Abstracts are grouped into topic areas, and then into categories (keynote addresses, symposia, panel discussions, clinical roundtables, skills classes, open papers and posters).

### Adult Mental Health

**Keynotes**

- Evidence-based Clinical Care for Self-harm Patients
- Relationship Functioning and Adult Psychopathology: Couple-Based Interventions to Treat Individual Disorders
- Meeting the Challenge of 'Personality Disorder' in Changing Times
- Cognitive Behavior Therapy in the Treatment and Prevention of Depression
- Cognitive Therapy for PTSD: An Update

**Symposia**

- Cognitive factors that maintain worry: The role of imagery and verbal processing of feared and benign worry outcomes
- Worry in imagery and verbal form: Effect on residual working memory capacity
- Intolerance of Uncertainty, Worry and Obsessive-Compulsive Symptoms: Common and Specific Features
- Ten years of published research on mood-as-input and perseverative worrying: Implications for GAD
- Assessment for PTSD in at-risk populations: Self-report vs. Clinical interview
- Contribution of cognitive factors to sex differences in PTSD prevalence
- Cognitive therapy for PTSD in routine clinical practice
- Dialectical-Behavior-Therapy for Severe Posttraumatic Stress Disorder after Childhood Sexual Abuse: A Randomized Controlled Trial
- Towards an Integrated Motivational-Volitional Model of Suicidal Behaviour
- Suicidal imagery in unipolar and bipolar depression
- Meta-cognitive awareness and reasons for not self-harming when feeling suicidal
- CBT interventions for deliberate self harm (DSH) - Achievements and new challenges
- Case illustrations of mental contamination in Obsessive Compulsive Disorder
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- Treating OCD when the problem is beneath the surface: The cognitive treatment of a case of pure mental contamination
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Deliberate Self-harm (DSH; intentional self-poisoning and self-injury) is one of the most common reasons for presentation to general hospitals in many countries. In England alone it is estimated that there are at least 200,000 presentations per year. It is also frequently encountered in clinical practice in other settings. The distress and psychiatric morbidity associated with DSH and the strong link between DSH and suicide mean that effective management of DSH in the general hospital and following discharge, as well as in other settings, is essential for suicide prevention. This requires establishment of good quality services and the provision of evidence-based clinical care. The UK National Institute for Clinical Excellence (NICE) published its ‘Guideline on Self harm’ in 2004, which included guidance on DSH services in general hospitals. The main features of this guidance will be reviewed. Increasing recognition that service users should have input into the design of services, that their attitudes towards care are important, and that clinicians’ attitudes to DSH patients influence care, have stimulated two recent systematic reviews by our group, the findings of which will be considered in relation to aspects of care which require attention in the design of an effective service. Until recently there has not been much positive evidence to shape the types of treatments that should be available for the aftercare of DSH patients when they leave hospital. The research that our recently updated Cochrane Collaboration systematic review provide much more information to assist in the planning of aftercare, at least for the provision of psychosocial intervention. Thus there is now clear evidence that brief psychological therapy (CBT/problem solving) can be effective in reducing repetition of DSH and also in reducing levels of depression, hopelessness and suicidal ideation. There are also early indications that maintaining contact with patients by post may have benefits. These results, which have obvious implications for the design of clinical services, will be summarised, together with consideration of the key components of the interventions which may enhance therapeutic efficiency.

Meeting the Challenge of ‘Personality Disorder’ in Changing Times
Dr Renee Harvey, Sussex Partnership NHS Trust
Treatment approaches for personality disorder have been revolutionised over the past few years, with particular reference to ‘borderline personality disorder’ or ‘emotionally unstable personality disorder’. In addition to overcoming stigma, rejection and pessimism towards this group of individuals, service providers are now facing dwindling resources, and the need to provide for increasing numbers of people presenting for help as, public awareness grows and individuals are being more accurately identified. There is increasing pressure to provide accessible therapies which are of relatively short duration as well as being evidence based. When is a short term approach just not enough to meet the needs of individuals with complex difficulties? Some options for meeting these needs and a consideration of the overall treatment approach will be discussed. The focus will be strongly maintained on the particular needs of this service user group, the crucial need for good relationships, and the importance of instilling hope.

Cognitive Behavior Therapy in the Treatment and Prevention of Depression
Professor Steven Hollon, Vanderbilt University, USA
The cognitive and behavioral therapies have emerged as a major alternative to medications in the treatment of depression. Although some trials suggested that medications might be superior in the treatment of patients with more severe depressions, a recent placebo-controlled trial indicates that when cognitive therapy is adequately implemented it can be as efficacious as medications. Moreover, cognitive therapy appears to have an enduring effect that lasts beyond the end of treatment. Patients who respond to cognitive therapy are about half as likely as patients treated with medication to relapse following treatment termination, and no more likely than patients continued on drugs. Given this enduring effect, cognitive therapy in general is likely to prove more cost-efficient than medication treatment. Cognitive therapy appears to be superior to medications for depressed patients free from personality disorders and for patients with more prior negative life events. It also appears to be superior for patients who are unemployed, and does a better job than medications in leading to improvement in employment. Adherence to specific components of cognitive therapy appears to drive subsequent symptom change, whereas the quality of the nonspecific working alliance appears to be largely a consequence of prior improvement. Competence predicts subsequent symptom change and can be enhanced by training. Patients who can best perform specific skills learned in cognitive therapy are least likely to relapse following treatment termination, and there are indications that insight into the role of cognition in the maintenance of depression precedes sudden gains in treatment, which in turn predict freedom from relapse. Cognitive change during treatment predicts subsequent change in depression in cognitive therapy but not pharmacotherapy (suggesting that it plays a mediation role in the former but not the latter) and change in attributional style is both specific to cognitive therapy and predictive of subsequent freedom from relapse. Adding cognitive therapy to medications appears to enhance response for patients with more severe or less chronic depressions, and a more purely
behavioral intervention may be as efficacious as medications and as enduring as cognitive therapy. The incidence of severe adverse events and risk for suicide both appear to be reduced for patients treated with cognitive and behavioral interventions relative to medication alone. There are even indications that a cognitive behavioral intervention can prevent episode onset in at-risk adolescents. Taken in aggregate, these findings suggest that cognitive behavioral therapy may be a viable alternative to medications in the treatment of major depression and that it works through specific mechanisms for somewhat different patients.

Cognitive Therapy for PTSD: An Update
Professor Anke Ehlers, Institute of Psychiatry, King's College London

Ehlers and Clark (2000) proposed a cognitive model of posttraumatic stress disorder (PTSD). This model suggests that chronic PTSD develops if trauma survivors process the traumatic event in a way that poses a serious current threat. The perceived threat has two sources: first, people with chronic PTSD show excessively negative appraisals of the trauma and / or its sequela. Second, the nature of the trauma memory leads to easy, cue-driven trauma memories that lack the awareness of the self in the past. Furthermore, the patients’ appraisals motivate a series of dysfunctional behaviours and cognitive strategies that are intended to reduce the sense of current threat, but maintain the disorder. A series of prospective longitudinal studies of trauma survivors and laboratory experiments supported the role of the maintaining factors suggested in the model. Prospective studies also supported the specificity of the proposed factors for PTSD versus depression. Ehlers and Clark's model has led to the development of Cognitive Therapy for PTSD (Ehlers & Clark, 2000). Six randomised controlled trials showed that the treatment is highly acceptable, and more effective than wait list, self-help or an equally credible psychological treatment. Comparable treatment effect sizes were achieved by trained clinicians in a community setting and a routine NHS clinic. Further studies showed that the treatment is also effective when given as a 1-week intensive treatment, and that is effective in very chronic PTSD following multiple trauma and terrorist violence.

Symposia

Cognitive factors that maintain generalised anxiety disorder and worry
Convenor: Colette Hirsch, Institute of Psychiatry, King’s College London

Cognitive factors that maintain worry: The role of imagery and verbal processing of feared and benign worry outcomes
Sarra Hayes, King's College London; Gemma Perman, King’s College London; Andrew Mathews, University of California, Davis, USA & Colette Hirsch, King’s College London

Chronic, excessive, and uncontrollable worry is the defining characteristic of generalised anxiety disorder. Worry largely consists of negative verbal thought and it has been postulated that this predominance of verbal thought in worry may contribute to its perseveration. In an investigation of this issue, high worriers were randomly allocated to think about the worry topic, or a benign outcome of the worry topic (depending on group allocation). Participants then focused on their outcome in the specified mentation style for three blocks of two minutes. They then completed the breathing focus task again. Finally they provided expanded descriptions of any intrusions during breathing focus for later rating by an assessor. Thinking in verbal form about the feared outcome perpetuated negative thoughts intrusions, but thinking in imagery about the feared outcome, or thinking about the benign outcome (whether in verbal or imagery form) led to a reduction in negative intrusions. The results support the theory that the predominantly negative verbal nature of worry may be responsible for the uncontrollability and maintenance of worry.

Worry in imagery and verbal form: Effect on residual working memory capacity
Eleanor Leigh and Colette R. Hirsch, King’s College London, Institute of Psychiatry

Worry-prone individuals have less residual working memory capacity during worry compared to low-worriers (Hayes et al., 2008). People typically worry in verbal form, and the present study investigated whether verbal worry depletes working memory capacity more than worry in imagery-based form. High- and low-worriers performed a working memory task, random interval generation, whilst thinking about a worry in verbal or imagery form. High (but not low) worriers had less available working memory capacity when worrying in verbal compared to imagery-based form. The findings could not be accounted for by general attentional control, amount of negatively-valenced thought, or appraisals participants made about worry topics. The findings indicate that the verbal nature of worry is implicated in the depletion of working memory resources during worry among high-worriers, and point to the potential value of imagery-based techniques in cognitive-behavioural treatments for problematic worry.

Intolerance of Uncertainty, Worry and Obsessive-Compulsive Symptoms: Common and Specific Features
Karen Price, Newcastle University and Northumberland, Tyne and Wear NHS Foundation Trust; Theresa Marrinan, Newcastle University and Northumberland, Tyne and Wear NHS Foundation Trust; Claire Lomax, Newcastle Primary Care Trust; Anna Goodson, Newcastle University; Natalie Englander, Newcastle University; Mark Freeston Newcastle University and Northumberland, Tyne and Wear NHS Foundation Trust

Intolerance of Uncertainty (IU) is a construct that has proven to be useful in the understanding and treatment of anxiety disorders, especially GAD and OCD. Two measures were originally developed, the Intolerance of Uncertainty Scale (Freeston et al. 1994) for GAD research and a self-scale of the Obsessive Beliefs Questionnaire (OCCWG, 1995, 2000) for OCD research; other measures and versions have developed since. A considerable amount of research has been conducted since the mid-nineties in GAD and some within OCD, and, in recent years the construct has been examined in a wide range of other disorders from eating disorders to the developmental disorders on the autistic spectrum. Despite the increasing popularity of the constructs and their measures, a number of conceptual and measurement issues have been identified. These include definition itself, the nature of the core features of IU, any differential features in GAD and OCD, specificity or not to OCD/GAD, its status as a transdiagnostic feature, etc. Based on our ongoing reconceptualisation of the construct, we have
developed a framework for examining the similarities and differences between IU in GAD and OCD. This presentation presents some initial data examining specificity or not of certain key features of the construct in accounting for variance in measures of worry and OCD symptoms

Ten years of published research on mood-as-input and perseverative worrying: Implications for GAD
Frances Meeten & Graham C L Davey, University of Sussex
We review 10 years of published evidence from laboratory-based analogue studies of mood-as-input effects and perseverative worrying. As predicted by mood-as-input theory, worryers deploy ‘as many as can’ rather than ‘feel like continuing’ stop rules during negative mood, which leads to perseveration on a worry catastrophizing task. The deployment of ‘as many as can’ stop rules is significantly related to worry frequency as measured by the PSWQ and is closely linked to the more stable beliefs that worryers have about the nature of worrying. Worriers do not appear to possess an iterative style that is independent of the stop rule they adopt, and their perseveration can be significantly modified under experimental conditions by changing the type of stop rule they deploy.

Assessment and treatment of PTSD in routine and high risk groups: New findings from prospective and treatment outcome studies
Convenor: Jennifer Wild, Institute of Psychiatry, King’s College London

Assessment for PTSD in at-risk populations: Self-report vs. Clinical interview
Jennifer Wild, Kirsten Smith, Erin Thompson, Anke Ehlers, Institute of Psychiatry
Ambulance workers are regularly exposed to trauma and are considered to be a group at risk of developing post-traumatic stress disorder (PTSD). Previous research has reported rates of PTSD based on self-report data to be in the range of 20% in this group (i.e., Sterud et al., 2006). As part of a large prospective study investigating predictors of PTSD, we assessed N=443 newly recruited ambulance workers with self-report questionnaires and with the Structured Clinical Interview for DSM-IV (SCID; First et al., 1996) during their first week of paramedic training. Participants completed questionnaires to assess symptoms of PTSD, depression, social phobia, and alcohol use disorders. They then attended an interview session in which the SCID was administered. We found significant discrepancies between rates of PTSD, major depression, social phobia and alcohol use disorders when assessed by self-report vs. clinical interview, with self-report over-estimating rates of these disorders. Efficiency data will be presented focusing on sensitivity and specificity ratings and kappa values. Our results highlight the importance of conducting interview assessments over self-report assessments to gauge rates of clinical disorders in at-risk groups.

Contribution of cognitive factors to sex differences in PTSD prevalence
Anke Ehlers and Dirk Hillebrandt, Institute of Psychiatry, King’s College London
Women have a greater chance of developing PTSD after traumatic events than men. Off et al. (2007) suggested that cognitive factors play a role in explaining these sex differences. A prospective longitudinal study of 320 assault survivors explored the question of whether cognitive factors mediate sex difference in PTSD prevalence. Candidate predictor were derived from (1) Ozer et al.’s (2003) meta-analysis of predictors of PTSD (such as perceived threat to life and social support), (2) from Ehlers and Clark’s cognitive model of PTSD (such as cognitive processing during the assault, negative cognitions about the self, nowness of intrusions, safety behaviours, and rumination), and (3) from conditioning models (panic symptoms and negative emotions during the trauma). At 1 and 6 months after the assault, 64% 39% of the women (n = 89) and 42% 22% of the men (n = 231) met diagnostic criteria for PTSD. Bootstrapping analyses showed that most of the theoretically derived predictor variables were significant mediators of the sex differences. The results were not explained by differences in assault characteristics.

Cognitive therapy for PTSD in routine clinical practice
Nick Grey, Anke Ehlers & David Clark, Institute of Psychiatry, King’s College London
There is good evidence from randomized controlled trials (RCT) that Cognitive Therapy for PTSD is an effective treatment. There is also initial evidence that this treatment can be successfully disseminated to clinical settings. Nevertheless, there is currently no evidence available regarding the effectiveness of CT for PTSD in patients who are seen in routine clinical practice, and especially, for those patients who would not meet criteria for participation in an RCT. The data presented here are from a long-term audit of all patients with PTSD (n=340) treated at the Centre for Anxiety Disorders and Trauma (CADAT) between April 2001 and October 2008. CADAT is an outpatient clinic specializing in anxiety disorders including PTSD receiving referrals from GPs and CMHTs from three boroughs in South London. About half of the patients were comparable to patients seen in previous RCTs, and half met one or more RCT exclusion criteria (e.g., multiple trauma, severe substance abuse, ongoing threat). Symptoms were assessed at every session, and pre-post treatment data were available for more than 95% of the patients. Outcome data and factors affecting outcome will be presented.

Dialectical-Behavior-Therapy for Severe Posttraumatic Stress Disorder after Childhood Sexual Abuse: A Randomized Controlled Trial
Regina Steil, Anny Dyer, Kathlien Priebie, Antje Krüger, Martin Bohus, Goethe University of Frankfurt and Central Institute of Mental Health, Mannheim
Objectives: We modified standard dialectical behavior therapy (DBT) to meet the specific needs of adult patients experiencing severe and chronic PTSD related to childhood sexual abuse plus severe co-occurring psychopathology such as BPS or eating disorder. We evaluated the effects of DBT-PTSD. Method: 80 women suffering from chronic PTSD related to CSA and co-occurring psychopathology were randomised to either a waitlist condition (WL) or a three month residential DBT-PTSD inpatient program. Patients were assessed prior to randomisation (t1), post treatment (t2, 3 months post randomisation), at 6 weeks and 3 months post discharge (t3, t4; 4.5 months and 6 months post randomisation). Assessments included Clinician Administered PTSD Scale (CAPS), Posttraumatic Diagnostic Scale (PDS), Beck Depression Inventory (BDI), SCL90R, and Borderline Symptom List (BSL). Results: Group Comparisons at t1 and t3 revealed significant response and remission for the DBT-PTSD group. MANOVAs revealed significant time x group interactions, showing a significantly greater reduction of symptomatology in CAPS, PDS, and BDI for DBT-PTSD as compared to WL. Cohen’s d (t1 vs. t3, CAPS) was 1.3 for DBT-PTSD and 0.11 for the WL. Conclusions: Data suggest that DBT-PTSD has high promise for reducing severe and chronic PTSD and comorbid psychopathology related to CSA. Key words: PTSD, Dialectical Behavior Therapy.
Towards an Integrated Motivational-Volitional Model of Suicidal Behaviour
Rory O'Connor, University of Stirling

The aetiology of suicide is complex, encompassing a multifaceted array of risk and protective factors. The overarching aim is to describe and illustrate a new model, the Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour. This tripartite IMV model maps the relationship between background factors and trigger events, and the development of suicidal ideation/intent through to suicidal behaviour. It incorporates the major components from predominant models of suicidal behaviour (e.g., arrested flight) into an integrated three-phase model of suicidal behaviour which is intended to discriminate between suicide ideators and suicide attempters. In brief, the IMV proposes that suicidal behaviour results from a complex interplay of factors, the proximal predictor of which is one’s intention to engage in suicidal behaviour. Behavioural intention, in turn, is determined by feelings of entrapment where suicidality is seen as the salient solution to life circumstances and entrapment is triggered by defeat/humiliation appraisals. Crucially, the transitions from the defeat/humiliation stage to entrapment, from entrapment to suicidal ideation/intent, and from ideation/intent to suicidal behaviour are determined by state-specific moderators. Evidence from clinical and non-clinical studies consistent with the model will be presented. The presentation ends with a brief discussion of potential next steps in the development, refinement and testing of the model.

Suicidal imagery in unipolar and bipolar depression
Emily A Holmes and Susie A Hales, University of Oxford

Little research has been conducted on suicidal imagery, though the incidence of intrusive, affect-laden imagery in a range of psychological disorders has been well documented. Therefore, we conducted three studies to investigate images of suicide or the aftermath of death (‘flashforwards’ to suicide) in the following populations: (1) a previously depressed clinical sample (Holmes, Crane, Fennell & Barnhofer, 2007), (2) a previously depressed community sample (Crane, Shah, Barnhofer & Holmes, in press) and (3) a currently depressed bipolar sample (Hales, Deeprose, Goodwin & Holmes, under review).

A quasi-experimental design was utilised for all studies. The Structured Clinical Interview for DSM-IV or DSM-III-R was used to confirm diagnoses. Quantitative and qualitative data were gathered through questionnaire measures (e.g. mood and trait imagery use). Individual interviews assessed suicidal cognitions in the form of mental images. At the time of greatest suicidal ideation, “flashforwards” to suicide were reported by the majority of participants across the three clinical studies. Interestingly, for all three samples the suicidal images were associated with a sense of comfort in addition to distress.

Meta-cognitive awareness and reasons for not self-harming when feeling suicidal
Mark Williams and Emily Hargus, University of Oxford

Mindfulness is increasingly being suggested as a valuable addition to the range of treatments for those depressed people who become severely suicidal when depressed. We selected the sub-sample of respondents to a web-based survey who gave information about suicidal ideation and behaviour, examining those who thought about harming themselves but did not actually do so. We asked them for reasons why they had not put their plan into action. We then categorised responses according to Linehan's Reasons for Living Inventory. Results showed the range of ‘reasons for living’ reported by Linehan, but also a category of response not reported before. This category of response (for example: ‘I knew it was the voice of depression speaking’) suggests a naturally occurring ‘decentred’ or meta-aware response. It this ‘decentred stance’ that mindfulness training invites participants to take, and other preliminary data from a pilot trial of mindfulness-based cognitive therapy (MBCT; Hargus et al., 2010) suggests is fostered by mindfulness training. MBCT offers promise as an approach to preventing suicidal thoughts from changing into suicidal actions.

CBT interventions for deliberate self harm (DSH) - Achievements and new challenges
Ella Arensman, National Suicide Research Foundation, Department of Epidemiology and Public Health, University College Cork, Ireland

Over the last 20 years, we have identified increasingly positive and consistent evidence supporting the efficacy of CBT interventions in reducing repeated self harm. However, it is unclear to what extent CBT interventions are effective in addressing ‘new’ risk groups and ‘new’ phenomena associated with DSH. Method - Literature review of treatment studies addressing the efficacy of CBT interventions for deliberate self harm (1990-2011); Analysis of patterns in deliberate self harm over time based on the National Registry of Deliberate Self Harm (NRDSH) in the Republic of Ireland (2003-2010). The majority of CBT interventions for DSH have shown positive and significant reductions in terms of repeated self harm and levels of depression, and improvements in self esteem and problem-solving. In most CBT studies including self harm patients, women are overrepresented. NRDSH data based on recent years provides information on ‘new’ risk groups and phenomena associated DSH including overrepresentation of men who engage in self harm and who engage in repetition, an increase in alcohol related self harm and highly lethal methods among adolescents. The evidence base for the efficacy of CBT in reducing repeated self harm is largely based on women and young people. The evidence for the efficacy of CBT in reducing repeated self harm among ‘new’ risk groups is limited. There is a need to prioritise studies investigating the efficacy of CBT interventions for DSH patients representing ‘new’ risk groups.

Mental contamination in Obsessive Compulsive Disorder
Convenor: Emma Warnock-Parkes, South London and Maudsley NHS Trust and Institute of Psychiatry

Symposium overview
Emma Warnock-Parkes, South London and Maudsley NHS Trust and Institute of Psychiatry, Kings College London; David Veale, Institute of Psychiatry, Kings College London

Psychological Processes and Suicidal Behaviour
Convenor: Rory O’Connor, University of Stirling
Mental contamination is a phenomenon recently identified in certain sub-types of obsessive compulsive disorder (OCD) whereby people experience feelings of contamination in the absence of any physical contact with a contaminant (Rachman, 2004). It is proposed by Rachman (2010) that standard cognitive behavioural treatments (CBT) need to be adapted here and that the failure to identify and adequately treat mental contamination may in part be responsible for poor treatment outcomes (Elliott & Radomsky, 2009). A developing empirical ground supports the phenomenon in an OCD population, but the need to adapt treatment has yet to be determined or empirically tested. Therefore, this clinical and research symposium has been put together to combine some clinical case descriptions and treatment examples with recent research in this developing area. A brief introduction will be provided by David Veale and the first presentation (Callaghan & Patel) will use case descriptions and video examples from an OCD clinic to illustrate Rachman’s definition and subtypes of mental contamination and identify differences between contact and mental contamination. The second presenter (Coughtrey) will outline recent research into mental contamination, presenting a new experimental study of the spread of mental contamination. The third talk (Zysk) will present a retrospective study exploring the different origins of contamination fears in those with contact contamination, mental contamination and fears of morphing. Finally, the last presentation (Warnock-Parkes) will present a single case illustration using cognitive therapy to treat mental contamination, highlighting proposed adaptations in conceptualising and treating such cases. Jack Rachman (University of British Columbia, Vancouver, Canada) will summarise and discuss the talks.

Case illustrations of mental contamination in Obsessive Compulsive Disorder


Mental contamination is a term used to define feelings of contamination without any physical contact with a contaminant: Bear in mind it is non-physical in nature, people often locate the source of the illness in their mind and may describe it as an internal or emotional dirtiness; “washing is generally futile as the contamination is not physical in nature” (Herba & Rachman, 2007: 2805). Rachman (2006) identifies a number of sub-types of mental contamination including self-contamination, morphing, mental contamination following physical violation and mental contamination following psychological violation. Identifying mental contamination can be challenging using routine assessment tools and clinical descriptions of the fear of contamination can greatly differ. In cases of morphing, the person fears becoming contaminated or tainted by close proximity to a person perceived as undesirable, fearing they will acquire or absorb the undesirable characteristics of that person. Extreme forms of morphing are characterised by a fear of changing into the undesirable person. In cases of mental contamination following physical or psychological violation the person experiences feelings of contamination following physical or psychological ill treatment, such as a rape or significant betrayal. This talk, through case descriptions and video clips from our clinic, will illustrate clinical case examples of different subtypes of mental contamination and how these might differ from contact contamination. Issues around diagnosis, assessment and treatment implications will be discussed.

The spread of mental contamination

Anna Coughtrey, University of Reading, UK; Roz Shafran, University of Reading; Stanley Rachman, University of British Columbia, Vancouver, Canada

Patients with OCD often describe their fear of contamination transferring and spreading across time and localities. This presentation will focus on a new experimental study of the spread of mental contamination which is defined as the experience of feeling dirty, polluted, infected or endangered in the absence of physical contact with a contaminant (Rachman, 2006). Feelings of mental contamination were evoked in sixty student participants selected to have mental contamination fears. Participants were then asked to transfer these feelings to uncontaminated pencil both with (contact condition) and without (no-contact condition) touching it. Participants were then asked to spread this contamination to 12 neutral pencils in turn. The previously neutral pencil was reported to become contaminated by 71.67% participants in the contact condition and 48.34% participants in the no-contact condition, demonstrating that mental contamination can transfer with and without any contact with a contaminated object. In both conditions, participants reported that they did not wash. In a similar manner to contact contamination, mental contamination can spread rapidly and at full strength if left uncontained.

Origins of Contamination Fears

Eva Zysk, University of Reading, UK; Roz Shafran, University of Reading

This retrospective study was designed to explore the possible origins of contamination fears in individuals with Obsessive Compulsive Disorder. The study involved interviews with 25 adults with an OCD diagnosis and a fear of contamination. The interview measure was based on theories about fear acquisition. Participants were asked about the onset of their contamination fears and about past experiences which may have involved direct, vicarious or information/instruction learning (Rachman, 1977) for various contamination subtypes prior to the onset of their fears. Beliefs about contamination fear acquisition (e.g. following stressful events, victimisation, or the belief that the body is unclean and their dirtiness present from birth were also assessed. The study examined the acquisition of contamination fears in those with contact contamination, mental contamination and fears of morphing. The most common form of contamination was contact contamination (n=20). Eleven participants had mental contamination and three had a fear of morphing. The pathway to the acquisition of all forms of contamination fears was most commonly believed to have been through conditional learning and the least common was the belief of genetic transmission. Implications of the study for understanding the acquisition of fear across different forms of contamination will be discussed.

Treating OCD when the problem is beneath the surface: The cognitive treatment of a case of pure mental contamination

Emma Warnock-Parkes, South London and Maudsley NHS Trust, Institute of Psychiatry, Kings College London; Paul Salkovskis, University of Bath; Stanley Rachman, University of British Columbia, Vancouver, Canada

Rachman (2010) proposes that for effective treatment of mental contamination in obsessive compulsive disorder (OCD) standard cognitive behavioural treatment needs to be adapted. This is noteworthy given that although existing psychological treatments for OCD, including exposure and response prevention (Meyer, 1966) and cognitive therapy (Rachman 1997; Salkovskis 1999), have been found to be effective, a number of studies have reported high refusal and drop
out rates (Foa et al., 2005; Van Balkom et al 1998; De Hann, 1997). Furthermore, a number of people do not reach statistically reliable reductions in OCD symptoms at the end of treatment (Abramowitz, Taylor & McKay, 2005) and for those who do show significant improvement mean scores often indicate ongoing symptomology reaching clinical levels (Foa et al., 2005; Cottraux et al., 2001; Van Balkom et al 1998; De Hann, 1997; Greist et al., 2002). This leads us to question whether Rachman’s proposals could in part explain some of these findings (Radomsky & Elliot, 2009). However, Rachman’s proposals for adapting standard cognitive behavioural treatments (CBT) have yet to be tested. This talk presents a single case study of a patient presenting with pure mental contamination whose difficulties had not responded to past high quality CBT treatment and who was then offered a course of cognitive therapy adapted for mental contamination by the authors. All 14 sessions and follow ups of cognitive therapy for mental contamination were attended and scores on clinician rated OCD severity fell from the severe to non-clinical range across sessions. The presentation is used as an illustration of the need to consider an alternative way of conceptualising and treating such cases.

**Trauma and the self: Understanding the cognitive aftermath of traumatic experiences and its implications for therapy**

**Convenors:** Lusia Stopa and Soljana Cili, University of Southampton

**Memory and identity in amnesia: The importance of supporting the self**

Clare Rathbone, University of Reading

Autobiographical memories play an important role in supporting the self, as much of our identity is defined by what we remember about our lives. However, less is known about whether the sense of self is preserved in cases of amnesia. One method of examining self-relevant memories involves using self-images (e.g. I am a mother; I am anxious) as cues for memories which are then dated (e.g. ‘my daughter was born when I was 35’). This I Am Memory task (IAM Task; Rathbone, Moulin & Conway, 2008) has consistently shown that the memories of normal populations tend to cluster temporally around periods when new self-images are created. The IAM Task was used to examine the self-memory relationship in a case of amnesia. Patient PJM generated accurate self-images, but was unable to ‘remember’ episodic memories associated with them. Instead, PJM described semantic facts about events she ‘knew’ had occurred. These semantic facts clustered temporally around periods of self-image formation, in much the same way as episodic memories in non-amnesic individuals. Results suggest that semantic autobiographical knowledge can support the self when episodic memories are inaccessible.

**Impact of autobiographical memory recall on the self: Extending the concept of core beliefs to the concept of multiple selves**

Soljana Cili, University of Southampton

One of the main assumptions of cognitive-behavioural therapy (CBT) is that individuals hold core beliefs about the self, others, and the world that guide their cognition, affect, and behaviour. These core beliefs are thought to develop as a result of specific (usually negative or traumatic) past experiences. Despite the fact that this suggests a very close relationship between autobiographical memory (AM) and the self and that past experiences are key targets in therapy, however, research in clinical psychology has for a long time focused only on core beliefs without seeing patients’ broader sense of self. The memory-self relationship has, however, been the focus of recent cognitive and social psychological research. The self-memory system model (e.g. Conway & Pleydell-Pearce, 2000), for example, suggests that individuals have multiple selves and that AM recall influences the activation of these selves. This paper presents the findings of two studies investigating the impact of memory recall on individuals’ sense of self. In the first study, participants were asked to recall a positive and a negative memory in two different sessions. After recalling the memory, they completed a computer task and measures focusing on different aspects of the self. Results showed that the negative memory recall was associated with lower scores on the self-esteem and self-concept clarity measures than the positive memory recall. The second study extended the findings of the first one by investigating the impact of positive and negative memory recall on different self-aspects (including goals and self-cognitions), as well as by focusing on how memory characteristics (e.g., specificity, degree of integration with one’s life story) are related to the impact the memory has on the self. Data collection for the second study is still in progress. Results are expected to show, among other things, that the retrieval of memories that are more specific and less integrated within the life story will be associated with the activation of a more negative self. The implications of the findings of these two studies for understanding the mechanisms of change involved in CBT and for clinical practice will be discussed in the presentation.

**The influence of culture and trauma on autobiographical memory and the self**

Laura Jobson, University of East Anglia

Current models of posttraumatic stress disorder (PTSD) represent impressive advances in the understanding of the aetiology, maintenance, and treatment of PTSD. However, these models have been developed independently of recent findings indicating cultural differences in self-understanding impact on, and in numerous cases govern, many of the processes involved in PTSD. That is, research has demonstrated that the cultural distinction between an independent (generally emphasised in western, individualistic cultures) or interdependent (generally emphasised in non-western, collectivist cultures) self has an impact on the processes involved in the development maintenance and treatment of PTSD. This presentation will discuss some of our current research which has investigated the influence of culture on the processes involved in PTSD and the implications of these differences for posttraumatic psychological adjustment. Our findings demonstrate that cultural differences in self-understanding has a marked influence on (a) aspects of the trauma autobiographical memory; (b) the relationship between autobiographical remembering and PTSD; (c) the impact of trauma on self-definition and identity; (d) the relationship between trauma-related appraisals and PTSD; and (e) the meanings attached to the trauma. The presentation will consider the theoretical and clinical implications of these findings.

**Anger and psychopathology: Orienting treatment to transdiagnostic problems**

Convenor: Ray Novaco, University of California, Irvine, USA

**Treatment Engagement in CBT for Anger Problems as a Function of Clinical and Demographic Characteristics**

John Owen, Bolton Primary Care Trust and University of Manchester

Group-based cognitive-behavioural therapy for anger problems is commonly practised, and it has received modest empirical support as a clinical intervention. However, high drop-out rates commonly occur in therapeutic groups that operate in psychological therapy services. Little research has been done to understand anger programme drop-outs in community
service delivery contexts. The present study was a clinical audit of routinely collected data from a weekly CBT for anger group within a primary care psychological therapy service. The group has been attended by over 100 clients during its operation over several years. The interface of demographic characteristics (gender, age, and socio-economic status) with clinical distress characteristics (anger, anxiety, and depression) assessed at intake were examined for their relationship to subsequent engagement in the group programme. Young age, male gender, and social deprivation were associated with treatment drop-out through the programme of care. Anxiety (GAD-7) and depression (PHQ-9), but not elevated anger (NAS) were associated with drop-out. There was substantial co-morbidity of anxiety and depression with high anger. Therapeutic strategies to motivate and facilitate clients to remain in treatment will be discussed.

Towards a metacognitive framework on anger: Introducing the Metacognitive Beliefs and Anger Processing (MAP) scale

Stine Møller, Department of Psychology, University of Copenhagen

Few studies have explored the metacognitive components of anger, and there is presently no coherent metacognitive framework on anger. The Metacognitive Beliefs and Anger Processing (MAP) scale was developed with an eye toward clinical utility. Pre-tested with non-clinical and prisoners samples. the MAP demonstrated three empirically distinct dimensions of metacognition: positive beliefs (‘anger helps me handle threats and danger’); negative beliefs (‘anger could make me go mad’); and rumination (‘I cannot let go of angry thoughts’). The present two studies concerned a clinical sample (N = 88) and a forensic sample (N = 54). The reliability and validity of the MAP were tested and were found to be supported. Positive as well as negative beliefs were associated with rumination about anger events, which is consistent with the generic metacognitive model (Wells & Matthews, 1994; Wells, 2000). In the clinical sample, a hierarchical regression showed that the MAP subscales were stronger predictors of anger (NAS) than was the MCQ-30. A Structural Equation Model, with a path from positive beliefs to rumination and from rumination to negative beliefs and from negative beliefs to anger (NAS Total), was tested in the forensic sample. The SEM results suggest that positive beliefs are closely related to rumination and that negative beliefs may serve a key function in mediating the relationship between rumination and anger. The implications of such transdiagnostic processes for anger treatment will be discussed.

Anger, Shame, and PTSD among Combat Veterans: Cognitive and Emotional Processes in Post-Deployment Readjustment

Oscar Gonzalez, Department of Psychology, University of California, Irvine, USA

Combat exposure increases the risk for mental health problems, especially posttraumatic stress disorder (PTSD). Mounting evidence suggests that anger and shame play an important role in development and course of PTSD, but veterans deployment-related emotions have been insufficiently studied. A new measure, the Deployment-Related Emotion Questionnaire (DREQ), aims to address this gap by providing a systematic, self-report measure of anger at others, anger towards oneself, shame, guilt, and pride associated with previous military deployments. A web-based survey study completed by 131 male U.S. military Afghanistan/Iraq war veterans provided evidence of the DREQ’s high internal consistency, high test-retest reliability, strong concurrent validity with emotion measures, and strong associations with PTSD. Multiple regression analyses revealed that, after controlling for demographic and military service variables, anger at others, anger towards oneself, and shame significantly predicted variance in PTSD symptoms. A subsample of 10 participants also completed the DREQ in-person, followed by a semi-structured interview concerning the measure and its hypothetical constructs. This qualitative data will guide the process of creating a shorter 25-item version of the DREQ intended for use in a subsequent hypothesis testing study on anger, shame, and combat-related PTSD. Results suggest that future research and clinical interventions should not overlook the salience of anger and shame among combat veterans and other trauma-related populations.

Anger Dysregulation, Emotional Intelligence, and Anger Treatment Gains at a Forensic Hospital

Caroline Walker, The State Hospital, Scotland

Forensic hospital patients, detained because of their “dangerous and criminal propensities”, often have substantial difficulties associated with anger, which is associated with violence before hospitalisation, during hospitalisation, and after hospital discharge. Anger is responsive to treatment, particularly CBT, as a number of meta-analyses have demonstrated. Many anger treatment studies, however, have not involved seriously disordered patients, and most CBT-based interventions for anger have been conducted in an individual-based format. The anger treatment programme at The State Hospital, Carstairs, has drawn upon the cognitive-behavioural principles of Novaco (1994) and has been designed to meet the needs of mentally disordered offenders in a high security hospital. The protocol is structured yet flexible and is shaped by patient’s needs, including relapse prevention. Treatment delivery is multidisciplinary and occurs primarily in a group-based, 18-session programme, with 6-8 patients per group. Its procedural innovations are designed to address treatment-resistant characteristics of the client population, including cognitive impairment, suspiciousness, demoralization, low support resources, chaotic life circumstances, and general entrenchment of anger in their personality. Treatment efficacy concerning 12 groups of patients has been evaluated through multiple measures of anger and antagonistic behaviour on both patient-rated and staff-rated psychometric instruments. Significant declines in anger and aggression, as well as gains in anger control, were obtained. In conjunction with enhanced anger regulation, there were significant changes in emotional intelligence (EI), particularly on interpersonal dimensions of emotional self-awareness, assertiveness, and independence. The emotional intelligence findings have relevance for our views of forensic patients and for the interventions that we attempt with them. Results from patient focus-groups conducted on follow-up will also be presented.

New developments in suicide prevention

Convenor: Rory O’Connor, University of Stirling

Tackling socio-economic inequalities in suicide: how can suicide prevention meet the challenge?

Stephen Platt, University of Edinburgh

Recently there has been a convergence of approach to public health policy in Europe, with a growing commitment to tackle health inequalities. One major exception is in the area of suicide prevention: most national strategies, including those of UK nations, have concentrated on reducing the overall level of suicide and failed to incorporate an inequalities dimension. Systematic review of epidemiological literature on socio-economic inequalities in suicide, combined with analysis of possible remedial action at both policy and practice levels. While there is strong epidemiological evidence of socio-economic inequalities in suicide among individuals and between geographical areas, area variation is more plausibly explained by compositional effects than by contextual effects. The national policy response needs to consider both the strategic
approach (whether to take action at all levels of the social hierarchy or to focus on the most disadvantaged) and the target (people or places, or both). Action to reduce suicide is warranted in socio-economically deprived areas where suicide rates are high. However, targeting these areas will not necessarily result in successful reach of deprived people. Additionally, we are not yet able to identify which aspect(s) of area-level risk or of individual risk should be addressed, or which interventions are likely to be effective in reducing suicide risk related to socio-economic inequality. Much conceptual, empirical and policy-related work needs to be done before the commitment to tackle inequalities in suicide can be translated into effective preventative action at national level.

“It’s not that I wanted to die...” The complex relationships between suicidal thoughts, behaviours and intent, and how these are expressed through a ‘language of suicide’
Catherine Johnston, Samaritans
Samaritans commissioned the University of Nottingham to evaluate its emotional support services in order to improve understanding of the needs and experiences of callers, especially in relation to suicide and suicidal behaviours. A mixed-methods approach was adopted using both qualitative and quantitative methods, including: an online survey; in-depth individual interviews; observations at Samaritan branches; and thematic analysis of email and text strings. The sample was generated by a range of recruitment methods. Callers who described themselves as suicidal comprised a very broad group, from those who wished to die to those who had not in fact considered ending their life. Some callers wanted to end their life to get relief from pain. Others used suicide as a means of ‘being’ or as a coping strategy, finding relief in knowing it is a choice, though some experienced suicidal feelings as destructive, which they tried to resist. Callers therefore used a ‘language of suicide’ to express their despair, which did not necessarily reflect a desire or an intent to die. The evaluation revealed very complex relationships between suicidal thoughts, behaviours and intent, and how these are expressed through a ‘language of suicide’. This highlights the difficulties in assessing ‘risk’ in relation to suicidal intent. More work is needed to understand the ‘language of suicide’, in particular how those in crisis and despair experience, manage and express their suicidal behaviours and feelings.

Non-suicidal self-injury as a new DSM-V diagnosis: help or hindrance?
Keith Hawton, University of Oxford
In the new version of DSM-V it is proposed that Non-suicidal Self-injury (NSSI) be included as a new diagnostic category. This has received strong support from American researchers and clinicians but is viewed negatively by many researchers elsewhere. It reflects a dichotomous approach to self-harming behaviours that is popular in the USA, namely that these can be neatly divided into attempted suicide (i.e. where a person intended to die) and non-suicidal behaviour. The proposed definition for NSSI is that it is repetitive (five or more occasions in the previous year) self-inflicted damage to surface of the body, of a sort likely to induce pain, bleeding or bruising, for purposes not socially sanctioned (e.g. body piercing, tattooing etc.), performed with expectation that injury will lead to only minor or moderate physical harm and not death. In this presentation arguments will be presented for why this misrepresents the true nature of self-harm and may undermine clinical care. (1) Repetitive self-cutting is extremely common, as reflected in surveys of adolescents in the community. Thus NSSI could be a diagnosis for often transient behaviour in very large numbers of individuals. (2) The notion that suicidal intent is either present or absent is misleading; suicidal intent occurs on a continuum. (3) How will suicidal intent be judged (e.g. by self-report, clinical assessment etc)? (4) Where does ‘non-suicidal’ self-poisoning fit into this categorisation? (5) Could the NSSI diagnosis paradoxically lead to a trivialisation of self-cutting, because of its ‘non-suicidal’ label, when in fact self-cutting is a stronger predictor of future suicide than self-poisoning?

The C-SSRS: Assessing Suicide, Improving Precision and Reducing Burden
Kelly Posner, Columbia/FDA Classification Project for Drug Safety Analyses, Center for Suicide Risk Assessment, Columbia University
Suicide prevention efforts depend upon appropriate identification and screening, but the field of mental health has been challenged by a lack of clarity and standardized approaches in assessing suicidal ideation and behavior. The Columbia-Suicide Severity Rating Scale (C-SSRS), frequently recommended by the FDA and other international agencies, is being used globally in clinical and research settings (translated in over 90 languages) in the assessment of suicidal ideation and behavior with adolescents and adults across a wide range of areas, including inpatient and outpatient medical and psychiatric departments, primary care facilities and hospitals, surveillance efforts, community organizations, the military, and college and school systems. Although it is low-burden, it assesses the full-range of ideation and behavior, as well as intensity of ideation. The C-SSRS does not require specialized mental-health training and many non-mental-health practitioners, including physicians, nurses and coordinators have been trained internationally with excellent feasibility. The C-SSRS is useful in clinical settings in developing next steps, reducing unnecessary burden and referrals, and reducing false positives and has also been used in clinical trials to establish inclusion/exclusion criteria and collect safety and treatment outcome data. Prospective, systematic measurement of suicidal ideation and behavior help to optimize safety and management, reduce burden, and better track improvement or worsening of suicidal ideation and behavior.

Compulsive hoarding: From new research to clinical practice
Convenor: Stephen Kellett, University of Sheffield

Prevalence and Heritability of Compulsive Hoarding: A Twin Study
Alessandra C. Iervolino, Institute of Psychiatry, King’s College London
Compulsive hoarding is a serious health problem for the sufferers, their families, and the community at large. It appears to be highly prevalent and to run in families. However, this familiality could be due to genetic or environmental factors. We examined the prevalence and heritability of compulsive hoarding in a large population-based sample of UK twins. A total of 5,022 twins completed a validated measure of compulsive hoarding. The prevalence of severe hoarding was determined using empirically derived cutoffs. Genetic and environmental influences on compulsive hoarding were estimated using liability threshold models, and maximum-likelihood univariate model-fitting analyses were employed to decompose the variance in the liability to compulsive hoarding into additive genetic and shared and nonshared environmental factors. In total of 2.3% of twins met criteria for caseness with significantly higher rates observed for male than for female twins. Model-fitting analyses showed that genetic factors accounted for approximately 50% of the variance in compulsive hoarding, with nonshared environmental factors and measurement error accounting for the other half. Our findings show that compulsive hoarding is a serious health problem for suffers, their families, and the community at large.
hoarding is a highly prevalent and heritable condition, with nonshared environmental factors also likely to play an important role.

