treatment intervention for NHS clients presenting with affective disorders. This preliminary analysis supports the idea that EPT works, it is as effective as CBT in alleviating distressing symptoms for some clients presenting with affective disorders, and therefore, more research is warranted.

4.1.2 Secondary Hypotheses

The secondary research hypotheses were focused within participants who had EPT as their treatment intervention with the aim of identifying any aspects of this particular type of therapy that might throw some light on what and for whom it is particularly helpful.

With the emphasis of meaning inherent in EPT, the Purpose in Life Test (PIL) was used to gauge whether therapy had any effect on a sense of purpose in life. Using the Wilcoxon Signed Ranks Test, a significant difference ($p < 0.001$) was found showing that participants' ($n=14$) sense of purpose in life increased from pre to post therapy supporting the idea that meaning in life may be a factor in determining a client's mental health and well-being. With regard to Treatment Allocation, if a client describes their presenting difficulties as 'loss of meaning or purpose in life' for example, this may be an indication that EPT is a suitable treatment intervention.

As a therapy based on existential philosophy, EPT attempts to challenge assumptions and beliefs by exploration and clarification rather than directly aiming to change, fix, cure or get rid of symptoms and therefore, it is anticipated that this type of approach would have the effect of a change in the client's perception of the severity of their symptoms. A Paired Samples T-Test produced a significant difference between pre and post therapy ($p < 0.001$) thereby supporting the research hypothesis that participants' ($n=14$) perception of the severity of their problems decreased. These results suggest that whether or not the symptom has disappeared, the client's perception of their problem may be a factor in improving quality of life, aiding recovery or well-being.

The ongoing dichotomous debate about whether therapy is about *doing* or *being* can also be related to people needing different things at different times, in addition to how people think or what they respond to at different times in their lives. The plethora of available therapies is evidence of how different therapists are drawn to various models of therapy, and this allegiance to one particular therapeutic approach has been described as 'like coming home' (Spinelli and Marshall 2001: 166) by several practitioners. It was this idea that led to the hypothesis that maybe a therapy that 'spoke the same language' as the client would be a good indicator as to whom EPT may be most suitable. If CBT epitomizes a 'doing' therapy reflecting an extraverted person who speaks the language of concrete facts and figures, does EPT epitomize a 'being' therapy reflecting an introverted person who relates to a

language based on philosophical beliefs, values, ideas and lived experience. To explore the premise that there are inner and outer directed 'types' of people on the basis that this could provide helpful referral criterion, this was tested using the Direction of Interest Questionnaire. Results of the Wilcoxon Signed Ranks Test indicated no significant difference from pre to post therapy suggesting that the therapeutic intervention had no effect on the direction of interest of the participant ($N=14$). This means the tendency towards inner (being) or outer (doing) ways of thinking remained stable from pre to post therapy. Further research is required to investigate whether this factor is a good indication of whether EPT is a suitable intervention for inner or outer-directed clients.

Client participants were a mixture of inner and outer directed whereas, interestingly, most EPT therapists (7 out of 8) were inner directed congruent with a philosophical approach, as expected. Does this suggest therapists have more choice in which therapeutic approach to adopt?

4.1.3 Interpretation

There are many different ways to look at the effectiveness of therapy and, despite the beliefs of many existential therapists that the idea of measuring what we do is an anathema, if we wish to ensure NHS clients are not deprived of a choice of psychological treatment interventions including EPT, quantitative research is required. It is acknowledged that this idiographic way of working is resistant to manualisation, and raises the question of what it is exactly that we are measuring or providing evidence for, but a first step has been taken using standard, valid and reliable UK outcome measures, CORE-OM, to look at symptom reduction initially and establish whether EPT 'works', and is comparable to CBT, the NICE Guidelines Recommended Treatment for affective disorders such as depression and anxiety. The results show that, despite not working according to a manual, EPT therapists are providing something that is as effective as CBT. There are three more important points here:

- ❖ EPT is being used as the preferred Treatment Allocation for clients who present with *Severe* symptoms
- ❖ EPT is at least as effective as CBT, regardless of Severity
- ❖ EPT therapists were all experienced, but all were trainees

Taking these points in order:

Without wishing to detract from the fact that EPT trainee therapists are producing equivalent positive results with the more severely distressed clients, there are several possible reasons why these clients are being allocated to EPT as an appropriate treatment intervention. Firstly, CBT is the NICE Recommended Treatment intervention for clients presenting with *Mild to Moderate Depression* so it could be that EPT is allocated by default for the more severely distressed clients. Secondly, with CBT being the intervention most widely available, clients may have already had CBT and/or have not responded well to the CBT method, and therefore, there is more chance that they are offered EPT as an alternative. Or, a client may

come to an Assessment saying '*I don't want CBT*' and then EPT is offered as something quite different. This 'more experienced' client does fit with the finding that EPT clients were on average 7 years older than CBT clients. Thirdly, as many clients' difficulties do not fit neatly into one definitive category and co-morbidity, such as mixed depression and anxiety is very common, EPT, as a more unstructured approach, may appear to be the most suitable intervention. As a final thought which may underpin all of these ideas, if EPT epitomizes a *being-with* approach, it may be that it is more suitable for those clients who are treatment resistant, or who resist the CBT *doing* approach to therapy. In CBT, the therapist is seen as the expert directing the therapy, in comparison with an EPT approach that promotes the idea of a more egalitarian therapy where client and therapist meet as unique human beings both struggling with their lived experiences whilst the focus is kept on the client. The above are some tentative theories that may go some way to explain why EPT is allocated for those with more severe symptoms but more research into this area is needed because it may just be that EPT is allocated because it is more effective for this particular client group.

Whilst considering what it is that helps in therapy, it is often suggested that it is the therapist rather than the technique that is helpful, or rather, 'Good therapists of diverse psychotherapeutic allegiances, are helpful' (Mollon 2009). Barkham (NHS 2007) described how some therapists are 10 times more effective than the average therapist with average successful outcomes ranging from 9%-94% for individual therapists. His recommendation was that psychotherapy research should attempt to define what it is that those 'supershrinks' (Okiishi et al. 2003) are doing differently. The supershrinks were not only 10 times more effective, they regularly achieved these successful results in a significantly shorter time-span. Therapist allocation in the NHS is partly based on the supervisor's skill at matching client and therapist but mainly, on therapist availability. Although there was no analysis of this factor in this study, there were 11 CBT and 8 EPT therapists involved across 62 clients which means that the results are based on a good spread of therapists rather than one or two, who may have been 'supershrinks'. This number of therapists ($N=19$) involved

here is important because it also counteracts the point (Barkham et al. 2010: 35) that many current trials fail to take account of the therapist as a factor which could introduce significant bias into the analysis of results.

Whilst all EPT therapists were all highly trained and experienced, mainly to Masters or Doctoral level, none could be described as Fully Qualified or Chartered but they produced equivalent positive outcomes compared with a CBT sample of whom 50% were Fully Qualified Chartered Clinical or Counselling Psychologists. Maybe this dilutes the emphasis on the professional weight of Chartership for Counselling or Clinical Psychologists but it is a point worth making in favour of Existential Therapists being effective.

Although the PTS offered standard 12 or 16 weeks of individual 1:1 psychotherapy, there was quite a large range in the number of sessions attended with the minimum being 6 sessions and the maximum being 24. Although reflecting routine practice, this resulted in EPT clients having an average of one more session (average 13 sessions) than the CBT clients (average 12 sessions) which could mean this had an advantageous effect on the level of symptom reduction for EPT. This is assuming more sessions means more benefit which is not necessarily the case either (Barkham et al. 2006a; Barkham et al. 2002). More research is required into what this difference in number of sessions actually means.

There is a significant difference in the average age of those who had CBT (mean age 39) and those who had EPT (mean age 46) which could reflect some of the reasons given above, for example, those for whom CBT has not worked in the past, have now been offered EPT, or maybe an older population is more resistant to being told what to do with a more directive approach such as CBT and prefer a more philosophical approach such as EPT. More research is needed to identify why or how it is that there is an average age difference between those having CBT and those having EPT.

Taking these above points into consideration, whilst acknowledging that no manual currently exists, does not detract from the the fact that some evidence has been produced in support of the argument that EPT is effective for clients presenting with *Moderate to Severe and Severe* symptoms (CORE-OM >2.0) of depression and anxiety.

4.1.4 Implications

Current NHS treatment recommendations (NHS 2010) continually stress the importance of choice for psychological therapies but what is stipulated is that clients are given a choice of *evidence-based treatments*. The defining words 'evidence-based' present in the NICE Guidelines has meant that most therapies are excluded as no evidence has been provided to illustrate effectiveness. At present, CBT and Interpersonal Therapy are the only NICE recommended choices for depression and this does not provide much choice at all.

Traditionally, to qualify as an 'evidence-based' psychological therapy or an empirically supported treatment (EST) which can be used as a basis for Guidelines such as NICE, evaluations utilize '..... a minimum requirement of two RCTs showing superiority to a pill or placebo or by equivalence to an already established treatment' (Barkham et al. 2010: 27). Acknowledging the contemporary critique of RCTs being an inappropriate method of investigating the effectiveness of psychotherapy (Westen et al. 2004), these research results claim to be a pilot study providing preliminary evidence of effectiveness to support the argument that EPT is equivalent to an already established evidence-based treatment, CBT. More rigorous studies are now required which could be based on this design but possibly from different geographical locations.

With CBT dominating the NHS psychological services amid a prevailing atmosphere of 'one size does not fit all', these initial results are timely and should be welcomed amongst the therapeutic community as an appropriate alternative. EPT, with its much more unstructured approach and current lack of a manual, could almost be

seen as the antithesis of CBT as it sits at the opposite end of the spectrum of therapies which advocate specific 'methods' or 'techniques'. Further research is needed into what exactly it is that EPT therapists are doing so that a manual can be produced and findings replicated. Also, follow up studies to find out whether the outcomes of EPT endure, meaning that symptomatic change or recovery is lasting and continues to remain stable over a longer period of time once the therapy has finished.

If the above can be established, and in particular, the interesting finding that EPT is potentially the most effective treatment choice for the more severely distressed clients, it has some interesting implications. Referral recommendations for EPT could match the current NHS stepped-care model for depression, for example, where currently Step Two is for CBT, the Step Three recommendation could be for EPT. There does seem to be a gap between CBT as a recommended treatment for *Mild to Moderate Depression* and, just more of the same CBT, twice a week instead of once a week, for *Moderate to Severe depression*. As this practice-led research has indicated, we could speculate that EPT may be suitable for Step Three *Moderate to Severe Depression*, as is current routine practice at the NHS Trust in Edgware. Following this line of thought, Roth and Fonagy write 'One approach to this problem is entirely pragmatic: broadly, a form of stepped care in which those who do not respond to one treatment are offered another, with the extent of maximizing outcomes.' (2005: 134) Again, further research into this area of for whom EPT is most suitable is needed.

4.1.5 Findings in context

According to APA 2006 Task Force *Criteria for Empirically-Validated Treatments*, the findings of this pilot study suggest EPT may be eligible to be described as a *Probably Efficacious Treatment* because it has been shown to be ***Equivalent to an already established treatment*** (Chambless et al. 1998). In order to qualify for this status, this pilot study needs to be replicated twice and the therapy conducted in accordance with a treatment manual. Although Spinelli (2007b) has been used as

a guide in this study, the necessary and sufficient conditions of the requirements of a manualised therapy needs to be established and adhered to so that the findings of future research results can be cited with confidence.

This study aligned itself with the American Psychological Association's Task Force Report (APA 2006) on Evidence Based Practice in Psychology (EBPP) where the recommendation is to start with the patient and ask what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. In practice, this was translated here into using the UK standard outcome measure, CORE-OM, to ask the patient about their experience in an attempt to extract the best available evidence about psychological treatment interventions as they are currently being practiced in the NHS. CORE-OM measures the level of severity of presenting symptoms and is routinely used at waiting list, pre and post therapy. As with all research projects, there is a trade-off between internal and external validity and what this study lacks in randomization, it gains in generalizability by staying close to what actually happens in practice. Despite not being an empirically supported treatment, Existential Phenomenological Therapy is currently practiced in the NHS and this study has shown that it is effective in producing reliable and significant clinical improvement; EPT is at least as effective as CBT for affective disorders in this particular NHS setting. Statistical analysis has supported this finding as the best available evidence for EPT as a suitable psychological treatment intervention.

These research findings converge with past literature (Cuijpers et al. 2008; Elkin 1994; Smith and Glass 1977; Smith et al. 1980; Stiles et al. 2006; Wampold 2001: 217) that '...the average client receiving therapy would be better off than 79% of untreated clients' (Wampold 2001) and 'theoretically different approaches tend to have equivalent outcomes.' (Stiles et al. 2006: 555) It is generally accepted that psychological treatment interventions are safe, as effective as medication in the short term (IAPT 2008) and clients generally prefer talking treatments to medication (Summerfield and Veale 2008). This study extends the existing knowledge by being

the first study to measure and statistically analyse EPT quantitatively in comparison with a NICE recommended treatment for depression, CBT. The unexpected finding to emerge is that EPT is being used as the treatment of choice for the more severely distressed clients.

