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An exploration into effectiveness of Existential-Phenomenological Therapy as a UK NHS psychological treatment intervention

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**ABSTRACT**

Counselling and psychotherapy are rooted in humanistic and phenomenological approaches that place emphasis on a choice of therapies being available to individuals. Practice-based evidence makes an important contribution to the field of evidence-based practice upon which NHS clinicians and patients base decisions about psychological treatment interventions that are most likely to be effective. This research aimed to explore the effectiveness of Existential-Phenomenological Therapy (EPT) as routinely used to treat NHS patients in a UK *Secondary* Care setting.

Quantitative data were analysed from all available NHS routine patients’ (*N* = 143) Clinical Outcomes in Routine Evaluation Outcome Measures (CORE-OM) for all those who were treated with Existential-Phenomenological Therapy (*n = 34)* and Cognitive Behavioural Therapy (*n =* 109) from January 2008 to September 2010.

Differences were found between waiting list and post therapy (*p* = .016) and between pre-therapy and post-therapy (*p* = .03) for EPT research participants and mean results produced Reliable and Clinically Significant Change (RCSC) for some. A quarter of these participants moved from a clinical to non-clinical population from pre-therapy to post-therapy. A similar pattern was found for the EPT and CBT NHS routine practice patients.

**Key Words:** Practice-based evidence, Existential-Phenomenological Therapy, EPT, CBT, effectiveness, depression

Psychotherapists are only too aware of the trend in contemporary psychotherapy for some types of talking therapies to be squeezed out of existence (UKCP & BPC, 2013). Although the Improving Access to Psychological Therapies (IAPT, 2008) service is a major achievement for talking treatments in general, the predominance of Cognitive Behavioural Therapy (CBT) in the NHS for the most commonly presenting difficulties, such as depression (NICE, 2009), has resulted in the decline in the provision of other types of therapy.

Carr (2009, p.18) made a useful distinction between efficacy and effectiveness studies as representing the extremes of a continuum along which a variety of treatment outcomes fall. He defined efficacy studies as ‘telling us how well treatments work under ideal conditions’, with effectiveness studies providing information ‘about the impact of treatments under routine conditions’. Basham (1986, p.90) distilled confusing terminology to two key questions ‘Does it work?’, and ‘Which works best?’ The term effectiveness was used in this study to mean ‘Does it work?’

The demise of the less structured types of therapy (such as EPT and psychoanalytic psychotherapy), due to lack of evidence, is of great concern to many practitioners (Cooper, 2011, Lewis, 2012, Mollon, 2009). The perspective of the author, a psychologist who has experience of both Existential-Phenomenological Therapy (EPT) and Psychoanalytic Psychotherapy in the NHS (APP), in two separate Secondary Care hospital settings, is that CBT is the dominant therapy offered. Unless evidence of effectiveness in the form of transferable data is provided urgently, this demise may well continue with the result that NHS patient choice will become even more restricted. In this context, the effectiveness argument can be summarized under 3 headings; choice, modality and individual differences, as follows:

Firstly, the Government’s commitment toIAPT principles highlights the importance of a choice of therapies stating that ‘We will work towards ensuring PCTs [Primary Care Trusts] give all patients a choice of NICE-approved psychological interventions….’ (Tyson, 2008). This commitment is connected to the common acknowledgement that ‘one size does not fit all’ (Whalley & Hyland, 2009, p.291). The issue of patient choice is a primary concern within the NHS because UK and overseas research has shown that if patients have an active role in choosing, understanding and controlling their treatments, it is more effective (NHS, 2010).

Secondly, outcome research finds consistently that approximately eighty per cent of people who receive treatment benefit from psychotherapy (Carr, 2009, Smith *et al*., 1980, Wampold, 2001), regardless of the modality.

Thirdly, although there is still no solid evidence as to who will benefit from which therapy, there is a growing consensus towards the adoption of a pluralistic stance towards the provision of psychological therapies. Cooper and McLeod (2011, p.6) summarize this by suggesting that ‘different things are likely to help different people at different points in time’.