The role of attachment disturbance in compulsive hoarding
Emma Bodfield & Stephen Kellett, University of Sheffield
The current study investigated the role of attachment and social support in hoarding via a web-based survey methodology. Compared to community controls (n=379) and student controls (n=670), hoarders (n=380) reported significantly higher levels of attachment anxiety and avoidance and significantly lower levels of perceived social support. Attachment and social support dimensions, predicted 13% of the variance in hoarding. Attachment anxiety (but not avoidance) significantly moderated the inverse relationship between perceived social support and compulsive hoarding. Findings lend more support to the potential role of childhood and developmental factors in compulsive hoarding. Limitations of the study, as well as further research and clinical implications, are discussed.

When hoarding is a symptom of OCD: a case series and implications for DSM-V
Alberto Pertusa, Institute of Psychiatry, King’s College London
Mounting evidence suggests that (once other primary causes are ruled out) hoarding may be a discrete diagnostic entity, recently named Hoarding Disorder. However, hoarding can sometimes be a genuine OCD symptom. This can be confusing and clinicians may sometimes struggle to make the differential diagnosis. This paper describes a case series of 10 OCD patients with severe hoarding behavior diagnostically conceptualized as a symptom of OCD. This enables focus to be placed on the motivations for hoarding and for the overlapping of hoarding with other obsessive-compulsive symptom dimensions to be identified. It is estimated that this clinical presentation is relatively rare and accounts for a minority of severe hoarding cases; the unique characteristics of hoarding as a symptom of OCD are identified.

Hoarding Disorder: A proposed new disorder in DSM-5
David Mataix-Cols, Institute of Psychiatry, King’s College London
The Obsessive Compulsive Spectrum Sub-Work Group of the DSM-5 Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group is currently recommending the creation of a new diagnostic category in the nomenclature named Hoarding Disorder (HD: http://www.dsm5.org). At this stage it is unclear whether HD will be listed in the main DSM-5 book or in an Appendix for disorders requiring further investigation. In this talk, I will outline the rationale behind the proposed new disorder, the potential benefits and risks associated with the creation of such disorder and the research that is currently being conducted to validate the diagnostic criteria, including the field trials.

New developments and interventions for bipolar disorder
Convenor: Alyson Dodd, Spectrum Centre for Mental Health Research, Lancaster University

TEAMS (Think Effectively About Mood Swings): Putting an Integrative Cognitive Model of Bipolar Disorders into Practice
Warren Mansell, University of Manchester
The empirical support for an integrative cognitive model of moods swings and bipolar disorders (Mansell, Morrison, Reid, Lowens, & Tai, 2007) has been developed over the last five years in a range of studies from a variety of quantitative and qualitative methodologies. In sum, people with bipolar disorders report more extreme negative and positive beliefs about their internal states (e.g. high moods; energy levels; rates of thinking) than non-clinical and unipolar controls. These beliefs predict bipolar symptoms over timescales from four days to three months and are associated with behaviours that exacerbate symptoms. Perhaps most importantly, in case studies and a case series, these beliefs are reduced over the course of successful CBT based on the model (Searson, Mansell, Tai & Lowens, submitted). In this presentation, I will first explain the principles of the therapy. Essentially, the therapy first helps clients to describe their internal states and their conflicting beliefs about them ("I must be full of energy to overcome my depression" vs "When I am full of energy other people criticise and control me"). Second, the therapy helps them to challenge these beliefs by helping them to broaden the bandwidth of moods they can tolerate and accept to form healthy 'self-states' that help them achieve their personal goals and live according to values that are less dependent on mood state. The therapy is openly ambivalent in its alignment to first, second and third wave CBT, drawing widely on clinicians’ diverse skills, and yet tightly bound by an empirically grounded model. The therapy is now termed TEAMS (Think Effectively About Mood Swings). In conjunction with service-users and practitioners, we are developing self-help and therapist resources for the approach which will be tested in a NIHR-funded pilot randomised controlled trial (Mansell, Tai, Morrison, Morriss, Tinning, Dunn & Davies, in preparation).

Translating Evidence-Based Interventions into Clinical Practice - Relapse Prevention for Bipolar Disorder
Fiona Lobban, Spectrum Centre, Lancaster, ERP team, PARADES team
Effective psychological interventions are only useful if people are able to access them outside of research trials and specialist centres. Helping people with Bipolar Disorder to understand what triggers their mood changes and how to recognise and manage early warning signs of relapse is effective in increasing time to relapse, reducing hospitalisation, and improving functioning. The problem is that many people do not access this kind of intervention. Developing a range of effective ways to deliver this support to increase accessibility and offer choice is crucial. This presentation will provide an overview of the relapse prevention approaches that are being developed including individual therapy, group therapy, training case managers, and web based interventions. Data will be presented on trials completed to date, and the design and interim data from an ongoing large multi-site RCT to evaluate group approaches will be presented. The pros and cons of different methods of delivering relapse prevention approaches in Bipolar will be discussed including future plans to further increase dissemination.

“T he e-psychologist will see you now...” Bipolar Disorder, Psychological Therapy and the Internet
Nicholas J. Todd, Spectrum Centre for Mental Health Research, Lancaster University
Computerised psychological therapeutic interventions have been hailed as one of the most important advances in the treatment of anxiety and depression in the last 50 years. They have significantly improved access to psychological therapy for millions of people and have a proven track record of clinical effectiveness. There is now increasing evidence that people with Bipolar Disorder (BD) also respond well to psychological interventions, and pharmacotherapy alone has limited effectiveness. Unfortunately the same inequalities in access to face-to-face psychological therapy that plagued anxiety and
Involving service users in the development of a novel CBT intervention for enhancing recovery in early bipolar disorder

Steve Jones, Lancaster University

Recovery in mental health typically involves individual personal change in which the development of a new sense of self can lead to the establishment of a fulfilling and meaningful life, whether or not symptoms are present. Individuals’ perspectives on recovery in bipolar disorder are important but have received little attention from researchers. This talk will discuss why the popularity of recovery approaches amongst service users has not yet significantly influenced care delivery in bipolar disorder and will present initial findings from a treatment development study of recovery informed CBT for bipolar disorder (RfCBT). Study 1: Semi-structured interviews were employed with 17 individuals with a SCID confirmed diagnosis of bipolar disorder (9 recent (<5 yrs) and 8 established (>5 yrs)). Structured qualitative analysis was used to identify key recovery concepts from the interview transcripts. Study 2: The new Bipolar Recovery Questionnaire (BRQ) was developed based on themes from study 1 and feedback from service user, clinical and academic experts. This was evaluated in 60 individuals with bipolar disorder prior to implementation in Study 3. Study 3: Recovery informed CBT for bipolar disorder: 72 individuals with SCID diagnosis of bipolar disorder received within the last 5 years are currently being recruited into an RCT comparing RfCBT with treatment as usual. Recovery is widely discussed amongst consumers of mental health services but therapy approaches in bipolar that specifically facilitate recovery are lacking. Our work to date indicates that recovery themes can be used to inform new therapy developments. Potential challenges to full implementation of recovery informed approaches in clinical practice will be considered.

Universal processes and common factors in efficacious couple-based interventions

Convenor: Donald Baucom, University of North Carolina, Chapel Hill, USA

Integrative Approaches to Couple Therapy: Implications for Clinical Practice and Training

Douglas Snyder, Texas A&M University, USA

Although meta-analyses affirm that various treatments for couple distress produce statistically and clinically significant outcomes, research findings also indicate that a large percentage of couples fail to benefit or subsequently deteriorate following current therapies. Based on these findings, this presentation will advocate for potential advantages of integrative approaches to couple therapy. The presentation will distinguish among assimilative, transtheoretical, and pluralistic approaches to integration and describe exemplars of each. Integrative approaches to couple therapy will be compared to distillatory or common factors approaches emphasizing common elements of treatment components, therapist characteristics, and client or relationship attributes. It will be argued that clinical practice of integrative approaches to couple therapy requires conceptual and clinical decision-making skills transcending those of any one theoretical modality and emphasizing the selection, sequencing, and pacing of diverse interventions in a coherent manner. The presentation will conclude with implications of integrative couple-based treatments for clinical training and future research.

Integrating Individual-Based and Couple-Based Interventions by making use of Empirically-Derived General Mechanisms of Therapeutic Change

Mariann Grawe-Gerber, Klaus-Grawe-Institute for Psychological Therapy, Zurich, Switzerland; Donald H. Baucom, University of North Carolina, USA; W. Kim Halford, University of Queensland, Australia; Douglas K. Snyder, Texas A&M University, USA

Disorder-oriented research has contributed so much to the understanding of the disorder-specific dynamics that other important aspects of the psychological problems of a patient, such as the interpersonal dimensions have been neglected and are mostly not included in case formulations and treatment planning. However, it is increasingly being recognized and studied that individual and relationship problems often occur together and the quality of intimate relationships has a strong influence on individual, mental, and physical health and vice versa. For example, in their review of empirical studies of the association between relationship functioning and mental and physical health, Wishman and Uebelacker (2003) found compelling empirical evidence concerning the high comorbidity between couple distress and behavioral, emotional and physical disorders in one or both individuals. In everyday clinical practice, the decision to treat an individual exhibiting comorbid individual and relationship problems either in individual therapy, couple therapy, or a combination of the two is often determined by the therapist’s training rather than by the patient’s specific problems and resources. This presentation will focus on the question how clinicians can develop a more comprehensive understanding of a patient’s problem to help them decide whether individual based or couple based interventions will be more effective and/or how these could best be combined? It will be argued, that in order to increase its effectiveness, the treatment should be tailored to the specific interplay between relationship functioning and psychological and/or physical problems in a given case. In order to treat individuals and couples effectively the therapist needs to be able to integrate methods from different orientations and treatment modalities. The author will suggest that a researched-informed integration of treatment modalities and therapeutic procedures should make use of empirically derived general therapeutic mechanisms of change. Empirical psychotherapy research has found more and more that change achieved by therapeutic procedures and interventions seems to be more influenced by general principles and common factors in different therapy approaches rather than specific methods and techniques. The four empirically established therapeutic mechanisms of change and common factors in psychotherapy extracted by Grawe and his research team after years of studying thousands of findings from psychotherapy process research for their meta-analysis and further studies (Grawe 1997, 2004, 2007) will be described and the author will then talk about how a better understanding and utilization of these empirically based general principles of change can be used in order to develop an individual and couple based treatment plan adapted to the specific individual’s and couple’s psychological problems, disorders and resources.

Couple-based Interventions for Health Concerns: Going Beyond Relationship Distress

Donald Baucom, University of North Carolina, Chapel Hill, USA

The interplay between relationship functioning and mental and physical health is well established. Studies have documented a high comorbidity between relationship distress and physical and mental health outcomes, and numerous studies have demonstrated that psychological intervention can improve relationship functioning. However, in many cases, research indicates that comorbid individual and relationship problems either in individual therapy, couple therapy, or a combination of the two is often determined by the therapist’s training rather than by the patient’s specific problems and resources. This presentation will focus on the question how clinicians can develop a more comprehensive understanding of a patient’s problem to help them decide whether individual based or couple based interventions will be more effective and/or how these could best be combined? It will be argued, that in order to increase its effectiveness, the treatment should be tailored to the specific interplay between relationship functioning and psychological and/or physical problems in a given case. In order to treat individuals and couples effectively the therapist needs to be able to integrate methods from different orientations and treatment modalities. The author will suggest that a researched-informed integration of treatment modalities and therapeutic procedures should make use of empirically derived general therapeutic mechanisms of change. Empirical psychotherapy research has found more and more that change achieved by therapeutic procedures and interventions seems to be more influenced by general principles and common factors in different therapy approaches rather than specific methods and techniques. The four empirically established therapeutic mechanisms of change and common factors in psychotherapy extracted by Grawe and his research team after years of studying thousands of findings from psychotherapy process research for their meta-analysis and further studies (Grawe 1997, 2004, 2007) will be described and the author will then talk about how a better understanding and utilization of these empirically based general principles of change can be used in order to develop an individual and couple based treatment plan adapted to the specific individual’s and couple’s psychological problems, disorders and resources.
Over the past several decades, a large number of empirical investigations have demonstrated the efficacy of cognitive-behavioral couple therapy (CBCT), with a major emphasis on alleviating relationship discord and preventing relationship distress. In more recent years, the focus of couple-based interventions has broadened, recognizing the reciprocal associations between relationship and individual functioning. Thus, principles from CBCT have been adapted to assist couples in which one partner is struggling individually, either as a result of health problems or individual psychopathology. In this presentation, Baucom will discuss the major couple-based therapeutic strategies for assisting couples in which one partner has a health or medical problem. These strategies are aimed at helping the ailing partner make needed health-behavior changes, supporting both partners as individuals through these stressful events, and attending to new challenges in the relationship resulting from the health concerns. An overview of the empirical status of couple-based interventions for health problems will be included, along with representative findings from recent investigations conducted by the presenter and colleagues.

The Empirical Status of Couple-Based Interventions for Relationship Distress
W. Kim Halford, School of Psychology, University of Queensland

Across nearly all cultures, sharing a life-long committed relationship with an intimate partner comprises an almost universal and strongly-held ambition. Nevertheless, cross-national data reliably indicate a high prevalence of relationship distress and dissolution, with adverse emotional and physical health consequences for adult partners and their children. Meta-analyses of more than 30 randomized controlled trials show cognitive-behavioural and emotion-focused couple therapy produce moderate to large effect size improvements in relationship adjustment, with effect sizes of effects similar to the more successful cognitive and behavioural treatments of individual disorders. Moreover couple therapy has proved to be efficacious as the primary treatment of some individual disorders (e.g., depression), and as adjunct treatment for other disorders (e.g. alcohol abuse). However, there are significant limitations to the efficacy of couple therapy. Recovery of normal relationship adjustment occurs in only about 50% of treated distressed couples, and even for these couples some relapse occurs across a 2 to 4 year period. There have only been a few studies of effectiveness of couple therapy in routine care settings, but those suggest that the effectiveness is much below the benchmarks of effects reported in clinical trials. The procedures that might address enhancing effectiveness are to better attend to the life challenges of couples, to provide resources to therapists to enhance the effective delivery of couples therapy, and monitoring the progress in couple therapy and changing approach when therapy is not working. Finally, greater attention needs to be paid to assist couples to negotiate low conflict separations when the couple relationship is not repaired.

Bipolar disorders: Comorbidities and other transdiagnostic issues, and their implications for practice and research
Convenor: Thomas Meyer, Newcastle University

The perils and promises of exercise for people diagnosed with Bipolar Disorder: A qualitative study
Kim Wright, University of Exeter; Tamsin Armstrong, University of Exeter; Adrian Taylor, University of Exeter; Sarah Dean, Peninsula College of Medicine & Dentistry

The application of physical activity (PA) as an intervention for individuals with depression has been accompanied by calls for PA to be prescribed to individuals with Bipolar Disorder. However a recent review (Wright, Everson-Hock & Taylor, 2009) of the effects of PA upon physical and mental health in Bipolar Disorder identified very few relevant studies. Consequently there is little information upon which to draw conclusions about the safety and efficacy of PA as an intervention in this population, and to guide the development of such interventions. In the current study 25 individuals with a diagnosis of Bipolar Disorder provided information upon their exercise habits and participated in a semi-structured interview concerning their views on the relationship between PA and Bipolar Disorder. The data were subjected to qualitative analysis using an Interpretative Phenomenological Analysis (IPA) approach. The analysis revealed several novel themes that provide new insights into the experience of exercise and its management in Bipolar Disorder.

Alcohol use in bipolar disorder: comorbidity or symptom?
Thomas D. Meyer, Newcastle University; Jennifer L. McDonald, NHS Greater Glasgow and Clyde; Jessica L. Douglas, Newcastle University; Jan Scott, Newcastle University

Many clinical and epidemiological studies report extremely high prevalence rates for co-morbid alcohol problems in bipolar disorder (BP). Often the use of alcohol is immediately conceptualized as an additional issue which needs treatment, and there is the more or less explicit assumption that individuals with BD use alcohol to self-medicate. We will review the literature and also present data from a study using a repeated measures approach and looking at drinking motives in BP. Using Cooper’s cognitive motivational model of alcohol use as a framework it became evident that motivation to drink alcohol might differ across and between mood states and might actually not be as different from the normal population as perhaps often assumed. Interventions if at all aimed at modifying drinking behaviours in this population must target both individual and mood state variations in reasons for alcohol consumption. Assumptions that self-medication or coping explain this behaviour are over-simplistic.

Understanding and treating anxiety in the context of bipolar disorder: Qualitative findings and therapy development
S. Jones, Lancaster University; K Hampshire, P. Byrne, and S. Peters, University of Manchester

Comorbid anxiety is extremely common in bipolar disorder and is associated with significantly great risks for self harm and suicide and generally worse clinical outcomes. There has however been little research directed at understanding people’s experiences of anxiety and its management in the context of bipolar disorder. There are also no psychological treatments specifically tailored to address anxiety in this context. This talk will present initial findings from a treatment development study of integrated CBT for bipolar disorder with comorbid anxiety. In study 1, we conducted a qualitative investigation of the experience and consequences of anxiety in individuals with bipolar disorder. This indicated the importance of anxiety as an integral experience within bipolar disorder as well as experiences of anxiety separable from bipolar disorder. This work then informed a series of focus groups conducted with service users with bipolar disorder to facilitate the development of an anxiety in bipolar disorder therapy manual. Results of the thematic analysis of this focus group work will also be reported. The resulting randomized controlled trial is now in progress so the nature of the intervention and preliminary information on feasibility will be provided.
Is there a jumping to conclusion bias in bipolar disorders?
Larissa Wolkenstein, University of Tuebingen; Martin Hautzinger, Universitity of Tuebingen
Contemporary cognitive models and therapies of bipolar disorders are based on the assumption that bipolar patients show cognitive biases and dysfunctional attitudes. Jumping to conclusions (JTC) bias means the premature, early tendency to draw conclusions without considering all the available information and evidence. While numerous studies explore cognitive biases associated with depression, the investigation of cognitive biases associated with bipolar disorders is rather limited. The present study investigates if there is a JTC bias in bipolar disorder that might have implication in the formation and maintenance of the disorder. Furthermore, we examine if a JTC bias in bipolar disorder is associated to the degree of personal relevance of the actual situation that requires a conclusion. We hypothesized that bipolar patients show a JTC bias only if the conclusion they have to draw refers to a personally relevant situation. The performance on two measures of probabilistic reasoning is examined in twenty euthymic bipolar patients and twenty euthymic controls. Thereby, a commonly used modified version of the beads-in-the-jar task as well as a newly constructed, personally relevant version of this task is administered. Furthermore, several neurocognitive variables are controlled for. First analyses indicate that there is no JTC bias in bipolar disorder “” neither if the stimulus material in the JTC task is of personal relevance nor if it is not. In contrast, bipolar patients as well as non-clinical controls seem to be more careful in drawing conclusions if the stimulus material used in the JTC task is of personal relevance. This seems to be even more the case for bipolar patients than for healthy controls.

The role of the individual in relationship distress and interventions
Convenor: Douglas Snyder, Texas A and M University, USA
The PREP program for individuals and couples: Can interventions with one spouse help the relationship?
Howard Markman, Denver University; Marcie Pregulman, Denver University
A major issue in the couples’ intervention field is whether couples can benefit when only one partner receives the intervention. The prevailing belief based on early studies (e.g., Gurman & Kniskern 1997) is that individual interventions not only do not work, but they often do harm to the relationship (Gurman & Kniskern, 1977). Here we present a study designed to test in a randomized clinical trial if a version of the PREP (Prevention and Relationship Education Program) delivered to men and woman separately would have positive spill over to the marital relationship. Results to date indicate that when only one person attends the intervention, the other partner and the relationship improves. This suggests that when therapists can effectively work with only one partner “in the room” if they have a couples perspective as they conduct couples therapy. Implications for service delivery on a nationwide scale and for clinical practice are discussed.

Helping Couples Confronting a Major Life Challenge
W. Kim Halford, University of Queensland; Jemima Petch, University of Queensland; Suzanne Chambers, Griffith University
This talk brings together two recent themes in the couple therapy literature. First, the recognition that couple therapy needs to address the life stresses confronting couples, and the vulnerabilities each partner brings to a relationship, rather than just provide a context free focus on relating processes. Second, people in relationships who are confronting challenges often need assistance to conjointly cope with that stress with their life partner. The paper will present the results of three randomized controlled trials of couple based programs, one focused on couples in which the woman has breast cancer, one on couples in which the man has prostate cancer, and one in which the couple are making the transition to parenthood. A common theme across the studies is that couple based treatments that promote dyadic coping and develop effective mutual support can enhance individual and relationship functioning.

Marital Discord and Depression in a Community-Based Sample of Couples Seeking Treatment
Kurt Hahlweg, TU Braunschweig, Institut of Psychology, Braunschweig, Germany; David Atkins, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, USA
The common co-occurrence of marital discord and depression has led researchers to investigate the effectiveness of marital therapy in the treatment of depression. However, most of these studies are university-based efficacy trials, with specific inclusion criteria and modest sample sizes. The current study investigated the baseline and longitudinal association between marital discord and depression over the course of marital therapy, using data from two effectiveness studies in Germany and Austria (N = 538; Hahlweg & Klann, 1997; Klann, Hahlweg, Baucom, & Kroeger, 2008). The association of marital discord and depression over time was investigated as well as the moderating impact of clinical depression on resulting levels of marital discord. Results replicated the consistent, positive association between marital discord and depression within community-based settings. Additionally, moderator analyses demonstrated that marital therapy outcomes were significantly worse if depression material used in the JTC task is of personal relevance. This seems to be even more the case for bipolar patients than for healthy controls.

Side-by-Side: A Couples-Based Skills Intervention for Breast and Gynecological Cancer Patients
Tanja Zimmermann, Technische Universitat Braunschweig; Peter Herschbach, Technische Universtitat Munchen; Nina Heinrichs, Universitat Bielefeld
The cancer diagnosis is a stressful event that poses formidable and enduring challenges, not just to the women themselves, but also to their intimate partners. A conjoint process of mutual support has been suggested to be an effective coping strategy for patients who are married or in committed relationships. There are few interventions for couples facing cancer, although both partners may be affected by the disease of one partner. The primary aim of this study was to gather data on the potential benefits of a brief psychological intervention (“Side by Side”) designed to assist women and their partners to cope with breast or gynecological cancer. Ninety couples were randomly assigned to either the couples’ intervention or an information component containing the same educational materials, but no relationship focus. Multi-level analyses suggest that females receiving Side by Side showed larger reductions in cancer-related distress and fear of progression post-intervention compared to women in control group. Furthermore, couples in the Side by Side intervention showed less avoidance in dealing with the cancer, more posttraumatic growth, and better communication skills and dyadic coping relative to the control group. Hence, short-term changes in cancer-related functioning may be improved by enhancing couples’ dyadic coping skills during acute medical treatment of the disease.
A Case of Forgotten Trauma in the Formulation of an Anxiety Presentation

Craig Chigwedere, St Patricks University Hospital, Trinity College Dublin

Anxiety disorders are not always straightforward and often co-occur. Trans-diagnostically this can be challenging and therapists need to maintain a curious empathic stance until clarity emerges. Developing a working alliance, combining treatment specific models and accurate formulation is important when working with more complex cases. This presentation will take a case work approach to the assessment and treatment of a student, presenting with symptoms of panic, social anxiety and avoidance on a background of a disclosure of a shame based traumatic experience. Obstacles related to engagement, developing a therapeutic alliance and treatment planning are described, with reference to the literature.

Why Do I Get Nervous When I walk in the Room?

Yvonne Tone, Trinity College Dublin

Anxiety disorders are not always straightforward and often co-occur. Trans-diagnostically this can be challenging and therapists need to maintain a curious empathic stance until clarity emerges. Developing a working alliance, combining treatment specific models and accurate formulation is important when working with more complex cases. This presentation will take a case work approach to the assessment and treatment of a student, presenting with symptoms of panic, social anxiety and avoidance on a background of a disclosure of a shame based traumatic experience. Obstacles related to engagement, developing a therapeutic alliance and treatment planning are described, with reference to the literature.

Imagery Rescripting of Child Sexual Abuse in a Case of Anxiety

Colette Kearns, ckearns@spatsmail.com

Childhood sexual abuse has been associated with a range of disorders. Imagery rescripting and reprocessing is gaining increasing attention in work with trauma associated shame and guilt amongst other presentations. The presenter will draw on her own ongoing clinical research to illustrate the formulation and treatment of a case of OCD, where traumatic images associated with the experience of childhood sexual abuse were a complicating factor. New learning and implications for formulation and treatment from the current research will be discussed, with particular attention on how the focus on past trauma enhanced the treatment of the illustrative case.

Clinical Patterns of Co-morbidity in Anxiety and Trauma

Michael McDonough, St Patricks University Hospital

This presentation will draw on ongoing work and learning from the running of an anxiety programme at St Patrick's University Hospital to discuss the various clinical patterns of co-morbidity (e.g. separate maintenance cycles, primary versus secondary disorders, hidden co-morbidity etc) and explore how these relate to anxiety/trauma presentations and their management. Drawing from a case in preparation, co-morbidity, particularly trauma related challenges and presenting obstacles in the formulation and treatment of anxiety will be highlighted and discussed with the audience.

From Borderline Personality Disorder to working with Emotional Intensity: Taking STEPPS* towards accessibility in the UK (*Systems Training for Emotional Predictability and Problem Solving)

Convenor: Renee Harvey, Sussex Partnership NHS Foundation Trust

STEPPS in Sussex: Past, current, future

Renee Harvey, Sussex Partnership NHS Foundation Trust

The first session will be a presentation of the rationale for STEPPS (Systems Training for Emotional Predictability and Problem Solving) within the care pathway in Sussex. STEPPS is a 20-week psychoeducational package based on CBT and Schema Therapy, which has been running with considerable success within the UK since 2007. A brief history of the groups run so far will be given, and the outcomes of a pilot study carried out in 2008-9 will be presented. Some of the particular issues around the rollout of the programme within Sussex will be discussed, as well as issues around embedding this approach across the treatment system. Sussex has recently also opened a specialist treatment facility, Bluebell House, for individuals with complex needs around personality disorder. The value of STEPPS as an approach for managing emotional intensity within this service will be described. Future research plans as well as developments of the programme for early intervention and within CAMHS will be discussed.

Volunteers experience of STEPPS: Our personal journeys

Reuben Farhall, Sussex Partnership NHS Foundation Trust; Adele Huxley, Sussex Partnership NHS Foundation Trust; Jennie Hallett, Sussex Partnership NHS Foundation Trust; Jane Hughes, Sussex Partnership NHS Foundation Trust

A group of Service User Volunteers from Sussex will talk about their experience of STEPPS in their own personal journey to recovery. All are currently working as volunteers within the Tier 3 service, Bluebell House in Burgess Hill, and will share what the process of moving from being a service user to being involved with services in a very different capacity has meant for them. The process of helping others move towards engaging in a more active way in their own recovery, and instilling hope and confidence is crucial, while at the same time providing realistic support and understanding from personal experience.

STEPPS in Kent

Vaughn McGill, Kent and Medway NHS and Social Care Partnership Trust

STEPPS was introduced to East Kent’s community mental health teams in 2008 following a successful training workshop by Nancy Blum in 2008. There is now a STEPPS group treatment programme running in each of the community mental health teams in Eastern and Coastal Kent. This session will report on the service wide evaluation of the STEPPS Programme and explore some of the challenges related to the roll out of STEPPS to all teams (eg. resource allocation, team ownership and competing demands). It will also highlight the lessons learned from “high outcome” groups. Future developments, including managing transition points between STEPPS and Mentalization Based Therapy (MBT) groups and the development of routine outcome measures will be discussed.

STEPPS in Surrey

Christine Openshaw, Surrey & Border NHS Partnership Trust; Dale van der Watt, Surrey & Border NHS Partnership Trust
The development of the Exeter Systemic-Behavioural Couples Therapy model for depression
Janet Reibstein, Exeter University

Behavioural Couples Therapy is a treatment applicable to someone with a diagnosis of depression who is in an ongoing partnership. It is a time-limited, psychological intervention derived from a systemic model of relationships. Interventions aim to help participants understand the effects of their interactions on each other as factors in the development and/or maintenance of depressive symptoms and problems. The aim is to change the nature of the interactions so that the couple may develop more supportive and less conflictual relationships. A model of couples treatment which aims to build on the evidence base for behavioural treatment for depression (cf NICE guidelines, 2009) within a couples modality, while also acknowledging the evidence for systemic interventions (Asen and Jones, 2000; Leff, 2000) is beginning to be developed within a new training clinic (opened July 2010) within the University of Exeter Mood Disorders Centre. The developing model also draws on the work of Jacobson and Christensen, (Jacobson, et al, 2000; Christensen, et al, 2004) on the importance of what they have termed developing “acceptance and tolerance” within the relationship for sustaining the effectiveness of behavioural interventions. The Exeter model is attempting to identify practices within Systemic work that can be seen to be both within the ‘behavioural’ and ‘acceptance/tolerance’ rubrics. A research and training manual describing the interventions will be the product. The aim will be to investigate the effectiveness of elements of behaviourally defined Systemic work with depression. The classification of Systemic work into ‘behavioural’ categories potentially builds possibilities for collaborative work across Systemic and behavioural practitioners and researchers. The presentation from Prof Reibstein describes the model being built and the sample on which it is being developed.

The Exeter Systemic-Behavioural Couples Therapy model for depression- an illustrated overview of some of the techniques
Hannah Sherbersky, Exeter University

This presentation follows on from the theoretical model presented by Prof Janet Reibstein and will provide an illustrated overview of some of the techniques and interventions that are currently being developed within the new training clinic at the University of Exeter Mood Disorders Centre. The presentation will differentiate between ‘systemic behavioural’ and ‘systemic empathic’ techniques and will offer an opportunity to watch a number of short video clips demonstrating the techniques. It is proposed that these interventions, already well-established as systemic, such as role-play, enactments, active listening, sculpts, interviewing internalised other and genograms, can also be understood as essentially behavioural. The intentionality and emphasis of the interventions will be explored. This presentation by Hannah Sherbersky, the co-therapist in the clinic with Janet Reibstein, will draw together the integrative aspects of this behavioural model and demonstrate that these interventions are useful in increasing the couple’s reflective understanding of interactions and helping them to establish a more supportive and less conflictual relationship.

Behavioural, systemic and empathic techniques in couple therapy for depression: a case study
Guy A. Mizon, Exeter University

Couple therapy for depression is an expanding area of clinical activity. I will use a case study as a means to illustrate and discuss aspects of an integrative systemic-behavioural approach to couple therapy for depression. This case presentation is intended as an illustration of an approach whose theoretical basis will be discussed in other presentations in this symposium (by J. Reibstein and H. Sherbersky). The approach draws on systemic couple-focused techniques that have a growing evidence base in treating depression (Leff et al., 2000), as well as behavioural and empathic techniques that have produced promising outcomes when addressing couple discord (e.g. Jacobson et al., 2000; Christensen et al., 2004). In particular, in this case presentation I will focus on illustrating the combination of systemic-empathic techniques (empathic joining around the contribution of “family scripts” to current difficulties) with behavioural techniques (communication training).

The use of Interpersonal Therapy for depression with couples
Heather O’Mahen, Exeter University

Interpersonal therapy (IPT) is a well-established treatment for depression, and is recommended by NICE guidelines for depression. IPT focuses on addressing interpersonal difficulties within four possible domains: grief, transition, dispute, and social skills deficits. IPT aims to help clients improve effective communication and become re-engaged in interpersonal domains. IPT has traditionally had an individual focus, although its delivery framework can incorporate work with couples and family members on a flexible basis. This paper will present the key communication strategies employed in IPT. It will include two case models of IPT work with couples. A key difference between IPT and other systemic and couples based systems is that the partner of the client is defined as the “supporter” while the depression is located primarily as a problem the client him or herself is struggling with. Ways of managing this difference within the IPT context will be presented.

Integrating Cognitive-Behavioural and Systemic Family Interventions when working with couples with psychosis and comorbid conditions
Frank Burbach, Somerset Partnership NHS Foundation Trust

Family Intervention services work with a range of family members, and other people who provide regular support and care for those experiencing psychosis. This usually involves working with the family of origin of young adults with psychosis, but in some cases, involves working with their partners. In the former, sessions often address parenting issues, and in the latter, focus on the couple relationship. Both aspects are integral to the successful adaptation to, and recovery from, psychosis. This paper will present the types of work undertaken with couples in the Somerset Family Intervention in psychosis service.
This service was developed from 1995 by training teams in our collaborative, family needs-led approach via an accredited one-year course. Case examples will be used to illustrate how we apply our integrated Cognitive-Behavioural and Systemic approach to work with couples with psychosis and co-morbid conditions.

Panel Discussion

All bona fide psychological treatments for depression are equally effective
Convenor: Tim Dalgleish, MRC Cognition and Brain Sciences Unit

Speakers:
Tim Dalgleish, MRC Cognition and Brain Sciences Unit
Michael Lambert, Brigham Young University, USA
Alex Wood, University of Manchester
Steve Hollon, Vanderbilt University, USA
Gerhard Andersson, Linköping University and Karolinska Institute, Sweden
Ed Watkins, University of Exeter

In Alice in Wonderland the Dodo famously proclaimed that “everybody has won and all must have prizes” This spawned the Dodo bird hypothesis pertaining to psychological treatments for emotional disorders which states that all bona fide interventions will be equally efficacious and enduring due to their combination of non-specific and specific ingredients. The Dodo bird hypothesis has proved provocative and in this debate we explore the arguments on both sides as they relate to clinical depression, taking in different schools of psychotherapy, meta-analytic data, different severities and subtypes of depression, and the emerging literatures on personalised treatments, case formulations and transdiagnostic approaches.

Two speakers for, and two against, the motion that treatments are equally effective will present their views and will have the right to reply to what the others say. After each talk members of the audience will be invited to ask 2 or three questions and at the end it will be opened up for audience discussion and questioning of the speakers. The debate will end with an audience vote.

Clinical Roundtable

CBT for Complex PTSD: One case 4 ways
Convenor: Julia Coakes, the Retreat, York

Speakers: Julia Coakes, the Retreat, York
Andrea Brown, the Retreat, York
Mark McFetridge, the Retreat, York
Lucy Abraham, the Retreat, York

Complex PTSD is believed to be caused by prolonged exposure to social and/or interpersonal trauma within the context of perceived helplessness and lack of control. It is recommended that treatment for Complex PTSD is multi-modal and should differ from that for typical PTSD in an increased focus on functional impairment. The UTKG (UK Trauma Group) in their 2008 position paper concerning Complex PTSD recommended a multi-phasic and multi-modal treatment plan incorporating the three stages of treatment: 1. Establishing stabilisation and safety; 2. Psychological therapy, incorporating trauma-focused elements and some exposure to the trauma; 3. Rehabilitation. This clinical roundtable explores the stages of treatment for a patient with complex PTSD. A clinical case is used throughout the discussion to highlight the pros and cons of each treatment strategy, and stage to emphasise the options for clinical practice. A single patient, Jemima is followed through a typical treatment course and the use of Mindfulness, Dialectical Behaviour Therapy, Compassionate Mind Training and Imagery Rescripting are discussed. We explore the typical complications seen in this type of client such as problems with initial engagement, overdosing and self harm, dissociation, attachment issues, re-traumatisation through abusive relationships, and unplanned pregnancy. The treatment is adapted to offer ideas for managing this. Time will be allowed for discussion amongst the panellists and questions from the audience.

Skills Classes

How to incorporate Safety Behaviour into CBT for anxiety disorders
Adam Radomsky, Concordia University, Canada, Jack Rachman, University of British Columbia, Canada

Safety behaviour can be effectively integrated into treatments for anxiety disorders. This skills class will demonstrate how to incorporate safety behaviour into cognitive- and exposure-based treatments for a wide range of anxiety disorders including phobia, panic disorder and OCD. The presenters will highlight the presence of safety behaviour in current and past CBT interventions for a wide range of problems, and will then focus on newer techniques through case descriptions, videos and discussion. Attendees are encouraged to bring along their own case information for discussion. It is hoped that greater flexibility will be employed when approaching safety behaviour discontinuation in the context of CBT for anxiety disorders and related problems.

The Rough Guide to Dissociation: what’s happening and what you can do about it
Helen Kennerley, Oxford Cognitive Therapy Centre

Dissociative symptoms are seen across psychiatric conditions and they can challenge and bewilder therapists. For some presentations, such as flashbacks, we have well defined models and treatment guidelines, but for others, such as amnesias and fugue states, there is little to the help the cognitive therapist work with patients. Fortunately, the last decade has seen a rise in interest in dissociative disorders and our understanding of both the psychology and the neurology of dissociation has increased so that we can now begin to develop cognitive-behavioural formulations for dissociative problems. Such conceptualisations can guide the therapist towards appropriate treatment plans. Learning objectives: To demystify dissociation by:
  • Exploring its neuropsychological basis
• Formulating dissociative presentations
• Reviewing basic CBT skills which can be used to help patients. Training modalities: Didactic presentation with clinical illustration and opportunity for audience discussion and questions

Using enhanced reliving to work directly with trauma memories associated with PTSD
Debbie Lee, Berkshire Traumatic Stress Service, Kerry Young, Central North West London Foundation NHS Trust
In spite of a compelling evidence base many clinicians working with PTSD are reluctant to work directly with people’s trauma memories for fear of making people worse or re-traumatising them. Yet working with trauma memories is key to both trauma focused CBT and EMDR which are the recommended treatments for PTSD (NICE, 2005). So this clinical skills workshop offers clinicians an opportunity to learn how to do use reliving to access trauma memories and uncover unhelpful meanings. The class will briefly outline the theoretical underpinning to this technique, and then describe how to do reliving.

A video demonstration will be used aid learning and promote discussion about this method. The workshop is suitable for clinicians who are already familiar with Trauma focused CBT and work with PTSD but would like the opportunity to explore this particular technique. Teaching method: didactic, video demonstration, role play

Open Paper
A qualitative analysis of suicidal feelings
Outi Benson: SANE
Suicidal ideation and suicidal feelings have been used interchangeably whereas they are different constructs. The aim of this study was to provide an in-depth analysis of suicidal feelings. 120 participants with suicidal feelings completed an on-line survey about their experience. The data were analysed using the grounded theory method with philosophical phenomenology. Our results so far suggest that there are important interpersonal similarities in experiences of suicidal feelings, which transcend external ‘risk factors’ and psychiatric diagnoses. There is a sense in which a suicidal person is “already dead”; disintegrating and absent from the world. The results will include a rich description of the experience of suicidal feelings combining quotes from participants with analytic commentary. It is concluded that a full understanding of suicidal feelings could pave the way forward for important new developments in CBT.

Poster
Insomnia pre- and post-treatment for Anxiety and/or Depression
Elizabeth Mason, Clinical Research Unit for Anxiety and Depression (CRUfAD); Allison Harvey, Department of Psychology, University of California, Berkeley
Insomnia is a very common complaint amongst individuals with anxiety and mood disorders. A clinical question is whether treatment should focus on improving sleep or whether the focus of intervention should be on reducing anxiety. To examine this proposal, in this study, insomnia severity was assessed in a group of patients presenting for treatment at an anxiety disorders clinic. Participants were individuals who presented at a specialist clinic for anxiety and depression. Insomnia severity was measured using the Insomnia Severity Index pre- and post-treatment for anxiety or depression. Individuals with a primary diagnosis of panic disorder, social anxiety disorder, generalised anxiety disorder (GAD), or depression, assessed to be suitable for internet-based cognitive behavioural therapy (iCBT), were assigned to one of four iCBT programs on the basis of their primary diagnosis, or to a fifth program designed to treat mixed anxiety and depression. All programs have been shown to be effective in treating anxiety and/or depression. Pre-treatment data suggest that individuals with clinically significant insomnia report significantly more severe symptoms of depression, GAD, distress, and disability than patients without clinically significant insomnia. Participants will also be examined following treatment to examine whether treatment focussed on anxiety/depression also reduces insomnia severity, as well as whether insomnia severity pre-treatment predicts treatment outcome. This study will help to elucidate the relationship between sleep disturbances and anxiety disorders so that we may better treat both sleep and anxiety disorders. Implications for the science and practice of CBT: This research will provide insights into whether interventions focussed on improving anxiety also improve sleep functioning.

Basic Processes and New Developments
Keynotes
Why Can’t I Stop Worrying? The Role of Cognitive Processes in the Maintenance of Worry and Generalised Anxiety Disorder
Dr Colette Hirsch, Institute of Psychiatry, King’s College London
Generalised anxiety disorder (GAD) is characterised by the repeated experience of chronic, excessive, and uncontrollable worry regarding a range of topics. Although anticipation of probable danger may be adaptive in ensuring an individual’s safety, it is less clear why excessive worry persists when it causes mental distress without producing apparent benefits. As will be discussed, GAD is characterised by increased attention to threat and greater access to threatening interpretations of ambiguous events. It is also associated with a predominance of negative verbal processing and a lack of imagery, Furthermore, worry itself takes up working memory resources that are needed to shift attention to more benign thoughts. Whilst it is important to establish that biases exist, it may be the case that the biases are incidental or even a secondary consequence of the emotional problem. Given this, research examining causality is essential. This can be achieved by manipulating a given cognitive bias and assessing its impact. Research will be presented which demonstrates the role of cognitive biases of attention, interpretation and the predominance of verbal processing in preference to imagery in maintaining worry and GAD. These biases make it more difficult for individuals with GAD to redirect their thoughts away from worry and onto more benign topics, therefore causing their worry to persist. Research investigating causality involves developing techniques to promote more benign biases. These methods can be adapted for use in treatment, or can (or could) be used to guide the development and focus of treatment interventions in GAD. The potential utilisation of these methods will be discussed.
What Can We Learn From the Rapid Expansion of Internet-delivered CBT?

Professor Gerhard Andersson, Linköping University, Sweden

Internet-delivered CBT (ICBT) is a relatively new treatment format which dates back to the late 1990’s. Since then there has been an extensive research activity, and there are now well above 50 controlled trials in which ICBT has been tested for various conditions in which face-to-face CBT has been found to be effective. An increasing number of comparative trials on anxiety disorders such as panic disorder and major depression, and somatic conditions such as tinnitus effects have compared ICBT with face-to-face CBT. Effect sizes for ICBT have been well within the range of face-to-face CBT with the exception of unguided programs (e.g., not even minimal therapist contact), which usually, but not always, result in smaller effects. Most likely Internet treatment studies will gradually increase in number and there is now a tendency that novel treatment methods are tested in Internet trials soon after that they have been developed, and that new treatment therapies will even be developed directly for use with the Internet. One example of this is a recent new treatment for Irritable Bowel Syndrome, which moved quickly from a pilot group-based trial to the Internet format which was tested in two large controlled trials and one effectiveness study. Since controlled trials on ICBT are more easy to conduct than time and resource consuming clinical trials, it is possible that ICBT can help move the field of CBT forward more rapidly, for example by conducting dismantling studies. One aspect that the Internet has added to the CBT field is the use of online questionnaires, and research has consistently shown that this administration format is feasible and works as well as paper-and-pencil questionnaires. Studies on guided ICBT may reveal that previously less well known factors may be important for treatment adherence, such as the importance of having a deadline for completing treatment, following which an interview is conducted. Implications and potential risks of ICBT will be further discussed in the talk. A projection into the future is that ICBT will become integrated with other services in a clinician’s tool box.

Symposia

CBT interventions transferred to the Internet
Convenor: Gerhard Andersson, Linköping University and Karolinska Institute, Sweden

Individually-tailored, Internet-based treatment for anxiety disorders: A randomized controlled trial
Per Carlbring, Dept of Psychology, Umea university; Linda Maurin, Linkoping university; Charlotte Torngren, Linkoping university; Emma Linna, Linkoping university; Gerhard Andersson, Linkoping university

Previous studies on Internet-based treatment with minimal to moderate therapist guidance have shown promising results for a number of specific diagnoses. The aim of this study was to test a new approach to Internet treatment that involves tailoring the treatment according to the patient’s unique characteristics and comorbidities. A total of 54 participants, regardless of specific anxiety diagnosis, were included after an in-person, semi-structured diagnostic interview and randomized to a 10 week treatment program or to a control group. Treatment consisted of a number of individually-prescribed modules in conjunction with online therapist guidance. Significant results were found for all dependent measures both immediately following treatment and at 1 and 2 year intervals. Mean between-group effect size including measures of anxiety, depression and quality of life was Cohen’s d = 0.69 at post-treatment, while the mean withingroup effect size was d = 1.15 at post-treatment and d = 1.13 and d = 1.04 at 1 and 2 year follow-up respectively. The tentative conclusion drawn from these results is that tailoring the Internet-based therapy can be a feasible approach in the treatment of anxiety in a homogeneous population. Reference: Carlbring et al. (in press). Individually-tailored, internet-based treatment for anxiety disorders: a randomized controlled trial. Behaviour Research and Therapy.