In support of the argument that EPT is non-manualisable, and regardless of whether this is true or not, these findings show that a manual is not necessary for a successful outcome of therapy. Roth & Fonagy (2005: 457) write 'there are no within-study contrasts of manualized or nonmanualised approaches' and it could be said that this study goes some way to addressing this point. Successful therapeutic change occurred for clients whilst therapists did not adhere to a manual in this EPT sample whereas CBT is a manualised treatment. These results are in accordance with findings from meta-analysis conducted on the effectiveness of manualised treatments for depression whereby they did not result in superior outcomes (Robinson et al. 1990: 36). The findings contradict the argument that non-manualised therapy is not effective although it is appreciated that the stipulation for a manualised therapy arises more from the need for rigour in experimental trials whereby replication is a compulsory requirement. It is accepted that for EPT to gain credibility, a manual is desirable if not obligatory, but it should be noted that this does not have to be directive or encyclopedic.

Specifically, it is thought that what is new about these findings is that we now have some statistical support and reliable evidence for the argument that Existential-Phenomenological Therapy 'works'. This provides answers to some preliminary efficacy and effectiveness investigations about whether EPT is an appropriate psychological treatment intervention for adults presenting in NHS Secondary Care with affective disorders, such as depression and anxiety.

4.2 IMPLICATIONS OF FINDINGS

These findings imply that Existential-Phenomenological Therapy is a valuable psychological treatment intervention for some people and therefore, further research into for whom this particular approach is most appropriate is needed so that it can thrive and survive as a reliable and valid choice for clients within the NHS.

This is not a surprising finding as there has been an abundance of psychotherapy research since 1950's, initially provoked by Eysenck's (1952) criticisms, to support the claim that 'psychotherapy is successful in general, and the average treated client is better off than 80% of untreated subjects' (Norcross 2002: 26). Norcross' (2002) research summary also supports the findings of this study in that there is an equivalence of the effectiveness of therapies in terms of client changes found in comparative studies. The percentages attributed to different factors thought to be important in contributing to a successful therapy outcome are summarized in the following diagram:



Figure 3 Percentage of Improvement in Psychotherapy Patients as a Function of Therapeutic Factors. Extratherapeutic change: those factors that are a part of the client (e.g. ego strength and other homeostatic mechanisms) and part of the environment (e.g. fortuitous event and social support) that aid in recovery regardless of participation in therapy. Expectancy (placebo effects): that portion of improvement that results from the client's knowledge that he or she is being treated and from the differential credibility of specific treatment techniques and rationale. Techniques: those factors unique to specific therapies (e.g. biofeedback, hypnosis, or systematic de-sensitization). Therapeutic relationship: includes a host of variables that are found in a variety of therapies regardless of the therapist's theoretical orientation (eg empathy, warmth, acceptance, encouragement of risk taking).

(Lambert 1992 cited in Lambert and Barley 2002: 18)

The pertinence for this research project is that only a small percentage (15%) of the Specific Therapy Techniques have been found to contribute to a successful therapeutic outcome and although important, an EPT approach is primarily focused on the Common Factors (30%) such as the therapeutic relationship and alliance, whilst also acknowledging Extra Therapeutic Change (40%) such as client characteristics or effects of the external environment such as family, friends, self-help, employment and support groups which help recovery but are not dependent on participation in the therapy itself.

Despite measurement difficulties of Common Factors that, of course, applies to all psychotherapy models, it is possible to produce reliable and valid results by using existing and standard UK measures such as CORE-OM as a benchmark plus a battery of questionnaires specific to EPT. Firstly, it is important that a reliable and valid standard measure such as CORE-OM is used as a benchmark to address the issue of chaos and confusion in the use of outcome measures raised by Lambert & Hill (Chapter 3 in Bergin and Garfield 1971: 74) 'A total of 1,430 outcome measures were identified for a wide variety of diagnoses, treatment modalities, and therapy types. Of this rather large number, *840 different measures were used just once!*' It is acknowledged that this reflects the diversity, complexity and multifaceted nature of psychotherapy but highlights the need to adopt measures which are comparing like with like and not attempt to *re-invent the wheel*. CORE-OM is the obvious choice as it is, and has now been routinely administered within the UK NHS for over 10 years to measure symptom change but what it does not provide is a description of what may be unique to EPT, for example. Therefore, within the EPT field of research, it would be useful to identify and recommend other quantitative measures such as PIL, PRS or DIQ, which researchers could routinely adopt and employ to build a substantial body of knowledge which is specific to this particular therapeutic way of working, in addition to qualitative research. This is based on a realistic view of the state of psychological treatment interventions in the NHS where recommendations are devised on the best available evidence, according to Government NICE Guidelines.

If the statistical data from this project can be accepted as a reliable and valid pilot study supporting the argument for EPT as a suitable psychological treatment intervention in the NHS, the next logical step would be to investigate how to get EPT into the NICE Guidelines as a recommended treatment for depression and anxiety, possibly suitable for Step Three *Moderate to Severe and Severe*.

As this study has shown, it is time consuming, very expensive and too ambitious for one individual. Therefore, the question of funding should be raised, such as whether the UK Government's commitment to choice includes support for research into effective therapies or whether an interested body such as The Society for Existential Analysis, or its' associated college, Regents School of Psychotherapy and Counselling, could take a long term view into managing and supporting this type of research.

As this particular study is up and running with NHS IRAS approval, it could be continued to get an adequately powered sample for the secondary questionnaires, plus following up these participants, but the question is who can undertake this project when the obvious candidates would be DCounsPsy trainees. Although whole theses could be developed and based on any one of the three questionnaires used in this study, DCounsPsy research trainees need to develop their own original studies so it is unclear whether this is a possible option. There is also the option of basing qualitative research on the semi-structured interviews carried out at the end of therapy that could be individually tailored to a DCounsPsy thesis. As previously indicated, the development of a manual for EPT is also needed and could possibly form the basis for a research project. There are all sorts of options including research into EPT and severity of symptoms, the ages of clients, previous counselling experience of clients, use of medication, individual therapists' outcomes, inner or outer directedness of clients and therapists, etc. The trouble is that trainees, like me, will run out of time to collect an adequately powered sample, so unless funding becomes available for professionals, it is unlikely this will happen,

with the depressing consequence that EPT may not survive in the NHS as one of the psychological treatment interventions on offer to clients.

4.2.1 Does practice support the theory?

The implications of these findings mean we have some practice-led, tangible evidence to support the argument for Existential-Phenomenological Therapy and a contextual approach to psychotherapy (Wampold 2001). A contextual approach is philosophical, looks at the research evidence and asks what is it that the therapeutic relationship provides that is healing, or relieves suffering. Instead of pulling the Dodo Bird Effect (Rosenzweig 1936) apart to justify individual therapies as beneficial, this research study seeks to investigate what it is all therapies have in common in varying degrees. The varying degrees can account for the measure of success or failure of the individual therapeutic outcome, for example, how some therapists have an average of 10 times more success than others. Presumably most authentic therapists would like to describe themselves as supershrink rather than pseudoshrink and therefore, have a vested interest in knowing how best to practice to be most effective with the most number of clients. According to Lambert (1992; Lambert and Barley 2002), the therapist does not appear to have an effect on 40% of the attributed outcome, described as Extra-Therapeutic Factors, which leaves 15% Expectancy or Placebo, 15% Technique and 30% Common Factors available for the therapist to influence.

Presumably, the Placebo or Expectancy effect can occur regardless of how the therapist practices. However, with Placebo or Expectancy at 15%, it is a substantial percentage that means, if helpful, it is worth asking how and if it can be used to maximize a successful therapeutic outcome. Spinelli (2007b) elaborates on this contributing factor by calling it a 'magic feather' aligned with the idea that the special nature of this unusual and unique relationship, a weekly 50 minute intimate but non-sexual relationship, can be exploited in a positive manner to enhance the work. Boundaries, the therapeutic frame, the asymmetric but reciprocal 'I-Thou' (Buber 1958/2000) nature of the relationship, and the therapist's belief in their

particular way of working all contribute in lesser or greater ways to the Expectancy or Placebo Effect. Even if the Placebo or Expectancy effect may occur regardless of how the therapist practices, it is still worth paying attention to and ensuring the 'magic feather' or special nature of the therapeutic relationship is maintained to support belief in the practice to ensure chances of a successful outcome are maximized.

Working on technique or the way the therapy is practiced is clearly important to the client as it does account for 15% of the outcome, but twice as important are the factors most closely linked with the individual therapist that facilitate the strength of the therapeutic relationship, and are described as Common Factors. If clients attribute the largest percentage, 30% of what was helpful about the way the therapist works to Common Factors, it suggests that this is the most important area for therapists to concentrate on because again, these factors can be developed and maximized by therapists. It is suggested that the compulsory personal psychotherapy required throughout the duration of the three year DCounsPsy training is an invaluable asset in this area because not only has the Counselling Psychologist as a therapist gained first hand knowledge of *being a client* making him/her very aware of the therapeutic experience in terms of development, process and outcome, but she also meets her client in a genuine, mutually reciprocal understanding of the therapeutic alliance. This means Counselling Psychologists are experiencing the theory first-hand before applying this practice second-hand to clients which has, if effective, hopefully, instilled a genuine and deeper belief in the theory. Personal psychotherapy was probably the most important and influential part of my training, over and above supervision because it was a first hand emotional learning experience.

According to Wampold (2001), the contextual model of therapy proposes that all therapies have the following common components:

- (a) An emotionally charged confiding relationship with a helping person
- (b) A healing setting that involves the client's expectations that the professional helper will assist him or her
- (c) A rationale, conceptual scheme, or myth that provides a plausible, although not necessarily true, explanation of the client's symptoms and how the client can overcome his or her demoralization, and
- (d) A ritual or procedure that requires the active participation of both client and therapist and is based on the rationale underlying the therapy

(Wampold 2001: 206)

All the above components can be accommodated within an Existential-Phenomenological Therapy approach as described by Spinelli (2007b) and it is assumed by the researcher that this is how EPT is currently practiced within this NHS research setting.

This research analysis was conducted on clients working with therapists who did not adhere to a manual, although they did comply with a set of Core Competences (Appendix B) and have regular weekly supervision whilst adopting a stance of unknowing, offering no fix or cure for a client's symptoms but rather an emphasis on relatedness, uncertainty and anxiety. This is perceived as using the therapeutic relationship itself as means of therapy that may or may not have the effect of reducing symptoms, according to CORE-OM as a measure in this instance. This particular practical approach, based on the theoretical idea of relatedness in EPT, and as measured by CORE-OM, is supported in this sample.

4.2.2 Does theory support the practice?

As most experienced clinicians will report, clients just do not behave in the way the manual suggests! So although it is generally accepted that therapy is more effective when therapists adhere to their preferred model, a psychoanalytic stance based on Freud's original advice for the practitioner to adopt a stance of free-floating attention, or Bion's idea of approaching each session 'without memory or

desire' (1970) can be comfortably situated within an EPT attitude. Is this psychoanalytic terminology not very similar to Husserl's (1931; 1965) phenomenological approach of epoche, horizontalization and equalization, using different words? This is where EPT seems to be most helpful for all therapies as a constant reminder that an EPT, CBT or APP approach is just one possibility, one possible way of working and for the client, it is best to keep questioning one's practice, informed by research. The contemporary idea that 'one size does not fit all' is reflected in the Division of Counselling Psychology's Statement of Values (BPS 2007) and Standards of Proficiency (HPC 2009), embracing many therapeutic approaches and a training that requires knowledge of two or more approaches, plus personal psychotherapy. I would argue that EPT epitomizes this philosophy and supports our practice by constantly raising questions, critiquing and thereby, reminding all practitioners of whatever orientation that there are always other possibilities. Therefore, it seems to be beneficial to have gained knowledge or competence in two or more models, as long as we keep in mind that 'they are all models, theories and what often gets lost when we talk about mental illness or psychopathology is that all models are nothing more than abstractions.' (Lemma 1996: 2)

Models, like diseases, are abstractions. They are inventions of the human mind to place facts, events, and theories in an orderly manner. They are not necessarily true or false. Models which are the closest to reality and the most comprehensive seem more satisfying intellectually.

(Siegler and Osmond 1974: xviii)

Applying EPT theory in practice means adopting a critical, challenging, questioning stance, whereby its' strength is to constantly remind therapists of possibilities within the particular context.

The EPT model postulates that change is inevitable and therefore, does not need to be induced. As shown by the results in this research, reliable symptomatic change has occurred by working this way and this is comparable to CBT, an accepted

evidence-based psychological treatment intervention. Rather than an attempt at removing symptoms or difficulties, EPT advocates a position whereby the therapist encourages the client to stay with difficulties and explore what is experienced by fully describing, clarifying and questioning beliefs, values and assumptions. This stance is described as *being with* or *being for*, derived from Heidegger's concept of *Dasein* where the client and therapist is actively engaged in pursuit of how the client's lived experience is at this moment in time. Whilst what could be described as the client and therapist *bearing the unbearable* (Brenman 2006: xvi), it is very common for physical symptoms to dissolve or disappear in the same way as Freud originally discovered.

"I was really scared to talk about it. I was shaking on the first session.....talking about it took it all away"

(Participant 2, 2009)

"I think back to when I was filling in those forms when you last saw me, and those questions really choked me and now they're just like....la, la, la.....I was going off work ill a lot but not now....off work due to illness but haven't actually been ill in a while"

(Participant 12, 2010)

"I would recommend it for anyone in my situation because CBT didn't work for me. I suffered from depression since my teens.....I look at *[root causes]* in a different way now.....*[EPT]* had a big impact"

(Participant 15, 2010)

4.2.3 What are implicit assumptions about this type of therapy?

The implicit assumptions about Existential-Phenomenological Therapy are based on the premise that we are all human beings struggling with our lived experiences to varying degrees at different times in our lives, and the quality of our experience depends on the condition of our relatedness. The therapeutic relationship is one

type of relatedness, possibly a novel experience whereby our experience is explored and, through this particular process, change is inevitable. The therapy is about two people meeting together to grapple with one person's particular struggles in an attempt to ease those difficulties and more often than not, being with an-other in this particular way, has the effect of the process itself being remedial, therapeutic, or to put it another way, to ease suffering.