As reflective scientist-practitioners (researcher and therapist) and as practitioner-scientists (client and therapist), psychotherapists are aware of the extensive research evidence in support of the above arguments. Crucially, NHS directives identify the importance of the benefits of offering a choice of therapies. Due to the lack of evidence, the demise of historically well-respected psychological therapies (such as EPT and Psychoanalytic Psychotherapy in the NHS) is a contradiction of NHS policy and research findings. Therefore, the aim of this study was to provide some specific evidence of the effectiveness of EPT, as described by Spinelli (2007), to support a pluralistic approach (Cooper and McLeod, 2011) within a pluralist society.

A comprehensive literature review was conducted using MEDLINE, PSYCHINFO and The Cochrane Library. There were two active relevant Cochrane Protocols including Existential Therapy under the more generic heading of Humanistic Therapies (Churchill *et al*., 2010, Davies *et al*., 2010). Qualitative research would seem a ‘sine qua non’ (Finlay, 2012, p.187) for EPT. Whilst Cooper in 2008, noted there was a paucity of quantitative research into the efficacy of EPT, Plock, in 2010, identified that there was a growing interest in qualitative research. Further investigation shows this still to be the case in 2016. This is probably because its perceived method, of reducing the rich context of human beings to figures, is contrary to the philosophical underpinnings of counselling and psychotherapy (Woolfe *et al*., 2010). However, this research was partially driven by the recommendations delivered by the Chairman of NICE, Rawlins (2008) who recommended that researchers embrace a diversity of research approaches including both qualitative and quantitative methods.

A Cochrane Review into ‘ ‘Third wave’ cognitive and behavioural therapies versus other psychological therapies for depression’ concluded that ‘third wave CBT and CBT approaches are equally effective and acceptable in the treatment of acute depression’ and ‘underscores the importance of completing further studies to compare various third wave CBT approaches with other psychological therapy approaches to inform clinicians and policymakers on the most effective forms of psychological therapy in treating depression’ (Hunot et al., 2013). Vos *et al.* (2015) found 14 Randomised Controlled Trials about Existential Therapies (ET) throughout the world (USA, Canada and The Netherlands); most were focused on physical conditions such as cancer, and none were based in the NHS. It was concluded that ‘ET may have positive therapeutic outcomes at a magnitude similar to other humanistic, relational and positive-psychological psychotherapies’ (Vos *et al*., 2015, p.60). Since Vos *et al*.’s (2015) review, a similar quantitative study to the current study has been published, using the same CORE-OM measures in the same NHS setting but in Primary Care, making this a timely contribution in the NHS Secondary Care setting. Rayner & Vitali (2015) investigated the effects of ET, also as formulated by Spinelli (2007), on distressing psychological symptoms for patients (*N*=52) in NHS Primary Care. A large effect size (Cohen’s *d* = 0.89) was found between pre-therapy and post-therapy, according to the CORE-OM. The current study is the first UK research study to analyse the effectiveness of EPT within NHS *Secondary* Care using a quantitative paradigm (Cooper, 2008, Vos *et al*., 2015)

**Existential-Phenomenological Therapy**

It is a fundamental premise of this type of therapy that there is no one definitive way of working existentially (Deurzen & Adams, 2011, Spinelli, 2007) as this approach is diverse (SEA, 2013), but all share the notion that ‘existence comes before essence’ (Sartre, 1948/1973, p.26). For the purposes of this research, Spinelli’s formulation (2007), where the concepts of *relatedness, uncertainty* and *anxiety* shape the individual’s world, was used. As a founding member of the British School of Existential Analysis, Spinelli considers the therapeutic relationship itself as key to facilitating change in ways which are unpredictable but taken to be a *given* (Spinelli, 2007).

The phenomenological method originated in the work of Husserl (1931) and Spinelli’s version of practice is additionally derived from Ihde (1986, 2012). This particular method adheres to the rules of *bracketing* (an attempt to put aside biases and assumptions), *description* (exploration, challenge and clarification), and *horizontalization* (treating all phenomena as equal). EPT is focused on what emerges in the ‘here and now’, combined with the concept of intentionality (Spinelli, 1989, 2007). Within this NHS practice, the EPT approach was grounded in a descriptive exploration of what it means to exist as a human being capable of language and reflection which provides the capacity for freedom, responsibility and choice as to how one is to live one’s life.

**Presenting Difficulties**

The clinical setting from which the data were collected was unusual in that the description of the patients’ presenting difficulties such as depression, anxiety, etc. was applied at the end of therapy on the CORE-OM form by the therapist. The offer of therapy was based on the severity of presenting symptoms as assessed on an individual basis; it was common in the practice setting that there was no official diagnosis. This was true for all patients and reflects practice as usual.