Behavioural couples therapy over the Internet: a randomised controlled trial
Gerhard Andersson, Linkoping University, Sweden; Maria Gustavsson, Linkoping University, Sweden; Anna-Karin Andersson, Linkoping University, Sweden; Hillevi Andreen, Linkoping University, Sweden; Per Carlbring, Umea University, Sweden

Background: Behavioural couples therapy is an effective treatment for couples in distress, but probably not utilized as much as needed due to practical issues such as booking appointments. Objective: The aim of this paper was to report the findings of a recent controlled trial on acceptance oriented behavioural couples therapy delivered via the Internet. Methods: We included 79 couples, with a total N of 158. Participants were randomised to either guided Internet treatment, which consisted of 10 weekly modules, or to an online discussion forum (control group). Participants in the active treatment (i.e., the couples) worked both separately and together with the treatment which was based on Integrative Behavioural Couples Therapy developed by Christensen and Jacobson. The treatment was guided by psychology students who were supervised by an experienced clinician. We also included movie clips with actors to illustrate treatment components. Results: Following treatment 7.6% had dropped out, with remaining participants providing posttreatment data. Results on the main outcome measure Dyadic Adjustment Scale showed between group Cohen’s d effect sizes of d=0.68 for women and d =0.63 for the men. Results at a 1-year follow-up showed an average pre- to follow-up effect size of d =0.57. Conclusion: This is probably the first controlled trial on Internet-delivered guided behavioural couples therapy. We conclude that Internet-delivered couples therapy can be effective.

Internet-delivered CBT for Irritable bowel syndrome - theory, treatment, and empirical results.
Ljotsson Bjarni, Karolinska Institutet, Sweden; Hedman Erik, Karolinska Institutet, Sweden; Ruck Christian, Karolinska Institutet, Sweden; Lindefors Nils, Karolinska Institutet, Sweden; Andersson Gerhard, Linkoping University, Sweden

Irritable bowel syndrome (IBS) is a functional gastrointestinal disorder, which is characterized by abdominal pain combined with altered bowel habits and bloating. IBS is associated with impaired quality of life and functioning. Since the disorder is common, with a point prevalence between 5% and 15%, it leads to large societal costs because of increased health care use and work loss. In the last 30 years, several psychological treatments for IBS have been developed and evaluated, including psychodynamic psychotherapy, hypnotherapy, stress management, biofeedback, relaxation therapy, cognitive therapy, and cognitive behavior therapy. All these interventions are based on the notion that IBS symptoms are caused and exacerbated by different external stressors. External in the sense that they are not part of the illness, but stem from sources such as difficult interpersonal relationships, maladaptive coping strategies, negative self-schemas, negative appraisals of daily stressors, or general life difficulties. However, recent research suggests that the primary source of stress causes symptoms is part of the illness itself. In analogue with current models of panic disorder, IBS-patients have developed hypervigilance.
Exploring emotion regulation processes in health and psychopathology

Convenor: Barney Dunn, Medical Research Council Cognition and Brain Sciences Unit, Cambridge

Exploring the time course of emotion experience to positive imagery in currently and previously depressed individuals.

Barnaby Dunn, MRC Cognition and Brain Sciences Unit; Rosie Banks, MRC Cognition and Brain Sciences Unit; Clem Edwards, MRC Cognition and Brain Sciences Unit

It is increasingly realised that disturbances in positive emotions are just as key to depression as elevations in negative emotions. However, existing CBT interventions focus to a much greater extent on reducing negativity rather than promoting positivity. This talk will present recent findings from our laboratory examining how reactions to positive material in depression can go awry, and testing out different ways to correct this. In particular, basic science is increasingly showing that emotions are dynamic phenomena which unfold over time (referenced to as ‘affective chronometry’; see Davidson, 1999). To best treat positivity disturbances in depression we need to know which parts of this dynamic response system are implicated. The current talk will discuss a recent experiment looking at the time course of emotional response to positive imagery in depression, to see if positivity disturbances reflect a lowered positive baseline, reduced reactivity to positive stimuli, or a faster return to baseline after positive stimuli. We examine this in both individuals currently in a depressive episode and those who have recovered from depression, to examine if positivity deficits are a state marker of disease severity or a trait vulnerability factor. Implications for treating the anhedonic features of depression, including the utility of adopting imagery approaches, will be considered. Reference: Davidson, R. J. (2003) Affective neuroscience and psychophysiology: Toward a synthesis. Psychophysiology, 40, 655-665.

How does mental fatigue relate to the emergence of depressive thought patterns?

Theresa Dahm, MRC Cognition and Brain Sciences Unit; Tim Dalgleish, MRC Cognition and Brain Sciences Unit

Cognitive impairments are a key characteristic of depression, and may also represent a risk factor for developing the disorder. These can appear as difficulties with executive tasks or as negative biases when processing emotional information, and while they are less apparent during remission they can still reveal themselves under certain circumstances. For example, while under concurrent mental load recovered depressed participants show a striking negative bias when processing ambiguous emotional material which is similar to that shown by currently depressed participants (Watkins & Moulds, 2007). This suggests that in remission depressive thought patterns are merely masked by effortful cognitive strategies. In healthy populations a consistent finding shows that executive control diminishes following prior attempts at exerting self-control, indicating that the capacity to regulate thoughts and behaviours is limited and can temporarily become depleted (see Hagger et al., 2010, for a meta-analysis). Surprisingly, no prior research has studied these fluctuations of executive control in depressed populations, despite the clear similarities with the work on concurrent mental load in remitted depressive cognition. This talk will present data from a study examining the hypothesized relationship, and other recently evaluated executive control impairments are also more apparent following an effortful executive task. In this experiment, never-depressed and previously depressed participants were compared on a measure of positivity. Half the participants had just carried out a tiring, executive task, whereas the other half had listened to a stimulating audio piece as a control task. By comparing performance on the positivity measure, we were able to infer whether the tiring, executive task had indeed led to an increase in depressive cognitions. The clinical implications of the results will be discussed with reference to other types of behaviours that typically disrupt adaptive thinking in depression, such as rumination. References: Hagger, M.S., et al., Ego depletion and the strength model of self-control: a meta-analysis. Psychological bulletin, 2010. 136: p. 495-525. Watkins, E.R. and M. Moulds, Revealing negative thinking in recovered major depression: a preliminary investigation. Behaviour Research and Therapy, 2007. 45: p. 3069-3076.

Is emotion suppression universally a bad thing? Investigating the consequences of effortful emotion Regulation in Borderline Personality Disorder

Davy Evans, MRC Cognition & Brain Sciences Unit, Cambridge, UK; Chess Denman, Cambridgeshire & Peterborough NHS Foundation Trust, Cambridge, UK; Inez Myin-Germeys, Department of Psychiatry and Neuropsychology, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht University, Maastricht, The Netherlands; Barnaby Dunn, MRC Cognition & Brain Sciences Unit, Cambridge, UK

Difficulties regulating emotions are believed to be core to borderline personality disorder (BPD), and are thought to lead to the self destructive behaviours seen in individuals with this diagnosis. This has resulted in the emergence of emotion regulation treatment approaches such as Dialectical Behaviour Therapy (Linehan, 1993). One heuristic clinical belief which these approaches share is that clients should be encouraged to accept their emotions and relinquish effortful attempts at emotional suppression. However, the evidence base supporting the beneficial effects of acceptance and the costs of suppression is presently limited, particularly in clinical groups. This talk presents data from a number of studies examining emotion regulation to negative material, in a sample of individuals who have varying levels of BPD features. This sample includes individuals with a formal diagnosis of BPD who would be seen in specialist personality disorder services, but also towards their own body and react with fear in response to naturally occurring gastrointestinal symptoms. Through positive feedback loops, fear and attention increase the experience of IBS symptoms. In order to experience less symptoms and worry about symptoms, IBS patients develop patterns of avoidance, control, and safety behaviors. These behavioral patterns lead to decreased quality of life and increase the fear of and focus on symptoms. We will present a “third wave” cognitive behavioral treatment based on this model of IBS. The treatment includes brief mindfulness training and exposure to IBS symptoms for fear-related contexts. We will also present three studies that have evaluated this treatment delivered via the internet. The studies have evaluated the treatment effects on IBS symptoms, illness related quality of life, general functioning and psychiatric symptoms. Study 1 included 85 self-referred participants randomized to either internet-based treatment or waiting list. Study 2 included 62 patients that were consecutively recruited from a gastroenterological clinic and were randomized to treatment or waiting list. Study 3 included 195 self-referred participants that were randomized to the exposure based treatment or a symptom management course, testing the specificity of the treatment. At post-treatment the between groups effect sizes on IBS-symptoms were Cohen’s d = 1.2 (study 1), 0.8 (study 2), and 0.4 (study 3), and the between groups effect sizes on illness related quality of life was Cohen’s d = 0.9 (study 1), 0.82 (study 2), and 0.5 (study 3). These studies show that the treatment is effective for both self-referred and clinical population and is superior to both a waiting list control and a credible treatment control. 12 month follow-up data will also be presented for study 1 and 2, and 6 month follow-up data for study 3.
those individuals with features of BPD that might be treated for axis-I difficulties in secondary care and high intensity IAPT services. These studies employ a variety of methods, including laboratory experimental tasks and Ecological Momentary Assessment that assesses emotion experience in the real world environment. Our findings support the idea that the problematic behaviours seen in BPD are in part a result of maladaptive responses to negative material. The role of emotional suppression in BPD will be discussed, including whether this strategy is as dysfunctional as commonly believed. The therapeutic implications, both for specialist personality disorder services and for more general therapeutic settings, will be explored. Reference: Linehan. (1993). Cognitive Behavioural Treatment of Borderline Personality Disorder: Guilford Press.

Affective control through cognitive control: Can brain-training be applied to the clinical domain?
Suzanne Schweizer, MRC Cognition and Brain Sciences Unit; Jessica Grahn, University of Western Ontario; Adam Hampshire, University of Western Ontario ; Dean Mobbs, MRC Cognition and Brain Sciences Unit; Tim Dalgleish, MRC Cognition and Brain Sciences Unit
Mood and anxiety disorders are characterised by pervasive emotional dysregulation as well as deficits in cognitive control, especially of emotional material (for a review see Aldao, Nolen-Hoeksema, & Schweizer, 2010) However, little is understood about how cognitive control capacity affects emotion regulation ability and vice versa. One idea is that working memory capacity, which is highly dependent on cognitive control, predicts individuals’ ability to suppress unwanted intrusive thoughts (Brewin & Beaton, 2002). This talk will review work from our laboratory examining how cognitive control is affected in posttraumatic stress disorder when individuals are exposed to trauma-related material. This raises the possibility that training individuals with mood and anxiety disorders to improve cognitive control capacities may be a useful therapeutic adjunct. Further, we will present results of a study that attempts to improve emotion regulation through training of cognitive control capacity. In a functional imaging study we scanned healthy participants (N=32) while they regulated their emotions before and after an intensive brain-training programme. This required participants to extensively practice the cognitive control of emotional material, such as images of negative facial emotions and negative words. How this practice impacted on subjective emotion experience and patterns of neural activation during emotion regulation will be discussed. Whether such approaches have potential to be implemented as low-cost and low-effort adjunct treatment to current evidence-based interventions for affective psychopathology will also be considered. References: Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. Clinical Psychology Review, 30(2), 217-237. Brewin, C. R., & Beaton, A. (2002). Thought suppression, intelligence, and thoughts (Brewin & Beaton, 2002). This talk will review work from our laboratory examining how cognitive control is

New directions and developments in behavioural activation
Convenor: David Ekers, Tees Esk and Wear Valleys NHS Trust and Durham University

Behavioural Activation for depression delivered by the non-specialist. A meta analysis and randomised controlled trial of clinical effectiveness and cost utility
David Ekers, Tees Esk and Wear Valleys NHS Trust and Durham University
Depression is set to become the second largest cause of disease burden by 2020. Cognitive Behavioural Therapy (CBT) is the standard psychological treatment but barriers to access exist. Behavioural activation (BA) if as effective as full CBT and may offer increased access if suitable for delivery by a wider range of mental health staff. We explored the clinical and cost effectiveness of BA through a meta analysis and randomised controlled trial with particular focus on the parsimony of the approach. Meta analysis: BA is effective compared to controls (k = 12, SMD -0.70, 95% CI 1.0 to 0.39) and as effective as CBT (k= 12 SMD 0.08 95% CI 0.14 to 0.30). All trials used experienced psychotherapists hence parsimony had not been demonstrated. RCT : We randomly allocated 47 depressed adults to 12 sessions of BA by mental health nurses or usual care. A difference was found in favour of BA of 15.79 (95% CI 24.55 to 7.02) on the Beck Depression Inventory-II. Functioning and satisfaction also showed a significant difference in favour of BA. We found BA to be superior in improvement of quality adjusted life year using generic health state measures. Cost increases associated with the intervention appeared minimal including a 6 month baseline costs in analysis. Results of bootstrapping analysis plotted on a cost acceptability and effectiveness curve suggested a 97% probability that BA is cost effective at a threshold value of £20,000. Findings of this small scale analysis indicate BA may be suitable for dissemination to a wide workforce however larger scale replication is required. Ekers, D, Richards, D and Gilbody S. (2008). A Meta Analysis of Randomised Trials of Behavioural Treatment of Depression. Psychological Medicine. 38(5) 611-623. Ekers D, Richards D, McMillan D, Bland M, Gilbody S. Behavioural Activation delivered by the non-specialist: phase II randomised controlled trial. British journal of psychiatry 2011; 198(1): 66-72.

Low Intensity BA
David Richards, University of Exeter
Behavioural activation will form a major part of any Low-intensity (LI) psychological therapist’s clinical repertoire. Whilst BA is available in a high-intensity variant (Martell et al. 2001; National Institute for Clinical Excellence 2009), a six-stage protocol has been successfully developed from clinical trials of collaborative care in the UK and applied in the UK’s IAPT programme. It is the same as that outlined in the clinical support materials for the UK's LI IAPT national curriculum. It is based on the same theoretical rationale as other forms of behavioural activation, but draws more heavily on theoretical work by Derek Hopko and colleagues (Hopko et al. 2003). It recognizes that when people are depressed and avoid activities, those activities can be categorized as routine, pleasurable, or necessary. Several recording tools are also used, including diaries and worksheets. LI workers provide support as patients learn behavioural activation strategies from written materials. Sessions are generally short (20 minutes or so), weekly at first, and range from three to eight contacts, although some patients may require more sessions. These techniques are suitable for face-to-face sessions, but are commonly applied through telephone contacts between patients and workers.

Internet behavioural activation for Postnatal Depression: A randomized controlled trial
Heather O’Mahen, University of Exeter; Jo Woodford, University of Exeter; Julia McKinley, Netmums.co.uk
Postpartum depression is both common (approximately 15%) and profound in its impact, affecting mothers and their infants during a critical developmental period. NICE has recommended priority expedient care for women suffering from postpartum depression. However, approximately only 30% of women suffering from postpartum depression receive appropriate treatment, even when treatment is available. Research suggests that the postpartum period presents specific barriers to
accessing office-based treatment, including practical (e.g., childcare, transportation) and attitudinal (e.g., stigma) barriers (O’Mahen, Flynn, Chermack, & Marcus, 2008; O’Mahen, Jones, Henshaw, & Flynn, 2011). Creative and flexible delivery systems, such as internet based interventions, may overcome these barriers and improve treatment engagement. This study examines the efficacy of an Internet Behavioural Activation (iBA) treatment for postnatal depression. Banner advertisements were posted on Netmums.co.uk (the hosting site) for the intervention trial. Women who were aged 18 or older and had a baby in the past year were eligible to participate. 736 women were randomly assigned to receive either iBA or treatment-as-usual (TAU). The intervention consisted of 11 weekly emailed sessions of iBA modified specifically for the perinatal period, an online chat room designated for the treatment participants and moderated by a health visitor, and a weekly online clinic supported by either a Clinical Psychologist or Health visitor. Women completed a battery of assessments at sign-up and at post-treatment. The primary outcome measure was the Edinburgh Postnatal Depression Scale (EPDS) 236 (32%) women completed both assessments. Both completer and intent-to-treat analysis with imputation revealed significant between-group pre-post differences, $t(7.732) = -3.42, p = 0.000$ (CI: -5.14; -1.71; ES = 0.53); $t(7.229) = -2.72, p = 0.009$ (CI: -4.76; -0.68). A significantly greater proportion of women in the treatment group achieved treatment remission, defined as scoring below 13 on the EPDS, than those in the control group, $t(2.54, p = 0.001$ (CI: -0.96; -0.42). Women reported they participated in the programme because they trusted the Netmums name, were searching for accessible skills and tools that might help them, and found it hard to talk face-to-face. Participants requested a more user friendly interface. The results of this programme are promising. They suggest that there is considerable interest in iBA in a perinatal population, and that it is an effective intervention. However, high attrition rates indicate the need for additional support, such as weekly brief telephone calls, which has been linked to lower attrition in internet based treatments. Future directions and implications will be discussed.

Addressing Depression in Muslim Communities

Ghazala Mir, University of Leeds; Dean McMillan, University of York; Shalista Meer, University of Leeds

NICE guidelines promote attention to variations in patients’ cultural background in choice of treatment for depression as these significantly affect treatment outcomes. Faith is a prime identity in Pakistani and Bangladeshi populations and in the UK religious coping is most likely to be used by people from Muslim backgrounds. Religious coping strategies have the potential to reduce levels of depression through providing a sense of meaning and purpose, improved social adjustment, reframing of experience and increased compassion towards the self. Religious beliefs can also be a resource for improved relationships by increasing connection between family members and providing increased resources to deal with discrimination. Detailed descriptions of the form and content of interventions for Muslim clients with depression are not available and the aim of this study is to fill current gaps in knowledge about how to address the needs of this population. A focus on Behavioural Activation therapy was considered appropriate because of its proven effectiveness in clinical trials and its potential to incorporate clients’ faith beliefs and values through attention to valued goals. The plan of investigation broadly follows the four phases outlined in MRC guidelines for development of complex interventions. The research process aims to identify necessary adaptations to an existing BA manual and the mechanisms by which these could influence outcomes. Areas of overlap and difference between established BA approaches and the religious and cultural context of Muslim clients will be highlighted.

Implementing Group Behavioural Activation in Primary Care

Joe Curran, Sheffield Health and Social Care NHS Foundation Trust; Paul Bliss, Sheffield Health and Social Care NHS Foundation Trust

Based on the results of 8 BA groups delivered as part of an IAPT service this presentation will report the outcomes of the intervention and examine a range of factors influencing its implementation. Particular attention will be paid to the primary care context, modifications made to the number of group sessions delivered, the populations seen (in terms of demographics, symptom severity and duration), the timing of change shown on outcome measures and characteristics of the therapists running the groups. Where possible, comparisons will be made between the delivery of BA groups in primary and secondary/tertiary care settings, based on the available data and the presenters’ clinical experience.

Emotion-Regulation: Clinical and developmental perspectives

Convenor: Pasco Fearon, University College London

The longitudinal development of emotion regulation in children at risk for externalising problems

Sarah Halligan, Lynne Murray, Peter Cooper, Pasco Fearon, Sarah Wheeler, Michelle Crosby

Background: Child emotion-regulatory capacities are hypothesised to have a key role in the development of externalising psychopathology. In addition, parental behaviour, particularly sensitive responding to child cues, is proposed to be an important influence on the development of child emotion regulation. However, evidence relating each of these together is limited. The current study examined the longitudinal development of child emotion regulatory capacities from the neonatal period through to 5-years child age, with the particular aims of examining the extent to which problems in emotion regulation represent a risk factor for later behavioural problems; and of investigating maternal influences on child emotion regulation development. Methods: 122 mothers and their children were recruited via a screening questionnaire in the antenatal period. Approximately half of the sample were experiencing high levels of psychosocial adversity, and were thereby at risk for child behavioural problems. Emotion regulation capacities and maternal sensitivity were assessed through direct observation in the first 3-months of life, at 12/18-months and at 5-year follow-up. Behavioural problems were also assessed, via maternal and teacher report. Result: Analyses indicated that: a) there was a degree of stability in child regulatory capacities from the second year of life through to childhood; b) children at risk for externalising behaviours showed relatively poor emotion regulation capacities right from early development, and poor emotion regulation was associated with externalising problems both cross-sectionally and longitudinally; c) higher levels of maternal sensitivity were associated with better child emotion regulation. Conclusions: The current observations are consistent with the hypothesised role of emotion regulation deficits in childhood psychopathology. Implications for both research and practice will be discussed.

The relationship between parenting and children’s emerging capacity for Emotion Regulation

Frances Warren, University of Reading; Kyla Vaillancourt, University of Reading; Pasco Fearon, University College London
Early emotion regulation is an important factor in predicting later socio-emotional development, with difficulties in coping with negative emotions being linked to the development of emotional and behavioural problems (Frick & Morris, 2004). The ability to effectively regulate emotion is a major developmental task for infants and toddlers; crucial to this early development is the relationship with their caregiver(s), depending on them for support in dealing with their emotions (Kopp, 1989). Emotional regulation research suggests that sensitive responding to infant’s emotions is associated with more optimal regulation of emotions later in life (Calkins & Johnson, 1998). However, little empirical research has looked at the role of parenting in children’s emotional development over time, nor adopted an experimental design to directly examine causal relationships between parenting and early regulation. The present study extends existing research by examining the influence of parenting on children’s developing regulation. A frustration-eliciting task was used, during which the level of support the mother could provide was manipulated, allowing a direct comparison of children’s responses when this external input is both permitted and constrained (Lambrey et al. 2010). Increased paternal involvement had a clear impact on infant distress: maternal involvement decreased facial anger, protest vocalisations and struggling, and increased smiling. It also led to increases in emotion-regulative strategies, particularly those involving socially-mediated regulation. Critically, the quality of parental care at 15 months predicted children’s use of socially-mediated regulation strategies even when prior emotional reactivity and regulation at 15 months were controlled out. The present study demonstrates the importance of early inter-personal regulation, with parental support facilitating children’s use of regulatory strategies such as distraction and social referencing. Our results suggest that earlier sensitive parenting specifically promotes later socially-mediated regulation.

Feeling worse or feeling better: An investigation of emotion regulation in non-suicidal self-injury (NSSI)
Katie Dhingra, University of Sheffield; Peter Totterdell, University of Sheffield; Digby Tantam, University of Sheffield; Paul Naylor, Aston University; Michael Campbell, University of Sheffield

Introduction: Emotion regulation involves the regulation of one’s own emotions (intraperso/neral emotion regulation) or other people’s emotions (interpersonal emotion regulation). Studies of emotion regulation in NSSI have usually assessed dysfunctionality in the strategies used to improve affect, but recent research has shown that individuals may sometimes also intentionally worsen their own (Riediger et al., 2009) and other people’s affect (Niven et al., 2009), often for instrumental or self-identity purposes. This paper presents the findings of a study exploring differences in the use of regulation strategies between students with and without a NSSI history and how regulatory strategies relate to NSSI characteristics. Method: University students (n = 123 self-injurers; n = 37 controls) completed two self-report measures: the Emotion Regulation of Others and Self scale (EROS; Niven et al., 2011) and the Personal experiences of NSSI scale. Results: Findings indicated that self-injurers make greater use of strategies intended to worsen their own affect relative to controls. Additionally, past self-injurers make greater use of strategies aimed at improving their affect than recent self-injurers; and recent self-injurers make greater use of affect-worsening and dysfunctional strategies relative to controls. Further, self-injurers’ greater use of affect-worsening strategies and lesser use of affect-improving strategies is associated with more frequent NSSI and a higher estimated likelihood of future NSSI behaviour. Discussion: Results suggest that use of intrinsic worsening strategies may contribute more strongly to NSSI behaviour than affect-improving strategies. Interventions should be aimed at reducing current self-injurers’ use of affect-worsening strategies and enhancing use of affect-improving strategies, perhaps through implementation intentions (e.g., Webb et al., 2010).

The use of virtual environments in CBT
Convenor: Matthew Wilcockson, Coventry and Warwickshire Partnership Trust, and Coventry University

Overview
Matthew Wilcockson, Coventry and Warwickshire Partnership Trust, and Coventry University; Silvester Czanner, University of Warwick; Sarah Parsons, University of Southampton

Virtual environments have been used in a as a therapeutic tool in the mental health field for about 15 years, and their use is increasing (Lambrey et al. 2010). Using highly realistic simulation, the client experiences three dimensional computer environments specific to their presenting problem, designed to help them overcome the said problem. Decreasing cost of this technology is now making ideas that people previously considered to be the territory of science fiction into a serious treatment option that can be cost-effective with common presenting problems. Within the context of Cognitive Behaviour Therapy (CBT), the 2 principal uses of virtual environments are Graded Exposure (VRET or VRGET), and Skills Training and rehearsal. Virtual guided imagery is also used in the management of chronic pain and other medical problems. The literature has described applications with Specific Phobias (E.g. Anderson et al. 2006), Social Phobia (Robillard et al. 2010), Panic Disorder, PTSD (Roy et al. 2006), Depression (Chirita et al. 2006), and Anger (Myahira et al. 2010). There is evidence that, particularly in VRET, that emotions are accurately elicited and extinguished (Lamson 1997), that relapse rates are low (Stuart, Treat, and Wade 2005), and that the number of sessions required (compared to standard CBT) may be reduced (Wiederhold and Wiederhold 2005). The use of simulated environments also opens access to areas which would not normally be available to CBT. Some examples of this include legitimate doubts about safety in the early stages (Driving, poisonous animals), cost (flying), inability to reliably predict an event (Thunderstorms, flying ants), issues of confidentiality or social contamination (social phobia) or risk to others (anger, impulsivity). It may also assist where an ability to imagine or recall of events is poor, and in complex conditions such as schizophrenia (Zany et al. 2009). Matthew Wilcockson will introduce the current literature and research, and briefly describe a therapeutic and training use of Virtual Environments in CBT. Silvester Czanner will describe the development of new technologies, particularly focusing on Virtual EgoCentric Holistic Environments, which stimulate vision and hearing, and is based on acquired user based information. He will consider what the appropriate level of realism is required to provide an effective user immersive experience. These technologies will be demonstrated in the presentation. Sarah Parsons will review the use virtual environments to enhance social skills training in autistic clients, with specific reference to her current research. There will then be a demonstration of the technology by the team, with the virtual environment visible on the screen.

The story so far, and 2 clinical applications
Matthew Wilcockson, Coventry and Warwickshire Partnership Trust, and Coventry University
Virtual environments have been used in a as a therapeutic tool in the mental health field for about 15 years, and their use is increasing (Lambrey et al. 2010). Using highly realistic simulation, the client experiences three dimensional computer environments specific to their presenting problem, designed to help them overcome the said problem. Decreasing cost of this technology is now making ideas that people previously considered to be the territory of science fiction into a serious treatment option that can be cost-effective with common presenting problems. Within the context of Cognitive Behaviour Therapy (CBT), the 2 principal uses of virtual environments are Graded Exposure (VRET or VRGET), and Skills Training and rehearsal. Virtual guided imagery is also used in the management of chronic pain and other medical problems. The literature has described applications with Specific Phobias (E.g. Anderson et al. 2006), Social Phobia (Robillard et al. 2010), Panic Disorder, PTSD (Roy et al. 2006), Depression (Chirita et al. 2006), and Anger (Miyazaki et al. 2010). There is evidence that, particularly in VRET, that emotions are accurately elicited and extinguished (Lamson 1997), that relapse rates are low (Stuart, Treat, and Wade 2005), and that the number of sessions required (compared to standard CBT) may be reduced (Wiederhold and Wiederhold 2005). This paper will review the literature so far, and discuss a clinical and a training application of virtual environments.

Making it real: A review of the technological frontiers in virtual environments
Silvester Czanner, University of Warwick
The aim of this talk is to introduce a novel solution for Virtual Reality - Cognitive Behaviour Therapy based on Virtual EgoCentric Holistic Environments. This is an alternative to the classical virtual environments (VEs) currently used and it is built on acquired user-based information. The high-fidelity system is accompanied with several important attributes which will stimulate the human senses such as vision and hearing. An intensive study of these senses is leading us to answer an important question, what level of realism is required to provide effective immersive experience for the end users. We will demonstrate the potentials of the virtual egocentric holistic environments on several projects they require visuals and audio to provide an appropriate level of realism.

Applying CBT principles and techniques to interactive technologies for supporting social competence in children on the autism spectrum: the COSPATIAL project
Sarah Parsons, Southampton Education School, University of Southampton
The Communication and Social Participation: Collaborative Technologies for Interaction And Learning (COSPATIAL) project is a 3-year (2009-12) multidisciplinary project funded by the European Commission to develop innovative interactive technologies for school settings to support the learning and understanding of social skills for children on the autism spectrum. The project focuses on collaboration and social conversation as the two main social competencies and is informed by the principles and techniques of CBT to develop children’s understanding as well as skills. Our two main technologies - Collaborative Virtual Environments and Shared Active Surfaces ™ have been developed to provide opportunities for learning and reflection as well as direct experience or practice; thereby supporting cognition and behaviour through a combination of human (teacher or therapist) and technology-based mediation. This presentation will discuss how CBT principles and techniques have been distilled into the development of the technologies to support learning in educational contexts (we are not a clinical team and are not implementing CBT per se). A formal learning intervention study is currently underway and some preliminary data or impressions from the study will be briefly presented.

Interpersonal threat: Cognitive behavioural processes in social phobia and paranoia
Convenor: Lusia Stopa and Katherine Newman Taylor, University of Southampton and Hampshire Partnership NHS Foundation Trust
Persecutory delusions and the self: An investigation of implicit and explicit self-esteem
Katharine MacKinnon, University of Southampton & Hampshire Partnership NHS Foundation Trust; Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust; Lusia Stopa, University of Southampton
Persecutory delusions are proposed to be a defence against low self-esteem reaching conscious awareness (Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001). Key predictions of this proposal are that individuals with persecutory delusions will have lower implicit self-esteem and equivalent levels of explicit self-esteem compared to healthy controls. This study aims to test the predictions regarding implicit and explicit self-esteem in people with persecutory delusions. Of 22 people screened for persecutory delusions, 16 were recruited for the study. Twenty healthy control participants were recruited. The Implicit Association Test was used to measure implicit self-esteem and the Rosenberg self-esteem scale was used to assess explicit self-esteem. Positive and negative self and other schemas were also assessed using the Brief Core Schema Scales. People with persecutory delusions had positive implicit self-esteem, comparable to that of the control group. Explicit self-esteem was lower for the persecutory delusion group, but was associated with increased depression and anxiety. Negative self and other schemas were higher in the clinical group. The results do not support the contentment that persecutory delusions defend against negative self-representations and low self-esteem reaching conscious awareness. Non-defensive cognitive models are discussed as an alternative way of understanding persecutory delusions. (MacKinnon, K. et al. 2011). J. Behav. Ther. & Exp. Psychiat. 42, 54-64.

Group CBT for paranoia: A comparison of CBT based psycho-education and MBCT in a non-clinical sample
Kirsty Deas, University of Southampton; Lusia Stopa, University of Southampton; Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust
Conservative estimates indicate that at least 10-15% of the general population regularly experience paranoid thoughts (Freeman, 2007). There is now broad agreement that a continuum or ‘hierarchy’ of paranoia exists, from common social evaluative concerns with minimal impact on daily functioning, through to persecutory delusions experienced by a minority of individuals, which can significantly disrupt people’s lives (Freeman et al., 2005). Although the psychological literature now focuses more on understanding and intervening with specific psychotic experiences rather than broad diagnostic groups, there is currently little evidence for psychological interventions specifically for paranoia. This study investigated the value of two cognitive behaviour group therapies adapted for people with paranoia: Cognitive Psycho-Education (CPE) and Mindfulness Based Cognitive Therapy (MBCT). A non-clinical sample was recruited to the two group interventions (17 participants) and a no intervention control group (19 participants). Both groups ran for six weeks. The results showed significant improvements in measures of paranoia and distress in the CBT groups compared with the control group: (i) frequency of paranoid thoughts reduced in the CPE group; (ii) trust increased in the CPE group; (iii) stress decreased in the
CPE group; and (iv) depressed mood decreased in the MBCT group. No significant interactions were found between CPE and MBCT groups. Qualitative analysis of the process of change in the MBCT group revealed that participants had started to develop mindful responses to internal events over the course of the intervention, but that the practice was often experienced as effortful, and participants resorted to more habitual responses in the face of difficulty. Taken together, these findings suggest that CPE may be more effective than MBCT as a short term intervention for paranoia; mindfulness based interventions are likely to require commitment to a longer period of practice in order be effective. These results now require replication with clinical groups.

Working with the process as well as the content of thought in paranoia; The role of strategic cognition
Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust; Lusia Stopa, University of Southampton

Recent work in the area of cognition and emotion has focused on the process as well as the content of thought. Metacognitive approaches have included studies of people’s relationship with internal experience (cf. Teasdale and Barnard, 1993), and the overarching beliefs that guide allocation of internal resources to manage distress (cf. Wells, 2000). This presentation discusses three linked studies of ‘strategic cognition’ (following Wells, 2000) in paranoia. It is argued that these processes now need to be assessed routinely in our clinical practice, named in clinical formulation, and targeted in change based interventions.

The fear of others: A qualitative analysis of interpersonal threat in social phobia & paranoia
Lusia Stopa, University of Southampton; Ruth Denton, University of Southampton; Megan Wingfield, University of Southampton; Katherine Newman Taylor, University of Southampton & Hampshire Partnership NHS Foundation Trust; Nick Page, Institute of Psychiatry, Kings College, London; David Veale, Institute of Psychiatry, Kings College, London; Paul Salkovskis, Institute of Psychiatry, Kings College, London

As part of a wider study into treatment adjuncts for Cognitive Behavioural Therapy for Obsessive Compulsive Disorder (OCD), Imagery Rescripting as an experimental treatment adjunct was investigated for its efficacy in addressing Obsessive Compulsive symptomatology. The presentation will include an overview of the study as a whole and a more detailed look at one particular case. The study aimed to establish whether Imagery Rescripting could be an effective intervention for OCD. 10 participants were involved in a randomised case series. All participants were first involved in a semi-structured interview to establish imagery phenomenology and then randomized to 7, 14, 21 or 28 days where they received the imagery intervention. Outcomes were measured by idiosyncratic daily measures, weekly self-report measures and a weekly Y-BOCS clinician administered questionnaire. The subject presented here in more detail received an Imagery Rescripting session similar to that outlined in Arntz’s Treatment of Childhood Memories (1999). The case detailed in the presentation showed significant improvements on many of the measures following the imagery intervention. Imagery interventions show promise as treatment adjuncts to Cognitive Behavioural Therapy as usual for OCD and could be particularly useful in treatment resistant OCD. They are entirely consistent and therefore compatible with the Salkovskis (1999) model for OCD. Keywords: Obsessive Compulsive Disorder, Imagery. References: Arntz, A. Weertman, A. (1999) Treatment of childhood memories: theory and practice. Behaviour Research and Therapy, 37, 715-740. Salkovskis, P. M. (1999). Understanding and treating obsessive-compulsive disorder. Behaviour Research and Therapy, 37, s29-52.

Mental Imagery and Chronic Pain
David Gillanders, University of Edinburgh; Jennifer Lonsdale, NHS Tayside

On-going work from our lab indicates that a substantial number of pain patients (up to 40%) experience and can describe mental images related to their pain. We have now replicated this finding in three separate samples, totalling 372 individuals. The presence of pain related imagery is associated with increased anxiety, depression and catastrophising, but not increased pain. This presentation will give a brief background to the work we have done so far and describe some clinical characteristics of pain related imagery. The results of a novel experimental study will then be presented. In this study, people with chronic pain and related mental imagery completed visual analogue scales relating to pain and 5 basic emotions. They were then randomised to two experimental manipulations. In condition 1, participants viewed their pain related imagery, whilst in condition 2 participants read and considered pain relevant words that were descriptive of their pain. The study was within group design, all participants completed both conditions in randomised order. Following each condition they completed the same visual analogue measures of pain and basic emotions. Results showed that both verbal and imagery based processing of pain resulted in increases in negative emotions and decreases in positive emotions. The imagery condition also resulted in an increase in sensory pain, which was not observed in the verbal condition. The results
are discussed in relation to theories of pain, cognition and emotion. The presentation will provide delegates with an overview of this small field, describe research challenges and suggest next steps for both research and clinical practice.

Cognitions in Bipolar Affective Disorder versus Unipolar Depression: Imagining suicide
Susie Hales, Department of Psychiatry, University of Oxford; Guy Goodwin, Department of Psychiatry, University of Oxford; Emilie Holmes, Department of Psychiatry, University of Oxford
Bipolar disorder has the highest rate of suicide of all the psychiatric disorders. Suicidal ideation needs to be better characterised, and imagining suicide has been neglected. In unipolar depression, individuals report vivid, affect-laden images of suicide or the aftermath of death (‘flashforwards’ to suicide) during suicidal ideation but this phenomenon has not been explored in bipolar disorder. Therefore the authors compared imagery and verbal thoughts related to past suicidality in individuals with bipolar disorder (n = 20) and unipolar depression (n = 20). The study used a quasi-experimental comparative design. The Structured Clinical Interview for DSM-IV was used to confirm diagnoses. Quantitative and qualitative data were gathered through questionnaire measures (e.g. mood and trait imagery use). Individual interviews assessed suicidal cognitions in the form of (a) mental images and (b) verbal thoughts. All participants reported imagining ‘flashforwards’ to suicide. Both groups reported greater preoccupation with these suicide-related images rather than verbal thoughts about suicide. However, compared to the unipolar group, the bipolar group were significantly more preoccupied with ‘flashforward’ imagery, rated this imagery as more compelling, and were more than twice as likely to report that the images made them want to take action to complete suicide. In addition, the bipolar group reported a greater trait propensity to use mental imagery in general. Mental imagery of suicide may be a neglected feature of suicidal ideation, particularly in bipolar disorder. If so, it will warrant further investigation for clinical assessment procedures.

Using compassionate imagery to resolve shame based flashbacks
Deborah Lee, Berkshire Traumatic Stress Service

Understanding cognitive changes in imagery rescripting: Is the memory-self relationship the key?
Soljana Cili, University of Southampton; Lusia Stopa, University of Southampton
Imagery rescripting (IR) is a cognitive-behavioural technique which focuses on changing the meaning of negative or traumatic memories that are characterised by vivid images and are thought to be at the origin of negative core beliefs (Arntz & Weertman, 1999; Smucker, Dancu, Foa, & Niederee, 1995). Research focusing on different disorders has shown that it is an effective therapeutic technique as it addresses distressing images and alleviates disorder-specific symptoms even when administered in a single session or as a stand-alone treatment (e.g. Brewin et al., 2009; Rusch, Grunert, Mendelsohn, & Smucker, 2000; Wild, Hackmann, & Clark, 2007, 2008). The research conducted so far, however, has mainly focused on the impact of this technique on symptomatology, leaving aside the impact it has on the self. The aim of the current study was to address this issue by investigating the impact of one session of IR on the self in a non-clinical student population. In accordance with Brewin’s (2006) retrieval competition account of CBT, which argues that cognitive-behavioural techniques make positive self-representations more accessible and inhibit negative self-representations, and with Conway’s (e.g. 2005) self-memory system model, which postulates a reciprocal relationship between memory and the self, we predicted that one session of IR would lead to the activation of a more positive self and to more positive affect following memory recall. The study used a within-participants design and comprised three sessions. In the first session, participants recalled a specific negative experience and reported images, beliefs, and feelings associated with this memory. Following memory recall, they completed a series of self and mood measures. Approximately one week later, participants took part in one session of IR focusing on their negative memory. After rescripting, they completed some self and mood measures. The final session (one week later) had the same structure as the first session. Results showed that, in the final session, participants reported higher state self-esteem, higher positive affect, lower negative affect, and lower state anxiety following the memory recall than in the first session. They also reported a reduced strength of the belief encapsulated in their negative memory. There were no significant changes in any of the other variables under scrutiny (e.g. memory characteristics). The findings partly support the original hypothesis. Together with findings from other studies conducted in our lab, they suggest that, as a result of the change in meaning attached to the negative memory, IR helps individuals access a more positive self-representation when they recall this memory and it may do so even if the memory remains equally vivid and distressing. This study is the first one to date to focus on the impact of IR on the self and shows that the self as a whole, and not just negative self-beliefs, needs to be taken into consideration in therapy. As such, it may be the first step towards understanding the mechanisms of change operating in IR in particular and in CBT in general and towards finding ways in which they can be refined and made more effective.

2011: A CBM odyssey. Developing Cognitive Bias Modification as a novel computerized intervention
Convenor: Simon Blackwell, University of Oxford

Targeting maladaptive appraisals of negative intrusive memories in dysphoria: A comparison between computerised cognitive bias modification and a cognitive behavioural education session
Jill Newby, School of Psychology, The University of New South Wales; Tamara Lang, School of Psychology, The University of New South Wales; Emily Holmes, Department of Psychiatry, The University of Oxford; Michelle Moulds, School of Psychology, The University of New South Wales
This study sought to compare the efficacy of computerised bias modification (CBM) versus cognitive behavioural education (CBT) that aimed to target and alter negative appraisals of a negative intrusive autobiographical memory. Dysphoric participants (N = 51) provided baseline ratings of a negative intrusive memory. Impact of Event Scale scores, negative appraisals and avoidance responses. They were randomly allocated to receive one-session of CBM or CBT, or were allocated to wait-list (WL) control condition. Participants were followed up one week later to compare the efficacy of the interventions in reducing negative appraisals, intrusion-related distress, memory frequency and other intrusive memory variables. Results showed significant reductions between baseline and follow-up on measures of mood (depression and anxiety), intrusiveness (IES Intrusion), negative appraisals and rumination, regardless of group. The CBT group reported the greatest reduction in intrusion-related distress at one-week follow-up. The CBM group reported intermediate reductions in distress, whereas the WL group reported the smallest reduction. Our findings highlight the clinical utility of both CBT and CBM interventions in reducing intrusion-related distress by targeting maladaptive appraisals of intrusive memories.

Greater positive affect change after mental imagery than verbal thinking in a student sample
Sabine Nels, University of Leuven, Belgium; Koen Vanbrabant, University of Leuven, Belgium; Emily Holmes, University of Oxford, UK; Filip Raes, University of Leuven, Belgium
Previous experimental studies found that imagining positive events was superior to verbally processing the same events in producing positive affect, and further that field rather than observer perspective imagery had a more powerful impact (Holmes, Coughtry, & Connor, 2008; Holmes, Lang, & Shah, 2009; Holmes, Mathews, Dalgleish, & Mackintosh, 2006). Promoting positive affect is of clinical relevance. For example, depression is characterized by an absence of positive affect (e.g., Brown, Chorpita, & Barlow, 1998; GenAboz, 2002). Further, depressed mood appears to be associated with a deficit in imagining positive, but not negative, events (Holmes, Lang, Moulds, & Steele, 2008). This study sought to replicate previous work in a student sample, to determine whether the impact of positive imagery is more powerful than verbal thinking on measures of positive affect. Seventy-eight students listened to 100 positive events randomly allocated to one of three conditions: imagining them via a field or an observer perspective or listening to the same events while thinking about their verbal meaning. Positive affect was measured before and after the task. Positive affect change was greater after imagery (field and observer) than the verbal condition, replicating previous research (Holmes et al., 2006; Holmes et al., 2009). Contrary to predictions, there was no significant difference in affect change between the field and observer conditions. To explain the latter result, we reflect on methodological and motivational explanations. In conclusion, there was greater positive affect change after positive mental imagery than positive verbal thinking.