Although the client probably does not realize it, they have already done a huge amount of work by making the decision to have therapy before they pick up the phone or walk in the door; their motivation to seek help to change something has already been activated. Although not necessarily true and with the pre-requisite that this needs to be explored and clarified, the assumption that a client is seeking to change something is presumed by their embodied expression of asking for help from another person.

Whilst transcribing the end of therapy semi-structured interviews which asked clients what they found helpful or unhelpful about EPT (Appendix S), several comments were repeated to suggest that the helpful aspects of therapy were that it felt individual, tailor-made, challenging of clients' assumptions and beliefs with the prospect of uncovering possibilities. It was also commonly seen as positive that 'It's not CBT!' (Participant 15). Unhelpful aspects tended to be that 16 sessions was not long enough. These are just initial and speculative quotations and an in-depth analysis of these interviews is planned in the future to produce more substantial findings.

Implicit within an Existential-Phenomenological perspective towards therapy is a challenging approach which constantly questions the client's beliefs and assumptions, for example, *"How is it that you cannot get out of the house to do anything 6 days of the week, but you can get out to come to therapy?"* Psychiatrists such as Laing and Szasz are famous for criticizing their own profession for over-pathologising or labeling people with medical diagnostic terms rather than

attempting to understand symptoms as embodied expressions of the client's meaningful worlds. Laing (1960) was famous for proposing that even schizophrenia was understandable and the serious symptoms expressed were meaningful to the patient. This approach is helpful as a constant reminder that people cannot simply be reduced down to their disease, they are always more than a diagnostic label. However, as much as this EPT critique is valid and a helpful reminder to clinicians, a common language amongst medical professionals for communication is necessary and useful.

4.2.4 What would theories predict about results?

The main arguments presented by an Existential-Phenomenological Approach to psychotherapy are compatible with the Division of Counselling Psychology's Statement of Values (BPS 2007; HPC 2009) whereby training and knowledge of two or more theoretical models is compulsory. Extending these specific values of EPT and the Division of Counselling Psychology to the wider context of counselling and psychotherapy in the UK and as expressed by the mood of The New Savoy Partnership, means taking a stand against the current 'one size fits all' dominating trend of CBT being the main recommended psychological treatment intervention in the NICE Guidelines in 2009 for affective disorders, such as depression and anxiety. The philosophical and theoretical stance of the Division of Counseling Psychology and EPT can be extended to the cultural and political arenas as values to be applied to the whole field of counselling and psychotherapy; a pluralistic approach for a pluralistic society. Underlying the contextual argument for different clients needing different therapies at different times also means different therapies work at different times, therefore, there is an argument for more types of therapy than CBT to be on offer within the NHS (Cooper and McLeod 2011). This theory is supported by the evidence produced in this research project; NHS clients do better when they feel they have a choice in the type of treatment intervention, EPT is a suitable treatment intervention for affective disorders, such as depression and anxiety therefore, these results mean steps should be taken for EPT to be included as recommended in the

NICE Guidelines so that clients can continue to be offered a choice of suitable effective therapies.

4.3 Research Methodology

With regard to the research methodology, the original design was substantial enough to answer the research question as to whether there was any difference either way between CBT and EPT as suitable psychological treatment interventions for use in the NHS for clients presenting with affective disorders, such as depression and anxiety. The original proposal was adequately powered to provide reliable and valid evidence but due to time constraints, it was not possible to administer the full array of secondary questionnaires to the originally proposed number of participants in both CBT and EPT conditions. This has meant that although it has been possible find strong support for the question of efficacy posed in Part I, that is 'Does EPT work?', it has not been possible to do more than make preliminary indications in answer to Part II questions of effectiveness, that is 'Who, or what is most suitable for EPT?' It can be asserted that EPT works at least as well as CBT as a suitable psychological treatment intervention for clients in this particular NHS setting and it is currently being used as the treatment of choice for those presenting with more severe symptoms (CORE-OM >2.0). There were insufficient CBT and EPT participants available within the timeframe to be able to compare the differences in responses to the secondary questionnaires, as planned.

As Part I used CORE-OM routinely collected data for the analysis, this was close to a RCT design in that none of the participants were aware that they were in a research project but analysis has been conducted on real-life situation where clinicians and clients made a co-operative choice about which treatment is most suitable. Depression and anxiety were the most commonly presenting difficulties for all clients across both CBT and EPT conditions so although not randomized, the study is strong in terms of ecological validity. As a pilot study, the clients being blind to the research is fortuitous. This naturalistic practice-led method of analyzing routine data has indicated the effectiveness of EPT in day-to-day NHS secondary care

although it is still unknown exactly which clients for whom EPT may be most suitable. It may be that it is suitable for all clients or, it may be suitable for those unsuitable for CBT. More research is needed into this area.

However, with regard to methodology, there are many different ways of researching what works in psychotherapy, such as:

- ❖ which treatment is most suitable for which diagnosis
(current preferred UK method)
- ❖ which client is most suitable for which treatment
- ❖ which treatment is most suitable for which client

Guided by the current UK political and cultural context where NICE Guidelines recommend treatments for clients according to diagnosis, this study pragmatically attempted to measure EPT as a treatment suitable for affective disorders but research design could equally focus on alternative factors as shown above. Hypothetically turning it upside down, in this particular NHS setting, the fact that clients do currently get a choice of available therapies may infer that those included in this study had some kind of choice, accepted their preferred treatment and therefore, the choice helped to facilitate effective treatment. When making assessments for treatment allocation, this particular NHS service does currently adhere to research recommendations that clients tend to fare better if they are involved in the decisions about their care and therefore, clients are offered a choice. The danger with IAPT currently only offering CBT to all clients because it is the only evidence-based therapy is that we deprive clients of a comprehensive choice and as is constantly re-iterated, choice is an important factor in terms of aiding recovery. So although the outcome of this research methodology is limited in terms of providing statistical support by identifying for whom EPT is suitable by using specific questionnaires, when taken within the context here that client preference is a kind of choice, self-selection provides some indication for whom EPT may help, as shown in this study. The above argument was echoed by the words of Professor Appleby,

National Director for Mental Health in England, when he stated at the first Savoy Conference 'There is an opportunity to develop evidence other than CBT.....and it must be remembered that patient preference is a kind of evidence; the choice the patient makes will have a significant effect.' (NHS 2007)

In future, an attempt to produce statistically significant results as closely aligned with RCT methods as possible, and learning from the experience of this research method suggests selection of participants by matching initial CORE-OM scores at waiting list for CBT and EPT participants. Due to the current NICE Guidelines for depression, in this NHS service, most clients are offered CBT for depression and anxiety which meant there are far more CBT clients (114 CBT, 31 EPT) available for analysis. Therefore, it would be possible to use EPT clients' waiting list CORE-OM scores and match with CBT clients' waiting list CORE-OM scores, and possibly even to match the age group, previous experience of CBT and length of time on the waiting list. This would help to show whether symptom severity and/or age made a difference to the effectiveness of CBT and EPT, and consequently, whether one or the other treatment intervention was more suitable for a particular client group. At present, client and clinician choice of treatment is determining that the more severely distressed clients are being allocated to EPT but what we do not know is whether this is by default or because the treatment is more effective for that particular group. If it is because the EPT is more effective as a treatment for those presenting with more severe symptoms, an application for inclusion in NICE Guidelines could be instigated.

Conducting this research study has affected my private practice in that it has deepened my belief in researching how to practice as a Counselling Psychologist, as a scientist-practitioner. There is an argument for not interfering with the therapeutic relationship and conflicting research with practice but my experience is that CORE-OM is a reliable and valid benchmarking tool that most clients perceive as a helpful, collaborative aid to their recovery. All private clients are asked to complete CORE-OM outside the therapy session as an option pre and post therapy.

Most do choose to complete the form and it is used to help verify my perception of our initial assessment session but also, may highlight something missed in the session. For example, a common aspect of depression is that the person who is depressed is very good at disguising their distress and CORE-OM has helped to identify clients who were far more severely distressed than they had appeared during our first meeting. It provides extra knowledge that can be used to understand the client, their way of relating and the therapist has the choice of whether and how to use this additional knowledge, and whether or not to share this with the client. An indirect by-product of routinely administering CORE-OM is to find out whether the client does or does not choose to complete and return the forms. The client may perceive this action as concrete evidence of the therapist's genuine interest that, I would argue, can help build rapport or, they may perceive it as intrusive and/or controlling. The pre and post therapy graphs (Appendix P) are usually welcomed as tangible evidence of the work and can support what has been achieved, or not. The downside could be that the client perceives this activity as part of a 'research project' or that they are 'just a statistic' which may have a derogatory effect on the therapy itself. My perception from personal experience is that the gains have outweighed the losses but I do wonder what the client really thinks about this aspect of their therapy, bearing in mind the knowledge that therapists tend to be over-optimistic about how well the therapy is proceeding and tend to be very bad at accurately assessing what it is that has been helpful in the therapy according to the client (Bachelor and Horvath 1999: 139; Llewelyn 1988).

4.4 Limitations

On reflection, the main and overwhelming point was that this project was far too ambitious for one individual in terms of time, funding and energy. It was not practical to envisage collecting data at three junctures from 62 client-therapist pairs (31 CBT, 31 EPT) as originally proposed, within the timeframe. Although NHS IRAS ethical approval was gained early on in the process with unremitting energetic support from the EPT clinical supervisor, Mr Mark Rayner, originally the researcher did not have a good enough understanding of how the Psychological Therapies

Service operated. All clinicians were already inundated with routine administrative paperwork and therefore, it was difficult to ask anyone to fill out another form, or participate in another interview without it seeming burdensome. Specifically, in relation to CBT, it seemed pointless for clinicians to do more research, and create more paperwork, particularly when CBT is already an established treatment, so this part of the research fell down. The practicalities of all clinicians and supervisors already being completely overwhelmed by routine paperwork meant it was impossible to recruit CBT participants. This over-optimism was a serious issue that, without access to the routine CORE-OM data, could have jeopardized the whole research project.

Linked to the above, there were also unforeseen difficulties that affected the length of time initially anticipated. Originally, there were 6 EPT therapists each seeing 3 clients for 4 months and therefore, by calculating 18 available clients at any one time meant it was reasonable to think within a year, 54 available clients would produce 31 research participants. What actually happened was that there were 2 therapists available, the therapy in the PTS was extended to 6 months, only 50% of those invited consented to participate (Appendix Q) and there were also 3 drop-outs. After a year, only 2 full research datasets were available, therefore, it was decided to conduct analysis on the PTS routine data for Part I, and collect as many full datasets for Part II as possible. By September 2010, 59 clients were invited to participate in the research project, 30 EPT clients had consented to participate and 14 full datasets were complete (Appendix R). There were no CBT research participants recruited for Part II of the design, as originally proposed.

4.4.1 Design

Internal validity of the design whereby Part I was an analysis of the routinely collected data provides strong support for the continued use of EPT as an effective psychological treatment intervention as EPT is comparable to a scientifically accepted, evidence-based therapy, CBT. Its' strength is that routine practice, like a natural laboratory, was being measured and compared but in terms of an

experiment, it can only be described as quasi-experimental study with its' weakness being that participants were not randomly assigned to treatment conditions, nor was there a therapy manual.

4.4.2 Generalisation

With regard to external validity, how far these results can be generalized from this sample to the wider population, it is more complex. The results of Part I are adequately powered to indicate support for generalization to a wider population, that is, adults presenting to NHS secondary care with *Moderate to Severe* or *Severe* affective disorders, such as depression and anxiety, may be treated effectively with EPT. More research is needed into the specific age group, previous counselling experience, number of therapy sessions offered, average waiting list time, choice, assessment, what else is available, life-span timing, and the client's experience of visiting the hospital every week for treatment (perceived care including additional research sessions) versus actual care, the therapist's length of training experience and most importantly, a manual defining what distinguishes EPT from other therapies.

4.4.3 Measurement

The CORE-OM is a standard, established UK measurement tool and therefore, the results from analysis in Part I can be regarded as valid and reliable, therefore, EPT has been shown to be an effective psychological treatment intervention for use in the NHS for affective disorders, in particular those with symptoms described as *Moderate to Severe, or Severe* (CORE-OM >2.0).

Although the secondary questionnaires, Part II, have been fairly well documented and used quite consistently according to the literature (Caine et al. 1981; Crumbaugh 1966; Langle et al. 2005) they are not as well proven as CORE-OM and therefore, can only be used as an initial indication for future research. Also, due to the time limits, we have insufficient numbers to ensure a normal distribution to inform valid and reliable significant statistical analysis for Part II. This has meant

having to rely on non-parametric testing at this stage. The Problem Rating Scale was a self-report, not that well supported in the literature and therefore, may be quite unreliable as a test. This could be analysed in comparison with the CORE-OM Problem (P) scores in future. The DIQ produced similar results to previous research findings providing a benchmark for EPT clients; that is, the therapy did not affect the type of person presenting but surprisingly, they were a mixture of Inner and Outer directed clients, whereas the majority of therapists were Inner-directed. Maybe EPT can be employed more universally than the research initially hypothesized? This Inner directedness was expected of EPT clients and therapists with this trait being associated with those interested in philosophical ideas, values and beliefs as opposed to concrete facts and figures. The PIL test is valid in that it measures one important aspect of existential thinking, meaning, and produced a significant pre to post therapy difference but again, due to the time constraints, there were insufficient numbers for the results to be taken as reliable.