The main research hypothesis was that EPT contributes to a significant reduction in CORE-OM scores (an assessment of clinical effectiveness).

A secondary hypothesis, that EPT will not differ significantly from CBT in clinical effectiveness scores, was also explored. This hypothesis was based upon the *Equivalence of Outcomes Paradox* (Stiles *et al*., 1986: 165) that states ‘most reviews of psychotherapy outcome research show little or no differential effectiveness of different psychotherapies’.

**METHOD**

This research was granted ethical approval by the NHS Central Office Research Ethics Committee (COREC) via the Integrated Research Application System (IRAS) on 18th August 2008, covered by NHS COREC Reference 08/H0723/51.

**Design**

This practice-based study adopted a single site, non-randomised design that measured routine patients and research participants at waiting list, pre-therapy and post-therapy.

**Participant Selection**

109 CBT and 34 EPT patients were included in the study. All patients with complete CORE-OM datasets in the system at the time of the study were selected for analysis. In order to understand the effect of EPT more fully, the 34 patients following that therapy were invited to take part in pre-therapy and post-therapy interviews. 14 of the patients accepted. The subgroup of 14 participants had the same data collected from routine records but, in addition, had a pre-therapy and post-therapy interview. The small sample of 14 participants that were tracked more closely were analysed separately because it was thought there might be a research effect whereby the increased awareness of their therapy experience may cause them to differ from the remaining EPT patients in the study. Thus, the sample size of EPT patients included in the analysis of routine data was reduced to 20. This affected the choice of statistical data analysis.

**Therapist Selection**

The intervening EPT therapy was undertaken by a group of therapists who worked closely together and met every week for group supervision. This coherent group shared a similar perspective and understanding of EPT. Through the process of group discussions, some standardisation of therapeutic experience was maintained but it is also accepted that there is a limit to standardisation because there is always a newly constructed relationship between any two people, even when the same therapist remains consistent across two different patients. For CBT, it was understood that this was a manualised intervention in this setting.

**Measures**

The effect of EPT or CBT on the patient’s distress was measured by posing the same 34 questions at assessment, before therapy began and after the last session using the CORE-OM. This measure produces a mean score, ranging from 0.00 (*Healthy*) to 40.00 (*Severe*) that can be compared with the current level of psychological global distress (from *Healthy* to *Severe*). The CORE-OM was selected for the research because it is widely accepted in the UK as the main standard outcome measure for psychological therapies in assessing clinical effectiveness across all models of therapy (Evans et al., 2002, Jacobson and Truax, 1991). It was developed to monitor symptom reduction as well as dimensions of *well-being, functioning, problems* and *risk*, as perceived by the patient.

As CORE-OM is not diagnosis-specific, it was thought to be apt in reflecting an existential-phenomenological attitude that regards how one relates to experience as more important than simply relying on diagnosis. By contrast, this has been the main criticism of CORE-OM for use within the medical environment; where it is seen as a disadvantage that it does not address diagnosis specifically.

In this field, it is conventional to evaluate meaningful change using two indices; Reliable Change and Clinically Significant Change (Jacobson & Truax, 1991). Firstly, the Reliable Change Index (RCI) uses a clinical score higher than five points to determine whether we can be confident that the change is not due to chance or measurement error. Secondly, Clinically Significant Change is reported when a patient has moved in the direction towards a mean score more representative of the general population than a clinical population. The original CORE-OM System states this cut-off figure is 11.90 for males and 12.90 for females (Evans *et al*., 2002: 58, Barkham *et al*., 2010: 188). Later studies (Connell *et al*., 2007, Barkham *et al*., 2010) using a larger clinical population and a general population sample, including males and females combined, have produced a lower average adult cut-off score of 10.00. Ten is now considered the overall average norm for a clinical population cut-off score. Combined, these two indices are referred to as Reliable and Clinically Significant Change (RCSC).