Can we use home computers to change the way that people think? Cognitive Bias Modification using mental imagery in depression.
Simon Blackwell, University of Oxford; Tamara Lang, University of Oxford; Catherine Harmer, University of Oxford; Phil Davison, University of Oxford; Emily Holmes, University of Oxford
Depression is characterized by negative interpretation biases (Beck, Rush, Shaw, & Emery, 1979), that is a tendency to interpret information in a negative way. Depressed mood is also associated with a deficit in generating positive imagery about the future (Holmes, Lang, Moulds, & Steele, 2008). A Cognitive Bias Modification (CBM) paradigm targeting both interpretation bias and positive imagery may therefore have particular potential in developing innovative treatments for depression (Holmes, Lang, & Deeprose, 2009). Initial support for the potential effectiveness of such a CBM paradigm in depression comes from a single case series investigation (Blackwell & Holmes, 2010). This study also provided valuable information as to how such a paradigm may need to be adapted for success as an innovative treatment in depression. We present a study that built on these initial findings by comparing the impact of repeated sessions of a ‘multi-component’ CBM to a control condition. The CBM incorporated three complementary paradigms: auditory presentation of training scenarios, a ‘picture-word’ CBM, and a CBM targeting appraisals of intrusive memories. Twenty-eight currently depressed individuals were randomly allocated to complete either positive imagery CBM or a neutral control condition daily at home over one week. Outcome measures were collected pre and post-treatment, and at a two-week follow-up. The results are discussed in relation to the development of novel computerized interventions for depression and future developments in this field.

Cognitive bias modification for attention and interpretation in a clinically anxious population: results from a pilot study
Laura Hoppitt, University of East Anglia; Lee Brosan, Cambridgeshire and Peterborough NHS Foundation Trust; Lorna Shalfier, University of East Anglia; Alison Sillence, University of East Anglia; Bundy Mackintosh, University of East Anglia
Highly anxious individuals show biases in their cognitive processing such that they have a tendency to interpret emotional ambiguity in a threatening way, and that they tend to focus on threat impacting aspects of the environment. These biases have been shown to be causally linked to anxiety vulnerability. Cognitive Bias Modification (CBM) refers to a constellation of techniques that attempt to directly modify these biases using computer based tasks designed to train attentional disengagement from threat, and positive interpretation of emotional ambiguity. Recent research suggests that CBM could be effective at reducing anxiety in a clinical population. However, most previous research focusses on re-training only one of these biases at a time. We attempted to re-train threat related interpretive and attentional biases simultaneously in a clinically anxious population to see whether this would increase its clinical impact. Furthermore, we wished to understand the patient experience of CBM in more detail. Thirteen clinically anxious individuals referred to an out-patient psychology service took part and received 4 sessions of Cognitive Bias Modification for attention and interpretation. The results suggested successful reductions in trait and state anxiety, as well as reductions in threat related attentional and interpretive bias. These results provide further indications of the benefit of CBM as a treatment tool. Comments from participants in the study also give insight into how CBM might need to be modified in order to make the final leap from the laboratory to the clinic.

The transdiagnostic approach: Perspectives on formulation, imagery, exposure and control
Convenor: Warren Mansell, University of Manchester

Trans-diagnostic case conceptualisation
Robert Dudley, Newcastle University
Case conceptualisation is the process of integrating the unique experience of the individual with psychological theory and is often described as a central process in effective therapy. Hence, a key question facing a clinician working from a cognitive behavioural perspective is which theory should be chosen as the basis of the conceptualisation with a particular client? This
question is addressed by first considering the strengths and limitations of the disorder specific and trans-diagnostic approaches. From this, the differences between the approaches are framed as a conundrum or puzzle that is solved through a principle based approach to case conceptualisation that allows clinicians to individualise therapy by selecting and incorporating the most appropriate theory and research be it disorder specific or trans-diagnostic. Furthermore, by considering how to achieve lasting improvement for the client it is argued that we should emphasise incorporating client strengths and resilience into both disorder specific and trans-diagnostic approaches. To achieve this we necessarily extend beyond consideration of models of disorders, and draw on models of wellbeing, and resilience, and so do require theoretical accounts not only of disorders but also of resilience. This process will be illustrated with reference to the key literature (summarised in Dudley, Kuyken and Padesky, 2011; Kuyken, Padesky and Dudley, 2009) but also through a case example.

Intrusive imagery across disorders – a transdiagnostic review
Lusia Stopa, University of Southampton
Intrusive images occur across a range of disorders and are often repetitive, uncontrollable, and distressing (Brewin, Gregory, Lipton, & Burgess, 2010). PTSD, acute stress disorder, and obsessive-compulsive disorder all include the presence of images as diagnostic criteria (DSM-IV-TR; American Psychiatric Association, 2000). In other disorders, such as social phobia, distorted negative images maintain distress and are key treatment targets (e.g. Clark & Wells, 1995). The distress associated with images is in part due to their capacity to act as emotional amplifiers. Holmes and Mathews (2010) argue that images trigger affective responses through direct influence on the brain’s emotional systems, through use of the same neural structures as perception, and through the activation of autobiographical memories. Distorted self-perceptions in which the self is seen as threatened or damaged, weak or vulnerable are increasingly recognised as crucial maintaining factors in many disorders (Stopa, 2009). Experimental studies show that negative self-images produce more fear and avoidance performance than images of social anxious/phobic participants (e.g. Hirsch, Clark, Mathews, & Williams, 2003; Hirsch, Meynen, & Clark, 2004; Stopa & Jenkins, 2007). These negative beliefs about the self become incorporated within the individual’s self-perception and then help maintain a vicious cycle of self-criticism, behavioural change (e.g. avoidance, withdrawal), and physiological and emotional responses. This paper will review the phenomenology of imagery in different disorders, the role of images in the maintenance of these disorders and will discuss treatment techniques that have been designed to modify these images.

Cognitive and behavioural maintenance processes as arbitrary control: A transdiagnostic approach
Trishna Patel, Stepping Stones, Oxleas NHS Foundation Trust
Cognitive Behaviour Therapy research to date has focused on studying the role of cognitive and behavioural processes in the development and/or maintenance of symptoms in specific psychological disorders. The transdiagnostic approach highlights the commonalities in these processes across multiple disorders (e.g. Harvey et al., 2004). To identify transdiagnostic processes of interest, a measure called the Cognitive and Behavioural Processes Questionnaire (CBP-Q) was developed. It incorporated questions to measure 18 different processes identified in the literature as transdiagnostic (e.g. self-focus, thought suppression, avoidance, worry). The CBP-Q was administered to a mixed clinical group (n = 80) and a control group: student (n = 172) and community (n = 57), to undertake preliminary analysis of its psychometric properties and its relationship with symptom-based measures. A principal component analysis resulted in a 13-item version of the CBP-Q, consisting of one theoretical construct. Based upon current literature, this theoretical construct was labelled as ‘arbitrary control’. Arbitrary control involves the attempt to control an experience (e.g. feelings, thoughts, mental processes), in a way that inhibits an import. For example, suppressing anger would be a problem to the extent that it blocks goals that may require the experience and expression of anger (e.g. to be assertive). Findings from the study suggest that arbitrary control may in fact be a transprocess - a process that represents the shared dysfunction of a range of processes in the literature - the theoretical implications of which will be discussed. Future research will be required to determine whether arbitrary control encapsulates the core process of psychopathology more accurately than alternatives (e.g. experiential avoidance, metacognitive beliefs, self-destructive social mentalities).

Exposure: A transdiagnostic element of successful cognitive and behavioural techniques
Timothy A. Carey, Centre for Remote Health, Flinders University & Charles Darwin University, Australia
It is perhaps unfortunate that when exposure was first developed as a therapeutic technique it was defined in terms of responses to feared stimuli. The unfortunate consequence of this has been that it has limited our understanding of exposure in both practice and research. If the focus shifts from the technique of exposure to the principle of exposure it becomes apparent that exposing people to material they would otherwise avoid is a fundamental property of all forms of therapy. Many apparently different techniques such as behavioural experiments, cognitive defusion, systematic desensitization, and cognitive restructuring can all be understood as different ways of promoting the common principle of exposure. Perceptual Control Theory (PCT) provides a theoretical framework that traverses the cognitive-behavioural divide by explaining the effects of exposure from a functional perspective (Carey, 2011). PCT suggests that exposure helps people to regain control through a greater awareness of important higher-order goals. Exposure, informed by PCT, may hold the key to understanding how effective psychotherapy is effective. Whether or not to use exposure should never be questioned. The far more important clinical questions include: what information to expose a particular client to, in what form (cognitive, behavioural, or both) should the exposure take place, at what pace should the exposure occur, and how much structure is needed for exposure to create its effects.

Understanding cognitive processes in depression: New insights from the laboratory
Convenor: Michelle Moulds, The University of New South Wales

The effect of rumination on the affective impact of positive experiences in depression
Kate Hetherington, The University of New South Wales; Michelle Moulds, The University of New South Wales
Engagement in positive reinforcing activities is a central component of behaviour therapies for depression. While behaviour therapy is known to be effective, positive material does not always have the expected affective consequences for depressed people. For example, recent studies from the memory literature have found that recalling happy memories does not repair sad mood in high dysphoric participants, and results in currently depressed participants feeling more sad.
One possible explanation for these findings is that when recalling happy memories high dysphoric participants adopt an abstract processing mode, akin to rumination, dampening the happy memories positive affective impact. Results of experimental investigations in to the affective consequences of adopting an abstract mode of processing with positive material (including happy autobiographical memories and a success experience) will be presented. Findings will be discussed in relation to theoretical and clinical implications for the treatment of depression.

The pain of being on the outside: Exploring how dysphoric participants respond to social rejection and subsequent social reclusion
Barnaby Dunn, MRC Cognition and Brain Sciences Unit, Cambridge; Jeanette Brodbeck, MRC Cognition and Brain Sciences Unit, Cambridge

Interpersonal processes are increasingly seen as key to depression (Joiner, 2000) and yet ways to understand and manage client’s interpersonal reactions are relatively under-specified in current CBT treatment approaches. For example, depressed clients in the clinic often describe feeling hyper-sensitive to signals of social rejection. Exactly how depression impacts on how people react to social rejection cues has been the focus of relatively little empirical research to date, however. This talk will present recent findings from our laboratory in dysphoric adults using the ‘O-CAM’ paradigm. In this task, participants are led to believe they have been socially rejected during an online web conference (Goodacre & Zadro, 2010). We examine how this social ostracism manipulation impacts on mood, psychophysiology responses, dysfunctional attitudes, perception of others, and generosity to others. Subsequently, we measure how participants react to social reincluision in a later conference. Implications for managing the interpersonal features of depression will be discussed.


Processing Mode in Mood Regulation: Why Depressed and Recovered Depressed Individuals Can’t Use Their Happy Memories to Improve Sad Mood
Aliza Werner-Seidler, The University of New South Wales; Michelle Moulds, The University of New South Wales

Recalling positive autobiographical memories is a powerful emotion regulation strategy that can be used to repair low mood and alleviate negative affect. However, unlike healthy individuals, those with current or previous depression do not experience an improvement in their mood as a consequence of recalling positive memories. In our study, we examined whether differences in processing mode might account for the impaired ability of these groups to use positive memories to regulate low mood. We instructed depressed and recovered depressed individuals (who were in a state of low mood) to recall a positive memory and think about it while adopting either an abstract, ruminative mode of processing or a concrete mode of processing. Participants in the abstract processing condition experienced no change in mood, while those in the concrete processing condition showed improved mood following positive memory recall. Our findings suggest that in the context of depressive disorders, the process by which positive memories are recalled is important in determining the emotional outcome.

Emotional reasoning processes in depression
David Berle, The University of New South Wales; Michelle Moulds, The University of New South Wales

Emotional reasoning is the use of subjective emotions rather than objective evidence to form conclusions about oneself and the world. We aimed to determine whether depression is characterised by emotion reasoning, as has been demonstrated for anxiety disorders. This presentation reports on a series of studies where emotional reasoning tendencies were assessed in a student sample, in high (BDI-II >= 14; n = 42) and low (BDI-II <= 4; n = 28) dysphorics, and in a community sample comprised of currently depressed, previously depressed and never depressed participants. In each study, participants provided ratings for a series of scenarios that varied in emotional tone (neutral vs dysphoric). High dysphorics tended to engage in emotional reasoning to a greater extent than low dysphorics, especially for self-referent ratings of situations (i.e., rating dysphoric scenarios about oneself more negatively than corresponding neutral scenarios). In the community sample, current and previously depressed participants engaged in greater emotional reasoning than individuals who have never been depressed. Although the differential ratings were small in magnitude and not always significant, these findings raise the possibility that emotional reasoning may characterise clinical depression and that it may become a “cognitive scar” that persists following the remission of a depressive episode.

Disgust across the disorders
Convenor: David Veale, Institute of Psychiatry, King’s College London

Vomiting is disgusting!
Ana da Costa, The Maudsley Hospital and Institute of Psychiatry, King’s College London; David Veale, The Maudsley Hospital and Institute of Psychiatry, King’s College London; Phillip Murphy, The Maudsley Hospital and Institute of Psychiatry, King’s College London; Nell Ellison, The Maudsley Hospital and Institute of Psychiatry, King’s College London

A specific phobia of vomiting (SPOV) is a chronic disorder, with a large gender bias towards women. Compared to other specific phobias, individuals with a SPOV are often significantly handicapped (for example, avoiding a desired pregnancy or escaping from their own children vomiting). We report on a survey of the phenomenology of 100 vomit phobics compared to community controls. We focused on their experience of safety seeking and avoidance behaviours including their disordered eating; their imagery and memories of vomiting; and the cognitive processes of worry and self-monitoring. The clinical implications of CBT for SPOV are discussed.

Moral Disgust and Mental Contamination in Obsessive Compulsive Disorder
Anna Coughtrey, School of Psychology and Clinical Language Sciences, Reading University; Roz Shafran, School of Psychology and Clinical Language Sciences, Reading University; Stanley Rachman, Department of Psychology, University of British Columbia

Patients with Obsessive Compulsive Disorder (OCD) often describe a fear of contamination that arises in the absence of physical contact with a contaminant. This experience of mental contamination is associated with physical, emotional or moral violation, morphing, immorality, betrayal and humiliation and leads to intense feelings of dirtiness, pollution and moral disgust (Rachman, 2006). This presentation will describe a case of mental contamination in a young woman with OCD.
where moral disgust was a prominent feature. It will focus on the features of moral disgust in the presenting problems and the impact on cognitive behavioural therapy (CBT) for OCD. Treatment involved 10 sessions of CBT following which the woman no longer met the diagnostic criteria for mental contamination or any mental health problem. These gains were maintained at 3 and 6 month follow up.

The baby and the bathwater: contamination fears in the postnatal period
Fiona Challacombe, Institute of Psychiatry, Kings College London and The Maudsley Hospital; Paul Salkovskis, University of Bath; Matthew Woolgar, Institute of Psychiatry, Kings College London and The Maudsley Hospital
Introduction: Obsessions and compulsions related to fear of contamination are common features of OCD during pregnancy and postnatally. By clinical definition these are time consuming and interfere with several aspects of functioning. For any mother the infant forms the dominant context in the postnatal months; a potentially serious issue in the case of postnatally occurring OCD is that the infant is often the focus of the obsessions, compulsions and avoidance. Method: Six mothers with young babies (6-14m) who had contamination OCD were treated with intensively delivered CBT as part of an ongoing treatment trial. Results: All mothers reported significant interference with parenting at the pre-treatment assessment. This included the OCD impairing their subjective experience of parenting as well as leading to restrictions around the infant and their activities. During treatment mothers challenged their fears with behavioural experiments including taking risks around the care of the infant. All mothers’ OCD and reported interference in parenting significantly improved with intervention which was maintained at follow-up. Conclusions: Postnatal contamination OCD causes significant functional impairment for the sufferer, and affects the daily tasks of childcare. These issues should always be explored and can form a useful set of treatment goals.

The experience of self-disgust (shame) in Body Dysmorphic Disorder
David Veale, The Maudsley Hospital and the Institute of Psychiatry, Kings College London; Rob Willson, The Institute of Psychiatry, Kings College London
The core experience of BDD is of excessive self-focused attention on a felt impression of a distorted body image and constant comparing and ruminating. The emotion is of self-disgust and shame. It is often fused with past aversive memories of being rejected and humiliated. The experience of BDD is discussed in terms of the beliefs about the cognitive processes and the use of imagery rescripting with some new data from individuals with body dysmorphic disorder.

Worry, negative mood and information processing
Convenor: Frances Meeten, University of Sussex
Chair: Graham Davey, University of Sussex

Catastrophic worry and systematic processing: Exploring an information processing account of perseveration
Suzanne Dash, University of Sussex; Graham Davey, University of Sussex
This experiment assessed the role of systematic information processing in mediating the facilitative effect of negative mood on worry. Participants were exposed to a negative (n = 30), neutral (n = 30) or semantic priming (n = 26) mood induction. Participants completed 100-point Visual Analogue Scales measuring mood (sad, happy), ‘As Many As Can’ (AMAC) stop rule deployment, systematic processing facilitators (responsibility, desire for control, accountability, need for cognition), and a catastrophising interview (behavioural measure of worry). Experimentally induced negative mood facilitated the endorsement of cognitive appraisals known to increase systematic information processing. In addition, a multiple-mediator analysis showed that a composite measure of the systematic processing facilitators together with a measure of AMAC stop rule deployment fully mediated the relationship between negative mood and a measure of worry frequency (Penn State Worry Questionnaire). These findings are consistent with the view that negative mood may cause perseverative worrying by facilitating factors known to influence the deployment of systematic information processing. Similarities and differences between systematic processing and chronic worrying, and implications for understanding worrisome thought will be discussed.

The role of specific negative moods in a mood-as-input account of perseverative worry
Frances Meeten, University of Sussex; Graham Davey, University of Sussex
Previous research has demonstrated that a combination of negative mood and rigorous ‘as many as can’ stop rules can be used to help explain a range of perseverative psychopathologies such as pathological worrying, compulsive checking, and depressive rumination (known as the mood-as-input hypothesis). This paper discusses a study designed to examine whether specific emotions of the same valence will have similar or differential effects on task perseveration. The study experimentally induced discrete moods and manipulated task stop rules in an analogue population, and found that perseveration at a worry-based interview task conformed to standard mood-as-input predictions in which perseveration was significantly greater when an ‘as many as can’ stop rule was paired with a negative mood or a ‘feel like continuing’ stop rule was paired with a positively valenced mood. The pattern of results revealed no significant inherent differences in processing depending on the type of discrete negative mood being experienced. Findings support a view of mood-as-input effects where overall valency is the important factor in determining perseveration.

Do children use mood as information when worrying?
Charlotte Wilson, University of Dublin, Trinity College
Childhood worry is a poorly researched and understood area despite it being a prevalent problem that has a significant impact on development. The mood-as-input theory attempts to explain why worriers persevere during individual worry bouts whereas non-worriers will stop much earlier on. There has been support for the theory in studies using adult populations, but no current research in children or adolescents. Sixty-eight young adolescents (aged 11-13 years) completed standardised measures about worry (PSWQ-C), beliefs about worry (COWS), and stop rule endorsement (SRC). They were also randomised into four experimental groups testing whether there was an interaction between stop rule and mood induction on perseveration of worry. During this procedure they tracked their mood and following it they answered some open ended questions about their experience. In general the results from the questionnaires mirrored those found in adult populations, with associations found between worry, beliefs about worry and stop rule endorsement, and differences in stop rule endorsement and mood found between high and low worriers. The experiment was less successful however, with the results indicating no interaction between mood and stop rule and the qualitative answers indicating some difficulties with
participants following the instructions. The discussion will focus on the developmental issues of testing perseveration in children and adolescents, including impact of emotional, cognitive and language development.

Implications of the mood-as-input hypothesis for clinical populations suffering pathological worrying
Graham Davey, University of Sussex
This paper discusses some of the reasons why clinical populations may be particularly vulnerable to mood-as-input processes that will generate perseverative worrying. In particular, mood is more likely to be used as information if the individual is in a negative mood, if the individual is unable to use more concrete or objective evidence to make decisions (e.g. because of poor problem-solving confidence or abilities), and if the individual deploys an information processing strategy that inflicts a high cognitive load (e.g. deploys systematic or deliberative processing during negative mood). These are all important characteristics of pathological worriers. Similarly, it appears to be core negatively valenced affect that provides the informational content in mood-as-input effects and so will contribute to the transdiagnostic nature of worrying Negative affect is also likely to lead to the deployment of stricter ‘as many as can’ stop rules for the task at hand and combine with negative mood to provide a configuration conducive to perseveration.

Working with service-users to develop a mood-as-input based approach to worry
Fergal Jones, Canterbury Christ Church University; Ruth Chandler, Sussex Partnership NHS Foundation Trust; Graham Davey, Sussex University
Mood-as-input theory offers an empirically supported account of the perseveration of worry in conditions such as generalized anxiety disorder. It emphasises the interaction between ‘stop-rules’ and mood. However, to the best of our knowledge, cognitive behavioural therapy has not yet made significant use of this theory. Therefore, our aim in this study was to begin to examine whether therapy techniques based on mood-as-input theory have the potential to help alleviate worry. We also wished to explore ways in which we could involve service users in the development of therapy techniques. To these ends, we ran a series of focus groups with service users who were troubled by worry. During focus group sessions and for homework, the service users were invited to try a number of mood-as-input based therapy techniques; for example, identifying their stop-rules, exploring the way in which they may interact with mood to lead to worry, and working to develop alternative stop-rules. In the latter part of each focus group session, the service users were invited to provide feedback on the techniques. They also each received an in depth individual interview after all the sessions had been completed. As well as reporting the initial findings of this consultation with service users, we also present some of our experiences of service user involvement in therapy development, and outline some of the benefits that we think this can bring, along with some of the challenges.

Skills Classes

Targeting Ruminatoin by Changing Processing Style: Experiential and Imagery exercises
Ed Watkins, University of Exeter
Rumination has been identified as a core process in the maintenance and onset of depression (Nolen-Hoeksema, 1991; 2000) and as a possible mechanism contributing to co-morbidity (Harvey et al., 2004). Furthermore, rumination seems to be a difficult-to-treat symptom, which is associated with poorer outcomes for psychological therapy. This workshop will illustrate how the CBT approach can be modified to reduce rumination in chronic, recurrent and residual depression, using new approaches derived from clinical experience and experimental research. A programme of research by Dr Watkins has suggested that the thinking style adopted during rumination can determine whether it has helpful or unhelpful consequences on social problem solving (Watkins & Moulds, 2005) and emotional processing (Watkins, 2004, 2008). This experimental work has inspired a novel approach to treating depression, called Rumination-focused CBT, which focuses on changing the process of thinking, rather than simply changing the content of thinking, in order to be more effective in successfully reducing rumination and treating depression. There is now empirical backing for the efficacy of this approach for difficult-to-treat patients in terms of a positive open case series (Watkins et al., 2007) and a randomised controlled trial funded by NARSAD. The workshop will review novel interventions within this approach focusing on use of imagery and experiential exercises.

Learning objectives:
1. To review elements of the rumination-focused CBT approach, including modifying thought-form-process, training in shifting thinking style, experiential exercises that counter rumination including relaxation, mental absorption and compassion
2. To illustrate treatment approaches to depressive rumination via video and experiential approaches
3. Workshop participants will have insight into CBT approaches for rumination in depression.
4. Workshop participants will practise novel process-focused techniques for changing patients relationship to their ruminative thoughts. Didactic, experiential, video
The workshop is designed for therapists with an intermediate knowledge of CBT.

Implications for the science and practice of CBT: A focus on changing style rather than challenging discrete negative thought.
Potential strategies to overcome blockages that occur in ruminative clients, especially in response to thought challenging.

Working with Metaphor and Metaphorical Imagery in CBT
Richard Stott, Institute of Psychiatry, King's College London
Metaphor is not only a fascinating phenomenon of language, but also of cognition more generally. Many therapists across a variety of disciplines have experimented with the use of metaphor, attempting to harness some of its intrinsic properties of effective communication, memorable imagery and ability to encapsulate meaning in a succinct way. Recently, there has been increased interest in metaphor use within cognitive behavioural therapy. This workshop will first provide a theoretical framework for conceptualising metaphor in CBT. At a practical level, common benefits and pitfalls of metaphor will be described, with reference to a variety of examples. Participants will have the opportunity to learn and practise skills relevant to the fruitful application of metaphor and metaphoric imagery, both therapist-generated and client-generated, through experiential exercises and audience feedback.

Learning objectives:
To provide participants with a conceptual framework, illustrative examples, confidence and skills to work creatively with metaphors and metaphorical imagery in therapy.

Training modalities:
Mixture of didactic, experiential, and audience participation.

This learning and skills from this workshop will be directly applicable in a therapeutic context, across a variety of clinics and diversity of settings. It will also foster the thoughtful integration of clinical art and clinical science, and encourage participants to develop and enrich their own clinical practice in an ongoing way.


Modern Statistical Techniques for Analysing Clinical Data
Andy Field, University of Sussex

The workshop has implications for evidence-based practice in that it will get participants to think about methods for analysing quantitative data collected in clinical settings. Data from clinical scales and clinical populations are often particularly prone to having non-normal distributions and missing data. Substantial skew has been shown in outcome measures relevant to clinical trials (Delucchi & Bostrom; 2004; Tang et al., 2005). This is true of both general measures such as economic and cost indicators (Barber & Thompson, 2000; Hlatky, Boothroyd, & Johnstone, 2002), quality of life (Aroztegui, Nunez-Anton, & Quintana, 2007) and social functioning (Tyrer et al., 2005), but also measures of disorder specific constructs such as mania (Picardi et al., 2008), suicidal ideation (Rinks et al., 2006) and depression (Rutter, & Miglioretti, 2003; Zimmerman, Chelminski, & Posternak, 2004). Bootstrapping and multilevel hierarchical modelling offer flexible and general alternatives to ‘traditional’ data analysis. Bootstrapping can be used to find SIs and CIs for any statistic, and multilevel models can be used to analyse data (such as RCTs) that have missing values. This workshop offers a primer on bootstrapping and hierarchical linear modelling and their application to clinical-relevant data using the computer package R.

Learning objectives:
- Understand issues frequently encountered with clinical data.
- Gain a conceptual understanding of bootstrapping.
- Gain a conceptual understanding of hierarchical linear modeling.
- Gain an impression of how to implement these techniques using the software R.

Open Papers

Martin Wolgast, Lars-Gunnar Lund, Gardar Viborg: Lund University

The last two decades has seen a rising discussion regarding the clinical usefulness of strategies focusing on changing versus accepting experiential content. Given this background, the purpose of the present study was to compare the effects of cognitive reappraisal and acceptance on subjective distress, physiological reactions and behavioral avoidance in relation to aversive emotional states elicited by film-clips. Ninety-four participants were randomized to one of three groups. The Reappraisal group was instructed to think about what they saw in a way that minimized negative emotional reactions, the Acceptance group was told to let their feelings come and go without trying to control or avoid them, while the Watch (control) group was told to watch the film-clips. Compared to the control condition, both reappraisal and acceptance led to significant reductions of subjective distress, physiological reactions associated with aversive emotions and behavioral avoidance. On the three types of measures there were few significant differences between the Reappraisal and Acceptance groups, but when such differences existed they were to the benefit of the Reappraisal condition. In the reappraisal condition there was however a positive correlation between elicited aversive emotion and avoidance, while no such correlation existed in the acceptance condition. The results are interpreted and discussed in relation to the theories underlying reappraisal and acceptance as well as the conceptual framework for emotion regulation established by Gross (2007). In conclusion, the present study expands the research on cognitive reappraisal and acceptance as emotion regulation strategies and provides several interesting findings on the similarities and differences of cognitive reappraisal and acceptance that is of interest to the theories underlying both traditional cognitive behavioral therapies and the so called third wave behavior therapies. The implication for CBT research and practice is that reappraisal and acceptance oriented approaches to aversive emotions share important common features but also seem to be distinct processes and potential mechanisms for change.

Deficits in Emotion Regulation Associated with Pathological Gambling.
Alishia Williams, Jessica Grisham, Alicia Erskine, Eva Cassedy, Clinical Research Unit for Anxiety and Depression, University of New South Wales

The concept of emotion-regulation features in many models of psychopathology and it has been proposed that individuals with poorly regulated emotions often engage in maladaptive behaviours to escape from or down-regulate their emotions, creating risk for a range of disorders. One such disorder may be pathological gambling. To our knowledge, no study had assessed the use of specific emotion regulation strategies in this population. The goal of the present study was therefore to examine emotion regulation difficulties among a sample of pathological gamblers (n = 56), a mixed clinical comparison group (n = 50), and a sample of healthy community controls (n = 54). Participants were recruited from the community and a gambling treatment unit in Sydney, Australia and completed clinical diagnostic interviews (ADIS-IV; SCIP), self-report measures of psychopathology (DASS-21), substance use (AUDIT), and emotion regulation difficulties (DERS; ERQ).

Multivariate analysis of variance (MANCOVA) controlling for age and gender revealed that pathological gamblers and the clinical comparison group reported significantly less use of reappraisal as an adaptive emotion-regulation strategy, and reported a greater lack of emotional clarity and impulsivity than individuals in the healthy community comparison group. Pathological gamblers also reported a greater lack of emotional awareness compared to the healthy control group and reported limited access to effective emotion regulation strategies compared to both comparison groups. The results support...
specific deficits of emotion regulation in pathological gamblers and emphasize the need to address these underlying vulnerabilities in addition to directly targeting gambling behaviours in therapy. The findings of the current study highlight the importance of cognitive behavioural approaches in the treatment of pathological gambling. More specifically, given the gamblers in the current study demonstrated limited access to effective strategies for managing difficult emotions, it is important that clinicians emphasize cognitive therapy as part of any comprehensive treatment package. Gamblers need to be able to recognize and modify unhelpful thinking patterns (both in relation to problem gambling situations and, more generally, to other life stressors) and individualized case formulations can help guide the clinician to the exact targets for each individual during therapy. It is also important that the clinician is aware of any deficits in emotion regulation strategies to ensure that the client is prepared to guard against relapse, given that the ability to tolerate distress is associated with increased length of abstinence from gambling. In addition, given the finding that gamblers are less aware of their feelings, mindfulness strategies may be useful to increase awareness of one’s emotions. This could potentially be helpful in reducing automatic and habitual responses, particularly in high-risk situations. Decreasing emotional avoidance through mindfulness may also assist pathological gamblers in better understanding the impact of various mood states on their behaviour.

The Bidirectionality Hypothesis: Are Clinical Constructs both Causes and Effects of Symptoms? Graham Davey, Gary Britton, University of Sussex

One way of testing the explanatory value of clinical constructs is to manipulate these variables under controlled experimental conditions and observe their effect on measures of symptoms. Most of the published research that has adopted this method has provided support for the clinical construct as a cause of symptoms and consequently has supported the use of that construct as part of an explanation of the psychopathology. However, very few studies have been conducted to investigate the opposite causal pathway - whether experimentally manipulating symptoms causes changes in measures of the construct. We describe a series of experiments that have manipulated mood-variability and clinical constructs related to OCD. The results suggest that experimental manipulation of clinical constructs such as inflated responsibility and intolerance of uncertainty cause increases in measures of negative mood (such as anxiety), and that manipulation of negative mood caused increases in measures of both inflated responsibility and intolerance of uncertainty. If such causal bidirectionality does exist, then this calls into question the explanatory value of the construct as a causal factor in the acquisition and maintenance of symptoms. The bidirectional nature of clinical constructs and symptoms suggests that clinical constructs may be more descriptive of psychopathology than explanatory, and this would need to be considered when designing interventions.

Do Socially Anxious Individuals Hold Positive Metacognitive Beliefs About Rumination? Quincy Wong, Michelle Moulds; University of New South Wales

The Self-Regulatory Executive Function (S-REF) model of affective dysfunction (Wells & Matthews, 1994) suggests that metacognitive beliefs are important for initiating and maintaining repetitive thought processes in emotional disorders. Consistent with this model, there is evidence that individuals with generalised anxiety disorder and depression hold positive metacognitive beliefs about the advantages of worry and rumination, respectively. Rumination is also reported by socially anxious individuals. Hence, given the pattern of transdiagnostic evidence, it was hypothesised that individuals with higher levels of social anxiety would report stronger positive metacognitive beliefs about rumination. The hypothesis was tested in two samples. In sample 1, 250 undergraduates completed measures of social anxiety, depression and positive beliefs about rumination. A hierarchical regression analysis was conducted with social anxiety as the dependent variable, and gender, depression and positive beliefs about rumination as predictors. In sample 2, 136 undergraduates completed measures of social anxiety, depression, rumination and positive beliefs about rumination. Another hierarchical regression analysis was conducted with social anxiety as the dependent variable, and gender, depression, rumination and positive beliefs about rumination as predictors. Consistent with prediction, across both samples, higher levels of social anxiety were associated with stronger endorsement of positive beliefs about rumination. This effect was obtained even when gender and level of depression were controlled (sample 1) and when gender, level of depression and level of rumination were controlled (sample 2), confirming that social anxiety and positive beliefs about rumination have a unique relationship that is independent of other variables. The results support the S-REF model, and raise the possibility that positive metacognitive beliefs about rumination may play a role in maintaining the ruminative process in socially anxious individuals. The next step in research will be to conduct experimental studies and attempt to manipulate positive metacognitive beliefs about rumination to see how this impacts on the extent of ruminative thinking that occurs (e.g., in relation to a social-evaluative event). If positive beliefs about rumination can lead to the engagement of the ruminative process, and given evidence that rumination is maladaptive, then this suggests that positive beliefs about rumination will need to be targeted as part of CBT for social anxiety.

Cognitive factors maintaining persecutory delusions in psychosis: the contribution of depression. Natasha Vorontsova, Institute of Psychiatry, King’s College London; Daniel Freeman, University of Oxford; Philippa Garety, Institute of Psychiatry, King’s College London

Persecutory delusions are one of the most common and distressing symptoms of psychosis (e.g. Appelbaum et al., 1999; Sartorius et al., 1986). Development of better treatments that have manipulated mood-variability and clinical constructs related to OCD. The results suggest that experimental manipulation of clinical constructs such as inflated responsibility and intolerance of uncertainty cause increases in measures of negative mood (such as anxiety), and that manipulation of negative mood caused increases in measures of both inflated responsibility and intolerance of uncertainty. If such causal bidirectionality does exist, then this calls into question the explanatory value of the construct as a causal factor in the acquisition and maintenance of symptoms. The bidirectional nature of clinical constructs and symptoms suggests that clinical constructs may be more descriptive of psychopathology than explanatory, and this would need to be considered when designing interventions.

A Social Rank Model of Psychopathology and Symptom Judgment

Alex M. Wood, University of Manchester; Gordon D. A. Brown, Peter J. Taylor, Christopher J. Boyce, and Karen Melrose

Within clinical psychology there is a common assumption that it is the objective level of a stimulus that predicts a psychological outcome. For example, that the actual amount of money a person earns predicts their levels of psychopathology and the number of days symptoms are experienced predicts subjective assessment of illness. In contrast, we present six studies suggesting that people are only sensitive to how they rank amongst other people rather than the objective characteristics that they possess. Studies 1 to 3 suggest that low social rank cognitions (a) prospectively predict...
suicidality and (b) are the mechanism through which many well-known risk factors of suicide operate in community and psychosis populations. In a 15 year annual panel survey of 30,000 people, Study 4 shows that psychopathology is prospectively predicted not by the actual money a person earns, but rather how their income ranks amongst similar others (e.g., people in the same region). In Study 5 and 6, people’s judgments of whether they are depressed are not predicted by how many days per week they have symptoms such as sadness, but rather how they perceive their levels of symptoms rank amongst what other people experience. The studies are consistent with evolutionary approaches suggesting that the rank concerns underlie disorders and recent work within cognitive psychology showing that judgements are based on the rank position of a stimuli rather than its absolute magnitude. The talk provides the first application of these findings to clinical psychology.

How does attention training work in social phobia: Disengagement from threat or reengagement to nonthreat?
Alexandre Heeren, Pierre Philipot: Universite Catholique de Louvain

Individuals with Social Phobia exhibit an attentional bias for threat in probe detection paradigms. Attention training programs, whereby probes always replace nontreat cues, reduce attentional bias for threat and self-reported as well as behavioral anxiety. However, it remains unclear whether the therapeutic benefits of attention training result from people learning to disengage attention from threat cues or learning to capture attention towards nontreat cues. In the present single-session experiment, Individuals with Social Phobia were randomly assigned to one of four conditions in which they were trained either to disengage their attention from threat cues, or to engage it towards nontreat cues, or to disengage it from threat cues and reengage it to nontreat cues, or to a control condition (i.e., no contingencies between cues and probes). The differential effects of the experimental manipulation were examined on physiological, subjective, as well as behavioral responses to a subsequent stressor, which was a speech performance. Results showed that training social phobics to disengage or to reengage cues reduces self-report and behavioral measures of threat. These effects were robust and significant in a 2 by 2 design, in which effects of training were compared between two groups of individuals with Social Phobia. The present study examined whether training a more positive interpretation bias or attention bias resulted in transfer of effects to the untreated cognitive domain. Ninety-seven first year undergraduates who had self-reported anxiety took part in the study. Participants were randomly allocated to four groups: attention training (n=24), interpretation training (n=27), control task training (n=24) and no training (n=22). Training was computer-based and took place in eight sessions over four weeks. Baseline and four-week follow-up measures of attention and interpretation bias were taken. Mixed repeated measures ANOVAs and paired sample t-tests revealed a significant reduction in interpretation bias in the attentional training group. The interpretation training group did not exhibit a significant reduction in attention bias. This was significant as compared with the control training and no training groups. There were no effects on self-reported mood measures. Whereas interpretation training did not modify attentional bias, attentional training successfully induced attention bias as measured by the dot probe, as well as transferring to the interpretation bias test. This suggests that attentional processing may precede stimulus appraisal and have broader cognitive effects than previously realised. First targeting attentional processes may facilitate down-stream restructuring of evaluative processing. Individual differences in basic attentional processing may influence how well an individual is able to challenge and re-evaluate currently held thoughts and beliefs in CBT. Attention bias modification could be used in the pre cognitive behavioural therapy phase, laying the foundation for cognitive restructuring during CBT. Cognitive bias modification also has the potential to be used as an adjunct therapy to CBT, for instance between sessions.

Prize Talk: Internet-based Cognitive Bias Modification: interpretation bias modification for anxiety in University students.
Jo Illingworth, University of Cambridge; Bundy Mackintosh, University of East Anglia; Colin MacLeod, University of Western Australia; Barney Dunn, Medical Research Council Cognition and Brain Sciences Unit, Cambridge; Adam Hampshire, University of Western Ontario; Laura Hoppitt: University of East Anglia

A tendency to interpret emotional ambiguity in a threatening way is a key characteristic of anxiety. Recent research has suggested that it is possible to retrain these maladaptive cognitions to be more positive by repeated computer based training. In a typical experiment, participants are presented with a series of 100 or more emotionally ambiguous scenarios and are encouraged by the task to form an image of a positive ending. This can induce a more positive interpretive bias and initial studies suggest that this is accompanied by reductions in anxiety and anxiety vulnerability. These types of training protocols are known as Cognitive Bias Modification for Interpretation (CBM-I). In the present study we assessed whether CBM-I could be delivered remotely (over the internet) to anxious students about to start university. One hundred participants were allocated to either a CBM-I condition or a placebo control condition. The control condition also carried out online tasks, but these were not expected to modify bias or anxiety (they were simple memory and attention games). All participants carried out five sessions of their tasks over the two weeks before they started university. The results suggest that over the course of the training, there were greater reductions in fear of negative evaluations in the CBM-I group as compared to the control group (who showed no change). However, there appeared to be no difference between the groups in trait and state anxiety, or positive and negative affect. We assessed participants again after four weeks of term. There was some evidence of a greater reduction in fear of negative evaluations in the CBM-I group as compared to the control. Interestingly, after four weeks state anxiety has reduced significantly more in the CBM-I group as compared to the control group. These results add further support to the hypothesis that negative interpretative biases play a causal role in anxiety. They also suggest that online CBM-I could be an effective treatment for anxiety and should be explored further.

It is about time: The effect of rumination on the maladaptive self-beliefs characteristic of social anxiety before and after a social-evaluative situation.
Quincy Wong, Michelle Moulds: University of New South Wales
At the core of the Clark and Wells (1995) model of social phobia, there are three types of persistent maladaptive self-beliefs (high standard, conditional, and unconditional beliefs) that lead an individual with the disorder to perceive danger in social-evaluative situations, and subsequently experience anxiety. One hypothesised process that reinforces these beliefs is ruminative thinking, which can occur either before or after a social-evaluative situation. To date, no studies have examined the impact of ruminative thinking on the three belief types. It was hypothesised that ruminative thinking would strengthen all maladaptive self-belief types relative to distraction both before and after a social-evaluative situation. Study 1 employed high (n = 40) and low (n = 40) socially anxious undergraduates and had participants engage in an anticipatory ruminative thinking task or a distraction task before participating in a social-evaluative speech task. Study 2 employed high (n = 46) and low (n = 47) socially anxious undergraduates and had participants engage in a social-evaluative speech task before engaging in either a post-event ruminative thinking task or a distraction task. In both studies, the strength of the three maladaptive self-belief types were measured before and after the induction tasks with the Self-Beliefs Related to Social Anxiety (SBSA) Scale. Study 1 found prior to the speech task, high socially anxious individuals who were instructed to engage in anticipatory ruminative thinking reported greater endorsement of high standard and conditional beliefs (but not unconditional beliefs) compared to those who distracted. Study 2 found high socially anxious individuals who participated in the speech task and were then instructed to engage in post-event ruminative thinking demonstrated a persistence of unconditional beliefs (but not high standard or conditional beliefs) relative to those who distracted. The obtained effects in both studies were specific to high socially anxious individuals. Our hypothesis was only partially supported. The studies suggest that rumination can strengthen maladaptive self-belief types, but the period in which ruminative thinking occurs is an important determinant of the type of belief that is strengthened. Ruminative thinking is a relatively maladaptive process for socially anxious clients. Hence, it needs to be assessed and targeted as part of CBT for social anxiety. Furthermore, the two studies suggest that high standard and conditional beliefs should be addressed using CBT for time periods before a social-evaluative situation, and unconditional beliefs should be addressed using CBT for time periods after a social-evaluative situation.

Observer Perspective Imagery in Social Anxiety: Effects on Negative Thoughts and Discomfort.

Lydia Kearney, Julie Morgan, Kingston University

Observer perspective imagery is hypothesised to have wide ranging deleterious effects in social anxiety. This study examined the ways in which imagery perspective influenced negative thoughts and level of discomfort during a conversation. High and low socially anxious individuals were assigned to an observer or field perspective imagery induction condition. The effects of imagery type on negative thoughts and discomfort experienced were assessed using questionnaires. Participants with high (n = 24) and low (n = 24) social anxiety, as measured by the Social Phobia and Anxiety Inventory engaged in an imagery task to focus their attention on an observer or a field perspective image of the situation. They then took part in a semi-structured conversation with the experimenter. Following this, participants completed the Negative Thoughts Questionnaire, and the Discomfort Scale. Group comparisons showed that the high socially anxious group rated the images they formed as clearer, more realistic, and easier to keep in mind than the low socially anxious groups. Univariate analyses showed that high socially anxious individuals reported experiencing more negative thoughts and feelings of discomfort during the conversation, regardless of imagery type used. Univariate analyses also showed that participants who focused on an observer perspective image reported more discomfort than those who focused on a field perspective image, regardless of anxiety group. The findings support the possibility that images of social situations are particularly salient for socially anxious individuals. The findings also support cognitive models which suggest socially anxious individuals experience negative thoughts during social situations. The results also tentatively support the possibility that observer perspective imagery may have a causal role in social anxiety, possibly by causing a negative emotional response to the situation, which may then be reflected upon in maladaptive fashions and play a role in the provenance of more cognitive social anxiety. Results are discussed in the context of cognitive theories and therapies. This study supports the use of imagery modification as an element of CBT for social anxiety. The clarity, realism and persistence of both types of images for socially anxious individuals suggests that field perspective images in socially anxious people may warrant further investigation.

Ewww, gross! Disgust is resistant to extinction: Implications for the treatment of anxiety disorders.

Elizabeth Mason, University of New South Wales & Clinical Research Unit for Anxiety and Depression (CRuAD); Rick Richardson, University of New South Wales; Jonathan Gaston, Emotional Health Clinic, Macquarie University; Andrew Page Anxiety disorders have traditionally been conceptualised as involving maladaptive fear responses. However, there is growing awareness that dysfunctional disgust responses play a key role in certain anxiety disorders, such as phobias of blood and spiders as well as obsessive compulsive disorder and post-traumatic stress disorder. Indeed, the disgust response is often more prominent than the fear response. The “gold standard” treatment for anxiety involves gradual exposure to feared objects and situations. Although exposure is effective in reducing fear responses, little is known about its efficacy in targeting disgust responses. Our research examines this using a laboratory model of exposure (extinction). Participants were first year psychology students. In study one, participants underwent disgust conditioning and half of the participants underwent extinction. In study two, participants were randomly assigned to disgust or fear conditioning and extinction. Disgust was measured using both self-report ratings as well as an objective behavioural measure, visual avoidance. This research indicates that unlike fear, learned disgust reactions are resistant to extinction, as indexed by both self-report and visual avoidance. That is, despite extinction, disgust responses did not decrease. This research, which extends other studies in the field, suggests that exposure treatments for anxiety may not adequately target disgust reactions. Potential strategies for treating excessive disgust responses are being explored and will be discussed in the context of a group treatment program for blood-injection-injury phobia that we have recently established. This research suggests that clinicians should consider maladaptive disgust responses in their treatment of individuals with certain anxiety disorders.