4.4.4 Statistical Analysis

Due to the time constraints, there were insufficient participants to produce a powerful result for Part II and this is disappointing because it was this part of the research where it was anticipated we would discover for whom EPT is most suitable; the type of person who we may be able to say with confidence may be referred as most suitable for this particular type of therapy. It is hoped that data will continue to be collected for the full number of participants in future.

4.4.5 Future Directions

This research is up and running at this particular NHS setting but whether anyone else will be able to continue to collect the data is questionable. As CORE-OM is an established measurement tool and already regularly implemented, maybe it is more realistic just to concentrate on analyzing this data with a focus on EPT. Certainly following up these particular research participants would add to the strength of the results but again, time, energy and funding is required for anyone willing to continue the research.

The main question the research findings raised was whether EPT is a more effective psychological treatment intervention for those clients presenting with *Moderate to Severe* or *Severe* symptoms according to CORE-OM, or whether this is just where clients end up when no-one knows what else to do with them? Currently, there is no clear referral path for EPT so does this mean all clients are suitable, or, is it because the clients mention key words such as 'death' or 'meaning in life' in their assessment, or, clients do not know what they want apart from often being clear they do not want CBT, and this is taken as a request for EPT? These are questions we do not have answers to at present but require attention in the future, if constructive referral criteria for EPT are to be produced.

Although this research study is based on the work of Spinelli (2007b) and premised on the key concept of relatedness as the cornerstone of EPT, this philosophical concept could be applied to most therapies to some degree, so there is still an outstanding question of what distinguishes EPT from other therapies, particularly in the eyes of the client. If a client were to ask 'why should I have EPT?' or in sales terms, 'what is the unique selling point of EPT?', the answer is often elusive because there are so many possibilities. As much as the selling of therapy seems a bit crass and incongruous, clients do ask this question. The central difficulty of defining EPT may also be its downfall when its' mantra is that one definition will always be too restricting, and its openness to seemingly limitless possibilities is its strength. In order to promote EPT to prospective clients, to UK governing and commissioning bodies, to referring GPs, insurance companies, etc., I would argue that a clear and simple distinguishing definition is required even if it means it is not perfect; words are always one step removed from experience. Kierkegaard and all therapies have the same defining difficulties. My perception is that an interest in philosophy predominates in EPT and therefore, EPT could simply be described as *the practical application of philosophy to life* (Deurzen and Adams 2011) where a distinguishing feature of EPT is that it asks and attempts to clarify the biggest question which faces us all, 'How am I to live my life?'

It would be really interesting to know more about what clients think distinguishes EPT from other therapies, what they found helpful or unhelpful and, does this initial apparent improvement continue over time. Although semi-structured end of therapy interviews (Appendix S) were recorded, transcribed and a few quotations have been used in this thesis, there was not enough time to conduct a full qualitative analysis. It is anticipated this will be done in the future.

4.5 Discussion Conclusion

I have assumed, that is to say, that psychoanalysis is not a specialised branch of medicine. I cannot see how it is possible to dispute this. Psychoanalysis is a part of psychology; not of medical psychology in the old sense, not of the psychology of morbid processes, but simply of psychology.

(Freud 1926/1986: 67)

Freud's words are echoed by Wampold (2001:203) nearly 100 years later, where he states that there is an urgent need to dislodge psychotherapy from the chains of the medical establishment because, he argues that, if psychotherapy is conceptualized as a medical treatment, it changes the endeavour and this has the potential to destroy its usefulness. In the search for evidence demanded by Governments and private insurance companies, the attempts to specifically measure the therapeutic relationship, by using weekly monitoring sheets, asking the client to do something for us, and videoing or recording therapy, changes the process and may well destroy the pivotal or crucial therapeutic factor. Again, Freud's words spring to mind, '....but the 'analytic situation' allows of the presence of no third person' (Freud 1926/1986: 8). Therapy is an intimate 1:1 relationship and therefore, caution is recommended when inviting a third person, in the shape of a researcher, into the room. It is important to provide evidence of the effectiveness of therapy as routine practice and in particular, to adhere to the Hippocratic Oath *Primum non*

nocere, 'First, do no harm' (Hippocrates 400 BC), but caution is also advised in collecting data at the expense of the treatment itself.

In the context of recommending EPT as a suitable psychological treatment intervention, EPT represents the antithesis of CBT by suggesting that it is as, if not more important to focus on the Common Factors (30%) described here as *being with/being for*, as it is to focus on Techniques (15%) described as the *doing to* elements such as goal setting, homework, etc where the therapist takes the role of an expert teacher.

Freud's words above also reflect the values of Counselling Psychologists whereby we are not necessarily solely trained within the context of the medical world and restricted to the NHS, Government Guidelines and Insurance Company directives. Whilst often employed within medical settings that tend to focus on curing sickness, the wider role of Counselling Psychology emphasizes the promotion of wellbeing, prevention and enhancing development (Woolfe 1990: 532) in all areas of human experience; employment, old age, sport and exercise, nutrition, child development, and occupational health. This holistic approach also means Counselling Psychologists are well placed to offer a balanced perspective on what constitutes mental health and illness. At this point, it seems relevant to refer back to the *Grandfather of Psychoanalysis*, and remember Freud always recommended the limited, cautious, tentative use of his method of treating some patients with this particular discovery, the *Talking Cure*. Freud's work has evolved and developed into the diverse and comprehensive world of counselling and psychotherapy, but we would do well to follow his example, err on the side of caution whilst being reminded that 'one size does not fit all'. In this context, this means being aware that following the medical model and demanding evidence in the form of RCT's may not be a suitable method (Westen et al. 2004) of researching psychotherapy, as recently expressed by Professor Mollon, an experienced and highly respected clinical psychologist working in the NHS;

For most forms of psychological distress, none of the main psychological therapies studied in randomised controlled trials can be considered *clinically* effective, even though they facilitate some degree of *statistically* significant change.

(Mollon, 2009)

This research project has attempted to use Existential-Phenomenological Therapy as one example of a way of working effectively to treat affective disorders, such as depression and anxiety, within the NHS and which does not adhere to the medical model. Not only does this represent a philosophical argument for the contextual model of psychotherapy in practice as being effective, it supports the wider context of psychotherapy as a unique and particular way of working within the National Health Service and many other settings. EPT could also be seen as a model of therapy that epitomizes an approach that fully recognizes the Common Factors argument ‘...different therapies embody common factors that are curative, though not emphasized by the theory of change central to any one school.’ (Hubble et al. 1999: 29) EPT does not rely on diagnostic labels but prefers to investigate one human being’s difficulties by facilitating a genuine meeting with another human being in a professional therapeutic way. By reflecting, focusing, recognizing and emphasizing non-specific factors such as client motivation, relatedness, attachment, being with/being for, telling the story, bearing the unbearable, strengthening the ego that are all related to Heidegger’s concept of Dasein, *Being There* (1962: 32-35), it also draws attention to the possibility that these may be the very crucial facilitating aspects of a successful therapeutic outcome and may not be measurable: how does one measure *Being There, Being With or Being For?*

Instead of attempting to measure these intangible but possibly critical factors, this research project has addressed the problem of producing evidence for EPT by comparing it with an already established evidence-based psychological treatment intervention, CBT, using a reliable and valid UK standard outcome measure that focused on the reduction of symptoms as an indication of relative effectiveness. It was found to be *Equivalent to established treatment [CBT]* which means it may

have the potential to be described as a *Probably Efficacious Treatment* (Chambless et al. 1998: 4).

The American Psychological Association (APA 2006: 274) and the Chairman of NICE Guidance in the UK (Rawlins 2008) recommends multiple types of research evidence (efficacy, effectiveness, cost-effectiveness, co-benefit, epidemiological, treatment utilization). Therefore, an investigation into whether EPT 'works', whether it is clinically effective in the NHS for affective disorders is an important first step. It is now known that there is reliable and valid evidence available to support the theory that EPT works as well as CBT for some clients presenting with affective disorders, such as depression and anxiety. There is also reliable and valid evidence to show that EPT is the psychological treatment intervention of choice for those clients presenting with *Moderate to Severe or Severe* symptoms (CORE-OM >2.0) of depression and anxiety.

5. CONCLUSION

More than one measure (CORE-OM, Purpose in Life and Problem Rating Scale) has been employed to support the argument that EPT is an effective psychological treatment intervention. All quantitative measures point in the same direction and therefore, not only do we have evidence in the form of statistical analysis (CORE-OM, PIL, PRS) but also some answers to questions specific to EPT with regard to meanings (PIL) and attitudes (PRS) being significant factors for change relevant for this particular type of therapy. This means we can assert with confidence that EPT is effective in alleviating suffering for some clients presenting with affective disorders, such as depression and anxiety, in the NHS.

As a way of getting around the current political dilemma of how to produce evidence of effectiveness, when current UK NICE Guidelines require diagnosis-specific psychological treatments and EPT is diagnosis-averse, this research design utilized standard and routinely administered measures (CORE-OM) for analysis by comparing the client-rated scores for EPT with CBT, a scientifically accepted evidence-based therapy. Although a practice-led study, it involved an RCT-type design but instead of randomly selecting clients according to their diagnosis which artificially manipulates the sample, all EPT clients who had chosen this particular therapy together with their assessing clinician, made up the sample, and by coincidence, the primary presentation for 84% of that group was depression. It should also be noted that the design is in accordance with the current rhetoric whereby choice is considered an important factor in aiding recovery. It is ecologically valid, with a sufficiently powerful sample to produce significant results to show that EPT is equivalent in effectiveness to an empirically supported therapy, CBT, in this particular NHS setting and therefore, could be described as a *Probably Effacious treatment* (Chambless et al. 1998: 4). Due to the numbers involved and a variation on randomization, it is also high in external validity meaning that these findings can be confidently generalized to the wider population. Part I has high internal validity as use of the routinely administered CORE-OM measures meant that

neither the client, nor the therapist, nor the researcher were aware that the therapeutic process was to be eventually analysed, mimicking a double-blind trial. It is also notable that the researcher allegiance (Luborsky et al. 1999) is primarily towards *Psychoanalytic Psychotherapy in the NHS (APP)* where her belief is that this is the most suitable treatment for NHS clients presenting with the most severe symptoms (CORE-OM>2.0). This is a powerful pilot study into EPT being effective and provides a firm basis to warrant further research.

Despite EPT's resistance to diagnostic labels, this research has shown EPT is effective for clients described as suffering from affective disorders and has gone some way to answering the recurring question for psychotherapy '*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances?' (Paul 1967: 111) One true possible answer is as follows:

Existential-Phenomenological Therapy (Spinelli 2007b), delivered by an EPT-oriented therapist is effective in reducing symptoms for older adults (mean age=46) presenting with *moderate to severe and severe* depression (CORE-OM>2.00) in NHS Secondary Care (Step 3 in Stepped Care Model). It may be most suitable for those CBT-resistant clients who prefer a more egalitarian approach. Change is a given and comes about when providing a talking therapy that does not attempt to remove symptoms but instead aims at description, exploration and clarification whilst challenging sedimented assumptions and exploring hidden possibilities in answer to the deeper philosophical question of 'How am I to live my life?'

In an attempt at authenticity reflecting an existential way of thinking, this thesis closes with an open question: how can this knowledge now be used to further promote this particular type of therapy which is clearly valued by so many clients?

42,450 Words

6. APPENDIX

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Psychological Therapies available at NHS Barnet, Edgware and Haringey Trust **Information Pack** (Reproduced without Resources Information)

The Psychological Therapies Service for Adults in Barnet

USING THIS INFORMATION PACK

This information pack has been designed for people who use the Psychological Therapies Service. It answers some of the questions that are often asked about the service about psychological therapy.

WHAT IS THE PSYCHOLOGICAL THERAPIES SERVICE (PTS)?

The Psychological Therapies Service (PTS) for Barnet was launched on the 3rd March 2003. The Service provides a range of therapies for people with moderate to severe mental health difficulties. It aims to ensure that all people who are referred to the service with moderate to severe mental health problems have equal access to therapy.

The service is provided by a team of qualified therapists from different professional backgrounds, including nursing, social work, psychology, psychiatry, occupational therapy and specialist therapists. There are also a number of therapists who are in training who work under supervision.

WHAT ARE THE DIFFERENT TYPES OF THERAPIES OFFERED?

The main type of psychotherapy currently offered by the PTS is Cognitive Behavioural Therapy (CBT). The service also provides Personal Construct Psychotherapy (PCP), Psychodynamic Psychotherapy, Existential Psychotherapy and Sexual/Relationship Therapy. The Psychological Therapies Service continues to look at innovative ways to manage the high demand for our services and to decrease waiting times.

The majority of therapy is offered in groups, which run on a weekly basis for a set number of weeks (generally 8-18 weeks) with two therapists facilitating each group. Each group session lasts for either 1.5 or 2 hours. If you are referred to the service you should expect that the therapy you will be offered is likely to be in a group, usually with up to eight participants. One of the benefits of group therapy is meeting other people who are learning to cope with similar difficulties.

Currently there are several different kinds of groups that run at the PTS:

- **CBT groups** are structured and there is a strong emphasis on learning and applying psychological skills and techniques to cope with difficulties. CBT groups currently offered include: CBT Skills to manage depression and anxiety; a group for people with symptoms of panic, a group for people with obsessions and compulsions; a Self-acceptance group for overcoming low self-esteem; a group for people with depression and a group for survivors of childhood abuse.
- **PCP group** aimed at 'Improving relationships with self and others'
- **Existential therapy** group
- **Psychodynamic therapy** group

Individual Therapy

When there is no appropriate group therapy available, a one-to-one therapy will be considered. Sessions are weekly and last up to one hour. The therapist will discuss the likely number of sessions required at the beginning of treatment. For a small number of people with particularly long-term and complex difficulties, there are some opportunities for longer-term therapy, which consists of weekly appointments for up to one year.