Patients initially presented at the NHS Psychological Therapies Services (PTS) with a range of distressing symptoms, having been referred via GPs, Community Mental Heath Team (CMHT) psychiatrists, inpatient treatments and, also from the Improving Access to Psychological Therapies (IAPT) service (as IAPT was primarily designed for those with mild to moderate difficulties, those with more complex mental health issues were referred to the PTS). Referred patients were placed on a general waiting list. They were then invited to attend an Initial Assessment Session where, together with a clinician, they took an active part in choosing the most appropriate type of therapy for their difficulties. Whilst on this waiting list, and once the patient was assigned to a therapist, the researcher contacted all those who chose EPT as their psychological treatment and requested consent to participate in the research. As soon as the assigned therapist and participant had availability, weekly therapy commenced. The standard number of therapy sessions offered was 11 although this could be extended depending on individual circumstances. When therapy ended, the researcher contacted the participants and invited them to attend a post-therapy meeting where data were again collected. Semi-structured interviews lasting from 1-1.5 hours were conducted before and after therapy but most of the content is not considered in this paper.

**Data Analysis**

Due to an imbalance in the sizes of the groups following CBT and EPT, and the lack of any control due to the use of routinely collected data, a non-parametric approach was deemed more suitable to analyse the data.

Exploration of the quantification of therapeutic effects was undertaken using Friedman tests to examine changes between waiting list, pre-therapy and post-therapy in each group. Pair-wise comparisons were used to determine which particular time points were different. Mann-Whitney U tests were used to identify potential differences between therapies. The selected significance level of *p* < .05 was modified with Bonferroni correction for multiple statistical tests, where appropriate (Howell, 2013). SPSS Version 20 was used for analysis. Effect sizes were calculated using *r* for non-parametric tests (Rosenthal, 1991).

**RESULTS AND FINDINGS**

**Participants**

Routine EPT (*n* = 20) and CBT (*n* = 109) patients’ details can be seen in Table 1. Difficulties were described as 81% *depression*, 17% *anxiety/stress* and 11% as *other*.

The EPT sampled subgroup consisted of eleven females and three males ranging in age from 25-60 (mean 44.78, SD 9.99) years, and the EPT routine group were aged 25-58 (mean 44.25, SD 9.03). The CBT routine group were aged between 20-61 (mean 38.41, SD 11.08).

The number of therapy sessions undertaken by routine and subgroup patients was also quite varied and ranged from 11 to 20 (mean 14.2: SD 2.86). This variation was due to an NHS policy change where the number of standard sessions offered increased from 11 to 16, as well as perceived need of the individual patients.

**Table 1**  Descriptive Statistics of EPT sample CORE-OM scores at different stages of treatment.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Minimum | Maximum | Median (IQR\*) |
| **EPT Routine (*n* = 20)** |  |  |  |
| Waiting List (CORE-OM Score) | 17.90 | 38.60 | 26.25(9) |
| Pre-Therapy (CORE-OM Score) | 12.90 | 40.00 | 26.45(9) |
| Post-Therapy (CORE-OM Score) | 5.40 | 27.10 | 21.10(11) |
| **CBT Routine (*n* = 109)** |  |  |  |
| Waiting List (CORE-OM Score) | 1.10 | 36.80 | 23.20(11) |
| Pre-Therapy (CORE-OM Score) | 3.90 | 40.00 | 22.50(11) |
| Post-Therapy (CORE-OM Score) | 0.70 | 36.40 | 14.30(13) |
| **EPT Subgroup (*n* = 14)** |  |  |  |
| Waiting List (CORE-OM Score) | 10.40 | 35.40 | 26.10(11) |
| Pre Therapy (CORE-OM Score) | 15.00 | 35.40 | 25.00(10) |
| Post Therapy (CORE-OM Score) | 4.30 | 31.80 | 10.55(15) |

 \* interquartile range

Fourteen participants were tracked through their treatment. Fig. 1 shows they experienced no reduction in CORE-OM between waiting list and pre-therapy, although the pattern of scores changed. The spread of data reduced as the patients waited for therapy with more severe range of scores in evidence as therapy approached, although the median reduced slightly. The interquartile range of post therapy CORE-OM scores was below that of when patients were put on waiting list suggesting that ¾ of the fourteen patients had reduced CORE-OM post-therapy, and over ¼ had final scores below the adult clinical cut off score of 10.

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**Fig. 1** Boxplots of mean CORE-OM scores for the 14 patients who took part in interviews.