Posters

Can positive affect broaden the scope of attention?
Emma Hill, MRC Cognition and Brain Sciences Unit; Fionnuala Murphy, MRC Cognition and Brain Sciences Unit; Cristina Ramponi, MRC Cognition and Brain Sciences Unit; Philip Barnard, MRC Cognition and Brain Sciences Unit

It has been shown that positive affect has the potential to broaden the scope of attention in certain situations (Rowe, Hirsh and Anderson, 2007). This study aimed to determine whether the relationship between positive affect and the scope of attention extends to positive stimuli that involve complex cognitive processing. It additionally addressed whether directing
the focus of attention to one’s mood influences the relationship. Sixty-eight healthy participants completed an adapted flanker task at baseline before viewing positively- or neutrally-captioned cartoons that were designed to induce positive or neutral mood. During this induction a series of questions encouraged participants to focus on either their mood or on the properties of the cartoon picture itself. Following the mood induction, participants completed the flanker task a second time. The results showed that relative to the neutral mood condition, a positive mood induction resulted in increased interference from incompatible distance from the central letter. This difference between the furthest pattern of results is consistent with a broadening of spatial attention due to positive mood. Whether or not participants were directed explicitly to focus on their mood did not affect the pattern of results. Positive mood induced using cartoon stimuli resulted in a broadening of the scope of spatial attention. Whether participants were required to focus attention on their own mood or properties of the induction stimuli, however, did not influence this broadening effect. These findings extend work showing that positive affect induced via musical mood manipulation broadens cognitive processing, demonstrating that more cognitively-generated routes to positive mood can similarly broaden the scope of attention. This knowledge adds to the growing literature on mood-cognition interactions. Implications for the science and practice of CBT: This study contributes to the knowledge of the relationship between positive emotion and cognitive function.

A prospective study using structural equation modelling to identify a core process that predicts psychological distress

Timothy Bird, University of Manchester; Warren Mansell, University of Manchester; Maria Faruq, University of Manchester; Sara Tai, University of Manchester

According to the transdiagnostic approach to CBT, there exist a number of cognitive and behavioural maintenance processes that are elevated for individuals with a range of disorders, and targeting these during therapy will enable the development of simple interventions that are effective across disorders. There is recent evidence that the multitude of processes that have been identified are very similar and may actually represent different aspects of a small number of core processes (Field & Cartwright-Hatton, 2009; Aldao & Nolen-Hoeckema, 2010). Structural equation modelling (SEM) has previously been shown to be an effective way of exploring the presence of these core processes (Field & Cartwright-Hatton, 2009). Here, SEM was used to investigate the existence of a single cognitive process that predicts depression. Two models were constructed: the first treats measured cognitive processes (e.g., rumination, worry) as separate predictors of depression, while the second treats them as indicators of a single, higher-order latent variable. Goodness-of-fit tests suggest that the best conceptualisation of these processes as explanations of depression is provided by the single latent factor model. A factor analysis was then carried out to explore this latent factor. The results of this analysis are consistent with the hypothesis that the common factor model is better able to predict depression than the separate process model.

The differential effects of negative mood, intolerance of uncertainty, and problem-solving confidence on systematic information processing and worry

Suzanne Dash, University of Sussex; Graham Davey, University of Sussex

Three experimental studies manipulated characteristics relevant to chronic worriers (Experiment 1: negative mood; Experiment 2: intolerance of uncertainty, IU; Experiment 3: problem-solving confidence, PSC) and examined whether these characteristics affected systematic processing and worry levels. Participants underwent vignette-based manipulations of mood (negative, neutral or semantic priming), intolerance of uncertainty (IU; high vs. low), or problem-solving confidence (PSC; high vs. low). Participants completed 100-point visual-analogue scales measuring systematic processing facilitators (responsibility, desire for control, accountability, and need for cognition), and also completed a catastrophising interview (behavioural measure of worry) and the Penn State Worry Questionnaire. The negative mood group scored higher on a composite measure of the systematic processing facilitators, whereas the high IU and the low PSC groups did not show increases on the systematic processing facilitator composite. The negative mood group and the high IU group showed increases on the Penn State Worry Questionnaire and a trend towards generating more steps on the catastrophising interview, whereas no difference in worry scores was found between the high and low PSC groups. The results support the literature showing that negative mood increases cognitive appraisals that raise an individual’s sufficiency threshold (required amount of processing) and facilitate systematic processing. Future work will examine whether the differential effects on systematic processing facilitators are because negative mood affects threat perception (and raises sufficiency thresholds) while IU and PSC manipulate perceived ability to cope, which would be consistent with the literature showing lower self-efficacy beliefs reduce deployment of systematic processing. Worriers may experience conditions and appraisals that increase their desire to systematically process (e.g. negative mood, accountability, responsibility, desire for control, and need for cognition). Implications for the science and practice of CBT: An awareness that negative mood can lead to perseverative worry may help clients understand that their worrying is not necessarily reflective of a problem that requires effortful, analytical systematic processing. Similarly, the low self-efficacy beliefs that may be caused by feelings of intolerance of uncertainty and poor problem-solving confidence may increase clients’ use of the ‘feeling heuristic’ (how do I feel about this?) alongside their systematic processing. This increases sensitivity to their negative mood, and hence the cycle of perseverative thinking propagates as the negative mood signals the need for systematic processing of the issue. Consequently, practice could also focus on feelings of intolerance of uncertainty and poor problem-solving confidence in clients presenting with high levels of worry.

Specificity of intolerance of uncertainty in obsessive compulsive disorder and generalized anxiety disorder: An analogue study

Anna Goodson, Newcastle University; Karen Price, Newcastle University; Mark Freeston, Newcastle University

Intolerance of Uncertainty (IU) is an important cognitive phenomena that is prevalent across anxiety disorders (Starcevic & Berle, 2006). Its relationship with worry is well established (Ladouceur, Blais, Freeston, & Dugas, 1998) and research has indicated it is also associated with OCD with (Tolin, Abramowitz, Brigidi, & Foa, 2003). This has implications for treatment and it seems necessary to understand the nature of IU in terms of its broad and narrow specificity across different symptom profiles. Previous studies have been limited by design and measurement problems that this study is able to address to some extent. This study aimed to investigate the narrow specificity of components of IU to symptoms of GAD and OCD when controlling for the shared variance between these disorders. Research to date has been subject to measurement limitations of this construct and, to combat this, the current study used two measures of uncertainty: The Intolerance of Uncertainty Scale (IUS) and the Tolerance of Uncertainty (TU) domain of the ‘Obsessive Beliefs Questionnaire’ (OBQ-87). These questionnaires, along with symptom measures (Penn State Worry Questionnaire and the Obsessive Compulsive Inventory-Short Version) and measures of mood and related constructs, were completed by healthy volunteers (N=200, 153 women, 47 men, mean age 21, SD 6.02). Factor analysis identified two components in the IUS, namely, Desire for Predictability and...
Uncertainty Paralysis. There was a degree of overlap between the OBQ-TU and the IUS factors, but they appear to also measure separate constructs. Multiple regression analysis suggests that when controlling for the other uncertainty components, specific patterns arise in predicting GAD and OCD symptoms. Specific patterns are always found in the test of narrow specificity where the common variance between GAD and OCD symptoms are partialled out. The implications for the conceptualization and measurement of IU may be discussed with respect to GAD and OCD. The status of the construct is complicated by some recent research and some revised models for future research in this area. Implications for the science and practice of CBT: The finding that separate components of IU had differential contribution across disorders has potential implications for treatment. Specifically targeting separate components of IU, as opposed IU as a whole, may be fruitful for future intervention.

Mindfulness and Worry: The effect of attention control
Ben Ainsworth, University of Southampton; David Baldwin, University of Southampton; Paul Chadwick, King’s College, London; Matt Garner, University of Southampton

Attentional resource allocation towards worrisome thoughts reduces the resources available for goal-directed processing (Eysenck et al., 2007). Mindful individuals may be more adept at efficient and appropriate allocation of attentional resources toward goal-related cognitions, and away from worrisome thoughts. We predicted this relationship to be mediated by attention control; individuals better able to allocate their attentional resources would be able to focus on the 'objective view of the present moment' endorsed by mindfulness, thereby reducing worrying. 114 unselected participants completed 3 self-report measures: the Mindfulness Attention Awareness Scale (MAAS; Brown & Ryan, 2003), the Attentional Control Scale (ACS; Derryberry & Reed, 2001) and the Penn State Worry Questionnaire (PSWQ: Meyer, Miller, Metzger & Borkovec, 1990).

We examined the mediating effects of attention control subfactors: attention focusing and attention shifting, on the mindfulness-worry relationship. The mediating effect of attention focusing was significant, 
R^2 = .22, F(1, 112) = 17.77, p < .001, using the MPlus test (Preacher & Hayes, 2008). Significant confidence intervals, 95% CI: attention-focus (-.24, -.07), 95% CI: attention-shifting (-.16, -.00), demonstrated the full mediation of the mindfulness-worry relationship by both attention control subfactors. Mediation by both attention focusing and shifting highlights the integral role of attentional control skills in the relationship between mindfulness and worry, allowing individuals to maintain 'mindful' cognitions and abstain from worrisome tendencies. Through the understanding of the importance of goal-directed attentional resources to cognitive functioning, our study provides legitimacy for the increasing role of mindfulness as a treatment for anxiety and mood disorders. Implications for the science and practice of CBT: Mindfulness is an increasingly common method of treatment for sufferers of anxiety and mood disorders. However, there is some debate in the efficacy of attitudinal and cognitive therapies. Implications for the science and practice of CBT: Mindfulness may be an increasingly important method of treatment for sufferers of anxiety and mood disorders. However, there is some debate in the efficacy of attitudinal and cognitive therapies.

Identification bias of emotional facial crowds in Social Anxiety
Morgane Vanhaelen, University of Louvain; Celine Douillez, University Charles de Gaulle- Lille; Vincent Yzerbyt, University of Louvain; Pierre Philippot, University of Louvain

We investigated whether socially anxious individuals present a biased negative evaluation of facial crowds (e.g., faces combinations). Facial crowds were connoted positively or negatively by different ratios of neutral: angry: happy faces. Twenty highly socially anxious (SA) participants and 19 non-anxious controls (NACs) were asked to assess two dimensions of evaluation: disapproval and emotional cost for interacting. We postulated that SAs would rate more negatively predominantly disagreeing audiences as compared to NACs for both evaluations. Second, we expected different patterns of response for 2 types of neutral crowds. Specifically, no differences should be observed for crowds with only neutral faces but SAs should rate more negatively crowds with mixed emotional faces (6 angry, 6 happy and 4 neutral). Results supported the two hypotheses, even though for the evaluation of disapproval the difference between the groups was nearly significant. These findings highlight that socially anxious individuals present a negative evaluative bias towards disapproving emotional facial expression when presented as complex stimuli with conflicting information. Implications for the science and practice of CBT: If socially anxious individuals present an interpretive bias of facial expressions, it would be interesting to develop a training program focused on the interpretation of emotional facial expressions.

The development and validation of a measure of maladaptive self-beliefs related to Social Anxiety
Quincy Wong, University of New South Wales; Michelle Moulds, University of New South Wales

According to prominent models of social phobia, individuals with this disorder engage in cognitive and behavioural processes that reinforce maladaptive beliefs about how they should act and about perceived danger in social-evaluative situations. In particular, Clark and Wells (1995) proposed three types of maladaptive self-beliefs: high standard beliefs (e.g., “I have to appear intelligent and witty”), conditional beliefs (e.g., “If people see that I’m anxious, they’ll think that I’m weak”), and unconditional beliefs (e.g., “People think badly of me”). These beliefs are theoretically important in that they account for the persistence of social anxiety, yet to our knowledge there is no measure of these beliefs in the social anxiety literature. The current study aimed to develop a measure of these maladaptive self-beliefs. A sample of 93 undergraduates rated 49 unconditional beliefs adapted to the extent to which they applied to SA and low in social anxiety as non-rationales. The SBSA was designed to tap the three types of maladaptive self-beliefs: the high standard beliefs, conditional beliefs, and unconditional beliefs. The three factors accounted for 57.76% of the variance. Interpretation of the factor loadings indicated a first factor which represented the conditional beliefs, a second factor which represented the unconditional beliefs, and a third factor which represented the high standard beliefs. The SBSA was more strongly correlated with measures of social anxiety (r = .54-.66) than with a measure of depression (r = .36). The test-retest reliability of the SBSA was .79. Cronbach’s alpha for the SBSA was .93. The SBSA is a measure of the three types of maladaptive self-beliefs proposed by Clark and Wells (1995). The validity of the measure was also demonstrated with the SBSA having higher positive correlations with measures of social anxiety than with a measure of depression. The test-retest reliability and internal consistency of the SBSA were satisfactory. This study suggests that the SBSA is a valid and reliable measure of the maladaptive self-beliefs characteristic of social anxiety. Implications for the science and practice of CBT: The SBSA may be administered as an assessment instrument to a
client presenting with difficulties related to social anxiety, with the expectation that an individual with higher levels of social anxiety would score higher on the SBSA. The SBSA may also indicate specific self-belief types that may be held by a client, and that need to be challenged as part of CBT. The SBSA may be administered at post-treatment; pre- and post-treatment SBSA scores can then be compared to ascertain changes in the strength of maladaptive self-beliefs.

The relationship between automatic thoughts and needs of social comparison in female Japanese University students
Kumiko Yoshitake, Nagasaki Junshin Catholic University; Tamae Fujiwara, Nagasaki Junshin Catholic University; Nao Koizumi, Nagasaki Junshin Catholic University
Adolescents tend to frequently compare themselves with similar others. Social comparison has many positive effects, for example, self evaluation or self enhancement, but Ogasawara (2007) showed that those who have strong tendency to compare themselves with others score highly on the GHQ (general health questionnaire). The present study investigated the effects of automatic thinking of those who are liable to compare on mental health. The social comparison orientation test (SCOT; Sotoyama,2002), the GHQ-28, the automatic thinking test in four scenes (Kasori, 2009; free answer), and the Japanese version of the Irrational Belief Test (Mori, et al,1994) were administered to 160 female university students with a mean age of 19.39. High scorers of social comparison orientation test (SCOT) had poorer mental health than low scorers (t(143) = 4.26, p < .01). By categorization of their free answers on the automatic thinking test, differences were found between high SCOT scorers’ automatic thinking and low scorers’ ones. In three of four stressful scenes, high SCOT scorers showed more negative automatic thinking than those with low SCOT. In one scene, high SCOT showed more negative automatic thinking than low SCOT (t(2)=9.76,df=3,p<.05), such as more “maladjustment feelings” (p=0.10) and “less clear-cut attitudes” (p<.10). In addition, for high SCOT, over generalizations were found. The results of present study suggest the process by which social comparison may lead to poor mental health. We suggest that tendencies to compare oneself with others are hidden in the negative automatic thinking in adolescents.

Behavioural Medicine

Keynote

50 Years of Behavioural Medicine and CBT in Physical Health Care
Professor Craig White, University of the West of Scotland
The emergence of behavioural medicine, the application of the biopsychosocial model and the development of cognitive behaviour therapy (CBT) in physical health care settings have several facets in common with the development of CBT in general over the same period. Increasing technological advances in medicine and biomedical science have understandably influenced the nature of healthcare system responses to health, well-being and treatment. Over the past two decades the increasing prevalence of long term medical conditions and general interest in psychological dimensions of physical health have positively influenced work to examine cognitive behavioural dimensions of physical ill health, the application of CBT to co-morbid physical and health problems and the development of specific CBT protocols for conditions such as cancer, rheumatoid arthritis, fatigue, pain and tinnitus. As with developments in CBT for mental health care, CBT training developments have been developed for general nurses, physicians and healthcare professionals, and are now being used to enhance psychological care provision. There has also been a proliferation of guided self-help materials and CBT principles are being successfully applied in self-management programmes for long term medical conditions. Elements of CBT practice such as agenda setting are also being incorporated into self-management support initiatives. Although undoubtedly many more people are benefiting from CBT for problems associated with physical ill health in 2010 than was the case in 1960, the scope and nature of patient, system and societal benefits may require further changes in approaches and models of care delivery to address the needs of all who might benefit.

Symposia

Chronic Fatigue Syndrome: Treatment evidence and predictors of outcome
Convenor: Trudie Chalder, Institute of Psychiatry, King’s College London

Comparison of pacing, cognitive behaviour therapy, graded exercise therapy and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial
Trudie Chalder, King’s College London; Katharine Rimes, Bath University; Sam Lloyd, King’s College London ; Ann Kristin Knudson, King’s College London
Background: PACE (Pacing, graded Activity, and Cognitive behaviour therapy: a randomised Evaluation) was designed to compare the therapies of adaptive pacing therapy (APT), cognitive behaviour therapy (CBT) and graded exercise therapy (GET), when added to specialist medical care (SMC), with SMC alone; (b) compare APT against CBT and GET; and (c) examine these comparisons in sub-groups satisfying different diagnostic criteria for CFS and ME. Methods: 640 patients attending secondary care clinics with chronic fatigue syndrome (CFS) were recruited. Clinical psychologists or cognitive behavioural nurse therapists, physiotherapists or exercise physiologists and occupational therapists delivered CBT, GET and APT respectively. Co-primary outcomes were the Chalder fatigue questionnaire and the SF36 physical function sub-scale. Findings: We recruited 641 eligible patients. Compared with SMC alone, mean fatigue scores at 52 weeks were 3.4 (95% CI 1.8 to 5.0) points lower for CBT (p=0.0001) and 3.2 (1.7 to 4.8) points lower for GET (p=0.0003), but did not differ for APT (0.7 [0.9 to 2.3] points lower; p=0.38). Compared with SMC alone, mean physical function scores were 7.1 (2.0 to 12.1) points higher for CBT (p=0.0068) and 9.4 (4.4 to 14.4) points higher for GET (p=0.0005), but did not differ for APT (3.4 [1.6 to 8.4] points lower; p=0.18). Compared with APT, CBT and GET were associated with less fatigue (CBT p=0.0027; GET p=0.0059) and better physical function (CBT p=0.0002; GET p=0.0001). Discussion: CBT and GET can safely be added to SMC to moderately improve outcomes for chronic fatigue syndrome, but APT is not an effective addition.

Cognitive behavioural therapy (CBT) has been found to be effective in reducing fatigue and improving school attendance in young people with CFS. However, attendance at regular face-to-face appointments is not always possible, with many adolescents finding it difficult to travel to specialist units due to distance or travelling time. There is a need to develop evidence-based minimal interventions which provide an alternative for those for whom traditional clinic-based sessions are unsuitable. The objective of this study was to evaluate the efficacy of a telephone-based guided self-help intervention in reducing fatigue and improving school attendance in adolescents with CFS. A non-randomised longitudinal study with baseline measure. Participants were recruited from a specialist chronic fatigue unit, with 63 11- to 18-year-olds (23 male, 40 female) assigned to receive the intervention. Adolescents received a face-to-face assessment and were given a self-help manual based on the cognitive behavioural model of CFS. Participants received 6 fortnightly telephone conversations with a CBT therapist, lasting up to half an hour, over a 3 month period, as well as two follow-up sessions. The primary outcomes were fatigue and school attendance rate, with the main time-point for assessing outcome at 6 months follow-up. Reported fatigue was found to be significantly reduced at six-month follow-up, with the decrease observed during treatment found to be significantly greater than that between baseline and pre-treatment. A significant increase in school attendance was also found between pre-treatment and 6 month, although the increase during treatment was not significantly greater than that between baseline and pre-treatment. Baseline perfectionism was found to be associated with poorer school attendance at six-month follow-up. Telephone-based guided self-help is an acceptable minimal intervention which is efficacious in reducing fatigue in adolescents. Although improvement was seen for school attendance, this cannot be attributed to the intervention alone. Baseline levels of perfectionism may be important in predicting school attendance in response to an intervention.

Long term sickness absence among patients with chronic fatigue syndrome
Ann Kristin Knudsen, King’s College London; Max Henderson, King’s College London; Sam Harvey, King’s College London; Trudie Chalder, King’s College London
Chronic fatigue syndrome (CFS) is associated with high levels of occupational disability. Consecutive outpatients at a CFS treatment service were studied for associations between occupational status, symptom severity and cognitive and behavioural responses to symptoms. All patients had high symptom levels, however, those on long-term sickness absence had significantly more physical fatigue ($β=0.098$, p<0.05) and worse sleep ($β=-0.075$, p<0.05). Patients with long-term sickness absence also demonstrated more avoidance avoidance cognitions ($β=0.086$, p<0.05) and avoidance-resting behavioural responses ($β=0.078$, p<0.05). Identifying and addressing avoidance behaviours and cognitions regarding embarrassment in interventions may enhance the chances of CFS patients returning to work.

Salivary cortisol in adolescents with chronic fatigue syndrome, before and after CBT.
Katharine Rimes, University of Bath; Andrew Papadopoulos, King’s College London; Trudie Chalder, King’s College London; Anthony Ciearelli, King’s College London
Previous studies have reported low levels of cortisol in some adults with chronic fatigue syndrome (CFS) compared to healthy participants, but there has been little similar research in adolescents with this condition. Three studies will be presented investigating salivary cortisol in adolescents with CFS. In Study 1, cortisol output is compared between adolescents with CFS (n=49) and healthy control participants (n=36). Study 2 compares cortisol output before and after CBT for adolescents with CFS (n=24). Study 3 investigates whether pre-treatment cortisol levels predict response to CBT (n=43). Possible implications of the results will be discussed.

Making life taste sweeter? Different ways of working as a diabetes psychologist
Convenor: Sylvia Hepburn, St Mary’s Hospital, London, and Nicole Tang, Arthritis Research UK Primary Care Centre, Keele University

Using individual Cognitive Behavioural Therapy to treat diabetes burnout
Silvia Hepburn, St Mary’s Hospital, London
Diabetes is a long-term chronic medical condition which brings phenomenal challenges for patients. As well as increased risks of mortality and severe health problems such as cardiovascular events and kidney failure, people with diabetes suffer from significantly elevated levels of depression and poor psychological well-being. This is partly due to the physiological effects of high blood glucose levels, but it also reflects the burden of adjusting to a long-term illness, and the effort required to complete demanding self-care behaviours for decades without respite. Unsurprisingly, over time, many patients fall into a cycle of reduced motivation for self-care, deteriorating diabetes control, and increased hopelessness. Polonsky (1999) calls this pattern “diabetes burnout”. This presentation discusses the key aspects of diabetes burnout and gives case examples to demonstrate how traditional Cognitive Behavioural Therapy techniques can be successfully employed to treat it.

Using Mindfulness-Based Cognitive Therapy (MBCT) with Groups of People Living with Diabetes
Sonya Frearson, Mile End Hospital, London
People with diabetes commonly experience lack of well-being, low mood and reduced motivation to self-care. People may experience the relentless task of diabetes self-management as overwhelming especially if they have a perfectionist approach to self-management. They can end up coping with their inevitable failure to perfectly manage their diabetes by avoiding any thoughts, feelings or behaviours related to it. MBCT is proposed as one way to help people notice their self-care strategies and to allow them to re-engage with their diabetes in a more self-compassionate and less striving manner. The talk describes forming, adapting and piloting MBCT for use with groups of people with Type 1 & 2 diabetes.

The Diabetes-6 (D-6) Study: Teaching psychological skills to general practice nurses for Type 2 diabetes patients
Nicolde de Zoysa, Clinical Psychologist, King’s College Hospital, London
Research suggests that psychological therapies can significantly improve glycaemic control in diabetes patients (Alam et al, 2009; Ismail et al, 2004). However, mental health professionals with specific diabetes knowledge are an expensive and limited resource. The D-6 study assesses whether specific psychological skills can be taught to general practice nurses to enhance their medical consultations and thereby improve diabetes control and psychological well-being for their patients.
This study specifically targets those patients who persistently struggle to get better control of their diabetes, despite medical intervention. The nurses are taught the following skills: Active Listening, Managing Resistance, Directing Change, Supporting Self Efficacy, Addressing Health Beliefs and Shaping Behaviour. The skills are drawn from both Motivational Interviewing and Cognitive Behavioural Therapy and delivered by a Clinical Psychologist. The study is currently underway and this presentation outlines how psychological skills training can be delivered, evaluated and maintained for general practice nurses working with chronic disease.

**Applying a Cognitive Behavioural Model to A Diabetes Self Management Education Programme**

Yvonne Doherty, Heather Daly, Lorraine Martin Stacey, Cheryl Taylor and Jacqui Troughton and S Craddock

DESMOND (Diabetes Education for Self Management Ongoing and Newly Diagnosed) is a nationally recognised evidence based programme that aims to promote management of Type 2 Diabetes. This far the programme has focussed on the newly diagnosed. ‘Going Forward with Diabetes’ is the follow up programme to DESMOND and is aimed at supporting longer term self management. This curriculum is about to undergo investigation via randomised control trial following an initial development phase. At its heart is the recognition of the importance of psychological issues as barriers to self management. The six cycles maintenance model for depression (Moorley 2010) has been adapted and employed to allow participants to discover and explore the factors that could be impacting on their psychological well being and their capacity to engage in self care and lifestyle change. Key aspects of the intervention will be described alongside the initial experiences of delivering this model in groups by Diabetes Educators.

**Maximising the effect of treatments for musculoskeletal pain: Strategies in primary and secondary care**

Convenor: Nicole Tang, Institute of Psychiatry, King’s College London and Keele University Discussant: Lance McCracken, Bath Centre for Pain Services

**Evaluating and predicting outcomes of cognitive-behavioural based pain management programme: The roles of rumination, health anxiety, mental defeat and cognitive flexibility**

Melanie Edwards, Institute of Psychiatry, King's College London; Nicole Tang, Arthritis Research UK Primary Care Centre, Keele University; Paul Salkovskis, Department of Psychology, University of Bath

Cognitive-behavioural pain management programmes are the choice of intervention for rehabilitating people distressed and disabled by chronic pain. However, these CBT programmes vary in their content and emphasis, and when evaluated as a treatment approach as a whole, the effects of CBT on pain, disability and mood were weak (ES = -0.15 - -0.21; Eccleston et al., 2009). It has also been noted that variability in treatment response is high, with some patients even reporting increases in pain and distress following treatment (Morley et al., 2008). These findings highlight the necessity of refining treatment targets and the urgency to identify factors that better define patients' needs. This talk will present findings from a prospective study that evaluated the outcome of a well-developed cognitive-behavioural pain management programme. A total of 138 patients were assessed on a range of measures at the beginning and end of the programme, as well as 3 months after the treatment. Regression analyses were carried out to examine the roles of rumination, health anxiety, mental defeat and cognitive flexibility in predicting outcomes and the changes that occurred throughout the programme. Results from these analyses will be discussed to suggest directions for future treatment development. References: Eccleston, C., Williams, A.C. de C., & Morley, S. (2009). Psychological therapies for the management of chronic pain (excluding headache) in adults (Review). Cochrane Database of Systematic Reviews 2009, 2. Morley, S., Williams, A.C. de C., & Hussain, S. (2008). Estimating the clinical effectiveness of cognitive behavioural therapy in the clinic: Evaluation of a CBT informed pain management programme. Pain, 137 (3), 670-680.

**Integrating psychological principles into the primary care management of back pain**

Gail Sowden, Interdisciplinary Musculoskeletal Pain Assessment & Community Treatment Service, The Haywood Hospital and the Arthritis Research UK Primary Care Centre, Keele University

Low back pain (LBP) affects over one third of adults at any one time, and each year approximately 3.5 million people in the UK develop back pain. Most patients with back pain are treated in primary care, where an estimated 85% will have 'non-specific' LBP. In the UK, referral to physiotherapy is a popular management option for GPs, with LBP accounting for more than half of physiotherapists' workload. Patients with poorer physical functioning and higher levels of distress (fear of activity, depression, anxiety and catastrophising) are more likely to have a worse outcome. Targeted management of these more disabled and distressed patients in primary care could lead to better outcomes. It is possible to train and support physiotherapists to manage a proportion of these more complex patients in a manner which is credible and acceptable to patients. Results of a randomised controlled trial (the START Back trial) and an implementation study (The IMPaCT Back study) in which 'low', 'medium' and 'high' risk subgroup of low back pain patients were identified and then received matched treatments will be briefly presented. The "high risk" Intervention and physiotherapy training and clinical package will be presented. The need for appropriate referral of the most distressed patients to interdisciplinary pain services and / or CBT therapists and clinical psychologists will also be explored.

**Towards a more comprehensive understanding of effective psychological treatments for those with chronic pain**

Kevin Vowles, The Haywood Hospital & Keele University

The occurrence of chronic pain is widespread, costly, and is associated with significant suffering. The psychological therapies have a decades long history of assisting those with chronic pain to decrease pain-related interference and improve overall quality of living. The mechanisms by which such treatments work, however, are not clear as some of the posited mechanisms have not been supported within the extant literature. For example, improvements in coping concepts such as pacing, relaxation, and cognitive restructuring or positive thinking do not appear to be necessary for treatment improvement or reliably related to treatment outcomes. Recent developments, principally under the clinical and theoretical model underlying Acceptance and Commitment Therapy (ACT), have examined a set of mechanisms that differ from previous work, where the focus is on decreasing the struggle for pain control, increasing awareness of what is valued, and progressing in areas of meaningful functioning. To date, there is good evidence that the processes specifically targeted within ACT for chronic pain are relevant to treatment outcomes achieved within psychological treatments for chronic pain. This presentation will provide an overview of this area, including an in depth focus on the treatment processes that appear to facilitate more meaningful functioning in individuals with chronic pain.
Skills Class

Working with Acceptance, Mindfulness, and Values in Chronic Pain: An Introduction and Skills Building Workshop

Diana Sanders, Marion Elliot: University of Oxford Health NHS Trust and Oxford Radcliffe Trust

The psychological needs of cardiac patients are well known, but many cardiac rehabilitation services have very little access to psychological treatments. In Oxford, we are looking at the value of offering psychological information and access to treatment in helping detect and treat psychological problems. Is it possible to offer a small amount of input and maximise the outcome? The psychologist, DS, is employed for three clinical sessions, across two hospitals in Oxfordshire. There are three aspects to the work: training and clinical supervision of cardiac rehabilitation staff, information sessions for patients about the symptoms and treatment of common psychological difficulties, and formal CBT assessment with up to three sessions of telephone follow up. All patients are screened using HADS; before and after measures, HADS and Dartmouth Coop Quality of Life Scales, are used for those attending formal CBT. We have preliminary results on the first six months of the project. The information sessions are well received, and those attending individual CBT improve. Given there is no control group, we are unable to draw definitive conclusions. However, other research shows that cardiac patients, if untreated, are at risk of further psychological and cardiac problems, therefore offering early intervention is highly likely to improve health and prevent further difficulties. With cardiac patients, it is possible to do a lot of work with little resource, through using a range of methods, formal and informal. Access to psychological input and help within cardiac rehabilitation is, therefore, highly valued and recommended. Whether this translates as increased funding is an open question.

Open Paper

A little goes a long way: a brief CBT intervention in Cardiac Rehabilitation

Diana Sanders, Marion Elliot: Oxford Health NHS Trust and Oxford Radcliffe Trust

The psychological needs of cardiac patients are well known, but many cardiac rehabilitation services have very little access to psychological treatments. In Oxford, we are looking at the value of offering psychological information and access to treatment in helping detect and treat psychological problems. Is it possible to offer a small amount of input and maximise the outcome? The psychologist, DS, is employed for three clinical sessions, across two hospitals in Oxfordshire. There are three aspects to the work: training and clinical supervision of cardiac rehabilitation staff, information sessions for patients about the symptoms and treatment of common psychological difficulties, and formal CBT assessment with up to three sessions of telephone follow up. All patients are screened using HADS; before and after measures, HADS and Dartmouth Coop Quality of Life Scales, are used for those attending formal CBT. We have preliminary results on the first six months of the project. The information sessions are well received, and those attending individual CBT improve. Given there is no control group, we are unable to draw definitive conclusions. However, other research shows that cardiac patients, if untreated, are at risk of further psychological and cardiac problems, therefore offering early intervention is highly likely to improve health and prevent further difficulties. With cardiac patients, it is possible to do a lot of work with little resource, through using a range of methods, formal and informal. Access to psychological input and help within cardiac rehabilitation is, therefore, highly valued and recommended. Whether this translates as increased funding is an open question.

Poster

Beating the blues after a stroke: A case presentation

Sara Simblett, University of Cambridge and NIHR CLAHRC for Cambridgeshire and Peterborough; Jessica Craven, University of Cambridge and NIHR CLAHRC for Cambridgeshire and Peterborough; Jackie Mercer, Cambridge Community Services; Fergus Gracey, NIHR CLAHRC for Cambridgeshire and Peterborough; Howard Ring, University of Cambridge; Andrew Bateman, Oliver Zangwill Centre for Neuropsychological Rehabilitation

Mood disorders such as depression and anxiety are common complications following stroke. If left untreated, these difficulties have been found to significantly impact on functional recovery and reduce people's quality of life. There is some evidence to suggest an association between the use of maladaptive cognitive and behavioural strategies (such as worry and avoidance) to cope with stressful situations and subsequent development of mood disorders. Cognitive behaviour therapy (CBT) techniques aimed at helping people to use more adaptive coping strategies (such as problem-solving and activity scheduling) may be useful in the treatment of mood disorders following stroke. CBT is now more widely available through online technology, however, little is known about the potential efficacy of these interventions within this population. We report the case of a 53 year-old woman (AB) who was guided through a computerised CBT (cCBT) intervention to help her cope better with feelings of depression and anxiety that had developed following her stroke that had occurred two years previously. Before AB began the cCBT intervention she completed measures of depression (Beck Depression Inventory; BDI-II), anxiety (Beck Anxiety Inventory; BAI) and general distress (Clinical Outcomes in Routine Evaluation questionnaire; CORE-34). Her scores on a number of neuropsychological assessments were retrieved from her medical notes to provide information about potential cognitive, perceptual and communication difficulties. She completed the eight sessions of cCBT over a period of three months, and inbetween sessions she completed a number of home-work projects. At the beginning of each session she was also asked to rate her perceived level of depression and anxiety, as well as her perceived level of distress in relation to specific problems she had identified (no longer being an physically able as she used to be, and difficulties with her interpersonal relationships). Immediately after completing the cCBT intervention AB completed the three outcome measures (BDI-II, BAI and CORE-34) a second time. Prior to commencing cCBT AB was scoring within the moderate range on measures of depression and anxiety (BDI-II and BAI), and scored above average on the 'reduced wellbeing' and 'risk' subscales on the measure of distress (CORE-34). Previous neuropsychological assessment indicated that AB may also have been experiencing difficulties with processing linguistic and visuospatial information, and engaging in executive functioning. Over the course of cCBT AB's perceived level of depression, anxiety and distress, in relation to all problems identified, declined. Similarly, her scores on the BDI-II, BAI, and all subscales of the CORE-34 immediately after completion,
reduced so that she no longer scored within the clinical range on any of these measures. These findings were maintained at a two-month follow-up assessment. As part of a reflection on her experience of using cCBT, AB has played an active role in writing this paper. This case study indicates that in spite of physical, cognitive and communication difficulties guided cCBT interventions may be useful for reducing distress and treating mood disorders that can develop following stroke.

Implications for the science and practice of CBT: This study contributes to the evidence-base for using cost-effective technology such as computerised Cognitive Behaviour Therapy to treat mild-to-moderate depression and anxiety amongst individuals with concurrent chronic physical health problems, including neurological conditions such as stroke.

**Children and Adolescents**

**Keynotes**

**Marrying Different Pathways to Children’s Fears: Something Old, Something New, Plenty Borrowed, Lots to Do**

Professor Andy Field, University of Sussex

Children’s fears and anxiety have been seen as developing through a variety of pathways: direct traumatic experience, verbal information, vicarious learning, media exposure, parenting, genetics and individual differences. This talk is an attempt to look at how learning and conditioning mechanisms can be integrated with these different pathways to provide a parsimonious framework for thinking about the etiology of fears and anxiety. I will begin by over viewing each of the pathways very briefly and describing the common ground between them. I will then outline some of my own research that has explored how verbal threat information fits in with other pathways to fear. Finally, I will look at whether these pathways can be reduced down to core common processes, and whether these processes fit comfortably within a single learning model of fear.

**The Role of the Father in the Etiology, Prevention and Treatment of Childhood Anxiety Disorders**

Professor Susan Bögels, University of Amsterdam, Netherlands

Children are born with fears that protect them against danger. Yet instinctive fears may undermine confidence and learning. Confronted with novel and potentially dangerous stimuli, newborns rely on their parents for clues as to whether the situation is an opportunity or danger, and thus should be approached or avoided. If parents are fearful themselves, they will show signals that may enhance child fear. From an evolutionary perspective, fathers have specialized in external environments (confronting dangerous animals, fighting strangers, exploring new territory) while mothers specialized in the internal environment (feeding and comforting the child). Given this evolutionary-based comparative advantage of fathers, two predictions can be made: First, fathers may play a different (but important) role in child upbringing, such as stimulating risk taking and competition. Second, infants may overvalue the signal of their father compared to their mother to decide whether the external environment represents threat or opportunity. In this keynote, first an overview will be given of the role of evolution in parenting. Available research on differences in paternal and maternal parenting behaviours will then be reviewed, in the context of child anxiety and avoidance and its opposite; confidence and risk taking. Next, research from our lab will be presented on the different roles of father and mother in preventing child anxiety, based on our longitudinal study of 140 first-born babies in interaction with both their father and their mother. Video-examples of typical father and mother behaviours in interaction with their child will be given to illustrate differences. Also, clinical research will be presented on fathers versus mothers as coaches of their child to help the child overcome anxiety disorders. Finally, the scientific, clinical and societal implications of this paternal model will be discussed.

**The Social Context of Adolescent Depression: Vulnerability and Consequences**

Professor Constance Hammen, University of California, Los Angeles, USA

Key risk factors for depression in adolescence include being female, maternal depression, interpersonal and family difficulties, stressors, and sensitivity to stress. These factors are explored in a 20-year longitudinal study of 800 families selected for presence or absence of maternal depression. Youth at risk are not only exposed to higher levels of stress but may also contribute to the occurrence of stressful experiences, including acute life events and problematic relationships, setting the stage for recurring depression, impairment, and the transmission of difficulties to the next generation. Implications for intervention will be discussed.

**Symposia**

**Parental cognitions: Associations with parental behaviours and child adjustment**

Convener: Cathy Creswell, University of Reading

**Maternal anxiety and cognitive biases towards threat in their own and their child’s environment**

Kathryn Lester, University of Sussex; Andy Field, University of Sussex; Sam Cartwright-Hatton, University of Manchester

Anxiety is the most prevalent psychological disorder affecting children and adults, and it is well established that anxiety runs in families. Anxiety disorders are also associated with a range of cognitive biases affecting attention, interpretation and reasoning. Approximately 30-40% of the association between parent and child anxiety is explained by genetic influences, leaving environmental influences to explain the largest proportion of unique variance in child anxiety (Eley et al. 2003). It is therefore highly plausible that characteristics of anxiety are transmitted environmentally from parent to child. One possibility is that a significant proportion of the concordance between parent and child anxiety may be accounted for by the intergenerational transmission of anxious cognitions/processing styles (Creswell, Cooper, & Murray, 2010; Field & Lester, 2010). However, the intergenerational transmission of anxious cognitions/processing styles is more likely if anxious mothers demonstrate biases not only about potential threats in their own environment but also about potential threats in their child’s world. The present study explores associations between maternal trait anxiety and established measures of cognitive processing tapping attentional and interpretation biases and catastrophic processing style. In a sample of 300 mothers, we examine whether high maternal anxiety is associated with biases toward potential threats in the mothers own environment but also whether these processing biases extend to influence how they attend to, interpret and catastrophise about potential threats in their child’s world. Results show that mother’s anxiety-related interpretative biases extend beyond...
their own environment to encompass how they interpret stimuli within their child’s world. High trait anxious mothers also generated a greater number of catastrophic outcomes to both self-referent and child-referent hypothetical situations. Findings for attentional processes were more equivocal, with weak evidence for maternal anxiety being associated with attentional avoidance of child-related threatening stimuli on a dot-probe task. However, no significant anxiety-related attentional biases were observed for generally threatening stimuli. We also report significant associations between different cognitive biases consistent with these biases sharing a common mechanism. Implications of these findings for the development of child anxiety and for understanding the causal mechanisms behind the possible intergenerational transmission of anxious cognitions will be explored.

Reinforcement of Threat and Vulnerability in Mother-Child Discussions: The Role of Maternal Anxiety and Cognitions

Linda Piper, University of Reading; Cathy Creswell, University of Reading; Elizabeth Hodgson, University of Reading; Vanessa Fearn, University of Reading; Jessica Satcchell, University of Reading

The familial aggregation of anxiety disorders is well-established. Children of parents with an anxiety disorder are more likely than children of non-anxious parents to also have an anxiety disorder (e.g., Beidel & Turner, 1997), while rates of anxiety disorders in parents of anxious children are higher than those of parents of non-anxious children (Cooper, Fearn, Willetts, Seabrook, & Parkinson, 2006). This strong association between parental and child anxiety suggests an intergenerational transmission of anxiety disorders. Information transfer of threat interpretation bias from mother to child has been proposed as one mechanism of this. Previous studies have found, consistent with the adult cognitive model of anxiety, anxious children show a bias towards interpreting ambiguous scenarios as threatening (Barrett, Dadds & Rapee, 1996). Furthermore, the interpretations styles of children and their mothers correlate significantly (Creswell, Schniering & Rapee, 2005). Studies of information transfer suggest that the communication of negative information to children increases fear beliefs and avoids threat interpretations (Dadds, Barrett, Rapee, & Ryan, 1996). Given anxious mothers’ biases, they avoid threat interpretation, the presence of maternal anxiety/avoidant cognitions is likely to enhance the FEAR effect, with increased communication and reinforcement of threat interpretations and need for avoidant behaviour resulting in an increase in anxious children’s anxious behaviour. To investigate this, one hundred and eighteen children, aged 7-12, and their mothers completed interviews to assess interpretation of ambiguity. Mother-child dyads were then given five minutes to discuss two of these scenarios. The content of mother-child discussions were coded by blind raters trained to a high level of reliability. This presentation will report on differences between anxious and non-anxious children’s (i) threat interpretation and predicted anxious behaviour; (ii) changes in children’s interpretation and plans following discussions. Associations with characteristics of the mother-child discussion, maternal anxiety and maternal threat interpretation will be described. The findings will be discussed with reference to possible targets for improving outcomes from child anxiety interventions.

Intergenerational Transmission of Social Anxiety: the Role of Paternal and Maternal Fear of Negative Child Evaluation and Parenting Behaviour

Wieke de Vente, University of Amsterdam, The Netherlands; Mirjana Majdand, University of Amsterdam, The Netherlands; Cristina Colommi, University of Amsterdam, The Netherlands; Susan Bogels, University of Amsterdam, The Netherlands

Parents’ fear of negative child evaluation (FNCE) has been proposed by Heinrichs et al. (2010) as a mechanism explaining the intergenerational transmission of social anxiety. Parents’ FNCE may result in child social anxiety through various learning processes, including those associated with parenting. To test these ideas, 109 fathers and 110 mothers completed the Fear of Negative Child Evaluation Questionnaire (FNCE-Q) when their child was 4 months old. Social anxiety disorder (ADIS-A) and social anxiety symptoms (SPAI-18) of both parents were measured before the birth of the child. At 1 year of age, early signs of infants’ social anxiety were assessed using the Revised Infant Behaviour Questionnaire (IBQ-R, combined father mother report), and both parents’ over-involved and negative parenting behaviour were measured using the Conflict Behaviours Parenting Behaviour Questionnaire (CPBQ). Fathers’ FNCE prospectively predicted negative social anxiety and FNCE predicted over-involved (mothers) and negative (both parents) parenting. The relation between maternal social anxiety (disorder) and over-involved and negative parenting was substantially mediated by FNCE. Our results suggest that already during infancy FNCE plays a role in the intergenerational transmission of social anxiety and that this role differs between parents.