WHAT COULD I EXPECT FROM DIFFERENT TYPES (STYLES) OF THERAPY?

• **Cognitive Behavioral Therapy (CBT)**

CBT looks at the relationship between how we think, how we behave and how we feel. The therapist and the client develop a shared understanding of how these factors are causing or maintaining the problems and then jointly agree goals to work on in therapy. The idea of the therapy is to help the client to generate solutions to their problems that are more helpful than their present ways of coping. Within this process the client and therapist will generally come to understand more about the roots of their identified difficulties. CBT is a structured therapy and involves the client trying out new things and completing agreed tasks in the period between each therapy session.

• **Personal Construct Psychotherapy (PCP)**

This is often referred to as Personal Construct Psychology (PCP). PCP is based on the understanding that our view of reality is based on how we construe personal experience and that each individual's experience is unique compared that of another. As individuals continue to experience the world around them so their constructs of that world are open to revision and definition. PCP is an approach that attempts to understand the whole person and facilitates individuals in exploring their world, identifying potential areas where they are psychologically 'stuck' and exploring their potential for a reconstruction of this view.

- **Psychodynamic Psychotherapy**

Psychodynamic therapists are likely to look at individuals' difficulties in terms of their whole life. Therapy will often explore connections between childhood experiences and adult personality and attempt to give the individual insight into how events in the past affect them in the present. The therapy will consider unconscious mental processes that may cause distress. Therapy sessions can often be fairly unstructured allowing for a sense of reflection. The individual and therapist may explore feelings, thoughts, fantasies, memories and dreams relating to both the past and the present. The therapist's role is mainly to listen and assist individuals in making sense of their feelings and behaviours. The aim of therapy would be for individuals gain new insights and better resolutions to current and long-standing problems.

- **Existential Therapy**

Existential therapy investigates a person's lived experience of being in the world and how they make sense of freedom and restriction from being able to make choices. Existential therapy does not necessarily focus on 'why' but rather 'how' a person structures their beliefs, values and relationships. The concept of relationship is central to existential therapy, which considers the person's own understanding of where they locate themselves in the world compared to their perception of others. These complexities are both considered in therapy and constituted in the therapeutic relationship. The therapeutic process involves both understanding and re-constructing ideas and beliefs about the self and the world that have led to the person seeking therapy. Existential therapy can focus on core issues and potentially re-construct previously fixed ideas so that new meanings may emerge.

- **Sexual and Relationship Therapy**

This form of therapy attempts to understand sexual and/or relationship difficulties both individually and within the relationship. It will consider factors which trigger and maintain the identified problem, be they medical, surgical, organic, traumatic or psychological. Sexual and relationship therapy aims to work towards the goals of individuals and/or couples. It also explores relevant cultural taboos and myths, which may be in conflict with conscious thoughts. It may seek to give permission where inhibition exists, and will educate in anatomy, physiology and a general understanding of sexual issues. This therapy would offer a 'safe' arena to discuss delicate and private issues surrounding sexuality and sexual and relationship difficulties.

Conclusion

There are many similarities and differences between therapies as well as different approaches within each style of therapy. Each of the therapies described above is rooted within a theoretical framework. Therapists who use these various styles would receive supervision that involves regular contact with other professionals who work in a similar way. The purpose of supervision is primarily to allow the therapist to consider their work with individuals and ways of effectively enhancing the therapeutic process.

WHEN IS THERAPY NOT APPROPRIATE FOR AN INDIVIDUAL?

It is not usually thought to be advisable for an individual to receive two or more forms of psychotherapy or counselling at the same time. Trying to understand problems from two different perspectives at the same time is likely to be confusing and the ideas might even be in direct conflict, which will make it hard to benefit fully from either approach. The PTS does therefore not offer therapy if an individual is also receiving therapy or counselling elsewhere. At assessment you are also likely to be asked about any experiences of past therapeutic relationships and how they have, or have not, been of benefit.

If an individual is consuming significant quantities of drugs or alcohol then this is likely to interfere with therapy. In this case an individual would be recommended to seek help with, or to reduce, the drugs or alcohol consumption before starting therapy. The local service that works with drug or alcohol-related issues is Barnet Drug and Alcohol Service, based at Dennis Scott Unit, who will be able to provide advice and information about local services. The Barnett Drug and Alcohol service's telephone number is **020 8937 7770**.

HOW DO I GET REFERRED TO THE PSYCHOLOGICAL THERAPIES SERVICE IN BARNET?

GPs can refer people who live in the borough of Barnet directly to the Barnet Psychological Therapies Service (PTS). Other referrals are made to the PTS from the Community Mental Health Teams and the Primary Care Mental Health Team.

When the PTS receives a referral it might be dealt with in a number of ways:

1. We may request further information from the GP
2. We may suggest a referral to an alternative more appropriate resource
3. We may offer an initial assessment to the individual

When a referral is made to the PTS the individual is usually sent a form titled 'Going Ahead with an Appointment'. When the individual returns the completed form to the PTS giving details about how s/he sees their own difficulties, an appointment for initial assessment will be offered. However if the department does not receive the form it is assumed that the individual does not wish to see a therapist and no further service is offered.

An initial assessment is an appointment with a professional from the department. It is primarily to decide whether therapy is suitable for the individual's needs and if so, which is the most beneficial form of therapy for the individual; such decisions are based on information from the individual and referrer. The initial assessment also allows for the individual to have an informed choice as to the nature of services available that they can access.

WHAT IS THE DIFFERENCE BETWEEN COUNSELLING AND THERAPY?

This question is often debated. However, the simplest definition would be that counselling is a talking treatment that helps individuals find ways of coping with particular problems they are experiencing. Psychotherapy offers the same but also aims to help individuals to understand and change the way in which they feel, act and think. In order to benefit from therapy, an individual must therefore be prepared to consider changing aspects of him/herself and have some idea about the change that s/he wishes to achieve through therapy.

The PTS does not offer counselling. Please see resource list at the end of this booklet if you wish to find out about local counselling services.

WHAT OTHER WAYS CAN I ACCESS PSYCHOTHERAPY OR COUNSELLING?

GP practices often have counsellors and sometimes psychotherapist attached to their practice. There are also local voluntary organisations that can provide counselling and support (see 'Resources Information' for a list of these services). There are also agencies such as MIND or the Westminster Pastoral Foundation that can offer counselling and therapy from therapists and counsellors who are accredited or who are in the process of training and are supervised by qualified therapists in all the work that they do. The charges for each organisation vary. Some are free, others charge on a sliding scale based on income, others suggest a contribution. It would be necessary to contact the relevant organisation for specific details.

Finding a private psychotherapist or psychologist is best done through one of the organisations that accredit psychologists and psychotherapists in order to ensure that the person you contact has the appropriate qualifications. The details of these organisations are given in the Part 3 of the resources section below:

Core Components of EPT Practice

CORE COMPONENTS OF EPT PRACTICE

Mark Rayner

October 2009

This is a simple outline to describe the methodology for existential-phenomenological practice. This follows the phenomenological method outlined by Husserl (1965) to attempt to articulate the essential qualities of consciousness and also considers key existential concepts such as anxiety, relatedness, meaning, freedom, choice and responsibility.

Perhaps it is sensible to commence with a statement that existential-phenomenology is a type of therapy that elucidates the nature of conscious thought and experience that may include dreams but all the contents of which may, although perhaps not as yet reflected upon, be accessible to consciousness for reflection.

1. Reflection

Reflection commences with the motivation for engaging in therapy which is both focused upon the problem or concerns that a person brings to therapy and also is at the same time a reflection on what it might be like to be coming to therapy and the concomitant request for help.

Reflection can be summarised as the consideration of the process of coming to and being in therapy and the elucidation of the concerns or difficulties that are being discussed.

2. Background experience

In this (NHS) setting it is important to elicit a full description of the client's presenting concerns as well as precipitating factors and an historical depiction of experience and to ask in what way those ideas may contribute to how the person sees themselves at this point in time.

Consideration ought also to be given to such factors as how a person engages in self-reflection or willingness to be self-reflective, empathy towards self and others, motivation, resourcefulness and ability to engage with uncertainty and anxiety. Thought ought to also be given to whether the client has goals for therapy and whether these might be in the realm of solving problems, changing behaviours or feelings or understanding or meaning.

3. Investigate assumptions

Do this by exploring and clarifying assumptions as below.

This immediately brings to the foreground both the assumptions about the nature of the concerns, the assumptions about what therapy might represent for the client and the emergent assumptions about the person of the therapist and also the position that the client adopts in relation to relationships and the particular relationship with the therapist.

4. Description

Thus we would encourage the client to adopt a descriptive attitude towards their concerns, reflection and to suspend any prejudice that they might have in order to get closer to the nature of their concerns in dialogue with the therapist. This is in contrast to other methods that might involve explanation as a source of enquiry.

5. Clarification

The therapist adopts a stance of diligently suspending bias and assumption in an attempt to also get closer to a more adequate understanding of the nature of the client's concerns utilising the Husserlian method of epoche (and also encourages the same attitude on the part of the client).

6. Pathology

In attempting to bracket judgments about experience, either causal or consequential, existential therapy **challenges pathology**. From the commencement of existential psychiatry with the work of Jaspers, existential attitudes focus on subjective experience rather than an interpretation of that experience by some nominated authority which presumes an objective stance towards an individual and expertise on the part of the therapist about the possible meaning of a client's concerns and a solution to them. Jaspers (1951/2003) reminded us that there is a role for both science as well as subjective reflection in the treatment of the client.

Existential therapy in the NHS recognises the culture and context of the work being undertaken as being dominated with a diagnostic attitude towards treatment, but challenges the validity of such positions in terms of their usefulness or adequacy for understanding the complexity of human experience.

7. Anxiety

Consequently, existential thinking considers anxiety in a paradigmatically divergent manner from many other approaches. Namely, that anxiety is a fundamental constituent of being alive and serves important purposes. This is central to the existential endeavour, not only because anxiety itself may disclose significantly a

client's attitude to being either involved in their world or withdrawn from possibilities.

8. Meaning

In considering anxiety, existential therapy also considers any and all experience whether desired, desirable or otherwise to be **meaningful**. This is also a significant divergence from other approaches that might consider unwanted experience (anxiety or other types of experience) as meaningless and thus in need of eradicating or ameliorating. Hence **meaning**, how a person considers meaning and the process by which they attribute or develop meaning for and from their experience is central to the endeavour of existential therapy. This approach to therapy is not normative and asks the client in dialogue with the therapist to consider how meaning is a personal expression of experience that a person creates in the context of living.

9. Responsibility

Therefore, this presents the therapist and the client with the notion that it is the client in their world that is responsible for what they take from their experience. Clearly within the world of any person they are not necessarily responsible for many occurrences that contribute for their difficulties but existential therapy, like cognitive therapy, challenges the necessity of the meaning that a client gives to certain experience. However, unlike cognitive therapy, existential thinking does not assume, as stated above, that either the therapist or some other authority can offer or suggest any particular better way to interpret experience. Rather it is the focus on the manner in which or ways in which that a particular person develops meaning that is focused upon.

10. Worldview

The view of the world that a client adopts is considered in a similar manner to that articulated by Spinelli (2007). In other words, the attitudes, beliefs and assumptions that a client brings into contact with the world that they meet represent a way or position of looking upon the world and, therefore, are a fixed position. Thus, there can be an infinite number of these positions and the ability to consider first how any position is arrived at and then to consider how other positions may impact upon the meaning that a person attributes to experience is an important consideration for therapy.

11. Freedom

As a corollary of the above, it is assumed by existential thinking that, following an appreciation of the above notions of responsibility and understanding how beliefs, attitudes and thinking is constructed, a person is free to choose how they have or do adopt the positions that they adhere to or how they live. However, it is probably more preferable to consider Sartre's notion of situated freedom to express the NHS client arriving in therapy as, more often than not, they have either been subjected to experiences that have limited or inhibited or corrupted a reasonably possible

position of freedom or might find it more acceptable to consider or less pejorative to consider their part in their world as co-responsible.

12. Relationship

The relationship with the therapist ought to support the client to look at their experience in the above stated descriptive manner, to consider their relationship to that experience, to engage with their relationship to themselves, to explore a sense of the self that they would aspire to become and to challenge themselves to be committed to therapy. This commitment is about fully engaging and taking the risk to face the uncertainty that becoming open to new, as yet undiscovered experience or feeling or behaviour or being or meaning is a desired risk, albeit one that proposes anxiety. In this arena it is possible to consider how a client may prefer to stay with known, already present, albeit unwanted experience, since moving to hoped for, yet unknown, uncertain and, therefore risky new terrain might be daunting. The therapeutic relationship is thus a potentially novel experience of relationship which itself may bring about anxiety and, therefore, reluctance and so is a fertile arena itself in which to explore and consider the client's relationship to the world and the people in it.

13. Change

Change is asked for, offered, wanted, suggested and inevitable. Popular and historical depictions of existential, and some other, types of therapy have questioned modern and prevalent therapies' notions of change. Here it is argued that former ideas that existential, and other, therapies reject certain ideas around change are misconceptions. All therapy clients want change and all therapists offer change. Existential therapy in the NHS not only seeks to offer change, but also explores fully what those changes might be like, how they might be achieved, what obstacles might be encountered and how they change and difficulty might be measured. Existential therapy here described is committed to discovering and researching and articulating what constitutes change for a person, how it might be expressed and how presented as effective research into practice based evidence.