Friedman tests showed a significant difference between the three measurement occasions (χ2(2) = 9.897, *p* = .007). Significant reductions were found between waiting list and post-therapy CORE-OM scores (*p* = .016, *r* = -.588) and between pre-therapy and post-therapy CORE-OM scores (*p* = .03, *r* = -.633). The effect sizes are above the threshold 0.5 demonstrating a large effect (Cohen, 1988/2013, p.526).

The 20 routine EPT patients were used as a comparison group with the smaller sample of 14 EPT patients. No differences were found between the two groups, with the pattern of improvement remaining the same.

The routine data collection of CORE-OM from 20 EPT patients was compared to the routine data for the 109 CBT patients. Boxplots (Fig. 2) show that CBT patients had a wider range of scores at both waiting list and pre-therapy measurement points.

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**Fig. 2** Boxplots of EPT and CBT routine patients mean CORE-OM scores at Waiting List, Pre-therapy and Post-therapy.

Mann-Whitney tests revealed a difference in the groups’ CORE-OM scores at the pre-therapy stage (U=668.0, *p* =.006. *p* <.017). The effect size of treatment groups was very small (*r* = -.017*)* however, prior to comparison of the treatments post-therapy, the pre-therapy CORE-OM score was subtracted from the post-therapy score for each patient in order to evaluate the change in score.

**Table 2** Reductions in CORE-OM mean scores for both treatments.

|  |  |  |
| --- | --- | --- |
| Treatment | Median reduction | IQR of reduction |
| EPT | 6.3 | 10.3 |
| CBT | 5.7 | 9.6 |

Both EPT and CBT showed a reduction in CORE-OM scores for routine patients (Table 2). No difference was found between the treatments in the extent of the reduction (U = 1200, p = .474). Fig. 3 shows how the pattern of reduction in EPT scores compared to those for CBT scores.

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**Fig. 3** Pattern of reduction for the 20 EPT and the 109 CBT routine patients CORE-OM Scores.

**DISCUSSION**

Statistical measures selected to explore the differences before and after therapy supported the research hypothesis that EPT was an effective psychological treatment intervention for NHS patients presenting with distressing symptoms, according to the RCSC (Jacobson & Truax, 1991) within this NHS sample. Fig. 1 shows the reduction in CORE-OM to exceed 5 points meeting RCSC criteria.

Common to all psychotherapy research, the measure from waiting list to pre-therapy was valuable because it helped to highlight the differences compared with the post-therapy results, with the participant acting as their own control. The issue of innumerable confounding variables in psychotherapy research is highly problematic and although the results above indicate that there was a small difference between waiting list and pre therapy, it was not significant.

The findings for the EPT subgroup suggest that we can answer Basham’s (1986) question ‘Does it [EPT] work?’ in the affirmative, according to RCSC criteria. The reduction in CORE-OM scores was greater than ten points between waiting list and post-therapy (Table 1). Therefore, this sample displays a far greater reduction in CORE-OM scores than is minimally required (>5) to be confident that reliable and clinically meaningful change has taken place. This also contributes to Vos *et al*.’s (2015) review findings that EPT, as practised in the UK, may have positive therapeutic outcomes for psychological difficulties (for example, depression), as well as for the previously researched physical conditions.

A median decrease in mean CORE-OM score from waiting list to pre therapy (Fig. 1) suggested that, at least for some participants, the act of being taken off the waiting list and offered treatment may have a beneficial effect in itself. This was not true for all participants in this study as the minimum pre-therapy score increased from waiting list to pre therapy. The Initial Assessment Session is not often regarded as *treatment* but this can be a powerful meeting for some patients. If a real choice of therapy is offered, and importantly, if the patient feels listened to, it can provide a sense of agency and responsibility that, in turn, signifies hope, motivation and commitment to a newly constructed relationship. For therapy to be effective, both parties need to show responsibility, motivation and a commitment to work. The aim of the NHS Psychological Therapies Service is a reduction of distressing symptoms (CORE-OM) and results for this specific Secondary Care EPT subgroup indicate that not only has reliable change (ten participants) occurred but for many (eight participants), it was also clinically significant. It is also shown here that a quarter of these adults moved from a clinical to a non-clinical population (Jacobson & Truax, 1991, Evans *et al.*, 2002), and complements Rayner & Vitali’s (2015) findings of the effects of ET in Primary Care.