Maternal Responsibility and Child Anxiety

Adela Apetroaia, University of Reading; Cathy Creswell, University of Reading

Anxiety disorders often run in families (e.g., Noyes et al, 1987) and are only partially explained by genetic factors (e.g., Gregory & Eley, 2007). It is therefore important to examine the role of parental beliefs and behaviours in promoting or maintaining child anxiety. An area that has yet to be investigated consists of parental beliefs about how responsible they are for their children’s well-being (e.g., Field & Lawson, 2003). Mothers are likely to be a common source of such information about novel or ambiguous situations. In a seminal study by Barrett et al. (1996), an increase in anxious children’s choice of avoidant behaviour was found following family discussions. The authors argued a possible parental influence on children’s anxious cognitions and called this the FEAR (Family Enhancement of Avoidant and aggressive Responses) effect. Furthermore, examination of the family discussions showed that parents of anxious children reinforced their child’s threat interpretations and avoided threat interpretations (Dadds, Barrett, Rapee & Ryan, 1996). Given anxious mothers’ biases, they avoid threat interpretation, the presence of maternal anxiety/avoidant cognitions is likely to enhance the FEAR effect, with increased communication and reinforcement of threat interpretations and need for avoidant behaviour resulting in an increase in anxious children’s anxious behaviour. To investigate this, one hundred and eighteen children, aged 7-12, and their mothers completed interviews to assess interpretation of ambiguity. Mother-child dyads were then given five minutes to discuss two of these scenarios. The content of mother-child discussions were coded by blind raters trained to a high level of reliability. This presentation will report on differences between anxious and non-anxious children’s (i) threat interpretation and predicted anxious behaviour; (ii) changes in children’s interpretation and plans following discussions. Associations with characteristics of the mother-child discussion, maternal anxiety and maternal threat interpretation will be described. The findings will be discussed with reference to possible targets for improving outcomes from child anxiety interventions.
Maternal Anxiety. Moreover, Anxiogenic Behaviours mediate the relationship between Maternal Responsibility and Child Anxiety, consistent with a model of parental cognitions that influence parenting behaviours, which, in turn, contribute to child anxiety. Although there were no associations between Maternal Anxiety and Responsibility in this community sample, preliminary data using the MRS with a sample of anxious mothers and mothers of anxious children indicate that anxious mothers of anxious children have a significantly higher sense of Maternal Responsibility compared to non-anxious mothers, suggesting that Maternal Responsibility might be particularly important in the intergenerational transmission of anxiety.

The effect of inflated responsibility on maternal and child behaviours
Shirley Reynolds, University of East Anglia
Experimental studies are a useful way of highlighting the causal relationships which may underlie the development of psychological distress. There has been considerable debate about the role parents may play in the development of anxiety in children but there is uncertainty about the extent to which parental beliefs and behaviours are causally related to children’s anxiety. This paper will present 3 related studies in which the effect of inflated responsibility on children’s and mother’s behaviour is examined. According to Salkovskis (1985, 1999) inflated responsibility is a key causal factor in OCD and in adults there is a range of evidence that inflated responsibility is correlated with OCD. Reeves and Reynolds (2008) found some studies which demonstrated an association between inflated responsibility and OCD in children and young people but an absence of experimental evidence. In this presentation we will present evidence that in children, inflated responsibility increases OCD-like behaviours, i.e. checking, hesitating and the length of time taken to complete a task. This supports Salkovskis’ inflated responsibility of OCD. Further we present 2 studies which involve experiments with children and their mothers together. In study 2 we inflated responsibility beliefs only in children but not in their mothers. This led to an increase in OCD-like behaviours in children but not in their mothers. In study 3 we manipulated responsibility beliefs in children and in their mothers. This led to significant increases in maternal reassurance giving, and in child reassurance seeking and other OCD like behaviour. The effect of maternal responsibility beliefs appeared to amplify the effect of responsibility beliefs in their children. The data suggest that parental beliefs and behaviour may have a direct causal effect on the development of children’s anxiety.

Parental factors and child anxiety: Development and treatment
Convenor: Cathy Creswell and Adela Apetroaia, University of Reading

The impact of paternal anxiety on father-child interactions
Errity Darina, Trinity College Dublin; Wilson Charlotte, Trinity College Dublin
There has been increasing focus in recent years of the role fathers play in the development and treatment of their children’s anxiety problems. For example, Bogels and Phares (2007) propose a model in which fathers are crucial in encouraging autonomy and risk taking in their children. Furthermore, they propose that if anxiety occurs in fathers then this might have a greater impact than when it occurs in mothers, due to their role in encouraging everyday risk taking. However, to date, very few studies have explored how anxiety in fathers impacts on their parenting and in particular on their ability to encourage autonomy and independence in their children. Our aim is to recruit sixty fathers, half with elevated levels of anxiety and half with low levels of anxiety, and to observe them interacting with their 7-12 year old children. There will be two tasks tapping into autonomy granting and risk taking as well as a number of standardised questionnaires. We will report on our experiences of recruiting anxious fathers and on early stage observational results.

Investigating secondary school transition as a stressor for increasing social anxiety
Pui Yi (Mandy) Lau, University of Reading
Social anxiety is characterized by excessive fear of negative evaluation by others and avoidance of social situations (Clark & Wells, 1995). Few people with significant social anxiety recover spontaneously (Kessler et al., 1998); therefore, understanding its development is crucial for prevention. Social anxiety typically develops between 10-14 years of age (Wittchen et al, 1999), which overlaps with the period in which young people experience the social challenge of transition to secondary school (Sheridan et al, 2003). It is unclear whether this transition precipitates increases in social anxiety, in addition to the biological, cognitive and psychosocial changes experienced during adolescence (Erickson, 1968). One design which controls for these normative changes in adolescence is to compare rates of increased social anxiety following the secondary school transition (from pre-transition to post-transition) against such rates amongst same-age children not making the school transition (because of attending ‘middle school’). This project aims to investigate if transition to secondary school act as a stressor for increasing social anxiety across the school transition, in particular among shy children. In addition, it aims to investigate if parenting is a risk factor for moderating the impact of transition on changes of social anxiety.

100 and 123 children were recruited from primary and middle schools respectively. The participants were 10- to 11-year-olds moving from Year 6 to Year 7, either making the transfer from the primary to the secondary school or remaining in middle school. Children reported on their level of social anxiety prior to and following the transition from Year 6 to Year 7. Children’s demographic characteristics were obtained from school records. Spence Children’s Anxiety Scale (SCAS, Spence, 1997) was used to assess social anxiety and the EMBU-C (Castro et al., 1993; Grillsiener et al., 1999) was used to measure children’s perceived parental overprotection, rejection, and overanxious rearing. Preliminary regression analyses showed that pre-transition social anxiety scores significantly predicted post-transition social anxiety scores. However, the occurrence of the school transition did not significantly increase social anxiety, both overall and specifically among children with high shyness pre-transition. Moderate correlations were found between social anxiety (in both years 6 and 7) and over-anxious rearing, parental overprotection and parental rejection. None of the parenting measures significantly predicted changes in social anxiety from year 6 to year 7, and did not interact with the occurrence of the secondary school transition to predict change in social anxiety. Contrary to hypotheses, preliminary results suggest that the transition to secondary is not a stressor for increasing social anxiety, in general or for shy children specifically. Social anxiety was, however, consistently associated with perceptions of parental anxious rearing and overprotection, although perceived parenting did not predict change in social anxiety in relation to the school transition. A new sample is being recruited to examine if social anxiety changes at a one-year follow-up period.

Child Anxiety Treatment Response in the Context of Maternal Anxiety: The Role of Mother-Child Co-Constructed Narratives
Ray Percy, University of Reading
Concurrent maternal anxiety and the quality of the mother-child relationship are considered important factors in relation to child anxiety disorder treatment response. This is in light of evidence linking maternal anxiety, negative parenting, and the onset and maintenance of child anxiety (e.g. Cobham et al., 1998; Moore et al., 2004; Wood et al., 2003). Research with anxious and healthy samples suggests that mother-child conversations are a mechanism through which anxiogenic cognitions (e.g., overestimation of threat and fear, tendency to generate avoidant solutions) are transmitted from parent to child (Field & Lawson, 2008; Flisw & Nelson, 2006; Suveg et al., 2005). Such cognitions, common among anxious mothers and mothers of anxious children, have been linked with treatment failure in children (Barrett et al., 1996; Cobham et al., 1999; Watson, 1986). In addition, maternal encouragement of elaboration and evaluation during mother-child conversations has been linked with child well-being (e.g. Flisw & Sales, 2006). Examining the relationship between maternal and child anxiety, mother-child conversations, and child anxiety treatment outcome, will elucidate the processes involved in mother-child transmission of anxiety, and contribute to preventive and therapeutic interventions. This has been addressed within the context of a randomised controlled trial at the Winnicott Research Unit, University of Reading, investigating the effectiveness of different treatments for child anxiety disorders. A sample of 40 anxious mothers and their anxious children and 40 non-anxious mothers and their anxious children was recruited. Mother-child conversations about worrying experiences were filmed and assessed by applying standardised ratings of anxiogenic discourse to establish whether 1) maternal narrative style varies as a function of maternal anxiety; 2) maternal narrative style is predictive of treatment outcome in the presence/absence of maternal anxiety. In the context of child anxiety, anxious versus non-anxious mothers made significantly more references to threat during conversations with their children about worrying experiences, but made significantly fewer references to positive emotions and bold/autonomous behaviour. In the context of maternal anxiety, increased maternal use of threat references was associated with less favourable treatment outcome, whereas increased encouragement of elaboration and evaluation of worrying experiences was associated with better treatment outcome. These associations between maternal narrative style and child anxiety treatment did not emerge in the absence of maternal anxiety. Findings are discussed in relation to theoretical and clinical implications.

**Parental Anxiety and Processing of Child-Threat Information: An Experimental Study**

Sam Cartwright-Hatton, University of Sussex; Paul Abeles, Central Manchester and Manchester Children's Trust; Becky Hills, University of Manchester; Clare Dixon, University of Cambridge

We now know that being anxious affects the way we process information. So, we wanted to see whether parents who are anxious process information about their children in this biased way. Our earlier research has demonstrated that making parents feel slightly socially anxious did result in some differences in the way that they interpreted threatening child-related situations. We now wanted to determine whether a different sort of parental anxiety—worrying about dangers to children—would have a similar effect. We also set out to examine the effects of parental anxiety on new types of information processing, namely their ability to detect different emotions in children’s faces and voices, and attentional bias to threatening words. Ninety parents of children aged 6 to 10 years were recruited. Thirty of the parents underwent a manipulation that caused them to feel slightly socially anxious. Thirty of the parents were asked to think about their children in dangerous situations, and this too made them feel moderately anxious. Thirty parents received no manipulation and operated as a control group. All parents then completed a measure of emotion recognition in children’s faces and voices (DANVA) and a dot-probe task to detect attentional bias to social-threat words (e.g. ‘interview’) and child-threat words (e.g. ‘paedophile’). The results confirmed that anxiety in parents is associated with changes in their information processing. Anxious parents were less accurate at identifying emotions in children’s faces and voices, and were more likely to focus attention on threatening words in the dot probe task. There was some evidence of specificity of effects, according to the type of anxiety that was manipulated.

**Parental Transmission of Anxiety via Social Referencing: The Role of Infant Temperament**

Evin Aktar, University of Amsterdam, The Netherlands; Mirjana Majdand, University of Amsterdam, The Netherlands; Susan Bogels, University of Amsterdam, The Netherlands

An accumulating body of evidence supports the view that parents play a role in their offspring’s anxiety development. In addition to the genetic influences, which have a moderate effect on anxiety (Hettema, Neale, & Kendler, 2001), environmental factors have been found to be at least equally important (Murray, Creecy, & Cooper, 2009). Thus, scientific interest has grown on how anxious parents may contribute to the development of child anxiety via environmental influences. Evidence on the early environmental influences of parenting relies on the emergence of a new social capacity of the infant towards the end of the first year, referred to as social referencing (Carpenter, Nagell, Tomasello, Butterworth, & Moore, 1998). Social referencing occurs when infants use other people’s signals to regulate their affect and behaviour in face of unfamiliar/novel situations. Social referencing paradigms enable the infant to first observe the parent’s interaction with a stranger, and then to interact with the stranger in the presence of the parent (Murray et al., 2008; de Rosnay et al., 2006). The effect of the parent’s behaviour on infant behaviour has been investigated alone and in interaction with infant behavioural inhibition (Bl; Kagan, Snidman & Arcus, 1998). BI is defined as a biologically driven reactivity to novelty and it constitutes a temperamental disposition for the development of child anxiety (Kagan & Snidman, 1999).

Studies using social referencing paradigms have given priority to social phobia, based on the assumption that the simultaneous emergence of social referencing and stranger anxiety makes the infant particularly vulnerable to the development of social phobia in this period (Sroufe, 1977). There is only one study that investigated the effects of parental anxiety on child anxiety via social referencing among infants of socially anxious and healthy control mothers (Murray et al., 2008). This study confirmed the idea that social referencing can be a channel from which behaviourally inhibited infants take over their parent’s social anxiety. In the current study, 121 1-year old infants participated in a lab visit once with the father and once with the mother. Parental groups consisted of (1) healthy control parents, (2) socially anxious parents, (3) parents with other anxiety disorders and (4) comorbid parents with both social and other anxiety disorders. Infants were confronted with one social (i.e., a stranger) and one non-social (i.e., a remote-control dinosaur) novel stimulus in a social referencing situation with each parent. Infant behavioural inhibition was assessed via observations and questionnaires. The results will be presented at the conference.

**New developments in conduct disorder**

Convenors: Sarah Halligan and Cathy Creswell, University of Reading

Chair: Dale Hay, University of Cardiff
Callos-unemotional traits and clinical issues in family-based interventions for conduct problems

David J. Hawes, University of Sydney; Mark R. Dadds, University of New South Wales; John Brennan, University of New South Wales; David S. Pasalic, University of New South Wales; Aaron D. J. Frost, Griffith University

There is now considerable evidence that among children with high versus low levels of callous unemotional (CU) traits, conduct problems develop through somewhat distinct causal processes. The most clinically important implications of this model concern the differential effects of parenting practices in these two pathways. Recent data will be presented from a program of research that builds on our earlier findings that children with high levels of CU traits are at risk for poor developmental outcomes following parent training for conduct problems (Hawes & Dadds, 2005), and that highly stable CU traits are associated with unique affective and behavioural responses to specific components within such interventions (Hawes & Dadds, 2007). Emerging evidence of the interplay between parenting practices, CU traits, and conduct problems, suggests numerous ways in which the planning and delivery of parent training interventions may be informed by clinical information about the CU traits of children referred for conduct problems. Key clinical issues will be discussed in relation to conceptualisations of family processes in emerging developmental models of antisocial behaviour.

Rumination during adolescence: Familial antecedents and prospective relations with depression

Nicholas Allen, University of Melbourne; Edward Watkins, University of Exeter

This study examined whether the tendency to ruminate mediates the longitudinal association between a negative family environment and adolescent depressive symptoms. It also investigated adolescent gender as a moderator of these effects. A sample of adolescents provided self-reports of depressive symptoms and rumination across three waves of data collection (approximately at ages 12, 15, and 17 years). Family environment was measured via observational assessment of the frequency of positive and aggressive parenting behaviors during laboratory-based interactions completed by 163 mother-adolescent dyads, collected during the first wave. As predicted, adolescents who reported high levels of rumination at age 15 were more likely to show an increase in depressive symptoms at age 17. Rumination was prospectively predicted by the interaction of positive maternal behavior and adolescent gender, with low levels of positive maternal behavior predicting increases in levels of rumination for girls only. Contrary to expectations, high levels of aggressive maternal behavior did not predict adolescent rumination. A bootstrap analysis revealed a significant indirect effect of positive maternal behavior on adolescent depressive symptoms via adolescent rumination, suggesting that rumination might mediate the relationship between low levels of positive maternal behavior and depressive symptoms for girls. The implications of this for preventive interventions and treatments targeting adolescent depression are discussed and recommendations are made for future research.

The origins of unipolar depressions emerging in the adolescent years

Ian Goodyer, University of Cambridge

Unipolar major depressions occur at any point in the lifecourse but their largest incident risk emerges in the second decade between 13 and 18 years of age. Although the broad clinical phenotype is relatively well conserved through into the sixth decade of life there is a striking level of clinical heterogeneity both within and between ages. This clinical heterogeneity is accompanied by a substantial body of evidence also supporting aetiological heterogeneity with causal pathways involving genetic moderators and environmental mediators but with very little understood about the effects of these on the brain, the key organ of interest. Virtually all research studies over the past 50 years have demonstrated that a range of genetic and environmental factors are associated with the onset of depression, influence treatment response and the outcome of treatment. The precise role of genetic factors remains however very unclear. There is some biological plausibility of a main effect for genes without the mediating effects of the environment in some forms of these disorders. There is also a reasonable possibility that some depressions arise entirely through highly psychologically toxic acute events with no prior genetic or environmental vulnerability. Overall however the weight of both theory and scientific evidence is in favour of some form of interaction between environmentally sensitive genetic factors and exposure to adverse environments whose negative impact is likely to last weeks, months or years. This lecture will use selected data from a series of longitudinal studies, experimental investigations and randomised controlled trials conducted by our group in Cambridge to illustrate some of the current issues and prospects in aetiological research on the origins of depressive disorders that emerge in the adolescent years. For aetiological advances that can inform clinical practice I suggest four areas need to be addressed using modern data driven approaches: i) reconfiguring the clinical phenotype to reflect underlying dimensions of behaviour ii) delineating...
the developmental trajectories of life experiences iii) revealing biomarkers and iv) denoting intermediate phenotypes at the level of the brain.

**Predictors of Stress in a Longitudinal Study of Adolescents at Risk for Depression**

Convenors: Richard Meiser-Stedman, University of California, Los Angeles

Most depressions occur in response to stressful experiences, presumably due to neurobiological, genetic, cognitive, and personality vulnerabilities that lead to intense and prolonged negative emotional reactions and the associated symptoms of the depression syndrome. Increasingly we are acquiring more and more detailed understanding of the mechanisms of depression, and the transactions among these complex intrapersonal factors. While the translation of the experience of environmental stress into various interior processes is vitally important for understanding depressive disorders, I will focus largely on the exterior environment and the stressful conditions”early exposure to adversity, acute life events, and chronic role stressors---that promote depression in youth. It is increasingly recognized that individuals with histories of depression tend to have higher levels of current and future stress, especially negative interpersonal experiences to which they have contributed. Thus, the stress-depression relationship is bidirectional, therefore potending continuing cycles of depression-stress-depression. The present study will highlight findings from a large community sample of 815 families, selected to study risk for depression in youth from early adolescence to age 20. It is a high risk population, oversampling families with maternal depression histories (45% of mothers had a history of major depression or dysthymia, 55% no depression). The focus of the talk is to present several findings that pertain to predictors of the occurrence of stress in youth, including family functioning, interpersonal characteristics, and genetic factors. Thus, while each of these vulnerabilities may contribute to depression, they also contribute to the burden of stress experienced by youth, stress that in turn increases the likelihood of depression. Thus, the goal of the presentation is to emphasize the role of factors that contribute to stressor occurrence, and to identify the clinical implications.

**Paternal depression: An examination of its links with father, child and family functioning in the postnatal period**

Lamprini Psychogiou, University of Exeter

Depression occurs in 10-15% of mothers in the postnatal period and is associated with an increased risk of poor outcomes in children. One of the mechanisms by which depression can have impact upon a child’s development is through its effects on the marital relationship. Fathers also suffer from depression, but its effects on family functioning have been overlooked. The aim of this study was to examine the link between depression in fathers and family and child functioning, in the first 3 months of a child’s life. Fathers with (n=54) and without diagnosed depressive disorder (n=99) were compared on measures of individual and familial outcomes. Outcomes were assessed by both mothers and fathers’ reports. Fathers with depression have poorer quality of marital relationship, reported by fathers and their partners. This association remained significant after controlling for the effects of infant’s gender, father’s age and education, antisocial traits, and maternal depression. There were few differences in infant’s reported temperament in the postnatal period. Depression in fathers in the postnatal period can impact upon their partners and children. These findings highlight the importance of screening for paternal depression, with the potential to prevent poor outcomes in their children.

**Do trauma memory characteristics predict PTSD in Children and Adolescents?**

Claire Salmond, Institute of Psychiatry, KCL; Tim Dalgleish, MRC Cognition & Brain Sciences Unit; Richard Meiser-Stedman, MRC Cognition & Brain Sciences Unit; Patrick Smith, Institute of Psychiatry, KCL

Research into the phenomenology of trauma memories in children and adolescents is currently scarce, but adult cognitive models of PTSD make specific predictions about the nature of trauma memories in PTSD. A recent study investigated whether this theory might be applied to children and adolescents. This study involved comparing the nature of trauma narratives to narratives of unpleasant non-traumatic events in children and young people (aged 8-17; N = 50), shortly after a recent assault or road traffic accident. Participants with Acute Stress Disorder (ASD) had significantly elevated levels of disorganisation in their trauma narrative, both compared to trauma exposed controls and to their unpleasant comparative narrative. The present study comprises the 6-month follow up data from the same sample (n=45), and examined whether the same memory processes would be involved in the maintenance of ongoing symptoms. PTSD symptomatology at this follow up assessment was assessed using a self-report questionnaire, from which a PTSD diagnosis could also be derived. Symptom severity at six months was predicted by acute symptom severity, subjective threat at the time of the trauma, parental anxiety levels, pre-trauma emotional well-being, negative trauma-related appraisals, greater trauma narrative incoherence, and trauma memory quality. Trauma memory incoherence, negative trauma-related appraisals and parental anxiety (assessed at baseline) contributed to a regression model of PTSD symptoms at follow up, but trauma-related appraisals failed to remain in the model when baseline PTSD symptoms were included. These data support the application of a cognitive model of PTSD to chronic PTSD, and support the centrality of trauma memory quality in maintaining this disorder.

**A cognitive perspective on PTSD in young children: evidence from a prospective longitudinal study of road traffic accident survivors**

Richard Meiser-Stedman, MRC Cognition & Brain Sciences Unit; Patrick Smith, Institute of Psychiatry, KCL; Tim Dalgleish, MRC Cognition & Brain Sciences Unit

Very little is known about the chronicity of PTSD in young children, and there is little evidence concerning factors responsible for the onset and maintenance of PTSD in this vulnerable age group. The cognitive model of PTSD has been helpfully applied to older children and adolescents, but there have been no attempts to explore this theory in young children exposed to trauma. The study addressed these issues within a prospective longitudinal study of 2-10 year olds exposed to single-event trauma. A cohort of 114 children were assessed 2-4 weeks after a road traffic accident (RTA), then at six months (n=109) and four years (n=71) post-RTA. Parents and those children aged seven years or older were assessed using a structured interview for PTSD. Self-report questionnaires and interview items were used to investigate the role of psychosocial variables (e.g. parental mental health) and cognitive mechanisms (e.g. memory for the trauma, negative-related related appraisals) in the maintenance of PTSD. According to parent-report rates of PTSD, 13.9% at six months post-RTA to 2.8% at four years post-trauma. However, if child-report was considered (for those aged 7 or older) 17.8% had PTSD at 6 months and 20.9% had PTSD at four-year follow up. Demographic and trauma-related indices did not

**Post-traumatic stress disorder in youth**

Convenor: Richard Meiser-Stedman, Cognition and Brain Sciences Unit, Cambridge
Mindful parenting and teaching
Convenor: Steve Noone, Northumberland, Tyne and Wear Trust

Mindfulness Training for Divorced Fathers
Angela D. Adkins Singh
There has been a growing interest in mindfulness-based parent training. Several studies have shown that mindfulness training leads to enhanced parenting skills and reduced parenting stress. Further, some studies have shown that teaching mindfulness to parents occasions positive changes in their children’s behaviors, including aggression, disruptive behaviors, and compliance. However, most of these studies have involved mothers, with minimal involvement of fathers. In our study, we provided mindfulness training to divorced fathers who visited with their children during scheduled times each week. The fathers were greatly stressed with the behavior of their children during these visits. The fathers attended an individualized mindfulness-based training course during which they learned a small number of mindfulness meditations that cumulatively assisted them to engage in personal transformation. We present data on the fathers’ as well as their children’s behaviors before, during, and following mindfulness training.

Mindfulness Training for Mothers
Ashvind N. Adkins Singh
In previous studies we have experimentally tested, within multiple baselines designs, the effectiveness of mindfulness training for parents as a potential means of changing observed behaviors of their children. We showed that mindfulness training provided to mothers produced positive changes in their children, including reduced aggression and disruption, and increased compliance and social interaction with siblings. These studies included mothers whose children presented with serious clinical concerns (i.e., autism, developmental disabilities). In the present study, we replicated and extended our previous studies with mothers whose children did not have any clinical issues. These mothers volunteered for training in mindfulness because they wished to enhance their parenting skills, as well as for personal transformation. We present data on the children’s behaviors before, during, and following their mothers’ training in mindfulness.

Meta-analysis of Risk Factors for PTSD in Children and Young People
David Trickey, Child Bereavement & Trauma Service, Luton PCT; Andy Siddaway, School of Psychology, University of Hertfordshire; Richard Meiser-Stedman, MRC Cognition and Brain Sciences Unit, Cambridge; Lucy Serpell, Research Department of Clinical, Educational and Health Psychology, UCL; Andy Field, School of Psychology, University of Sussex
Post traumatic stress disorder (PTSD) can be a complex and chronic disorder that causes substantial distress and interferes with social and educational functioning. Consequently, identifying the risk factors that make a child more likely to suffer from traumatic distress is socially and clinically important. This meta-analysis estimated the population effect sizes of 25 potential risk factors for PTSD in children and adolescents aged 6-18 years across 64 studies (N = 32,238). Risk factors that could be considered small were race and younger age; a small to medium-sized population effect was observed for female gender, low intelligence, low SES, pre- and post-trauma life events, pre-trauma psychological problems in the individual and parent, post-trauma parental psychological problems, bereavement, time post-trauma (an inverse relationship), trauma severity, and exposure to the event by media; a large population effect was observed for low social support, peri-trauma fear, perceived life threat, social withdrawal, comorbid psychological problem, poor family functioning, distraction, PTSD at time 1, and thought suppression. The methodologies of the different studies enabled further analysis of how certain factors moderated some of the results. The type of assessment (interview vs. questionnaire), trauma type (intended or not, group or individual) and mean age were explored as moderators of the effect size of trauma severity, comorbid psychological problems, younger age and female gender. There were no significant moderators of trauma severity. Intended trauma (compared to unintended trauma) gave rise to significantly higher effect size for comorbid psychological problems and significantly lower effect sizes for younger age and for female gender. The effect size of female gender increased significantly as a function of mean age. In other words, the amount that being female significantly increases risk of having PTSD increases with age.

Applying forensic paradigms to investigate the relationship between children’s recall of traumatic experiences and the development of Posttraumatic Stress Disorder
Anna McKinnon, MRC Cognition and Brain Science Unit; Reg Nixon, Flinders University; Neil Brewer, Flinders University Cognitive models of Posttraumatic Stress Disorder (PTSD) propose that fragmented, disorganised and incomplete recall of traumatic experiences is central to the development of the disorder. However, assessing this relationship in an empirically rigorous fashion is difficult because researchers are not present to witness the traumatic experiences recalled by sufferers. There are now a number of adult analog studies that have tested this relationship using the trauma film paradigm, but ethical constraints prevent the application of this paradigm with children. Here two paradigms from the forensic field were applied (Chen, 2006; Peterson & Bell, 1996). In study 1, children (N = 58, 7-16 years) completed interviews within 4 weeks of an injury leading to a hospital admission (e.g., road traffic accident) and then again 8 weeks later. Children completed a comprehensive memory interview in which parent/witness interviews were used to establish cued recall accuracy, in addition to measures of PTSD and associated psychopathology. In Study 2 (N = 40, 7-16 years), children were videotaped undergoing a stressful orthopaedic procedure and then asked to rate their subjective perceptions (e.g., fear, pain etc.) immediately afterwards. One week later, children completed a similar memory interview and analog measures of PTS. Both studies found that neither cued recall accuracy or meta-cognitive monitoring performance differentiated children experiencing symptoms of PTS. In study 1, children’s ratings of fear and pain immediately following the procedure showed low test-retest correlations with the same ratings at 1 week, and these ratings were not influenced by current levels of PTS. These findings are discussed in the context of relevant theory and previous research.

Mindfulness Training for Mothers
Ashvind N. Adkins Singh
In previous studies we have experimentally tested, within multiple baselines designs, the effectiveness of mindfulness training for parents as a potential means of changing observed behaviors of their children. We showed that mindfulness training provided to mothers produced positive changes in their children, including reduced aggression and disruption, and increased compliance and social interaction with siblings. These studies included mothers whose children presented with serious clinical concerns (i.e., autism, developmental disabilities). In the present study, we replicated and extended our previous studies with mothers whose children did not have any clinical issues. These mothers volunteered for training in mindfulness because they wished to enhance their parenting skills, as well as for personal transformation. We present data on the children’s behaviors before, during, and following their mothers’ training in mindfulness.
Mindfulness Training for Teachers Changes the Behavior of their Students  
Judy Singh

There is a dearth of empirical literature on mindfulness-based training for teachers. In one of the few data-based studies available, teachers participated in a standard 8-week Mindfulness-Based Stress Reduction (MBSR) course. Results showed a decrease in their levels of anxiety, depression, and stress. In the present study, we provided mindfulness-based training to teachers of kindergarten children with intellectual disabilities. We measured the impact of the mindfulness-based training to the teachers on the behavior of the young children, including maladaptive behaviors, compliance with instructions, and appropriate social interactions with peers. Our data show decreased maladaptive behavior, increased compliance with instructions, but almost no change in social interaction.

Reducing obsessions and compulsions in kids and young people (ROCKY)  
Convenor: Shirley Reynolds and Harriet McIlwham, University of East Anglia

Obsessive Compulsive Disorder is a debilitating disorder, which affects between 1 and 3% of young people; and has significant, long term, negative impacts on them and their families. Currently the NICE recommended treatment for OCD in young people is Cognitive Behavioural Therapy (CBT) with parental involvement. However no studies update until now have explicitly compared individual CBT for the child with CBT which includes parents. This symposium reports progress on the ROCKY trial (Reducing Obsessions and Compulsions in Kids and Young People); a randomised controlled trial (RCT) which is being conducted in routine NHS CAMHs clinics. Fifty two young people aged 12 to 18years and their parents or carers, are randomised to receive either individual CBT or ‘parent enhanced’ CBT. In both arms of the trial participants receive up to 14 sessions of CBT. OCD symptom severity is assessed before treatment and at the end of treatment, and at 6 month follow. We aim to assess a range of other outcomes including parental mental health symptoms and the trial is designed to assess the cost effectiveness of treatment and the acceptability of treatment to young people and their families. This symposium aims to present clinically relevant material about the formulation and treatment of OCD in young people as well as to present new, clinically relevant research about cognitive appraisals in young people with OCD, the quality of the therapeutic alliance in individual and family enhanced CBT for OCD, and qualitative data relating to participants’ views about treatment with CBT, and the identification of key change mechanisms. The symposium therefore aims to address the practicalities of running research in NHS services, but also explore the experiences of the therapists and service users, using both clinical and research perspectives. Shirley Reynolds and Harriet McIlwham will provide a background to the ROCKY trial and discuss some of the challenges of setting up and running a research trial in a research-naïve NHS CAMHs. Sarah Clark and Gemma Bowers will present specific case studies from the ROCKY trial. They will discuss their experiences of working with young people and families with OCD and how these have developed their ideas about formulation and treatment. Joe Hickey will then describe research on the therapeutic alliance in the ROCKY project. In particular he will focus on the impact of young person, parent and therapist upon the therapeutic alliance. Finally, Rosie Burton and Shirley Reynolds will present data based on interviews with young people, parents and therapists about their experiences of treatment and their perceptions of key change mechanisms in CBT for OCD. The current symposium aims to inform clinical practice in the delivery of CBT to young people with OCD. The symposium will draw on multiple methodologies, including quantitative and qualitative research, and clinician and service user experiences. The trial provides important new information about the involvement of parents in working with adolescents, and the engagement of young people and family members in both research and CBT. In the long term the acceptability and outcome data produced from this trial will aim to inform the whether individual or family CBT for OCD is more effective and accepted by young people and their families.

Panel Discussion

OCD across the age range: the similarities and differences between treating OCD in childhood, adolescence and adulthood

Convenor: Eva Zysk, University of Reading

Speakers: Sarah Egan, Curtin University, Australia
           Shirley Reynolds, University of East Anglia
           Paul Salkovskis, University of Bath
           Tim Williams, University of Reading

Obsessive Compulsive Disorder (OCD) occurs across the lifespan. Up to half of all cases develop in childhood or adolescence, with half of these persisting into adulthood and older adulthood. This roundtable brings together a panel of clinical and research experts who will discuss specific cases and typical examples from across the age range. These clinicians and researchers will illustrate the similarities and differences in the presentation and treatment of the disorder as well as other related issues which may need to be considered and addressed within particular age groups. Consideration will also be given to the challenges that may arise from assessment and treatment of OCD and from working with each of these client groups. An interactive question and answer session with the audience will follow based on the material presented by the expert panel and the audience’s own clinical and research experience working with these client groups.

Skills Class

Supervision of CBT with Children, Young People and Families

Brenda Davies, Sussex Partnership NHS Foundation Trust and Anne Stewart, Oxford City CAMHS

Despite the expanding evidence base for the efficacy of CBT for a wide range of child and adolescent mental health disorders, a recent survey [1, below] highlighted a major lack of CBT skills and supervision in the UK Child and Adolescent Mental Health Services (CAMHS) workforce. Benchmarking of CBT therapeutic and supervisory skills has recently been facilitated by the development of competences frameworks but the key competences for CBT with children, young people and families are yet to be clearly defined. This is one of a series of interactive training events organised by the Child, Adolescent and Families Branch, CAFSIB, of BABCP, supporting skills development of clinicians offering (or planning to offer) CBT supervision within CAMHS, with the wider aim of promoting dissemination of best practice in CBT in CAMHS.

Learning objectives:
1) To promote awareness of the specific competences necessary to carry out CBT with children, young people and families and an ability to evaluate the developmental stage both of supervisees and of the self in this respect
2) To promote awareness of and support development of key supervisory skills, including specific CBT supervisory skills, as defined by the competences frameworks (e.g. foster ability to evaluate supervisee competences, manage situations that arise in supervision, understand the advantages of conceptualisation in supervision at procedural and process levels and increase awareness of current issues in CBT supervision & best practice but also of our own limits and support needs as supervisors and how these might be met)
3) To provide an opportunity for participants to reflect on how CBT practice and supervision is supported within their own services and consider how this might be enhanced. Training modalities: Training Modalities i.e. experiential, didactic, role play etc. The workshop will offer a range of training modalities including small and large group discussion, interactive exercises, role play and didactic presentation of material. Teaching format will be tailored to feedback throughout the day.

Open Papers

Do callous-unemotional traits moderate relationships between coercive and affective-based dimensions of parenting and child conduct problems?
Dave Pasalich, Mark Dadds, David Hawes, Lucy Vincent, John Brennan
University of New South Wales
Coercive processes in families have been consistently implicated in the development of child conduct problems (Patterson, 1982). There are converging lines of research, however, suggesting that conduct problems in children with callous-unemotional (CU) traits—i.e., lack of guilt and empathy—are less influenced by ineffective and harsh parenting practices (e.g., Wootton et al., 1997), and as such, show less change after behavioural parenting interventions (Hawes & Dadds, 2005). We will report on two studies that aimed to examine the alternative conceptualisation that affective-based dimensions of parenting are more strongly associated with conduct problems in children with CU traits. Participants in both studies (n = 95 and n = 59) varied in terms of gender and developmental level (Patterson, 1982).

In Study 1, coercive parenting—e.g., harsh discipline and criticism—was coded from observations of family interaction, and parents’ warmth was coded from Five-Minute Speech Samples. In Study 2, parents’ focus on emotions—i.e., frequency of emotion talk—was coded from observations of family emotional discussions. Overall, the results showed that coercive parenting is positively associated with conduct problems in low CU children, and that parents’ warmth and mothers’ focus on negative emotions are more strongly associated with conduct problems in high CU children. These results demonstrate for the first time that affective parent-child processes are important for conduct problems in high CU boys, and are consistent with the idea that high CU children are more effectively socialised through parents’ emotional bonds versus discipline practices.

Vicarious fear acquisition in children: Increasing fear relevance does not increase fear learning
Chris Askew, Zehra Ozdil, Andy Field: Kingston University
Studies suggest that fear may be vicariously transmitted to children if they observe someone acting fearfully with a stimulus. Some evidence seems to indicate that this only occurs when the stimulus is inherently ‘fear-relevant’; however, other evidence contradicts this. Askew et al. (2010) recently found no difference in vicarious learning in children for marsupials compared to less fear-relevant stimuli (flowers). The current study compared vicarious learning for the marsupials to stimuli believed to be more fear-relevant (caterpillars). Two groups of children (6-9 years, N = 59) saw pictures of scared faces presented together with pictures of either: one of two caterpillars (Automeris or Nymphalis) or one of two marsupials (Quoll or Cuscus). The other caterpillar or marsupial picture was always presented to children on its own in a control condition.

In addition, a measure of children’s approach-avoidance intentions was taken using the Nature Reserve Task (Field et al., 2007). Fear beliefs increased for animals presented with scared faces and there was greater avoidance of these animals in the Nature Reserve Task. Increases in fear beliefs and avoidance were no different for caterpillars and marsupials. Findings were similar to those of Askew et al. (2010) and suggested that vicarious fear-learning in children is not influenced by the fear-relevance of the stimulus. Understanding how fears develop will lead to the development of better treatments.

Parental signals and anxiety: fathers’ versus mothers’ relative role in their child’s anxiety in ambiguous situations
Eline Moller, Mirjana Majdandzic, Susan Bogels: University of Amsterdam
Social referencing can be defined as the process by which infants use signals from experienced others to guide their interpretation and behavior, when confronted with new objects, persons or situations (Feinman & Lewis, 1983). Social referencing has been almost exclusively studied with mothers. However, a review on the role of the father in child anxiety demonstrates that the few studies that did include fathers show their role is important, and potentially different from that of mothers (Bögels & Phares, 2008). In the present study, children aged 9-12 are presented scripts of ambiguous situations in which either the father or the mother acts anxious or confident. Children have to indicate how anxious or confident they would be. The relative weight that children put on fathers’ versus mothers’ signal about whether a situation is safe or threatening is tested. We expect that the dominance of the paternal versus maternal signal depends on the evolutionary expertise of males and females with the domain of the situation. From an evolutionary perspective, men have specialized in external environments (confronting dangerous animals, fighting strangers, exploring new territory) while women specialized in internal environments (feeding, soothing and comforting the child) (Bögels & Perotti, 2011). Similarly, it can be argued that women have more expertise in social interactions and men in social performances. The above situations are all evolutionary relevant (functional and protective in earlier times). There are, however, also evolutionary irrelevant situations (relatively ‘new’ situations, such as being in an airplane or elevator) with which men and women are assumed to have equal experience. We will carry out three experiments with different groups of children in which the above mentioned domains are tested against each other. Results will be presented at the conference.

Does therapist adherence and parent-therapist alliance predict outcome in a CBT guided self-help intervention for children with anxiety disorders?
Natalie Rodriguez, Cathy Creswell, Chris Barker, Kerstin Thirwall, Peter Cooper, University of Reading
Children’s fear beliefs for the marsupial/caterpillars were measured before and after the pictures were presented. In addition, a measure of children’s approach-avoidance intentions was taken using the Nature Reserve Task. Increases in fear beliefs and avoidance were no different for caterpillars and marsupials. Findings were similar to those of Askew et al. (2010) and suggested that vicarious fear-learning in children is not influenced by the fear-relevance of the stimulus. Understanding how fears develop will lead to the development of better treatments.
Cognitive-behaviour therapy (CBT) is an effective treatment for children diagnosed with anxiety disorders with around half no longer meeting diagnostic criteria at post-treatment (Cartwright-Hatton et al., 2004; In-Albon & Schneider, 2007). There have been comparative findings when treatment has been delivered via parents (Creswell et al., 2010; Waters et al., 2009). However, up to half of treated children still meet diagnostic criteria post-treatment. Understanding more about the mechanisms of change is essential to improve treatment efficacy. In recent years, more attention has been paid to the therapeutic relationship in CBT and its association with technique and outcome (Gilbert & Leahy, 2007). This study is the first to examine the relationship between therapist adherence and parent-therapist alliance and outcome in a CBT guided self-help intervention for children diagnosed with anxiety disorders, when treatment is delivered via parents. The parents of 60 children (aged 7-12 years) received four face-to-face and four telephone sessions of an effective CBT intervention (Creswell & Willetts, 2007). Anxiety diagnoses were assessed at pre and post treatment using the Anxiety Disorders Interview Schedule/Parental Form for Children/Parents (ADIS-C/P; Silverman & Albano, 1997), and child and parent rated anxiety severity and impact. Independent raters coded one early and late session for alliance using the Working Alliance Inventory observer form (WAI-O; Tichenor & Hill, 1989), and adherence using a manual specific scale developed by Creswell et al. (in press). The association between adherence and alliance and child treatment outcome will be presented, and implications for improving outcomes will be considered.

**Effect of Message Framing on Views of Postpartum Depression and Treatment**

**Erin Henshawe, Denison University, Heather O’Mahan, University of Exeter**

Most referrals for postnatal depression (PND) treatment are unsuccessful (Marcus et al., 2003). Recent research suggests treatment barriers include cognitive factors, such as symptom interpretation and stigma (O’Mahan et al., 2009). Treatment facilitators include receiving support based “cues for action” (Henshaw et al., unpublished). These findings point to the need to develop effective materials that reduce stigma while underscoring the need for treatment. However, currently little is known about what type of PND messages are most effective in reaching these goals. Loss-based health messages are framed in a way that highlights risks associated with avoiding treatment. In previous studies, loss-based appeals have successfully increased perceptions of severity associated with a target behaviour (Witte & Allen, 2000). However, some authors suggest that cost-based messages may unintentionally increase illness stigma (Gaebel, Zaske & Baumann, 2006). The goal of this investigation was to examine the effects of PND message framing (loss-based, gain-based, or normalizing messages) on women’s illness and treatment beliefs, and to evaluate whether message framing has a differential impact when women apply the information to their own symptoms or to others’ (referred to as self or other referencing). Three vignette experiments were conducted. In each experiment, non-depressed mothers of children under age 5 were randomly assigned to read basic information about PND (message framing conditions) followed by a brief vignette describing a woman with moderate PND symptoms. In two experiments, participants were also asked to imagine that the character was themselves, a close friend, or stranger. Experiment 1 (n = 48): Participants randomly received one of four messages: a) normalizing motherhood experiences, b) PND education, c) combination message, or d) control—no information. Both normalization and PND education groups reported significantly stronger recommendations for cognitive therapy than the control group. Both types of information (PND education and normalization) led to lower reported PND stigma and treatment compared to control group. Experiment 2 (n = 72): a 2 x 3 (message framing: demystifying motherhood, risks of PND x referencing: self, close friend, other) design was utilized. Participants endorsed cognitive therapy more strongly in “others” referencing groups than self. Participants reported more internal negative attributions for depression (e.g., “she is emotionally weak”) when referencing self compared to others. Internal negative attributions were higher in risk of PND group than demystifying group. The opposite pattern was found for external attributions (e.g., “it is not her fault”). Experiment 3 (n = 86): we utilized a 2 x 2 design (message framing: risks of PND, benefits of treated PND x referencing: self, close friend) The risk-based message group was significantly more likely to suggest cognitive therapy the benefits-based group. The opposite pattern was found for external attributions (e.g., “it is not her fault”).