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION
OUTCOME
MEASURE

Site ID	<input type="text"/>	<input type="text"/>	Male	<input type="checkbox"/>
letters only	<input type="text"/>	numbers only	Age	Female
Client ID	<input type="text"/>	<input type="text"/>	Stage Completed	Stage
Therapist ID	<input type="text"/>	numbers only (1)	S Screening	<input type="text"/>
Sub codes	<input type="text"/>	numbers only (2)	R Referral	
Date form given	<input type="text"/>	<input type="text"/>	A Assessment	
	<input type="text"/>	<input type="text"/>	F First Therapy Session	
	<input type="text"/>	<input type="text"/>	P Pre-therapy (unspecified)	
	<input type="text"/>	<input type="text"/>	D During Therapy	
	<input type="text"/>	<input type="text"/>	L Last therapy session	Episode
	<input type="text"/>	<input type="text"/>	X Follow up 1	<input type="text"/>
	<input type="text"/>	<input type="text"/>	Y Follow up 2	

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been **OVER THE LAST WEEK**.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt O.K. about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

Please turn over

Over the last week		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15	I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16	I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17	I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
19	I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
20	My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
21	I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
22	I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
23	I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
24	I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
25	I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
26	I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
27	I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
28	Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
29	I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
31	I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
32	I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
33	I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
34	I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	→	<input style="width: 50px; height: 20px;" type="text"/>	→	<input style="width: 50px; height: 20px;" type="text"/>
Mean Scores <small>(Total score for each dimension divided by number of items completed in that dimension)</small>	↓ <input style="width: 50px; height: 20px;" type="text"/>	↓ <input style="width: 50px; height: 20px;" type="text"/>	↓ <input style="width: 50px; height: 20px;" type="text"/>	↓ <input style="width: 50px; height: 20px;" type="text"/>		↓ <input style="width: 50px; height: 20px;" type="text"/>		↓ <input style="width: 50px; height: 20px;" type="text"/>
	(W)	(P)	(F)	(R)		All items		All minus R

Purpose in Life Questionnaire**Purpose in Life Questionnaire****Instructions**

For each of the following statements, indicate the number that would be most nearly true for you by circling the appropriate number. Note that the numbers always extend from one extreme feeling to its opposite kind of feeling.

A score of 4 = "Neutral" and implies no judgment either way; try to use this rating as little as possible.

1. I am usually:

1 2 3 4 5 6 7

1=Completely bored. 7=Exuberant, enthusiastic.

2. Life to me seems:

7 6 5 4 3 2 1

7=Always exciting. 1=Completely routine.

3. In life I have:

1 2 3 4 5 6 7

1=No goals or aims at all. 7=Very clear goals and aims.

4. My personal existence is:

1 2 3 4 5 6 7

1=Utterly meaningless without purpose. 7=Very purposeful and meaningful.

5. Everyday is:

7 6 5 4 3 2 1

7=Constantly new. 1=Exactly the same.

6. If I could choose, I would:

1 2 3 4 5 6 7

1=Prefer to have never been born 7=Like nine lives just like this one.

7. In achieving life goals I have :

1 2 3 4 5 6 7

1=Made no progress whatsoever 7=Progressed to complete fulfillment.

8. If I should die today, I would feel that my life has been:

7 6 5 4 3 2 1

7=Very worthwhile 1=Completely worthless.

9. In thinking of my life, I:

1 2 3 4 5 6 7

1=Often wonder why I exist 7=Always see a reason for my being here.

10. I have discovered:

1 2 3 4 5 6 7

1=No mission or purpose in life 7=Clear-cut goals and a satisfying life purpose.

11. I regard my ability to find a meaning, purpose or mission in life as:

7 6 5 4 3 2 1

7=Very great 1=Practically none.

Thank you for completing this questionnaire.

Problem Rating Scale**Problem Rating Scale**

Please write below what you consider to be the two major problems for which you are seeking help.

(If you think that you only have one problem, then complete only the Problem A section)

PROBLEM A**PROBLEM B**

For each problem, please now select a number from the scale below to indicate how severe the problem is at present. Write your chosen number in the boxes below.

0 1 2 3 4 5 6 7 8

Does not
Sometimes

Slightly/
Often

Definitely/
Very Often

Markedly/
Continuously

Very Severely/

Upsets me and/or interferes with my normal activities

Problem A

Problem B

Thank you for taking the time to complete this questionnaire

Direction of Interest Questionnaire

Page 1 of 2

Direction of Interest Questionnaire

Name

Age


Date

How to answer the questionnaire

Starting on the next page, you will find a list of choices. These are arranged in pairs across the page. Please choose one or the other item in each pair as being true or more true than the other member of the pair. An example is given below. Read the two statements and decide which is more true, on the whole, as far as you are concerned. Then put a tick in the space provided alongside the one you choose.

Example

Put a tick
Here or Here



I would prefer to live in town I would prefer to live in the country

With some pairs of items you may feel that both statements are partly true, or that neither of them is really true. In this case, try to choose the one that you feel is more true on the whole: if you really cannot make up your mind, leave that question blank.

There are no right or wrong answers. It is simply a question of what you yourself prefer.

There is no need to spend a lot of time making up your mind: there is no time limit but quick decisions are usually the best.

Try to make a choice between each pair of items even if it is difficult to decide. Remember, choose the statement that comes nearer to your own views or feelings, and only leave a question blank if you really cannot make up your mind.

Direction of Interest Questionnaire
Page 2

I prefer to see a film with a definite plot	1	I prefer to see a film which leaves a lot to my imagination
I think of myself as reliable	2	I think of myself as idealistic
I tend to get irritated by people who are always arguing about theories	3	I tend to get irritated by people who are only interested in practical problems
In visitiing place I am more interested in details than in 'atmosphere'	4	In visiting places, I am more interested in 'atmospheres' than in details
I would prefer to atend evening classes about the ideas underlying the various religions	5	I would prefer to attend evening classes about the chemistry of the human body
I get on best with realistic people	6	I get on best with imaginative people
I prefer conversations about the meaning of life	7	I prefer conversations about practical, everyday things or problems
I would like to be known as a person of vision	8	I would like to be known as a person of common sense
If I were a teacher I would prefer to teach engineering or domestic science	9	If I were a teacher I would prefer to teach philosophy
I like a holiday without any definite plan of action	10	I like a well-planned holiday with plenty of alternative activities
I prefer the conventional way of doing things	11	I prefer to invent my own ways of doing things
I usually prefer people who don't worry too much about 'fitting in'	12	I usually prefer people who take care to 'fit in'
I prefer to spend a free evening with a book about a person's emotional struggles with himself	13	I prefer to spend a free evening with a book about the rise to power of a successful millionaire
I would prefer to be known as a person who gets things done	14	I would prefer to be known as a person who has original ideas

End of Therapy CORE-OM Therapist Form

CLINICAL
OUTCOMES in
ROUTINE
EVALUATIONEND OF
THERAPY
FORM v.2

Site ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of sessions planned	<input type="text"/> <input type="text"/> <input type="text"/>
	letters numbers		
Client ID	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Sub Codes	Therapist ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SC4 numbers <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SC5 numbers <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date therapy commenced	D D / M M / Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of sessions attended	<input type="text"/> <input type="text"/> <input type="text"/>
Date therapy completed	D D / M M / Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of sessions unattended	<input type="text"/> <input type="text"/> <input type="text"/>

What type of therapy was undertaken with the client? Please tick as many boxes as appropriate

- | | |
|--|--|
| Psychodynamic <input type="checkbox"/> | Person-centred <input type="checkbox"/> |
| Psychoanalytic <input type="checkbox"/> | Integrative <input type="checkbox"/> |
| Cognitive <input type="checkbox"/> | Systemic <input type="checkbox"/> |
| Behavioural <input type="checkbox"/> | Supportive <input type="checkbox"/> |
| Cognitive/Behavioural <input type="checkbox"/> | Art <input type="checkbox"/> |
| Structured/Brief <input type="checkbox"/> | Other (specify below) <input type="checkbox"/> |

What modality of therapy was undertaken with the client? Please tick as many boxes as appropriate

- | | |
|-------------------------------------|---|
| Individual <input type="checkbox"/> | Family <input type="checkbox"/> |
| Group <input type="checkbox"/> | Marital/Couple <input type="checkbox"/> |

What was the frequency of therapy with the client?

- | | |
|--|---|
| More than once weekly <input type="checkbox"/> | Less than once weekly <input type="checkbox"/> |
| Weekly <input type="checkbox"/> | Not at a fixed frequency <input type="checkbox"/> |

Which of the following best describes the ending of therapy?

- | | |
|---|---|
| Unplanned <input type="checkbox"/> | Planned <input type="checkbox"/> |
| Due to crisis <input type="checkbox"/> | Planned from outset <input type="checkbox"/> |
| Due to loss of contact <input type="checkbox"/> | Agreed during therapy <input type="checkbox"/> |
| Client did not wish to continue <input type="checkbox"/> | Agreed at end of therapy <input type="checkbox"/> |
| Other unplanned ending (specify below) <input type="checkbox"/> | Other planned ending (specify below) <input type="checkbox"/> |

Research Participant Invite Letter

Private and Confidential

Psychological Therapies Service
2nd Floor
Dennis Scott Unit
Edgware Community Hospital
Burnt Oak Broadway
Edgware, Middlesex
HA8 0AD

Tel: 0208 951 2031

Fax: 0208 951 2011

Our Ref: LS/MR/TG

11th October 2010

Dear

**Evidence-Based Practice: An Inquiry into the effectiveness of short-term
Existential-Phenomenological Therapy**

We would like to invite you to take part in a research study inquiring into the effectiveness of psychological therapy.

The purpose of this study is to assess the effectiveness of the therapies we currently offer within the NHS with a view to providing the best available service to our clients. We would like to ask you some questions about how you experience therapy and this would involve completing some questionnaires when you go on the Waiting List, before the therapy starts and when the therapy finishes.

It is completely up to you whether you decide to take part or not, and your decision **either** way will not affect the standard of care you receive. All the data collected will be confidential, anonymous and treated with the utmost respect.

I will be in touch with you to discuss this further, but if you have any questions, please do not hesitate to contact me at the Psychological Therapies Service on 020 8951 2031.

Thank you for taking the time to read this.

Yours sincerely

Linda Stephenson
Counselling Psychologist in Training

Supervised by Mark Rayner

Client Information Sheet

Client Information Sheet
Existential-Phenomenological Therapy
Part I

TITLE OF THE RESEARCH PROJECT:

Evidence-Based Practice: An Inquiry into the efficacy of short-term Existential-Phenomenological therapy as a psychological treatment for affective disorders in the National Health Service

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of this study is to attempt to collect data from patients and therapists via a range of questionnaires designed to assess the effectiveness of *existential-phenomenological therapy* in comparison to *cognitive behavioural therapy* as a treatment for affective disorders such as depression and anxiety.

It is up to you to decide if you wish to take part or not. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

In order to assess the effectiveness of the therapy you have accepted, we would like to ask questions about how you perceive your current experience whilst you are on the waiting list (approximately 70 minutes), prior to undertaking therapy (approximately 55 minutes) and then again once you have completed your course of therapy (approximately 100 minutes). There will be one interview which we plan to audiotape and we seek your permission to do this. We plan to carry out the questionnaires and interviews in the same room where you normally have therapy. There will be 62 participants in this study completing the same questionnaires and interviews.

We will also be asking your therapist to complete similar questionnaires in parallel so that we can compare differences and similarities in perception as to what may have been helpful or unhelpful in this particular therapeutic relationship.

Your name and personal details will be removed from the questionnaires and replaced with a coded number in order to ensure confidentiality and your therapist will **not** have access to your answers. All information supplied by you will be treated with utmost respect and as confidential at all times.

The rationale for seeking evidence to show that *existential-phenomenological therapy* works is that, despite research showing that therapy works, there is still very little research into what it is that works and for whom it works best for. We value your contribution to this project and whilst we cannot promise the study will help you, we hope the results will benefit other NHS patients seeking therapy for affective disorders, such as depression and anxiety, in the future.

CONFIDENTIALITY AND ETHICS

The research project will be carried in accordance with the 'Caldicott Principles' as an ethical framework. As is routine practice within the National Health Service (NHS), the British Psychological Society (BPS) and UK Council for Psychotherapy (UKCP) Code of Ethics, we would like to inform you that your participation in this project is voluntary and you are free to withdraw at any time without giving any reason, without your medical care or legal rights being affected.

The completed questionnaires will be kept in a locked filing cabinet on NHS premises and will contain no reference to names, places, occupation, etc which might in any way identify who you are. All names will be replaced with a coded numerical reference.

If, during the course of the research questionnaires or interview, you experience emotional feelings for which you would like support, the services of a qualified supervisory counsellor are offered. Please inform me if you would like to use this service.

If you have any further questions or require any clarification on any of the above points, please feel free to ask.

If, once you have read and understood the above information, you are willing to participate in this project, please sign the Consent Form. If you require any further information or assistance, please do not hesitate to contact me via telephone on 07709 761876 or by email at

Linda.Stephenson@beh-mht.nhs.uk

Once again, I would like to thank you for considering participating in this research project.

Linda Stephenson
Counselling Psychologist in Training

New Information

Sometimes we get new information about the treatment being studied. If this happens, your research doctor will tell you and discuss whether you should continue in the study. If you decide not to carry on, your research doctor will make arrangements for your care to continue. If you decide to continue in the study she may ask you to sign an updated consent form.