Fig. 2 illustrates the differences between the routine EPT and CBT patients where it can be seen that, at waiting list, the median point for EPT patients fell within the *Severe* category, the median point for CBT patients fell within the *Moderate to Severe* category, according to national benchmarking (Barkham et al., 2006). The implication of this finding is valuable for EPT because currently there is no specific recommended NICE Guidelines’ psychological treatment for this NHS Step 4 patient group described as *Severe* (Fairfax, 2013, p.85). In addition, it has been suggested that offering an alternative therapy may be a pragmatic approach to maximizing outcomes (Roth & Fonagy, 2005, p.134).

At post-therapy, a significant reduction was found for both groups where CORE-OM scores had decreased by more than five points in the same, desired direction. EPT CORE-OM median scores reduced from a *Severe* level to a *Moderate to Severe* level of distress whereas CBT CORE-OM median scores reduced from a *Moderate to Severe* level to a *Moderate* level, from waiting list to post therapy (shown on Fig. 2). This is an important finding for EPT as it supports the argument that bona fide psychological therapies have similar outcomes and that EPT, as routinely delivered within the same NHS setting, facilitates a similar reduction in symptoms to CBT, the scientifically-accepted and NICE Guidelines (2004, 2009) recommended treatment intervention. As a very different type of therapy, this means the offer of EPT as a psychological treatment intervention opens up the possibility of a real choice for NHS patients, in line with NHS directives.

It is also significant that although initially both the routine EPT and CBT groups’ median CORE-OM scores were drawn from different populations, with the EPT group being more *Severe*, they became more similar post-therapy. At post-therapy, the EPT group was described as *Moderate to Severe* and the CBT group was described as *Moderate.* Neither treatment group changed significantly from waiting list to pre-therapy but both changed in the same way from waiting list to post-therapy.

**Limitations**

Treatment as usual in this NHS setting did not involve the use of a manual for EPT therapists and therefore, poses a threat to the internal validity of these findings. However, this method emulated Stiles *et al.’s* (1986) large scale practice-led research project where, although it was not known how individual therapists were practising, the outcomes of this study reflect the effects of EPT as ‘routinely delivered, using practitioners’ versions of the treatments and the patients who typically received them’ (Stiles *et al*., 1986: 556). It is argued that this is a confounding variable in all psychotherapy research as it is never possible to fully standardise a newly constructed relationship between any two people. Attention is drawn here to Westen et al.’s (2004) criticism regarding manualisation stating that ‘the assumption that the interventions specified in treatment manuals are causally linked to change is not well supported’ (Westen et al., 2004: 639).

Although treatment differences were found between EPT and CBT in routine practice with EPT patients described as in the more *Severe* category, this finding must be treated with caution due to the numbers of available EPT data. There is a tension between recruiting enough participants whilst allowing for freedom in the patients’ choice of therapy. As it would be unethical to influence a person’s choice of therapy, we worked with all that was availablebut to have more confidence in these findings, replication with larger numbers is needed.

Overwhelmingly, past effectiveness research (Bergin and Garfield, 1994, Carr, 2009, Cooper, 2008, Lebow, 2006) has found that psychotherapy works, or in the words of Wampold ‘psychotherapy is remarkably efficacious’ (2001: 71). Although the findings of this study were not surprising due to the concept of researcher allegiance (Luborsky et al., 1975), where the preferred theoretical orientation of the researcher is significantly associated with effect sizes found, in this research, the variation of treatment outcomes appear to be minimal.

**Conclusion**

This initial exploration provided support for the argument for further research into the contribution of EPT to the reduction in symptoms as identified by the CORE-OM, from waiting list to post-therapy, in this particular NHS setting. It was also of note that these EPT samples were described as *Severe* in terms of their psychological distress because there is still currently no specific NICE Guidelines’ psychological recommendation for this NHS Step 4 patient group (Fairfax, 2013).

The implications of these findings, for EPT psychotherapists who prefer to adopt this approach, is that initial indications found support for the argument that EPT (Spinelli, 2007) was an effective psychological treatment intervention. EPT, as routinely delivered in this NHS setting, produced Reliable and Clinically Significant Change (Evans *et al*., 2002, Jacobson & Truax 1991) for some patients presenting with distressing symptoms. It is hoped that these initial indications will provoke further interest in quantitative research into EPT to provide more transferable data and a platform for the type of evidence required by governments and decision-makers in policy funding so that a continued choice of therapies can be maintained where there is most demand, in the NHS.

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