**Posters**

**Development of a screening tool for early Posttraumatic Stress Disorder in children and adolescents for use in health and community settings**

Clare Dixon, Medical Research Council Cognition and Brain Sciences Unit; Richard Meiser-Stedman, Medical Research Council Cognition and Brain Sciences Unit; Anna McKinnon, Medical Research Council Cognition and Brain Sciences Unit; Tim Dalgleish, Medical Research Council Cognition and Brain Sciences Unit

Posttraumatic Stress Disorder (PTSD) can develop following the witnessing or experiencing of a traumatic event that involves actual or threatened death or serious injury (Criterion A, DSM-IV). In children, PTSD can interrupt development in several domains, suggesting early intervention is warranted. However, post-trauma symptoms are common, and in adults natural recovery can occur up to 3 months post-trauma, suggesting immediate treatment is unnecessary. This study investigated children’s natural recovery in the first few weeks post-trauma, to establish the appropriate time to intervene, i.e., when natural recovery ceases. Little is known about why natural recovery occurs in some children and not others, therefore individual differences were investigated to inform the development of a screening tool to monitor individuals at risk of PTSD. Invitation letters were sent to young people (8-17 years) seen in an Emergency Department or Victim Support Services in Cambridgeshire following a Criterion A event (DSM-IV). Consenting families completed telephone interviews and internet questionnaires at 2-weeks and 2-months post-trauma assessing diagnosis, symptoms, mood, anxiety and process measures. Data from the first 85 participants will be presented. Regression analyses identified predictors of PTSD. Natural recovery time and predictors of PTSD will be discussed along with implications for interventions in this population. Implications for the science and practice of CBT: These findings will inform the development of a screening tool for health and community settings. This tool, for use in health and community settings, could help identify and monitor young people at risk of PTSD and influence appropriate treatment in CAMHS and IAPT services.
Diagnostic specificity in Childhood Anxiety Disorders: Familial and environmental Influences
Jenny Crosby, University of Reading

Anxiety disorders are the most common form of psychopathology in children. They have a significant adverse impact on children's general socio-emotional functioning and commonly persist into adulthood. The role of parenting behaviours and environmental adversity have both been consistently linked to the development of childhood anxiety disorders. To date, however, studies have tended to group together different diagnoses of childhood anxiety disorders, and the idea that there is diagnostic specificity of social and familial risk factors has been generally overlooked. This study aims to examine the association between parenting behaviours (e.g., overcontrol, overprotection, modelling of anxious behaviour) assessed by observing mother-child interactions, and environmental adversity, assessed using standardised questionnaires, in relation to the following childhood anxiety disorders: Separation Anxiety Disorder, Social Phobia, Generalised Anxiety Disorder, and Specific Phobias. This study is based within the Berkshire Child Anxiety Clinic which operates from the University of Reading, School of Psychology. This is a specialist clinic for the assessment and treatment of children with anxiety disorders from all of Berkshire. Participants were 300 children (age 7-12) with a primary diagnosis of anxiety, and their mothers. Child and Maternal Anxiety will be determined using the Anxiety Disorders Interview Schedule, parent/child/adult versions (ADIS-P/ C/ A). The mothers and their children were asked to take part in a number of tasks, and their interactions were observed using video-cameras. The mother-child interaction tasks included a speech presentation task, a difficult tangram puzzle, and a black-box task (involving retrieval of 'scary' objects from a black box).

Questionnaires were also used to obtain additional information, including a modified version of the Life Events Checklist, the Community Characteristics Questionnaire (e.g. assessing graffiti, burglary, safety at night-time) and the Dyadic Adjustment Scale (e.g assessing parental marital adjustment). This study is currently ongoing. Once all the data has been collected, associations will be examined using correlational and logistic regression, in order to examine the predictor variables of each specific anxiety diagnostic group. This study was randomly allocated to one of three groups: inflated responsibility, reduced responsibility, and control. The proposed sample size (300) provides sufficient power (0.95) to detect a medium effect size of 0.4, consistent with the limited extant data (Murray, et al., 2008; Wood, et al., 2006). The findings of this study will make a major contribution to understanding the involvement of social factors to the maintenance and aetiology, of anxiety disorders in children.

Implications for the science and practice of CBT: These findings will inform the development of interventions that target specific risk factors for specific disorders.

"Is it scary mummy?" Vicarious acquisition and prevention of fear in children via a mother or a stranger
Guler Dunne, Kingston University; Chris Askew, Kingston University

Studies suggest that children can acquire fears vicariously through observation of others exhibiting these fears (Gerull & Rapee, 2002; Askew & Field 2007). This study looked at the relative effectiveness of modeling, by mothers and strangers, in both the acquisition and reduction of fear beliefs in children and their behavioural preference/avoidance towards unfamiliar stimuli. It also looked at whether fear beliefs acquired in this way could be effectively unlearned through counter-conditioning. The children (N = 60), aged 6 to 10 years, were presented with images of novel animals, paired with counterbalanced images of negative or positive facial expressions, posed by their mothers or strangers, or left unpaired (control). Fear-related beliefs were assessed before and after the vicarious learning task and again after the counter-conditioning task by means of a self-report questionnaire and a behaviour task. In the behaviour task the children's avoidance feelings for the animals was assessed by where they placed a figure that represented themselves on a board (the 'nature reserve') relative to the animals. The results showed that the children demonstrated increased fear beliefs and avoidance of the animals following negative expressions from their mothers or strangers. Conversely, the children's fear beliefs decreased when paired with happy expressions. The results post the counter-conditioning (unlearning) showed that where fear beliefs had previously been shown to have increased by being paired with scared faces, they decreased when subsequently paired with happy faces. Similarly, where fear beliefs had previously been shown to have decreased by being paired with happy faces, they showed an increase in this condition when subsequently paired with scared faces.

There was no significant difference in the effectiveness of the vicarious information where the source was the mother as compared with a stranger. Implications for the science and practice of CBT: If clinicians have a better understanding of how and why a fear was acquired or prevented this should assist treatment.

Effects of inflated responsibility on anxiety in children
Sorina Zielinski, University of East Anglia; Shirley Reynolds, University of East Anglia; Joanna Austin, University of East Anglia

In adults, obsessive-compulsive disorder (OCD) is associated with beliefs about inflated responsibility (Salkovskis, 1986). These beliefs lead to increases in anxiety and obsessive-compulsive behaviours. Previous experimental research (Reeves et al., 2010) with children replicated the effect of increased responsibility on OCD-like behaviours, but not on anxiety. Reeves et al. suggested that anxiety may have not increased due to the immediate effects of negative reinforcement resulting from unrestricted checking. As any other compulsion, unrestricted checking reduces anxiety; however, this reduction is only temporary and anxiety builds back up shortly after compulsions are terminated (Rachman, 2002; Salkovskis et al., 2003).

This study aims to capture this y measuring delayed anxiety (10 minutes and 24 hours after the task). We hypothesised that inflated responsibility will lead to increased OCD-like behaviours and higher delayed anxiety, compared to control. A non-clinical anxiety diagnosis of 9-12 year-olds (N = 46) of 9-12 years of age were randomly allocated to one of three groups: inflated responsibility, reduced responsibility, and control. A sweet sorting task was used. OCD like behaviours (checking, hesitating, and reassurance seeking) were coded from video recordings of children performing the task and anxiety will be self reported by children. The performance of children in the 3 groups was compared using repeated measures MANOVA, controlling for any group differences at baselines. The results will be discussed in relation to Salkovskis' model of inflated responsibility and OCD, and in relation to children's cognitive development. Implications for the science and practice of CBT: Results from this study will contribute to the understanding of cognitive mechanisms of OCD in youth and test whether adult cognitive models of the disorder apply to children.

Childhood Anxiety Disorders: Associations with heart rate variability and heart rate
Anna Alkozei, University of Reading; Cathy Creswell, University of Reading; Carien van Reekum, University of Reading; Peter Cooper, University of Reading

The clinical presentation of anxiety includes physiological reactions to a stressor. In terms of sympathetic activity, (e.g., heart rate (HR)) there have been no differences found in anxious vs non-anxious populations (e.g.Lyonfields et al., 1995), however, some research has shown that anxious adults evidence differences in parasympathetic activity in comparison to non-anxious adults, both at baseline and in response to stressful tasks (Lyonfields et al., 1995). The findings of one study
have been cited as evidence that this difference might also be present in clinically anxious children, but the methodology used (CO2 inhalation task) meant findings were confounded by changes in respiration (Monk et al., 2001). The present study aimed to establish whether anxious children differ in HRV and HR in stress and non-stress conditions in comparison to non-anxious children. HRV and HR were measured using Actiheart heart rate monitors and software (Version 4) during stress and non-stress conditions in 28 anxious and 28 non-anxious 7-12 year olds. HRV was measured by obtaining short-term recordings of the root mean square of the interbeat intervals (rMSSD). There was a significant main effect of task, such that HRV was higher during non-stress conditions than during stress conditions, regardless of group. With regards to HR, the reverse was found, such that HR was higher during stress than during non-stress conditions across both groups. The results suggest that, in contrast to previous suggestions, anxious and non-anxious children do not differ in their parasympathetic and sympathetic activity during stress and non-stress conditions. Implications for the science and practice of CBT: HRV and HR in anxious children warrant on-going study. In particular, physiological reactions in response to a variety of stressful tasks and in naturalistic settings need to be explored further.

Examining therapy procedures used in child and adolescent mental health care
Brigit van Widenfelt, Leiden University Medical Centre
There is a need for routine assessment of psychosocial treatment practices as an alternative to empirical trials as a way of evaluating treatment approaches with youth. This study investigated the documentation of how 164 Dutch therapists working in a variety of clinical settings carry out psychosocial treatment with children and adolescents. Therapists identified themselves to have different psychotherapy orientations: psychodynamic, (cognitive) behavioral, family, client-centered or experiential, and integrative. A Dutch translation of the Therapy Procedures Checklist (TPC) was completed by members of a child and adolescent therapist association on a clinical case they have treated. The therapists describe a number of problems the children aged 4-18 faced, which were primarily anxiety and depression, and rate the problems generally as moderate to severe. Children were mainly seen in individual child sessions. The factor structure of the Dutch version of the TPC was examined and revealed that the techniques therapists used could be organized in three highly reliable factors or subscales: psychodynamic, cognitive-behavioral, and family. In a second scale, four highly reliable factors on the etiological view of the problem were found: family/parents, psychodynamic, contingencies, and cognitive dysfunction/social skills. Therapists self-identified orientation was consistent with the techniques used and etiological views. Number of years of experience was not related to the factors. Implications for the science and practice of CBT: Having a way to assess usual psychosocial interventions can be very useful to both researchers and managers working in clinical settings to learn more about what works for whom in clinical settings. This instrument is useful in documenting how child and adolescent therapists work in their practice and with specific populations.

Training the attention networks of children with ADHD through mindfulness meditation
Karin Joanknecht, Uva-Virenze; Eva Van der Weijer-Bergsma, University of Amsterdam; Annemiek Vermeeren, University Maastricht; Susan Bogels, University of Amsterdam
Meditation and ADHD (Attention Deficit Hyperactivity Disorder) seem to share an underlying neurocognitive mechanism. While ADHD is characterized by problems of inattention, meditation enhances attention. Attention can be divided in a triad of subsystems: Alerting, Orienting and Executive Control (Posner & Peterson, 1990). ADHD is characterised by a dysfunction in the alerting and inhibition control networks. Meditation is associated with activation in all of the three networks. Based on these observations it was theorised that meditation would have a positive effect on ADHD symptomatology. Mindfulness training is an easy comprehensive meditation training, which made it a good candidate for therapy. Mindfulness group therapy for children with ADHD and their parents was provided in 8 weekly sessions of 90 minutes at an academic outpatient treatment centre. The ANT (Attention Network Task) separately measured the efficiency of the 3 subsystems of attention. A waitlist controlled, within subjects design was used with measurements at 2 times before the training (waitlist 6 weeks, pretest 1 week) and twice after the training (posttest 1 week, follow-up = 8 weeks). Multivariate Analysis of Variance was used. The independent variable was time (4 levels) and dependent variables were reaction times on the alerting, orienting and inhibition control elements of the ANT and the variance of those reaction times. We expected to find an improvement in the alerting network and the executive control network as these are the two networks that are impaired in ADHD. Results will be discussed during the poster presentation. Implications for the science and practice of CBT: Mindfulness meditation training can prove to be a fruitful non-pharmacological treatment for ADHD. This is especially interesting for those patients who wish to refrain from pharmacological treatment, and for those patients for whom medication does not alleviate the symptoms to an acceptable level.

To investigate the outcome of a Computer-Assisted CBT game on young Irish people with emotional difficulties: A randomised controlled trial
Aisling O’ Dwyer O’ Brien, University College Dublin; David Coyle, Trinity College Dublin; Sadhbh Coyle, National Educational Psychological Service; Gary O’ Reilly, University College Dublin
Cognitive Behavioural Therapy (CBT) is a common intervention for children with internalising disorders. However, our understanding of CBT with young people is still limited. Some children do not respond or do worse on a CBT programme (Hudson, 2005). CBT for children has often followed adult models which are not developmentally appropriate or tailored specifically for children (Cartwright-Hatton & Murray, 2008). This research aims to investigate the outcome of a computer-assisted CBT (C-CBT) game that young people play in session with their therapist called Gnatenborough’s Island. This poster will present the pilot phase of a Randomised Controlled Trial evaluation of a C-CBT programme delivered in a school setting by Educational Psychologists. Four participants were randomly allocated to the intervention or control group and were assessed using standardized instruments before and after the intervention. Participants were included if they were in the clinical range on an internalising disorder subscale of the Youth Self-Report. Case results from the pilot phase will be presented. The theoretical and methodological strengths and weaknesses of the pilot study and implications for the balance of data collection will be discussed. Implications for the science and practice of CBT: With the creation of a brief, evidenced-based, child-friendly, high-intensity CCBT intervention, CAMH services will be able to effectively intervene with more young people with a cut in time and cost (Marks, 2004).
Keynote

Treatment of Binge Eating Disorder: Current Status and Future Directions
Professor Carlos Grilo, Yale University, USA

This presentation will provide a systematic evaluation of controlled treatment research for obese persons with binge eating disorder (BED). Psychosocial, pharmacological, and combination approaches will be reviewed. Cognitive behavioral therapy (CBT) is the best established treatment; evidence also supports the effectiveness of interpersonal psychotherapy, dialectical behavior therapy, and behavioral weight loss therapy. Although these psychosocial interventions produce substantial improvements in binge eating and psychological functioning, they generally fail to produce needed weight loss. Evidence suggests that specific pharmacological treatments have a clinically significant advantage over placebo for achieving short-term remission from binge eating and short-term weight loss. Combining pharmacotherapy with psychosocial interventions fails to significantly enhance binge eating outcomes although some findings suggest specific medications may enable additional weight losses achieved with CBT and behavioral weight loss treatments. Finally, research on predictors and moderators of treatment outcomes will be presented with clinical implications for stepped-care treatment models for obese patients with BED.

Symposia

Experimental research in hot and cold cognition in eating disorders
Convenor: Kate Tchanturia, Institute of Psychiatry, King’s College London
Discussant: Rachel Bryant-Waugh, Great Ormond Street Hospital NHS Trust, Institute of Child Health, University College London

Performance-based Emotional Intelligence in Anorexia Nervosa
David Hambrook, Gary Brown, and Kate Tchanturia; Royal Holloway, University of London and King’s College London, Institute of Psychiatry

Emotional functioning in eating disorders (EDs) is a growing area of interest for researchers and clinicians. A number of recently conducted studies have highlighted that people with EDs exhibit difficulties in recognising their own and others’ emotions (Oldershaw et al., 2011), and report problems in the realms of distress tolerance, cold emotional expression and affect regulation (Hambrook et al., 2010; Harrison et al., 2010). It has been suggested that these difficulties may contribute to the maintenance of EDs and influence outcome (e.g. Fairburn et al., 2003; Schmidt & Treasure 2006). The current study seeks to build on existing research and explore emotional functioning in anorexia nervosa (AN) using a theoretically-derived, performance-based measure of emotional intelligence. Specifically, this study explores the abilities of adults with AN to identify emotions in themselves and others, to understand emotional meaning, use emotions to facilitate thought, and manage their own and others’ emotions through their behaviour. Results from a sample of people with AN will be compared with those from a sample of matched healthy controls. In addition to exploring differences between people with AN and healthy controls, we will report on the relationship between emotional intelligence and ED symptomatology, clinical characteristics, and social functioning. Implications for further research and the development of emotion focussed therapeutic interventions will be discussed.

Emotion Expression in Eating Disorders
Davies H*, Schmidt U, Tchanturia K; Institute of Psychiatry, London

We will present findings from two experimental studies which have explored facial expression, physiological response and verbal expression of emotion in people with anorexia and bulimia nervosa. Davies et al (2010) reported that people with AN are less facially expressive than HC whilst watching positive and negative film clips and report feeling less positive emotion but not less negative emotion than HC. The first study, presented here, provides a fuller picture of the emotion response system by adding a physiological measure to the paradigm, thus obtaining an objective measure of interoceptive awareness and complementing the data gathered on subjective response and expressivity. The second study has explored verbal expression and has used a quantitative text analysis to assess verbal expression when describing discrete emotional experiences. Findings from both studies will be discussed in relation to theories of emotion expression and emotion regulation strategies. These findings contribute to our understanding of why people with EDs have difficulties in relating to the self, the social milieu and also potentially why they are a difficult clinical group to treat.

Selective impairment in the automatic processing of facial expressions in restrictive anorexia and obesity
Renáta Cserjesi, Nicolas Vermeulen, László Lénárd, Olivier Luminit; Netherlands

There is growing evidence that disordered eating is associated with facial expression recognition and emotion processing problems. In this study, we investigated the question of whether restrictive eating (anorexia) and excessive eating (obesity) occur on a continuum. Findings from both studies will be discussed in relation to theories of emotion expression and emotion regulation strategies. These findings contribute to our understanding of why people with EDs have difficulties in relating to the self, the social milieu and also potentially why they are a difficult clinical group to treat. 

Hot executive functions and frontal-striatal systems in the treatment of adolescent obesity.
Antonio Verdejo-García, Elena Delgado-Rico, Laura Moreno-López, Natalia Albein-Urrios, Jacqueline Schmidt, and Carles Soriano-Mas, Spain

Background: Addiction and obesity show overlapping patterns of deficits in hot vs. cold executive function and dysfunction in brain circuits involved in incentive motivation and decision-making. Objective: The aims of this study are: (i) to assess hot and cold executive functions in obese adolescents, (ii) to examine brain activation during emotional processing and decision-making in obese adolescents using functional Magnetic Resonance Imaging (fMRI), and (iii) to explore the role of executive
functions in the prediction of treatment outcome in excess weight adolescents. Participants and Methods: We have administered a comprehensive assessment of hot and cold executive functions before and after a multidisciplinary treatment program for adolescent obesity including psychological trainings, nutritional counseling and physical activity in overweight vs. normal-weight adolescents. fMRI scanners are conducted before treatment onset and during actual treatment using food-cue and decision-making paradigms. Results: We will present results about: (i) neuropsychological performance in hot and cold executive indices in adolescents with obesity; (ii) the association between patterns of brain activation in response to high appetizing foods and personality traits of impulsivity and sensitivity to reward and neuropsychological indices; (iii) the predictive ability of neuropsychological measures and fMRI indices of fronto- striatal-midbrain activation and treatment outcomes. Conclusions: Overall, results support the existence of selective alterations in hot aspects of executive functions and their neural substrates in overweight adolescents. These alterations are further related with personality traits involved in higher sensitivity to immediate reinforcement, which may play a key role on treatment prognosis and clinical outcome.

Hot and cold cognition in eating disorders: developmental considerations
Discussant: Bryant-Waugh, R; Great Ormond Street Hospital NHS Trust, Institute of Child Health, UCL, London
Clinical presentations of childhood feeding and eating difficulties can shed important light on some of the questions and issues raised by the studies reported in this symposium. A consideration of such presentations can potentially contribute to a theoretical and practical understanding of some of the pathways involved in the development of the traits and tendencies reported here. Research involving children with feeding and eating problems specifically in relation to social and emotional functioning remains limited, yet there are many possible links to characteristics identified in older patients worthy of further exploration. The symposium will conclude with reflections set within a clinical and developmental context on some of the findings presented by the speakers.

New ideas in the inpatient treatment of eating disorders
Convenor: Bryony Bamford, St Georges Hospital

Developing a CBT Group for Inpatients with Severe Anorexia Nervosa
Bryony Bamford, St. Georges, University of London
Research has established that CBT delivered in a group setting can perform competitively against other group treatment approaches and individual CBT approaches in altering eating disorder psychopathology, weight and shape attitudes, social adjustment and self-esteem in individuals with bulimia nervosa. Within anorexia nervosa however, the efficacy of CBT groups is less well known. CBT group treatment for in or out patients has rarely been studied or described in the clinical literature. However, the efficacy of CBT group treatment in bulimia nervosa, together with the results of a small scale pilot study investigating the use of a CBT group on an inpatient ward for anorexia nervosa suggest this may be an area warranting further investigation. This paper will outline and describe the development of the a CBT group for inpatients with severe anorexia nervosa, briefly present group guidelines, session outlines and clinical tools used within the group and present results of a pilot study examining the efficacy of the group.

BodyWise: developing a new body image treatment for inpatients with anorexia nervosa
Victoria Mountford, South London and Maudsley NHS Foundation Trust, London, UK and Institute of Psychiatry
Body image disturbance is a core diagnostic feature of anorexia nervosa. It is one of the slowest features to resolve and poor body image at end of treatment is a negative prognostic factor. Research indicates that individuals are admitted to inpatient eating disorder wards at ever lower weights and many may not reach a healthy body weight over the course of their admission. Although body image treatments have been developed, these are often for outpatients or in patients who have reached a healthy weight, neglecting those at earlier stages of treatment. A manualised psychoeducative group treatment based on cognitive behavioural principles “BodyWise” was developed as a low intensity introduction to body image for such patients. This paper will outline the development of BodyWise and present preliminary findings from a randomised pragmatic study. Feedback from group participants and facilitators will further enrich such findings.

Pathways to Recovery in Inpatient Treatment: service user experience and feedback
Andrea Brown, The Retreat, York
A qualitative analysis of the current patients’ experience of the Naomi Pathways to Recovery was undertaken and the results are presented. Their experience was explored using focus groups and thematic content analysis of the data and a full evaluation of the reality of using the Naomi Pathways to Recovery will be described. This presentation will also include an exploration of how the use of therapeutic community principles enhance the use of CBT in an inpatient setting.

Patient-Keynurse Workbooks: Encouraging Motivational Change, Therapeutic Alliance, and Behaviour Change in Inpatient Treatment for Anorexia Nervosa
Richard Sly, St. Georges, university of London
Drop-out rates of inpatient treatment programmes for anorexia nervosa are high, with over half of patients not completing treatment. Past studies have examined patient characteristics as being key factors in this decision to withdraw from treatment, yet this model has yielded little predictive success. New research suggests that early response to treatment is a stronger predictor of treatment drop-out, with key areas being behaviour change, motivational change and development of therapeutic alliance. This session will outline a new nurse-led collaborative tool to assist in the early shifts in these areas that are needed to help increase chances of successful treatment.

Reward and punishment sensitivity in eating disorders: Empirical evidence and clinical applications
Convenor: Amy Harrison, Institute of Psychiatry, King’s College London

Experimental Measurement of Reward Sensitivity and Impulsivity in Eating Disorders
Amy Harrison, Institute of Psychiatry, King’s College London
Kaye (2004) has proposed that dysregulated reward pathways may underlie the development and maintenance of eating disorders (EDs). This is supported by a systematic review (Harrison et al. 2010) which found that people with an ED had elevated scores on trait measures of punishment sensitivity (anxiety and harm avoidance measured using the Tridimensional Personality Questionnaire (TPQ) (Cloninger, 1987), and the Temperament and Character Inventory (TCI) (Cloninger, 1993)
relative to healthy controls. It is possible that high levels of punishment sensitivity may reflect a dispositional tendency in people with EDs, as Wilksch and Wade (2009) report higher punishment sensitivity (measured using the Sensitivity to Punishment and Sensitivity to Reward Questionnaire (Torrubia et al., 2001)) in non-affected twin siblings of ED women, even after controlling for the temperament scores of the sister. This study aimed to measure reward sensitivity, specifically exploring tolerance of delayed reward using the Two Choice Task, time estimation and decision making under risky conditions using the Game of Dice Task in women with EDs (22 with restricting anorexia nervosa (AN), 11 with binge purge AN and 24 with BN), compared to 39 healthy controls (HCs). Reward reactivity was also measured using the Appetitive Motivation Questionnaire (AMS). For the Two Choice Task and the Game of Dice Task, women with restricting AN were able to delay reward longer and selected more safe choices than those with binge purge AN and BN. Women with EDs did not differ significantly from HCs in their ability to estimate the passage of time. In line with the experimental data, the AMS showed that women with EDs score significantly lower than HCs on a self-report measure of reward reactivity. Future work could explore these measures in those recovered from an ED to begin to examine state/trait features. Clinicians could help patients explore different strategies to use when making decisions under reward/risky conditions.

Heritability of Reward Sensitivity and Impulsivity in Twins with Eating Disorders
Natalie Kanakam, Institute of Psychiatry, King’s College London
Impulsivity has previously been defined as uncontrolled behaviour (Claes et al. 2009) and is associated with Bulimia Nervosa (BN), and the binge purge subtypes of Anorexia Nervosa (AN). Experimental research using the computerised task, the Game of Dice (Brand et al. 2005) in Eating Disorders (EDs) has shown encouraging results (Harrison et al. submitted). Familial studies will help to determine whether these traits are risk factors that run in families. This study assessed 72 clinical twins with EDs and their non ED cotwins in comparison to 42 control twins on the Game of Dice. In addition, the clinical twins were assessed for lifetime impulsive behaviours using the EATATE interview, which included impulse control behaviours, such as alcohol or substance abuse, self harm, stealing, disinhibited sexual activity or over-spending. These behaviours were assessed in relation to the computerised task scores as well as clinical symptoms such as purging, bingeing and illnes duration. Furthermore probands were compared to their non ED cotwins to investigate whether these were familial risk factors. Within pair correlations for identical and non-identical twins were used to explore the heritability of these traits. The aim of this study is to complete a study to see if they predict differences in clinical symptoms. Further work could explore these measures in those recovered from an ED to begin to examine state/trait features. Clinicians could help patients explore different strategies to use when making decisions under reward/risky conditions.

Risk for eating disorders, impulsivity and sensation seeking: Developing risk models
Radha Kothari, Institute of Psychiatry, King’s College London
The aim of this study was to explore patterns of impulsivity and sensation seeking that may affect risk status for disordered eating, in adolescence and young adulthood. Research indicates low inhibition, increased impulsivity, and high sensation seeking characterise individuals with bulimic behaviours (Kemps & Wilsdon, 2010; Claes et al. 2006; Kay et al. 1998; Toner et al. 1987). In contrast, restrictive anorexics have been shown to exhibit lower levels of sensation seeking than healthy controls (Strober et al. 2000). Evidence suggests variations in neurocognitive functioning within eating disordered groups (Konstantine et al. 2010), and it is possible that these differences could affect risk status for eating disorder related behaviours in adolescence. Individuals with eating disorders, and their unaffected sisters have been found to share similar deficits in neurocognitive functioning (Holliday et al. 2005; Roberts et al. 2010; Tenconi et al. 2010), implying an underlying vulnerability. To develop effective interventions, it is necessary to identify whether, and which, neurocognitive deficits are present prior to onset, however due to the limitations of current research (cross-sectional/retrospective design, use of clinical samples, and small sample sizes), it is difficult to imply causality. Assessing a group at high risk of developing eating disorder related behaviours is one method of investigating neurocognitive deficits prior to onset. Evidence suggests that eating disorders are more common in relatives of probands than in healthy controls or non-eating disordered psychiatric patients (Ben-Dor et al. 2002; Strober et al. 2000). It follows that there is potential for the children of mothers who have been diagnosed with an eating disorder to be at higher risk of developing eating disorder behaviours than the general population. The present study is an attempt to compare the levels of impulsivity and sensation seeking in children of women with and without eating disorders in a large prospective general population cohort, the Avon Longitudinal Study of Parents and Children (ALSPAC). The children of women with a lifetime eating disorder (n=441), and women without (n=10461), were investigated. Data on impulsivity/inhibition was obtained using the Stop Signal Task (Logan & Cowan, 1984), which has been used to show that restrained eaters are characterised by a deficit in the ability to inhibit ongoing responses (Nederkoor et al. 2004). The authors suggest that this could be an explanation for the unsuccessful restriction and erratic eating behaviours exhibited by bulimic groups. Data on sensation seeking was obtained using a modified version of Arnett’s (1994) Inventory of Sensation Seeking. Early identification of such neurocognitive abnormalities, in children at risk of developing eating disorder related behaviours, could help the development of early intervention/prevention programs targeting identified markers/precursors.

Social Reward Sensitivity in People with Eating Disorders
Valentina Cardi, Institute of Psychiatry, King’s College London
Experimental and neuroimaging evidence supports the idea of abnormalities in the reward system and learning and cognitive control in relationship to food in people with eating disorders (EDs) (Giel et al., 2010; Treasure et al., 2011). The aim of this work is to examine whether this abnormal reward sensitivity is specific to food or whether it is a more generalised deficit in the hedonic system. There are mixed and inconsistent findings into more general aspects of reward sensitivity in people with eating disorders (Harrison et al., 2010). The hypothesis of abnormal social reward sensitivity in people with EDs will be explored. Social reward is a primary reinforcer and it maps onto the same hedonic system involved in reward from food (Kringelbach & Berridge, 2010). People with EDs show abnormalities in social cognition and emotional processing (Oldershaw et al., 2010) and abnormalities in attention towards facial cues is present in both the acute and the recovered state (Harrison et al., 2010). A specific aspect of social behaviour is parenting. People with EDs have difficulties in this domain (Micali & Treasure, 2009) and they may show an abnormal processing of social stimuli like babies faces which are considered to produce an innate releasing mechanism for affection and nurturing (Lorenz, 1971). Recent studies found that the structural configuration of infant faces might act as a heightened attentional and emotional biasing mechanism in healthy subjects when compared to adult faces (Kringelbach et al., 2008). The results from pilot studies aimed at investigating the
cognitive processing (attentional bias) of social stimuli (adult and babies faces) in people with eating disorders will be presented. Furthermore, a theoretical model to explain a generalised deficit in the hedonic system will be discussed.

Hacking the Brain: Turning Symptoms into Therapy to Outperform Binges
Remi Neveu, Praxis/Center for Cognitive Neuroscience CNRS, Claude Bernard University, Lyon, France

Although medicine based- and/or cognitive behavioural therapies are efficient in bulimia nervosa (BN), the recovery and remission rates are low (20% and 39% on average respectively). Researchers and clinicians are currently looking for efficacious interventions which would improve treatment-resistant cases. Individuals with BN are impaired in situations that require self control. This impairment is likely to affect the mechanisms involved in decision making (measured using the Stroop, Wisconsin Card Sort Test, delay discounting and Tower of London tasks), rather than those inhibiting prepotent behaviors (measured using go/no-go, stop-signal and circle drawing tasks). These tasks recruit the lateral (IFPC) and the medial (mPFC) prefrontal cortex. The mPFC produces signals initiating actions and is under the control of IFPC. In BN patients, the IFPC is hypoactivated and the mPFC is hyperactivated compared to healthy subjects. This suggests that the IFPC hyporegulates the mPFC which, is likely to promote binge eating episodes. This presentation aims to describe a therapy based on neuroscience that targets critical periods of the disorder. The sequential binge therapy aims to 1) reduce spontaneously the food intake during binge eating episodes by replacing the usual end-signal of binges by the specific satiety signal, 2) develop self control towards food using a sequential binge paradigm in which patients change only the way they binge and 3) normalise the activity of mPFC and IFPC using training based on the aforementioned tasks. Promising findings in a series of thirteen inpatients who implemented the sequential binge suggest that binge eating episodes may be turned into therapeutic symptoms fully compatible with regular CBT for BN.

Panel Discussion

The use of target weights within inpatient treatment of anorexia nervosa
Convenor: Bryony Bamford, St. George's, University of London
Speakers: Lucy Serpell, University College London and North East London NHS Foundation Trust
Hubert Lacey, St. Georges University of London
Bryony Bamford, South West London and St Georges NHS Trust
John Morgan, Leeds Partnership Foundation Trust

Getting the 'B' Back Into CBT: Sticking To What Works for the Eating Disorders
Glenn Waller, Central and North West London NHS Foundation Trust

There is strong evidence in support of cognitive-behavioural therapy (CBT) as the first line approach for the eating disorders. However, as with many other domains where CBT has an evidence base, it is clear that this approach is more talked about than delivered in clinical settings. This workshop will stress the need to focus on what works rather than what is fashionable - stressing the importance of ensuring behavioural change rather than metacognitive analysis. In short, CBT needs to be seen as a 'doing' therapy rather than a 'talking' therapy, where the key therapeutic mechanism is behavioural change (e.g., exposure, skill training, behavioural experiments), with its impact on cognitions, emotions and physiology. The workshop will outline and demonstrate the key procedural elements of CBT for the eating disorders, but will also address other vital treatment issues (e.g., boundaries, therapeutic relationship, motivation) from a more behavioural stance.

Learning objectives:
The importance of behavioural change in delivering evidence-based CBT for the eating disorders.
The need to maintain therapeutic fidelity in both content and process of CBT for the eating disorders.
The ability to deliver effective CBT for the eating disorders, and to supervise others in doing so.
Training modalities:
A combination of experiential, didactic and role play. Case material to be used as appropriate.

Open Papers

Susceptibility to Thought-Shape Fusion in Adolescents and Adults
Jennifer Coelho, Pauline Dietre, Mary-Joe Siggen, Martine Bouvard: University of Savoie

Maladaptive eating-related cognitions may play a role in eating pathology. These cognitions are more prevalent in individuals with eating disorders than in non-clinical samples; however, biases may extend across the spectrum of eating pathology, with chronic dieters, and overweight these individuals also exhibiting maladaptive cognitions. A maladaptive cognition that is specific to eating has been identified, in which individuals believe that they have gained weight, done something morally wrong, or become fatter after merely imagining that they have consumed a fattening food. This cognitive distortion has
been labelled ‘thought-shape fusion’ (TSF; Shafran, Teachman, Kerry & Rachman, 1999). Existing research has primarily investigated this phenomenon in adults with eating disorders; however, it was expected that adolescents and adults without eating disorders would also be somewhat susceptible to TSF. Given research indicating that overweight individuals exhibit heightened reactivity to food cues (Tetley, Brunstrom & Griffiths, 2009), it was further expected that body weight would moderate susceptibility to maladaptive food-related thoughts (i.e., TSF). Two studies investigated TSF in normal-weight and overweight adults (n=60) and overweight adults (n=52). The adolescent sample included obese inpatients in a psychiatric treatment centre. The results indicated that overweight/obese individuals exhibited higher levels of trait TSF than did normal-weight individuals. The results of these studies suggest that overweight/obese individuals may have more general maladaptive cognitions consistent with TSF than do normal-weight individuals. The role of negative affect and depression on TSF susceptibility will be explored, and the potential impact of TSF susceptibility on behaviour will be discussed. Research on cognitive distortions such as TSF can provide insight into mechanisms involved in the development and maintenance of eating disorders and maladaptive eating behaviour.

The neuropsychology of starvation: Set shifting, Perseveration, Persistence and Central Coherence in a non-clinical sample.
Sarah Pender, Lucy Serpell, Sam Gilbert: University College London
Recent research has suggested that a range of neuropsychological deficits occur in anorexia nervosa. It is also important to consider the effects of starvation on neuropsychological performance, in order to establish whether starvation contributes to these deficits or whether they exist independent of starvation. To assess the contribution of short-term fasting to neuropsychological performance, we administered a number of tasks to non-clinical participants using a within-subjects repeated measures design. Participants were tested twice, once after fasting for 18 hours, and once when satiated. Measures included the Embedded Figures Test (Witkin et al., 1971) to measure central coherence; the Brixton Task (White, O’Reilly & Frith, 2009) to measure set shifting; and computerised tasks to measure perseveration and persistence. Data collection has now been completed and we are awaiting preliminary results. The results have considerable clinical relevance. If neuropsychological performance is even partly related to starvation, then refeeding patients may be sufficient to ameliorate some of their difficulties. This may also impact on the order in which existing CBT treatments would be offered.

An exploratory study of the role of values in Anorexia Nervosa.
Una Mulkerrin, Lucy Serpell, Bryony Bamford: University College London
Throughout the literature, Anorexia Nervosa (AN) is considered one of the most pervasive, difficult-to-treat psychiatric disorders (Bruch, 1973). Research to date suggests that engagement in psychological therapy among individuals with AN is particularly confounded by ambivalence and a resulting low level of motivation to change (Vitousek, Watson & Wilson, 1998). This ambivalence is considered to be a function of internal conflict between the ego-syntonic and ego-dystonic symptoms of AN (e.g. Casasnovas et al., 2007). In line with the development of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), the importance of focusing on personal values as a means of enhancing motivation to change has been highlighted recently (Merwin & Wilson, 2009). However, there is an apparent dearth of research in this context. This study used a qualitative methodology to explore personal values among individuals with a diagnosis of AN, with a broad focus on gaining an insight into their overarching life values, valued aspects of their eating disorder and how these relate to each other and interact. In-depth, semi-structured interviews were carried out among eight female outpatients and inpatients with a diagnosis of AN. Data was analysed using Interpretative Phenomenological Analysis (IPA; Smith, Jarman & Osborne, 1999). A number of inter- and intra- personal values have emerged; some being distinct from, and others overlapping with valued aspects of AN. Some pliancy in relation to values is evident, along with difficulties managing and resolving paradoxes and tensions between polarised and conflicting values. Findings relating to AN’s impact on participants’ abilities to identify and live according to their values is mixed. Preliminary analysis has provided exciting insights into this under-researched, yet increasing relevant area. The refined results will be discussed in the context of existing literature, methodological considerations, clinical implications and future directions. These findings will potentially provide useful phenomenological insights into ways of understanding, exploring and using values when working from a CBT and ACT perspective to enhance motivation to change among individuals with AN.

Attitudes towards self-help for eating disorders.
Carrie-Ann McClay, Chris Williams, Louise Ewan, Ulrike Schmidt: University of Glasgow
Bulimia nervosa (BN) is a disorder affecting many young women and men. Some individuals access services only when their condition becomes chronic and therefore miss the opportunity for early intervention. One resolution to this is self-help (SH). ‘Overcoming Bulimia Online’ is a SH package which aims to help individuals to change their thoughts, feelings and behaviour with regard to food using the principles of cognitive behavioural therapy. A previous RCT has shown that with support it can be effective as a treatment of BN. 253 participants completed an online questionnaire about their attitudes towards SH for eating disorders. The focus of the questionnaire was on the types of support participants thought they would need when using such a SH package. Participants completed an attitudes questionnaire and were then shown an online slideshow of ‘Overcoming Bulimia Online’. This slideshow delayed participants completing the same attitudes questionnaire again and changes in their opinions were evaluated. 73.5% of participants believe that some form of support would be helpful whilst using the self-help materials. The most popular medium of support was email, the preferred frequency of support was weekly and 65.2% of respondents said the duration of support sessions should be flexible. Detailed data of preferences towards the support (content, length and modality), needed for computerised treatment for BN will be described. The results provide valuable information regarding how individuals can be optimally support whilst using a SH intervention. The findings of this survey will provide information regarding attitudes towards self-help for eating disorders, whether this is a desirable treatment option and what types of support individuals with BN or EDNOS would like whilst using an online CBT intervention such as ‘Overcoming Bulimia Online’. This information can then be used in the development and introduction of self-help interventions in clinical practice.

Evidence-based Treatments in Eating Disorders: Treatment History Questionnaire.
Rachel van Schaick, Lucy Serpell, Blake Stobie: University College London
Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT) are indicated in NICE guidelines as treatments for bulimia nervosa (BN) and related eating disorders. However, individuals with these problems are frequently not offered such evidence-based treatments. Furthermore, research investigating treatments for anxiety disorders has shown that a large
investigated gender differences; and compared data with wellbeing studies investigating carers of people with other long-
difficulties. The current aims investigated wellbeing in carers of people with ED and specifically, carers of people with SEED;
disorders (SEED) almost nonexistent. Nearly 40% of carers of people with ED experience clinical level mental health
in those who are regaining weight or have non-underweight ED diagnoses.

These findings contribute towards an emerging understanding of the cognitive and affective processes which contribute to
symptoms in currently underweight ED-cases may be different. Implications for the science and practice of CBT:
underweight ED-cases via brooding on eating, weight and shape. The cognitive processes involved in maintaining ED
accepting and non-judgmental mode of processing, may be fruitful in reducing eating disorder psychopathology, particularly
the maintenance of ED psychopathology and suggest that that reducing disorder-specific rumination, by cultivating a more

Only 54 of 99 respondents (54.5%) recalled having received CBT (51, 51.5%) or IPT (3, 3%) and 11 (11%) respondents were not
sure what type of psychological therapy they had received. Contrary to predictions, there was found to be no difference in
self-perceived outcomes between participants who recalled receiving CBT or IPT and participants who recalled receiving other
types of psychological therapy. Of the respondents who recalled having received CBT, only 21 (41%) received CBT
judged as ‘adequate’, as rated by experts in the field. A non-significant trend was found for those who had received
‘adequate’ CBT to rate their self-perceived outcomes, both specific to their eating disorder and in general well-being, as
higher than those who had received inadequate CBT. The study provides evidence that many individuals with BN and related
eating disorders are not receiving evidence-based treatments. It supports previous findings from studies investigating
treatment for anxiety disorders that a high proportion of those who recall having received CBT have not received therapy
that meets minimum criteria to be labelled as such. Interpretations of the research findings are discussed. The study
findings raise many questions in regard to the implementation of CBT in clinical practice. For example, the trend for those
who engaged in ‘adequate’ CBT to rate their self-perceived treatment outcomes more favourably than those who engaged in
‘inadequate’ CBT points toward the need to closely follow treatment models.

Posters

Body dissatisfaction in Japanese female university students: Is dissatisfaction with one’s physical appearance other than
body weight and shape a problem?
Eriko Ambo, Graduate School of Human Sciences, Waseda University; Tina Suga, Graduate School of Human Sciences,
Waseda University; Kaneo Nedate, Faculty of Human Sciences, Waseda University

The purpose of the present research was to investigate the types of body dissatisfaction Japanese female university students
experienced (Study 1) and the relations between dissatisfaction with one’s body other than weight and shape and her
abnormal eating behaviors (Study 2). In Study 1, female university students (n = 261) were asked to write down a list of
physical characteristics they were dissatisfied with. In Study 2, female university students (n = 255) completed measures of
abnormal eating behaviors and 5 types of body dissatisfaction, namely dissatisfaction with one’s body shape, face, and entire
body, dissatisfaction with others’ evaluation of one’s body size, and anxiety about one’s entire physical appearance. Results
of Study 1 demonstrated that 69.2 percent of the female respondents reported dissatisfaction with their body other than
weight and shape, such as dissatisfaction with their face (17.2 %), and their entire body (8.5 %). Results of Study 2 showed
that dissatisfaction with one’s face was associated with abnormal eating behaviors (r = .26, p < .001). Results of step-wise
multiple regression analysis indicated that dissatisfaction with others’ evaluation of one’s body size and anxiety about one’s
entire appearance were predictors of excessive dieting (R² = .15, F = 22.10, p < .001) and bulimic symptoms (R² = .15, F =
21.12, p < .001). The findings suggested that dissatisfaction with one’s body other than weight and shape is very common
and positively associated with unhealthy eating behaviors in Japanese young women. Implications for the science and
practice of CBT: The findings of this research indicate that it is important to reduce individuals’ dissatisfaction with their
body other than weight and shape for improving unhealthy eating behaviors.

Experiential avoidance and low mindfulness as a predictor of eating disorder symptoms: The mediating role of
ruminative brooding
Felicity Cowdrey, University of Oxford, Rebecca Park, University of Oxford

Eating disorders have been associated with high levels of ruminative thoughts about eating, shape and weight as well as
experiential avoidance. This study examined the role of ruminative brooding on eating, weight and shape concerns in
mediating the effect of experiential avoidance and mindfulness on eating disorder (ED) symptoms. A sample consisting of both healthy adults (N = 275) and individuals who had experienced an ED (ED- cases); N = 93 completed a battery of on-line self-report measures. In the healthy sample, ruminative brooding (but not reflection) significantly mediated the effect of both experiential avoidance and mindfulness on ED symptoms. The results of the mediational analysis were replicated in the ED-case group consisting of both recovered and currently diagnosed participants. When examining the currently overweight participants only, brooding on eating, weight and shape concerns was not a significant mediator. Experiential avoidance and low levels of mindfulness may increase ED symptoms and may do so in non-underweight ED-cases via brooding on eating, weight and shape. The cognitive processes involved in maintaining ED symptoms in currently underweight ED-cases may be different. Implications for the science and practice of CBT: These findings contribute towards an emerging understanding of the cognitive and affective processes which contribute to the maintenance of ED psychopathology and suggest that that reducing disorder-specific rumination, by cultivating a more accepting and non-judgmental mode of processing, may be fruitful in reducing eating disorder psychopathology, particularly in those who are regaining weight or have non-underweight ED diagnoses.