If this happens, your research doctor might consider you should withdraw from the study. She will explain the reasons and arrange for your care to continue.

If the study is stopped for any other reason, we will tell you and arrange your continuing care.

Withdrawal

If you withdraw from the study, we will destroy all your identifiable samples but we will need to use the data collected up to your withdrawal.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (Linda Stephenson 07709 761876). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the hospital.

Harm

In the event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against NHS but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Confidentiality

If you join the study, some parts of your medical records and the data collected for the study will be looked at by authorised personnel. All will have a duty of confidentiality to you as a research participant.

Involvement of General Practitioner

We will inform your General Practitioner of your involvement in the study.

Client Consent Form

Consent Form

TITLE OF PROJECT:

Evidence-Based Practice: An Inquiry into the effectiveness of short-term Existential-Phenomenological therapy as a psychological treatment for affective disorders in the National Health Service

NAME OF RESEARCHER:

Linda Stephenson

- 1. I confirm that I have read and understand the information sheet dated July 2008, Version 1.1 for the above study. I have the opportunity to consider the information, ask questions and have had these answered satisfactorily.***
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
4. I agree to my GP being informed of my participation in this study.
5. I agree to take part in the above study.

Name of Patient

Signature.....Date.....

Name of Person taking Consent.....

Signature.....Date.....

Researcher's Contact Details: Linda Stephenson

07709 761876

Linda.Stephenson@beh-mht.nhs.uk

Research Participant Post Consent Letter

Private and Confidential

Psychological Therapies Service
Edgware Community Hospital
Burnt Oak Broadway
Edgware
Middlesex HA8 0AD

Tel: 0208 951 2031
Fax: 0208 951 2011

Our Ref: LS/MR/AJ

22nd May 2010

Dear

**Evidence-Based Practice: An Inquiry into the effectiveness of short-term
Existential-Phenomenological Therapy**

Thank you for meeting with me on Wednesday and agreeing to take part in the above research study inquiring into the effectiveness of psychological therapy. Please find enclosed a copy of the signed Consent Form and a copy of the letter sent informing your GP for your records.

As we discussed, the purpose of this study is to assess the effectiveness of the therapies we currently offer within the NHS with a view to providing the best available service to our clients

I will be in touch with you to arrange our next meeting when you have completed your course of therapy, but if you have any questions, please do not hesitate to contact me at the Psychological Therapies Service on 020 8951 2031.

I wish you well with your therapy experience and look forward to meeting with you again.

Yours sincerely

Linda Stephenson
Counselling Psychologist in Training
Supervised by Mark Rayner

Enc

cc GP Letter

GP Inform Letter

Private and Confidential

Dr

Psychological Therapies Service
2nd Floor
Dennis Scott Unit
Edgware Community Hospital
Burnt Oak Broadway, Edgware
Middlesex HA8 0AD

Tel: 0208 951 2031

Fax: 0208 951 2011

Our Ref: LS/MR/TG

1st April 2010

Dear Dr ,

**Evidence-Based Practice: An Inquiry into the effectiveness of short-term
Existential-Phenomenological Therapy**

I am writing to inform you that who is registered with
your practice, has agreed to take part in the above research study.

The purpose of this study is to assess the effectiveness of the therapies we
currently offer within the NHS with a view to providing the best available service to
our clients.

If you have any questions, please do not hesitate to contact me at the Psychological
Therapies Service on 020 8951 2031.

Yours sincerely

Linda Stephenson
Counselling Psychologist in Training
Supervised by Mark Rayner

cc Ms

Research Participant Post Research Thank You Letter

Private and Confidential

Ms

Psychological Therapies Service
Edgware Community Hospital
Burnt Oak Broadway
Edgware
Middlesex HA8 0AD

Tel: 0208 951 2031
Fax: 0208 951 2011

Our Ref: LS/MR/AJ

22nd May 2010

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I wish you well with your therapy experience and look forward to meeting with you again.

Yours sincerely

Linda Stephenson
Counselling Psychologist in Training
Supervised by Mark Rayner

Enc

cc GP Letter

The Caldicott Principles

The Caldicott Principles

- Principle 1 Justify the purpose(s) for obtaining the information
- Principle 2 Don't use person-identifiable information unless it is absolutely necessary
- Principle 3 Use the minimum necessary person-identifiable information
- Principle 4 Access to person-identifiable information should be on a strict need-to-know basis
- Principle 5 Everyone with access to person-identifiable information should be aware of their responsibilities
- Principle 6 Understand and comply with the law

Consent Form Therapist

Consent Form Therapist

TITLE OF PROJECT:

Evidence-Based Practice: An Inquiry into the effectiveness of short-term Existential-Phenomenological therapy as a psychological treatment for affective disorders in the National Health Service

NAME OF RESEARCHER:

Linda Stephenson

- 1. I confirm that I have read and understand the information sheet dated July 2008, Version 1.1 for the above study. I have the opportunity to consider the information, ask questions and have had these answered satisfactorily.***
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
4. I agree to my GP being informed of my participation in this study.
5. I agree to take part in the above study.

Name of Therapist.....

Signature.....Date.....

Name of Person taking Consent.....

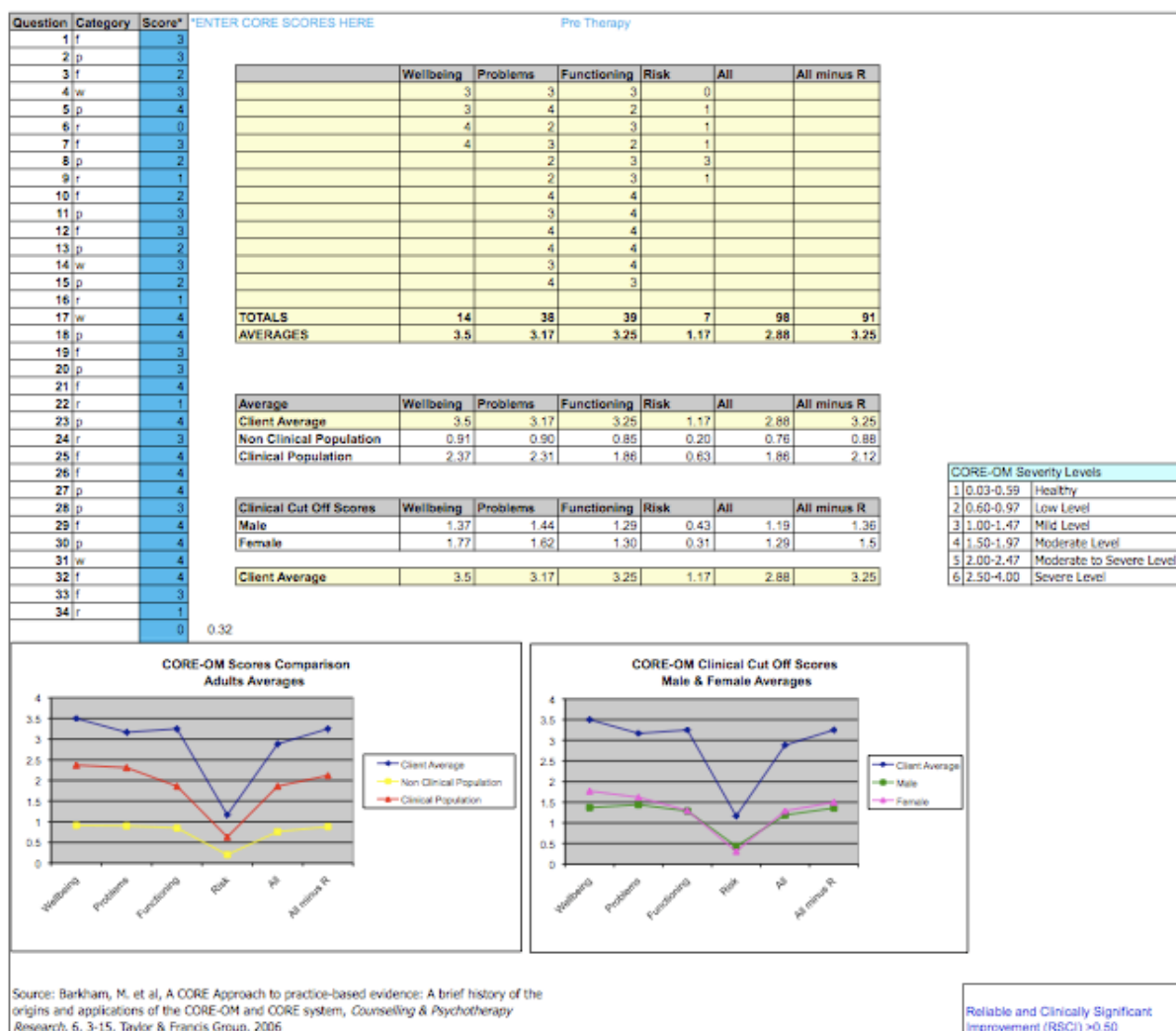
Signature.....Date.....

Researcher's Contact Details:

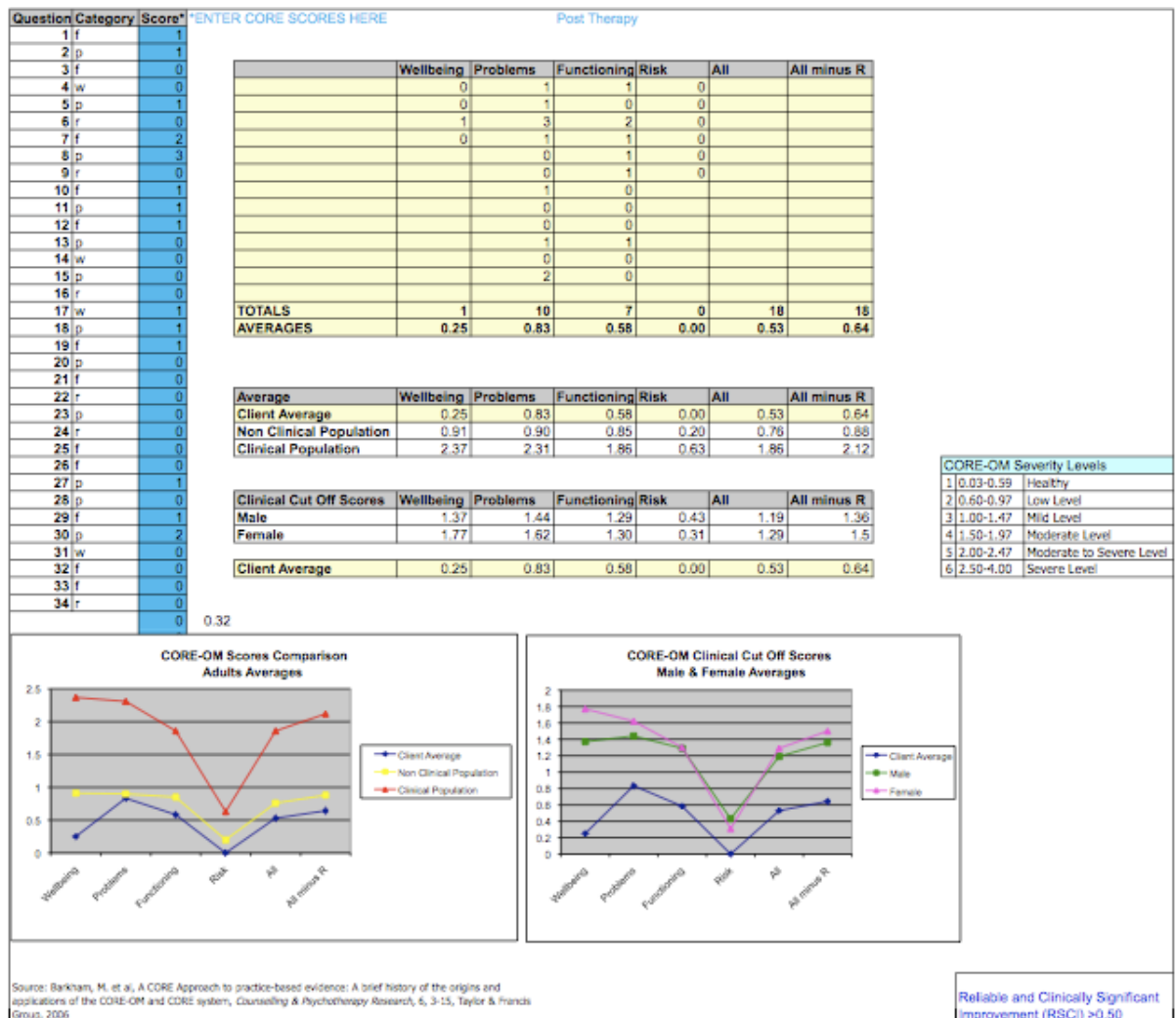
Linda Stephenson
07709 761876
Linda.Stephenson@beh-mht.nhs.uk

Pre and Post Therapy CORE-OM Graphs

Pre Therapy CORE-OM Graph



Post Therapy CORE-OM Graph



APPENDIX Q

Invited	Full Data Sets	Invitation Letter Date Sent (after IAS)	Date Followed Up with Phone Call	RIO Updated	Research Consent Appt Date	Information Consent Letter (Purpose in Life Questionnaire)	Consent (C)	Participating in therapy (T)	End of Therapy (P)	GP Info Letter Sent	Start Therapy Date
1		03.12.08	14.01.09								
2		07.01.09	14.01.09		Discharged						
3		07.01.09	14.01.09								
4		07.01.09	14.01.09								
5		07.01.09	14.01.09	✓	28.01.09	28.01.09	C1			28.01.09	XLD
6	P5	07.01.09	14.01.09	✓	29.01.09	29.01.09	C2	T1	5	29.01.09	13.02.09
7		07.01.09	14.01.09	✓	29.01.09						
8		07.01.09	14.01.09								
9		07.01.09	14.01.09	✓	July?						
10		07.01.09	14.01.09		Discharged						
11		14.01.09	21.01.09		04.03.09		C3				
12		14.01.09	21.01.09	✓	29.01.09		C4				
13	P2	14.01.09	21.01.09	✓	29.01.09	29.01.09	C5	T2	2	29.01.09	13.03.09
14	P1	14.01.09	11.01.09	✓	25.02.09	25.02.09	C6	T3	1	25.02.09	13.03.09
15	P3	14.01.09	04.01.09	✓	11.03.09	11.03.09	C7	T4	3	11.03.09	TBC May
16		18.02.09	27.01.09	✓	06.05.09	XLD Appt					
17		18.02.09		✓							
18		06.05.09		✓							
19		27.05.09	03.06.09	✓	10.06.09	10.06.09	C8	T5	4	10.06.09	21.10.09
20		03.06.09	10.06.09	✓	17.06.09	17.06.09	C9			24.06.09	tbc
21	P16	03.06.09	10.06.09	✓	01.07.09	01.07.09	C10	T6	17	01.07.09	23.10.10
22	P13	03.06.09	10.10.09	✓	30.06.09	XLD - try in August	C11	T7	12	08.10.09	08.10.09
23		03.06.09									
24	P10	03.06.09	10.06.09	✓	24.06.09	24.06.09	C12	T8	9	24.06.10	09.11.09
25		10.06.09	10.06.09	✓							
26		10.06.09	01.01.10	✓	15.03.10		C13			Withdrawn	
27		10.06.09	17.06.09	✓							
28	P8	24.06.09	30.06.09	✓	15.07.09	15.07.09	C14	T9	7	15.07.09	17.07.09
29	P9	24.06.09	30.06.09	✓	08.07.09	08.07.09	C15	T10	8	08.07.09	10.07.09
30		25.06.09	30.06.09	✓							
31	P6	25.06.09	30.06.09	✓	16.07.09	16.07.09	C16	T11	5	23.07.09	16.07.09
32	P7	09.07.09	14.07.09	✓	23.07.09	23.07.09	C17	T12	6	23.07.09	20.08.09
33		01.08.09	05.08.09	✓	17.08.09	17.09.09	C18			17.09.09	tbc
34		01.08.09	05.08.09	✓	10.09.09	Xld-having therapy Moved out of area - discharged					
35		01.08.09	05.08.09	✓	17.08.09						
36		01.08.09	Interpreter	✓							
37		01.08.09	05.08.09	✓	09.09.09	09.09.09	C19			09.09.09	tbc
38		01.08.09	Interpreter	✓							
39	P15	01.08.09	05.08.09	✓	17.08.09	17.08.09	C20	T13	13	17.08.09	16.12.09
40		05.11.09	12.11.10	✓							
41		05.11.09	12.11.10	✓							
42	P11	05.11.09	19.11.09	✓	03.12.09	14.01.10	C21	T14	10	22.01.10	22.01.10
43		05.11.09	12.11.10	✓	selling elsewhere - discharge						
44		05.11.09	19.11.09	✓	25.01.10	25.01.10	C22	T15		25.01.10	25.01.10
45		23.11.09	21.01.10		25.01.10	Felt unable					
46		10.02.10	15.02.10	✓	01.03.10	02.03.10	C23	T16	11	02.03.10	
47		18.02.10	23.02.10	✓	10.03.10	10.03.10	C24	T23		10.03.10	
48		18.02.10	23.02.10		Given to MC for research						
49		18.02.10	23.02.10	✓	Never turned up						
50	P17	18.02.10	23.02.10	✓	10.03.10	10.03.10	C25	T17		10.03.10	17.04.10
51	P4	18.02.10	23.02.10	✓	10.03.10	10.03.10	C26	T18	14	10.03.10	10.04.10
52	P14	18.02.10	23.02.10	✓	17.03.10	17.03.10	C27	T20	15	17.03.10	20.03.10
53	P12	10.03.10	17.03.10	✓	31.03.10	31.03.10	C28	T21	16	01.04.10	31.03.10
54		April	28.04.10	✓	05.05.10		C29	T22		22.05.10	22.06.20
55					26.05.10						
56											
57		22.07.10	26.07.10		29.07.10		C30				
58		11.10.10					C31				
59		11.10.10									
60											

APPENDIX R

Therapist	Invited	Consent (C)	Participating in therapy (T)	End of Therapy (P)
1	1			
1	2			
2	3			
2	4			
2	5	1		
2	6	2	1	4
3	7			
3	8			
3	9			
3	10			
2	11	3		
2	12	4		
3	13	5	2	2
3	14	6	3	1
3	15	7	4	3
4	16			
4	17			
2	18			
1	19	8	5	
5	20	9	20	
6	21	10	6	21
7	22	11	21	12
7	23			
7	24	12	8	9
7	25			
7	26	13		
6	27	14	9	7
2	28	15	10	8
6	29			
6	30			
6	31	16	11	5
6	32	17	12	6
33	18	PCP		
5	34			
2	35			
2	36			
8	37	19		
2	38			
5	39	20	13	13
6	40			
6	41			
6	42	21	14	10
6	43	0		
7	44	22	15	
7	45			
7	46	23	20	11
6	47	24	23	22
6	48	0		
6	49			24
8	50	25	16	16
8	51	26	17	14
8	52	27	18	15
5	53	28	19	16
2	54	29	22	23
8	57			26
TOTALS	57	30	23	15
				3 Dropouts
				26
				15 Full Datasets 11.10.10

Dropped out of therapy after 5 sessions

Dropped out of therapy after 5 sessions

Dropped out of therapy after 5 sessions

End of Therapy Questions for Semi-Structured Interview

Thank you for agreeing to this semi-structured interview about your experience of therapy. I am really interested in what aspects you found helpful about the therapy and what aspects you found unhelpful.

Can you summarize what you found helpful about the therapy?

Can you summarize what you found unhelpful about the therapy?

Appendix T

Data Summary: CORE-OM

Participant	Treatment	Wait List	Pre Therapy	Post Therapy	Treatment	Age	Gender
1	CBT	2.00	1.61	0.96	1	41	male
2	CBT	1.79	2.43	0.11	1	42	male
3	CBT	2.96	2.64	2.61	1	35	female
4	CBT	1.32	2.14	0.75	1	37	female
5	CBT	1.68	1.96	1.29	1	42	female
6	CBT	0.86	1.29	0.57	1	27	female
7	CBT	2.43	2.61	1.82	1	43	female
8	CBT	1.43	1.43	0.89	1	31	female
9	CBT	2.89	2.96	2.68	1	19	male
10	CBT	2.11	1.29	1.43	1	49	female
11	CBT	2.11	0.89	0.43	1	33	female
12	CBT	2.00	2.93	1.86	1	35	male
13	CBT	1.79	1.75	0.32	1	37	female
14	CBT	0.54	0.5	0.18	1	36	female
15	CBT	1.29	1.11	0.14	1	27	male
16	CBT	2.32	4.00	3.25	1	48	female
17	CBT	0.82	2.11	0.5	1	32	female
18	CBT	1.71	2.25	2.75	1	27	female
19	CBT	2.82	2.57	2.00	1	47	male
20	CBT	1.96	2.39	1.07	1	41	male
21	CBT	3.18	2.64	0.82	1	51	female
22	CBT	2.36	2.36	1.71	1	36	female
23	CBT	2.93	2.89	2.79	1	44	female
24	CBT	3.07	2.61	1.43	1	45	female
25	CBT	2.00	1.68	1.04	1	41	female
26	CBT	2.21	2.71	3.36	1	48	female
27	CBT	1.89	2.18	2.14	1	46	female
28	CBT	2.25	2.11	1.11	1	45	female
29	CBT	2.75	2.04	2.11	1	40	female
30	CBT	2.5	1.75	0.89	1	25	female
31	CBT	2.71	2.29	3.36	1	56	female
32	EPT	3.07	3.36	2.71	2	48	female
33	EPT	2.04	1.96	1.39	2	45	male
34	EPT	3.86	4.00	3.61	2	43	female
35	EPT	1.79	2.71	1.39	2	49	female
36	EPT	3.14	2.71	2.14	2	48	female
37	EPT	1.96	2.18	0.54	2	41	female
38	EPT	2.64	2.04	2.39	2	47	female
39	EPT	2.86	2.89	2.64	2	45	male
40	EPT	2.18	2.68	2.29	2	25	female
41	EPT	2.5	2.54	0.93	2	58	male
42	EPT	3.32	2.5	1.71	2	45	female
43	EPT	2.14	2.29	2.08	2	34	female
44	EPT	3.00	3.29	1.93	2	48	female
45	EPT	3.14	2.89	2.29	2	24	female
46	EPT	1.04	1.21	1.25	2	35	male
47	EPT	2.04	2.14	0.54	2	60	female
48	EPT	2.43	1.29	0.32	2	44	female
49	EPT	2.29	2.14	2.57	2	36	female
50	EPT	3.43	1.04	1.04	2	33	female
51	EPT	3.07	2.25	2.64	2	39	male
52	EPT	2.14	2.86	1.75	2	51	female
53	EPT	2.46	2.46	0.68	2	48	female
54	EPT	2.57	1.86	0.82	2	58	female
55	EPT	3.32	3.21	1.96	2	55	female
56	EPT	2.61	2.61	2.46	2	44	male
57	EPT	2.71	3.54	2.25	2	58	female
58	EPT	3.54	3.25	0.79	2	44	female
59	EPT	2.61	2.5	1.96	2	54	male
60	EPT	3.21	3.54	2.18	2	60	female
61	EPT	2.43	2.21	1.89	2	42	female
62	EPT	2.82	3.11	3.18	2	52	female
Average		2.37	2.34483871	1.656290323			

Data Summary: Purpose in Life

Participant	Pre Therapy	Post Therapy
1	44	61
2	40	54
3	33	53
4	32	56
5	30	46
6	43	70
7	34	55
8	31	21
9	47	44
10	30	53
11	20	46
12	21	30
13	20	61
14	23	20

Data Summary: Problem Rating Scale

Participant Problem 1	Pre Therapy	Post Therapy	Participant Problem 2	Pre Therapy	Post Therapy
1	4	3	1		
2	8	2	2	8	2
3	8	2	3		
4	8	2	4	6	0
5	7	3	5	7	5
6	6	2	6	6	2
7	8	2	7	8	5
8	7	8	8	8	8
9	7	2	9	8	3
10	7	2	10	6	1
11	8	6	11		
12	7	4	12	6	4
13	6	2	13	6	1
14	6	6	14	8	6
13	6	1			
14	8	6			

Data Summary: Direction of Interest

Participant	Pre Therapy	Post Therapy
1	22	20
2	4	12
3	12	14
4	26	18
5	26	18
6	22	13
7	10	10
8	24	24
9	10	14
10	18	22
11	12	8
12	12	12
13	8	10
14	18	12

Review of Identified Problems/Concerns			
Severity	Therapy Issue	Severity	Therapy Issue
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Trauma/Abuse	<input type="checkbox"/>
<input type="checkbox"/> Anxiety/Stress	<input type="checkbox"/>	<input type="checkbox"/> Bereavement/Loss	<input type="checkbox"/>
<input type="checkbox"/> Psychosis	<input type="checkbox"/>	<input type="checkbox"/> Self esteem	<input type="checkbox"/>
<input type="checkbox"/> Personality Problems	<input type="checkbox"/>	<input type="checkbox"/> Interpersonal/relationship	<input type="checkbox"/>
<input type="checkbox"/> Cognitive/Learning	<input type="checkbox"/>	<input type="checkbox"/> Living/Welfare	<input type="checkbox"/>
<input type="checkbox"/> Physical Problems	<input type="checkbox"/>	<input type="checkbox"/> Work/Academic	<input type="checkbox"/>
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/> Other <i>(specify below)</i>	<input type="checkbox"/>
<input type="checkbox"/> Addictions	<input type="checkbox"/>		

Risk <table style="width: 100%;"> <tr> <th></th> <th style="text-align: center;">None</th> <th style="text-align: center;">Mild</th> <th style="text-align: center;">Mod</th> <th style="text-align: center;">Sev</th> </tr> <tr> <td>Suicide</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Self Harm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Harm to others</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Legal/Forensic</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		None	Mild	Mod	Sev	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contextual Factors <table style="width: 100%;"> <tr> <th></th> <th style="text-align: center;">Poor</th> <th style="text-align: center;">Moderate</th> <th style="text-align: center;">Good</th> </tr> <tr> <td>Motivation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Working Alliance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Psychological Mindedness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Poor	Moderate	Good	Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Working Alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Mindedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	None	Mild	Mod	Sev																																						
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																						
	Poor	Moderate	Good																																							
Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
Working Alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							
Psychological Mindedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																							

Benefits of Therapy							
	Improved				Improved		
	Yes	No	Not addressed		Yes	No	Not addressed
Personal insight/understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Control/planning/decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression of feelings/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Subjective well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exploration of feelings/problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coping strategies/techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Day to day functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to practical help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other benefits	<input type="checkbox"/>						
<i>Tick box and then specify below</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>							

Has contact with this service resulted in a change of medication? Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>
If yes, is this change likely to be of benefit to the client? Yes <input type="checkbox"/> No <input type="checkbox"/>
Details of change: Started <input type="checkbox"/> Discontinued <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Modified <input type="checkbox"/>

Has the client been given a follow-up appointment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of months until appointment <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div>
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