The wellbeing of carers of people with Severe and Enduring Eating Disorders (SEED)
Stephen Linacre, University of Leeds; Andrew Hill, University of Leeds; Suzanne Heywood-Everett, Leeds Partnerships NHS Foundation Trust

Research on carers of people with eating disorders (ED) is limited and on carers of people with severe and enduring eating
disorders (SEED) almost nonexistent. Nearly 40% of carers of people with ED experience clinical level mental health
difficulties. The current aims investigated wellbeing in carers of people with ED and specifically, carers of people with SEED;
investigated gender differences; and compared data with wellbeing studies investigating carers of people with other long-
term conditions. The Stress Process Model (SPM) (Pearlin, Mullan, Semple, & Skaff, 1990) was used to better understand predictors of wellbeing. Carers (28 male, 76 female) were recruited from ED carer support groups. Carers were stratified using duration (since diagnosis) of their recipient’s ED (0-2 years, 2-6 years, over 6 years). The “over 6 years” category was classified as SEED. Comparison data were drawn from carers of people with dementia, brain injury, ED and psychosis. Standardised questionnaires measured wellbeing (SF-36), experiences of caregiving (ECI), perceived caregiver competence (MoCC), sense of personal mastery (MoPM) and expressive support (MoES). Carers of people with SEED were not significantly different on reported wellbeing to the whole sample of carers of people with ED. However, carers of people with ED reported significantly poorer wellbeing than community norms, carers of people with brain injury and dementia. Perceived dependency, carer gender and sense of personal mastery accounted for 29% of the variance in mental wellbeing scores. Differences in reported positive experiences of caregiving were identified. The mental wellbeing of carers of people with SEED and ED appears poorer than carers of other conditions. Further research on carers of people with SEED is needed. The SPM is a helpful framework to use. Implications for the science and practice of CBT: Clinical implications include ensuring that perception of dependency and the positive experiences of caregiving are addressed in workshops and support groups.

Individual experiences of using an online self-help package for Bulimia Nervosa
Carrie-Anne McClay, University of Glasgow; Chris Williams, University of Glasgow; Louise Ewan, University of Glasgow; Ulrike Schmidt, Institute of Psychiatry; Ciaran McHale, University of Glasgow

Self-help materials have shown the potential to significantly reduce symptoms of bulimia nervosa. Online CBT based packages could bridge the gap between onset of illness and specialist individual therapy and has been recommended in the NICE 2004 eating disorder guidelines. The objectives of this research were to explore individuals’ experiences and responses to using an online self-help package for bulimia nervosa (www.overcomingbulimiaonline.com). A number of participants who had been taking part in an RCT of an online self-help package for bulimia nervosa were randomly selected to take part in interviews. Eight participants were interviewed to explore their responses to, and experiences of, taking part in the intervention. Topics included: their reasons for choosing the self-help approach, their thoughts on the self-help intervention in comparison to other treatments they had previously received, their experience of taking part in an online study and questions pertaining to adherence and motivation. Follow up probing of participant’s responses allowed for clarification and elaboration. All interviews were recorded and transcribed verbatim. Thematic analysis is currently being used to analyse the interview content and the emerging themes will be discussed as part of this paper. The themes identified will provide rich information regarding participant’s experiences of using an online self-help package, the support they received whilst using it and also how the intervention compared to other treatments participants had accessed in the past. Implications for the science and practice of CBT: The findings from this study will be used in order to aid the future development and delivery of self-help resources for individuals with eating disorders and other mental health problems. The results will enable researchers and clinicians to understand why individuals are drawn to the self-help approach for treatment of eating disorders and how such materials can be best delivered.

IAPT and Primary Care

Keynote

Lessons of IAPT for Children’s Services
Emeritus Professor Lord Richard Layard London School of Economics

This presentation will discuss the lessons learnt from existing IAPT services for the children and young people’s IAPT project. The Government has committed to expanding IAPT to meet the needs of children and young people in 2011-12. The children and young people’s IAPT project will learn from the experience of the Adult Programme, but is being designed to meet the specific needs of under 18 year olds. The aim of this new project is to improve outcomes for children and young people by making sustainable changes in practice within services and increasing the capacity of existing targeted and specialist child and adolescent mental health services.

Symposia

IAPT on the ground
Convenor: Roz Shafran, University of Reading, and Jackie Prosser, IAPT Regional Clinical Lead, South Central Strategic Health Authority

IAPT implementation: A treatable condition (in hindsight)
Paul Sigel, Head of Primary Care Psychology NHS City and Hackney Community Health Services

The IAPT service in NHS City and Hackney Community Health Services is a Wave 1 site that serves one of the most economically and ethnically diverse areas in the United Kingdom. More than one third of the local population come from black or minority ethnic backgrounds, ranging from Eastern Europe, Africa and the Caribbean, to Turkey, Greece, Ethiopia, Somalia, India, Pakistan and Bangladesh. Such diversity has posed a stimulating challenge to the development of IAPT services. This presentation will describe the lessons learned from the development of the IAPT service, and the implications for the future expansion of IAPT to different populations and, in particular, to those with long-term conditions.

How to Be the Best - Strategies and Fine Tuning techniques to achieve “Best in Class” status
Judith Chapman, Clinical Lead, Talking Therapies (IAPT), Berkshire West, Berkshire Healthcare and former IAPT Clinical Advisor, South Central SHA.

Berkshire West Talking Therapies is a Wave One site with three years of practical experience behind it - which has consistently met or exceeded targets from day one. The Service also manages a Common Point of Entry for all of the Primary Care mental health resource available in the area. This session provides an overview of the synergies, structures, techniques and models used to create an effective and successful service delivery organisation within an IAPT context. It will demonstrate how to combine the use of both High Intensity & PWP staff, Information Tools, imaginative treatment concepts, modern communication methods, traditional therapy and effective marketing to:
• Meet targets consistently through Target Tracking
• Create flexible working practices to manage client flow as demand changes
• Influence demand through marketing and relationship management with GPs and Commissioners
• Maintain an effective, stable and motivated team

Are We Nearly There Yet? The development of new roles in an IAPT service
June Dent, Clinical Lead, TalkingSpace, IAPT Oxfordshire and former IAPT Clinical Advisor, South Central Strategic Health Authority
As IAPT reaches “full roll out” across England over 3700 people have taken on new roles and made them their own. This presentation draws on experiences of staff in TalkingSpace Oxfordshire, and in other services in the Region to describe the journeys:
• From trainee to qualified and accredited staff for Psychological Wellbeing Practitioners and for CBT Therapists
• For new “IAPTised” CBT supervisors and the emergent senior PWP’s
• For managers and clinical leaders of large and evolving services.
We will discuss the delights, the fulfillment and the hassles on the way, and will consider solutions for the way ahead.

General Practitioners in IAPT: the good, the bad and the future
Katie Simpson, South Central SHA, IAPT Programme GP Lead
GP's have had a primary role in the national IAPT programme, with each Strategic Health Authority having a GP lead with a special interest in what IAPT can achieve for patients in primary care settings. For many IAPT services, GPs are the main referral source. It was expected that GPs would warmly welcome IAPT services as they extend the range of interventions and the choices available to their patients. In many cases this has been the case and there are positive close links between GP practices and IAPT services. However, there have also been difficulties with the liaison between GPs and IAPT services. This presentation will review what has worked well in IAPT from the GPs perspective, what has not and what the implications of GP Commissioning may be for IAPT and other mental health services in the future.

IAPT: An update
Convenor: David Clark, National Clinical Advisor for adult IAPT

An update on the national adult IAPT programme
Kevin Jarman, Department of Health
The IAPT programme for adults with depression and/or anxiety disorders is now in it’s third year. This presentation will cover achievements to date and highlight future developments. The Coalition Government has made a strong commitment to IAPT as evidenced by it’s prominence in the new mental health strategy (No Health without Mental Health) and the NHS Operating Framework. Ways in which local stakeholders can help ensure that it continues to expand will be discussed along with the benefits for services and users of the new Information Standards Board (ISB) notice which requires all IAPT services to download a comprehensive set of data for central processing.

Enhancing recovery rates in adult IAPT services: some lessons from further analysis of the year one database
Alex Gyani, University of Reading and David Clark, King’s College London
32 year one IAPT sites downloaded for central processing their data on patients seen in the period 1st October 2008 to 31st September 2009. A preliminary analysis of the data showed that 42% of patients reached pre-defined recovery criteria. However, there was large variability in the recovery rates reported in individual sites. A further analysis was therefore conducted to determine the organizational, treatment type and patient characteristics that are associated with high versus low recovery rates. The main results of the analysis and their implications for the future design of IAPT services will be discussed.

Collaborative Depression Trial (CADET): multi-centre randomised controlled trial of collaborative care for depression
David A Richards, University of Exeter and colleagues (Adwoa Hughes-Morley, Rachel A Hayes, Ricardo Araya, Michael Barkham, John M Bland, Peter Bower, John Cape, Carolyn A Chew-Graham, Linda Gask, Simon Gilbody, Colin Green, David Kessler, Glyn Lewis, Karina Lovell, Chris Manning and Stephen Pilling)
Background: Comprising of both organisational and patient level components, collaborative care is a potentially powerful intervention for improving depression treatment in UK primary care which shows considerable efficacy and effectiveness internationally. However, as collaborative care has been developed and evaluated in the United States, it is necessary to establish the effect of collaborative care in the UK in order to determine whether this treatment model can replicate benefits for patients outside the US. Methods/Design: CADET is a multi-centre phase III clinical trial with cluster-randomised allocation of GP practices to usual care control or to collaborative care - a combination of case manager coordinated support and brief psychological treatment, enhanced specialist and GP communication. The primary outcome is symptoms of depression as assessed by the PHQ-9. Results: clinical outcomes of 550 patients randomised to collaborative care or usual care will be presented for four month follow up. Conclusion: the results of the CADET trial will provide evidence to enable NICE and the NHS to make a decision on the value of collaborative care in the organisation of depressed patients, and to assist service providers in the design of a model of enhanced depression care which should be both effective and acceptable to patients.

Developing a child IAPT programme
Peter Fonagy, University College London
The Coalition’s new mental health strategy (No Health without Mental Health) committed the NHS to developing a child focused version of IAPT. This presentation provides an overview of the new programme.

Panel Discussions

IAPT: Medical model or psychological model; night-club bouncers or open-door welcoming?
Convenor: Henck van Bilsen, Canterbury Christ Church University
Convenor: Marie Chellingsworth, University of Nottingham
Chellingsworth will act as discussant.

The UK government has unleashed an unprecedented investment aimed at improving access to psychological therapies for people with anxiety and depression problems. The IAPT (Improving Access to Psychological Therapies) initiative was aimed at setting up psychological therapy services offering a mix of (mainly CBT based) interventions. These interventions range in intensity, from internet based guided self-help to individual cognitive behavioural psychotherapy. The organisational models of the IAPT services vary considerably as does the access to the interventions the services have on offer and even the services themselves differ considerably. So, despite the centralised guidance, there still exists a disparity of psychological services available: in some places self-referral is an option while elsewhere a GP referral is needed, in some places there are still extensive waiting times, sometimes cognitive behavioural psychotherapy sessions are limited to 8, while at other times only fortnightly sessions are on offer. A general trend is a set-up whereby clinician guided triaging and selection is put in place. In general, the IAPT services seem to be set up based on a ‘night-club bouncer’s model’. This means that systems are put in place to keep people out and to make decision for people where they should go. This is in fact an application of medical model thinking within a psychological therapy services. Clinician rather than client preference dictates what is offered to the clients. In this panel discussion we would like to wipe the slate clean and start from scratch. We have asked the presenters to focus on what would be the ideal organisational set-up for a psychological therapy service aimed at offering evidence based interventions for anxiety and depression. We have asked them to underpin their organisational model as far as possible with a CBT and psychological evidence base.

In their opening statements they will address:
1. Which staff budget would you need for a population of around 500,000?
2. What would be the ratio between PWP and CBT-psychotherapists?
3. How would you organise access to the service?
4. How would you organise allocation of clients to PWP and CBT-Psychotherapy?
5. How would you prevent waiting times of longer than 2 weeks from occurring?
6. What would you see as the major roadblocks that might prevent putting this model in place?

The session is structured as a panel discussion whereby the panel members put their stake in the ground in brief opening statements followed by a discussion chaired by the discussant. The participants have been asked to contribute from their unique perspective. Adrian Withington is a former course director of an IAPT/ CBT course (Canterbury Christ Church University) and is currently Associate Director of Training: Psychology and Psychological Therapies of Sussex Partnership NHS Foundation Trust. Timothy Carey will present his ideas based on service efficiency improvement in rural settings. Tim is currently Associate Professor in Mental Health at the Centre for Remote Health and the Central Australian Mental Health Service. Jim White’s experience is from an inner city perspective and he will present his ideas based on experiences with the Glasgow STEPS model. The discussant Paul Johanson is the IAPT Programme Manager for the NHS South East Coast and will comment on the ideas and the discussion from his unique perspective. The chair will open the panel debate with a brief introduction, followed by each panel member putting their stake in the ground for not longer than 10 minutes, whereupon the discussant will open the debate. Panel members and audience alike can join in the debate.

Application of the Low-Intensity CBT clinical methods to working with patients with long-term conditions

Convenor: Marie Chellingsworth, University of Nottingham

Speakers:
- Adrian Whittington, Sussex Partnership NHS Foundation Trust
- Tim Carey, Centre for Remote Health and the Central Australian Mental Health Service, Australia
- Rosey Adkins, Samantha Cox, Sian Price: University of Reading
- Amanda Branson, Pamela Myles: University of Reading
- Marie Chellingsworth, IAPT Course Director, University of Nottingham
- Samantha Cox, Rightssteps IAPT Service, Turning Point, Derbyshire
- Sian Price, Berkshire Healthcare NHS Foundation Trust
- Tom Ricketts, NHS Devon
- Paul Johanson, NHS South East Coast
- Jim White, Greater Glasgow and Clyde NHS
- Tom Ricketts, NHS Devon
- Tim Carey, Centre for Remote Health and the Central Australian Mental Health Service, Australia
- Amanda Branson, Pamela Myles: University of Reading

The emphasis within the initial roll out of the Improving Access to Psychological Therapies (IAPT) programme was upon the treatment of patients with depression and anxiety. As IAPT has become established there is now an increased focus upon improving access to evidence based psychological therapies to patients with depression and anxiety that is comorbid to a long term physical health problem. Increasing access for patients with comorbidty cannot come a moment too soon given extensive unmet need amongst this patient group for evidence based psychological therapies. This clinical roundtable seeks to highlight the varied ways in which the low intensity CBT clinical method can be applied to patients with co-morbid physical health problems. Marie Chellingsworth will introduce the clinical roundtable highlighting the emerging policy context surrounding the increased focus within IAPT upon long term conditions and reviewing the latest developments regarding the development of training in this area. Current Psychological Wellbeing Practitioners - Rosey Adkins, Samantha Cox, Sian Price, will then give presentations concerning ways in which they have applied the low intensity CBT clinical method to long term physical health conditions including irritable bowel syndrome, tinnitus, ME/CFS, and chronic obstructive pulmonary disease. These presentations will initially focus upon the evidence base surrounding the low intensity CBT treatment of these conditions with a series of individual case studies highlighting ways in which the specific low intensity interventions have been applied to patients with varied long term physical health conditions. Finally each speaker will then discuss the challenges and opportunities they have experienced when treating patients with physical health problems using LI CBT. Following these presentations Paul Farrand will overview the evidence base surrounding low intensity CBT interventions for long term physical health problems, highlighting areas for optimism and emerging challenges. Marie Chellingsworth will act as discussant.

Open Papers

IAPT Training: Do we train in vain?

Amanda Branson, Pamela Myles: University of Reading
IAPT is a Government initiative to train therapists to deliver evidence based psychological therapies (typically cognitive behavioural therapy) for patients presenting with anxiety and/or depression. Despite a government investment of £170 million, little is known about the efficacy of such training programmes (Keen & Freeston, 2008). This is surprising considering the obvious need to ensure that therapists have the knowledge, skills and attitudes necessary to effectively treat patients. The aim of this research is to examine the validity of training measures and the impact of training on clinician competence. Therapists on High Intensity (HI) (n=87) and Psychological Wellbeing Practitioner (PWP) (n=101) programmes at the University of Reading were invited to take part in this longitudinal study. Clinical skill was assessed via audio recording (HI) and role-play (PWP) of a therapy session using standardized measurement tools. Data revealed that training improves clinical skill, as measured by course grades, for both HI and PWP trainees. The PWP role-play at the end of training achieved significantly higher scores (M=78.61, SE=1.08) than the role-play at the start (M=74.24, SE=1.21), t (99)=−3.08, p<.003. The HI recording received significantly better scores on the Cognitive Therapy Rating Scale Revised at the end of training (M=54.2, SE=0.95) than at the beginning (M=49.3, SE=2.32), t(77)=−3.69, p<0.001. The implications of these findings, limitations of using course grades to measure clinical skill and future lines of research will be discussed. The IAPT programme presents a unique opportunity to answer the question of clinical validity of the training measures and whether the knowledge, skills and attitudes acquired during training are transferred into practice.

Patients’ satisfaction with IAPT interventions delivered by Sussex Community NHS Trust’s ‘Time To Talk’ service.

Serenia Yip: Sussex Community NHS Trust

It has been found that patient satisfaction is a valuable measure of health care (Fitzpatrick, 1992), and that service users have a unique perspective of the care process that is important to any complete service evaluation (McAuliffe & MacLachlan, 1992). The present clinical research aims to investigate on patients’ satisfaction with the West Sussex north locality’s ‘Time To Talk’ service. The service is provided by the Sussex Community NHS Trust, and is offered in 3 service areas: Crawley, Mid Sussex and Horsham & Chantonnry. The research sampled and gathered data from 150 patients over the telephone, using an 8-question in-house Patient’s Satisfaction Questionnaire (2010) and a semi-structured interview. Patients were generated using a systematic sampling method from our in-service computer software IAPTUS; every 10th patient from the opted-in service list was contacted. The research consisted of two separate phases for each patient. The first phase included the administration of an in-house questionnaire on satisfaction (PSP) at patients’ convenience over the telephone. Patients’ responses to the semi-structured interviews were assembled and subsequently thematically analysed. Responses from patients were described as relating to a theme, and by constant comparison, similar themes were grouped into wider, super-ordinate themes. There were many cycles of texts and of themes re-examination. The results indicated that all interventions offered by our service have been used by our patients - Guided Self Help (GSH), CBT, Mood Management Group, employment Service, psycho-educational courses, counselling and information/signposting. Amongst the aforementioned services, GSH was most used by patients. It has been found that the majority of patients overall rated our service overall to be excellent by our service have been used by our patients.

Are the NICE guidelines for Depression used in Primary Care and what impact do they have on the treatments offered to patients? An exploratory study

Alex Gyani, Neil Pumphrey, Hannah Parker, Roz Shafran: University of Reading

The National Institute of Health and Clinical Excellence (NICE) clinical guidelines for depression were first issued in 2004 and revised in 2009. Previous research has shown that clinical guidelines for mental health disorders such as PTSD, eating disorders and OCD are not being read by GPs. The views and treatment decisions of GPs in Hampshire, Berkshire and Buckinghamshire were investigated using questionnaires and interviews. Six interviews were conducted and questionnaires were sent to 830 GPs. Two hundred and twenty two questionnaires were returned, giving a response rate of 26.7%. Seventy eight per cent of respondents reported that they had read the NICE guidelines for depression. GPs that had read the guidelines or had an Improving Access to Psychological Therapies (IAPT) service available for referral were more likely to treat depression in a NICE concordant manner than those who did not. The interviews indicated that some GPs may have limited awareness of IAPT and that a lack of local provision of CBT can lead to GPs feeling alienated by NICE’s recommendations for treatments that are not available to them. Patients’ treatment preferences were also found to be important factors in GPs’ treatment choices. This study indicates that the NICE guidelines have an impact on psychological treatments that GPs offer their patients. The results show that availability of IAPT services impacts whether GPs offer patients treatments recommended by NICE. More work needs to be done to increase GPs awareness of their existing local IAPT service and new services as they arise during the next phase of IAPT.

Making the PPiP squeak: maximising the IAPT investment to enhance Primary Care consultations

Ineke Powell: South Central Strategic Health Authority

The aim of this presentation is to share learning experiences from the ‘Psychological Perspectives in Primary Care’ (PPiP) project run by the South Central Strategic Health Authority. The project was developed in response to the need to train Primary Care staff to deal with emerging and mild anxiety and depression as well as psychological aspects of physical ill-health and long-term conditions. The project’s objectives are to relieve distressing symptoms, prevent further worsening of the condition where possible and effect positive behaviour change including where there might be poor motivation and/or treatment compliance. The presentation will describe the two main aspects of the project. The first comprises the delivery of educational modules delivered by specifically trained PWPs from local IAPT services; the second is the provision of ‘10 minute CBT’ training sessions developed in collaboration with Dr Lee David and delivered by PPiPCare trained senior and experienced IAPT HI therapists from local IAPT services. The presentation will describe the project’s success in engaging Primary Care staff, in particular GPs, and the benefits to IAPT workers.

A quantitative analysis of factors influencing implementation of Computer-aided CBT in IAPT services

Luca Palmili, Andre Tylee, Isaac Marks: Institute of Psychiatry, King’s College London
Many IAPT (Increasing Access to Psychological Therapies) services across England have adopted the NICE-recommended CCBT system FearFighter (FF). FF was clinically and cost-effective in open and randomised controlled trials, but factors affecting its implementation in routine Primary Care across the NHS deserve investigation. This study examines influences on patients’ uptake, completion rates and clinical improvement with FF at 3 levels: i) PCT (macro-organisation); ii) Service Provider (IAPT team delivering FF); iii) Psychological Well-Being Practitioner (PWP individual worker). Of 60 PCTs which purchased and implemented FF, staff from 19 IAPT teams were interviewed, as were 6 Nurse Advisors (staff supporting FF’s implementation in the NHS). The Nurse Advisors returned a questionnaire reporting activity (training, workshops, surgery visits) and engagement ratings for each PCT. 22 IAPT Team Leads returned a questionnaire about screening/assessment procedures, referral numbers, diagnoses, other interventions offered (including non-FF CCBT) and perceived barriers/boosters. Across the 22 Teams, 121 PWPs returned a Supporter’s questionnaire, describing: length and type of support offered to FF patients, access sites, training details, treatment preferences, opinions about CCBT. Outcome data for 3,528 FF NHS patients were extracted from the online Patient Progress Monitoring System. Some training, patient support and screening variables associated significantly with FF uptake and/or completion rates. These results will be discussed in relation to the current literature on diffusion of innovations in health care organisations. Implementation of CCBT in routine care can deliver sub-optimal results if attention is not paid to key training, support and screening aspects.

**Intellectual and Developmental Disabilities**

**Keynote**

Mindfulness-based Interventions for People with Intellectual and Developmental Disabilities and their Carers  
Professor Nirbhay Singh, American Health and Wellness Institute, USA

Mindfulness is very quickly getting to be the intervention de jour in diverse clinical populations. In this presentation, I will briefly cover the application of mindfulness-based interventions with people who have intellectual and developmental disabilities (ID/DD), and their carers. While mindfulness-based interventions in these populations is still somewhat of a novelty as far are research is concerned, its use is well enshrined in the community. Mindfulness-based interventions have been used to treat a number of issues of people with ID/DD, such as aggression, lifestyle/obesity, smoking, and sexually deviant behavior. Parents and paid carers have been taught mindfulness skills, and the effects of this training have been assessed on the learning and behavior of children, adolescents and adults with ID/DD. Extant research suggests that mindfulness-based approaches may be useful in these populations.

**Symposia**

The impact on participants and services of a Cognitive-Behavioural anger management intervention for people with intellectual disabilities  
Convenor: Paul Willner, Swansea University

Managers’ reports of challenging behaviours and effective service responses before joining a research trial of a CBT anger management group intervention: a qualitative study  
Rose, N., Learning Disabilities Specialist Health Service, The Ridge Hill Centre, Dudley; Stenfert Kroese, B., University of Birmingham; MacMahon, P., University of Glasgow, and Stimpson, A, Abertawe Bro Morgannwg University Health Board  
As part of a multi-centre cluster randomized controlled trial of a cognitive behavioural therapy (CBT) group intervention for adults with intellectual disabilities and problems with anger, the managers of the participating services were interviewed before the trial commenced in order to gain an understanding of the challenging behaviours within their agency and practices and policies employed in response to these challenging behaviours. Brief and structured telephone interviews were conducted with eleven service managers. Length of the interviews varied between 6 and 22 minutes with the majority taking more than 15 minutes. The topics addressed included: why the service was participating in the study; current practices and policies employed; causes and current consequences of challenging behaviours within the service; most effective current service responses. Participants’ responses were digitally recorded and transcribed. Thematic Analysis of the data was used as the interviews were highly structured. A number of common themes were identified which indicate that the managers perceived the trial as an opportunity to improve their services, compare themselves with other services, and achieve better outcomes for their service users. Most services already had service responses in place to address the needs of people with challenging behaviour although serious consequences for service users and those in their immediate environment were still observed (e.g. physical and emotional harm, exclusion and staff absenteeism). The themes that emerged from the analysis will be discussed in the context of the findings of the follow-up interviews (which are currently being conducted).

‘Getting in control’: Exploring service-users’ experiences of a cognitive behavioural anger management intervention for people with intellectual disabilities  
MacMahon, P., University of Glasgow; Stenfert Kroese, B., University of Birmingham; Rose, N., Learning Disabilities Specialist Health Service, The Ridge Hill Centre, Dudley; Stimpson, A, Abertawe Bro Morgannwg University Health Board  
Obtaining the perspectives of service-users has helped shape clinical and social services. However, few studies have reported the experiences of service-users with intellectual disabilities (ID) following engagement in psychological therapy. The aim of this study was to explore the experiences of individuals with ID who recently participated in group-based cognitive behavioural therapy (CBT) for anger management difficulties. Qualitative research methods were adopted. Random sampling was used to identify eleven service-users from the wider sample of group participants (N= 90), after participants considered not to have sufficient communication skills were excluded. Participants were encouraged to discuss recent experiences of engagement in group-based CBT for anger problems, and also the impact of participation. Participants’ responses were recorded and transcribed. Transcripts were analysed using Interpretative Phenomenological Analysis. A number of key themes emerged from preliminary analysis, including: positive views of group participation; memorable group experiences; altered relationships with lay therapists; and experiences of using the anger-management strategies taught in FF. Some participants externalised the source of their difficulties in controlling anger. Service-users’ accounts and responses may have been...
influenced by their perceptions of the interview situation. Emergent themes and their implications will be discussed in the context of how engagement with psychological therapies for service-users with ID can be improved. Methodological strengths and weaknesses will be discussed, together with the challenges of implementing qualitative research methods with individuals with ID. Recommendations for future research in this important area will be outlined.

The experiences of staff taking on the role of ‘lay therapist’ in a group-based cognitive-behavioural therapy anger management intervention for people with intellectual disabilities.

Stimpson, A., Abertawe Bro Morgannwg University Health Board; Stenfert Kroese, B., University of Birmingham; MacMahon, P., University of Glasgow; Rose, N, Learning Disabilities Specialist Health Service, The Ridge Hill Centre, Dudley Group-based cognitive behavioural therapy (CBT) anger management interventions are typically delivered by professional therapists, often clinical psychologists, within specialist health services for people with intellectual disabilities. For the current research trial, staff employed in daytime opportunity services were trained and then supervised by a clinical psychologist for the duration of the intervention. This study explored the experiences of staff who took on the role of ‘lay therapist’ in the running of the groups, who typically had limited prior knowledge or experience of CBT. Nine lay therapists were interviewed and specific areas for exploration included: experience of training and initial preparation to run the groups; experience of working with the manual and CBT model; general experience of running the groups and group outcomes; confidence in role as lay therapist and support needs; hopes/expectations for running future groups. The interviews were recorded and transcribed and the qualitative approach of Interpretive Phenomenological Analysis (IPA) was chosen to analyse the transcribed accounts. Several key themes emerged from the data such as perceived benefits/limitations of the manualised approach, group processes and dynamics, factors influencing group outcomes, experience of therapeutic role and considerations for running further groups. The themes will be discussed in the context of the evidence base of CBT for adults with intellectual disabilities. Broader service and clinical implications for the future implementation of anger groups by lay therapists in day service settings will be discussed.

CBT for low functioning and borderline intelligence clients

Convenor: John L Taylor, Northumbria University and Northumberland, Tyne and Wear NHS Foundation Trust

Delivering CBT in Community Intellectual Disability Services

Stephen Oathamshaw, Scottish Borders Learning Disability Service, UK

It is now almost 15 years since the publication of Cognitive-Behaviour Therapy for People with Learning Disabilities, which was designed to stimulate clinical and research interest in the use of CBT with people who have intellectual disabilities (ID). It has been suggested that within a couple of years of this publication, approximately one third of British psychologists surveyed reported using CBT approaches regularly, although it is unclear how many of these approaches involves the use of a formal course of structured individual, or group, CBT. Recent papers have also suggested there is now sufficient evidence to suggest that the majority of people with mild intellectual disabilities have the ability to engage in and benefit from some CBT approaches. During this period there has been considerable interest in how CBT as delivered in mental health services can be adapted and modified to meet the need of people with ID. There has also been a continuing debate and some criticism of CBT approaches as lacking a sufficient evidence base, being available and accessible to too few people with ID and adopting an individualised pathological approach that is antithetical to the environment that has dominated British psychological approaches to people with ID for the last 30 years. In this paper the author shall illustrate modifications to therapy, using examples from practice that can assist in making it accessible to people with mild and moderate ID and argue that CBT approaches to people with ID are in fact complementary to environmental approaches. Further, it will be argued that the success of therapy in community ID services can often rely on modifications and interventions in the environment around the person to support change achieved during individual or group CBT.

Adherence to Core Elements of CBT with Adults with Intellectual Disabilities: Is Consistent Inconsistency in Formulation a Problem?

Alastair L. Barrowcliff, 5 Boroughs Partnership NHS Foundation Trust, UK

The use of CBT as a therapeutic intervention for adults with intellectual disabilities has generated much interest over the past 15 years, with the publication of Cognitive-Behaviour Therapy for People with Learning Disabilities serving as an early catalyst for research, debate and clinical development of techniques. A range of subsequent publications since this time detailing, for example, general issues of adaptation or formulation have encouraged aspects of modification within the delivery of CBT: Principles of assessment regarding an individual’s ability to engage in the process of CBT have been promoted as a necessary foundation to this process. Although there remains a dearth in the publication of RCTs for CBT in addressing a range of mental health difficulties in adults with intellectual disabilities (with the associated measurement of and guidelines for aspects of treatment fidelity), the application of CBT by clinical practitioners stalwartly continues. In the main, however, literature detailing the adaptation of CBT for clients with complex mental health issues, such as psychosis, remains at the level of case studies or case series. Whilst the issue of whether selective disarticulation of CBT to meet the needs of the clinical population with intellectual disabilities results in the application of independent techniques, as opposed to the application of a coherent and internally robust and validated psychotherapeutic model may be raised, specific areas of necessary development remain in respect of CBT delivery for this cohort. A core element of CBT to be considered further in this presentation is that of clinical formulation and the application and utilisation of clinical formulation with adults with intellectual disabilities. A summarisation of the function and purpose of clinical formulation in CBT is considered, with specific reflections on such application with this population. Case examples from clinical practice are used to support this discussion.

Buddy-to-Buddy Mindfulness-based Anger Management Training

Nirbhay N. Singh, American Institute for Health and Wellness Institute, Verona, Virginia, USA

We taught a mindfulness-based strategy to an individual with mild intellectual disabilities (ID) to successfully manage his aggressive behaviour. On his own initiative, he began to teach his buddies to use the same mindfulness-based strategy to control their aggressive behaviour. We tracked the aggressive behaviour of three of the individuals he taught to use this procedure, as well as the fidelity of his teaching of the procedure. According to staff reports, aggressive behaviour of the three individuals decreased from pre-treatment to very low levels within four to five months of initiating training, and remained at very low levels for two years during which formal data were collected. The fidelity of his teaching the
procedure was high, if one takes into account his idiosyncratic teaching methods. These findings suggest that individuals with mild ID who have mastered an effective mindfulness-based strategy to control their aggressive behaviour can, in turn, teach their peers the same strategy to control their aggressive behaviour to a level that is acceptable for community living.

Maintaining Treatment Gains for Adults with Mild-Borderline Intellectual Disabilities and Serious Anger Control Problems
John L Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Foundation Trust, UK
The notion that psychological interventions alone can produce permanent changes in behaviour and attitudes has long been questioned, and the idea that follow-up or ‘booster’ sessions can help maintain treatment gains has been advocated for some considerable time. While there is some evidence available to support the view that maintenance strategies can help in sustaining treatment gains achieved through the implementation of behavioural and cognitive-behavioural intervention, the mechanisms by which maintenance approaches might work are not yet clear. Following the treatment of serious anger control problems amongst adults with mild-borderline intellectual disabilities maintenance programmes were implemented that included (a) review and discussion of patients anger diaries; (b) rehearsal of coping strategies a; and (c) practice of arousal reduction techniques. Follow-up of patients competing treatment in routine clinical settings indicated that significant post-treatment gains on self- and informant rated anger measures, and indices of aggression and violence were maintained despite the delivery of maintenance programmes being inconsistent and/or omitted.

The reasons for the difficulties in providing maintenance support to these patients and the implications for outcomes and progress in rehabilitation are considered and discussed.

Skills Class
Cognitive Behavioural Anger Treatment for Low Functioning Clients
John L Taylor, Northumbria University, Ray Novaco, University of California, Irvine, USA
Anger and associated aggression are common amongst people who are intellectually low functioning or have mild-borderline intellectual disabilities. This is now well established by clinical research, especially in the UK, as well as by international epidemiological studies. This can have serious consequences for clients, their families and carers, and for services attempting to support them. Cognitive-behavioural anger treatment is gaining sway over formerly preferred behaviouristic antecedent control contingency management and psychotropic medication regimes for challenging behaviour in this client group. The efficacy of CBT programmes for anger has been demonstrated across types of settings, types of institutions (forensic and non-forensic), and treatment formats (individual and group). In this skills class, a brief overview of the evidence base will be provided along with an outline of an intensive individually delivered cognitive behavioural anger treatment programme that has been shown to be effective in reducing anger and aggression in a number of controlled and service evaluation studies. Particular emphasis will be put on helping participants learn how to successfully use the stress inoculation paradigm as a component part of this adapted CBT intervention with clients with cognitive limitations.

Participants will generate anger hierarchies that will then be used to practice anger-coping strategies in vitro in analogues of clinical practice with low functioning clients. Learning objectives: To learn about the evidence base supporting the use of CBT interventions with low functioning clients. To become familiar with the content of an evidence based a-cognitive behavioural anger intervention designed for use with clients with cognitive limitations. To learn and practice therapy skills linked to the use of the stress inoculation paradigm in anger treatment. Training modalities: Didactic, experiential, role-play.

Poster
Utilising Behavioural Family Therapy (BFT) to support the system around a person with a learning disability with complex mental health needs
Keith Marshall, NHS Lothian
Behavioural Family Therapy (BFT) is a psychoeducational approach that focuses on the components of engagement, assessment, formulation, information sharing, positive communication and problem solving. Traditionally BFT was developed for working with families supporting a relative with psychosis (Fallow et al 1984). There are many parallels to the stress encountered in supporting a relative who has psychosis to that of supporting a relative or person with a learning disability with mental health issues. Sometimes individual treatment may be compromised if the system around the person is under stress. This system can be complex with family and support workers providing support to the person, therefore a family intervention may need to be used initially (Hastings and Beck, 2004). Two BFT therapists carried out 11 sessions with two family members and three support team members. The service user, George didn’t want to join the sessions. The framework for the sessions comprised of agenda setting, review of family/team meetings, discussion topic or skill and role play practice. The family members were encouraged to set and pursue personal goals. Discussion around George’s learning disability and mental health, with a view to challenging assumptions attributed to his behaviour. The group also covered aspects of positive communication incorporating active listening, expressing pleasant feelings, making positive requests, expressing unpleasant feelings. Finally the group covered a 6 step problem solving process, enabling them to work together in making decisions. In between sessions with the therapists, the family and team members met to utilise the skills from the sessions. All the family members showed a reduction in stress levels using the Caregiver Strain questionnaire. Both family and support team members showed an increase in effective functioning using the Family functioning questionnaire. George has remained in independent living for 15 months now, where historically his accommodation and support would have broken down after a few months. BFT demonstrates positive signs where helping family members and support staff reduce levels of stress, and help people work more closely together, utilising positive communication and problem solving. There is a need for further research into the use of approaches aimed at supporting systems around the person with a learning disability, rather than a reliance on treating the person alone. Implications for the science and practice of CBT: An approach like BFT can address the stress needs of the supporting system around the person with a learning disability, which should give interventions like CBT greater chance of success when used with the individual.

Older Adults
treatment for depressed older people. Improvement appears to be associated with specific factors in CBT and level of

between group differences in loneliness. Conclusion: CBT is an effective treatment for CBT on the CTS were high (mean [SD], 54.2 [4.1]) and showed no difference for nonspecific, but significant differences to 1.12) in BDI-II scores in favour of CBT vs TAU and TC respectively. CACE analysis found a benefit of 0.4 points (95% CI,

were recruited from primary care. The interventions were: treatment as usual (TAU), TAU plus TC, or TAU plus CBT. The TC and

improvements of 3.07 (95% confidence interval [CI], 5.73 to 0.42) and 3.65 (95% CI, 6.18 to 1.12) in BDI-II scores in favour of CBT vs TAU and TC respectively. CACE analysis found a benefit of 0.4 points (95% CI, 0.01 to 0.72) per therapy session of CBT over TC. Subjectively older people indicated talking was helpful, however ratings

were delivered. ITT analysis found improvements of 3.07 (95% confidence interval [CI], 5.73 to 0.42) and 3.65 (95% CI, 6.18

to 1.12) in BDI-II scores in favour of CBT vs TAU and TC respectively. CACE analysis found a benefit of 0.4 points (95% CI,

Objective: To determine the clinical effectiveness of Cognitive Behaviour Therapy (CBT) delivered in primary care for older

potentially due in part to neuropathological and physiological changes, cognitive, psychological and social factors may also play important roles in aetiology and maintenance. This offers opportunities for psychological management that are uniquely just been explored. The talk will provide an overview of current evidence on depression and its management in Parkinson's disease and highlight emerging work pointing to the clinical significance of GAD-like anxiety disorder. Drawing on evidence from GAD and health anxiety a model will be presented for anxiety in Parkinson's disease that combines aspects of both the mood disturbance and symptoms of the underlying movement disorder.

was offered up to 10 sessions of individualised CBT delivered in parallel. The paper will highlight the key components of the dual therapy
treatment manual with discussion of modifications to standard treatment protocols. Preliminary clinical results and observations will also be discussed.

Depression and Anxiety in Parkinson's disease: current research and implications for treatment

Richard Brown, Institute of Psychiatry, King's College London

Parkinson's disease is the second most common neurodegenerative disorder after Alzheimer's disease and is associated with progressive motor disability. Non-motor symptoms including depression and anxiety are common and a major source of additional disability. While probably due in part to neuropathological and physiological changes, cognitive, psychological and social factors may also play important roles in aetiology and maintenance. This offers opportunities for psychological management that are uniquely just been explored. The talk will provide an overview of current evidence on depression and its management in Parkinson's disease and highlight emerging work pointing to the clinical significance of GAD-like anxiety disorder. Drawing on evidence from GAD and health anxiety a model will be presented for anxiety in Parkinson's disease that combines aspects of both the mood disturbance and symptoms of the underlying movement disorder.

"I can t forget to worry": A pilot randomised controlled trial of CBT for anxiety in people with dementia.

Aimee Spector, University College London; Susan Sadek, University College London; Martin Orrell, University College London; Georgina Charlesworth, University College London

Anxiety is a huge problem in dementia, and has been associated with high physical dependency, problems in the patient/carer relationship, decreased independence and increased behavioural problems. Anxiety is often treated with anti-psychotic medication which has limited efficacy and can have serious side-effects. Despite this, there is a paucity of research in psychosocial interventions for anxiety in dementia. Four previous case / repeated case studies on CBT for anxiety in dementia all concluded that CBT for people with dementia is feasible and that larger trials are now needed. This trial began in November 2010 and is due to finish in April 2013. This presentation will describe the development phase, which occurred in five key stages: identification of key themes derived from the literature, identification of relevant cognitive and behavioural techniques for this population, expert consultation, a consensus conference, and field testing with five clients. Preliminary findings from the field testing will be presented, and the main layout of the manual discussed. The
methodology for the pilot RCT will be presented. 50 participants will be randomised to individual CBT (with carer) or treatment as usual and compared at baseline, 12 weeks, and 6 month follow-up. There will be qualitative interviews with participants, assessing acceptability of the treatment and examining whether changes generalised. Key aims will be a) to assess feasibility, for example considering recruitment, retention and compliance; b) to modify the treatment manual according to qualitative and quantitative findings; c) to make the manual widely available through creating an online version and d) to calculate effect sizes for a definitive RCT. It is hypothesised that CBT will reduce anxiety and improve quality of life, cognitive function, mood, carer relationship and behavioural function. The approach could lead to significant benefits, including reduced excess disability and reduced costs to the NHS, through decreased GP visits, use of medication and admission to care homes.

Panel Discussion

Inspirational developments and national strategy in Improving Access to Psychological Therapies with older people
Convenor: Jacqueline Wilson, Older Adults National Representative, NHS Education Scotland
Speakers: Jacqueline Wilson, Older Adults National Representative, NHS Education Scotland
Ross Warwick and Fionnuala Edgar, NHS Dumfries and Galloway
Polly Kaiser, Clinical Psychologist and Previous National Programme Lead, Age Equality in Mental Health for England

This session will cover some recent developments in both Scotland and in England aimed at increasing access to psychological therapies for older people. Dr Wilson will discuss her role in a team set up by the Scottish Government Health Department for two years to assist Health Boards to meet a forthcoming HEAT target for waiting times for psychological therapies and to roll out staff training to upskill the mental health workforce in delivering psychological therapies to older people. In addition, the Scottish National Dementia Strategy (2010) has implications for staff training in psychological interventions and Dr Wilson will discuss her recent work as a Psychologist to the Dementia Knowledge and Skills Framework. She will discuss how she sees a role for staff being trained in CBT for both initiatives. Ross Warwick and Fionnula Edgar will lend a local perspective to IAPT for older people in discussion of their work around challenging behaviour training in care homes around the Dumfries & Galloway region. Finally, Ken Laidlaw will discuss the Older Adult Matrix: The evidence base and implications for improving access to psychological therapies in Scotland. This panel discussion invites discussion from audience members regarding the way forward for increasing access to psychological therapies for an older client group.

Psychosis

Keynote

Cognitive Therapy Without Antipsychotic Medication: How Effective is it for People at High Risk of Developing Psychosis and People with Psychotic Disorders?
Professor Anthony Morrison, University of Manchester

Cognitive therapy (CT) for psychosis has traditionally been delivered in addition to antipsychotic medication. However, antipsychotics are frequently associated with severe side effects, meaning many people with psychosis choose not to take them and making them unsuitable as an early intervention for people at high risk of developing psychosis. Data will be presented from two studies evaluating the use of CT without antipsychotics. A randomised controlled trial comparing CT with treatment as usual in 288 patients with at-risk mental states (ARMS) has been conducted in 5 sites, and an open trial evaluating CT for people with psychosis in 20 patients has been conducted across 2 sites. Results from these trials will be presented, and qualitative data regarding the subjective experience of receiving CT in both trials will also be presented. Future directions for research and practice will also be considered.

Symposia

CBT for Psychois: New Interventions
Convenor: Craig Steel, University of Reading

CBT for improving social recovery in early and at risk psychosis
Fowler, D., Hodgkins, J., French, P., Turner, R., Lower, R., Wilson, J.

A substantive proportion of people with first episode psychosis do not make full social recoveries despite intensive case management and supported employment interventions provided by early intervention services. Delayed social recovery cases typically present with complex problems including social withdrawal, negative symptoms depression and anxiety and subthreshold psychotic symptoms. In this paper we highlight how understanding these types of problems in terms of avoidance provides a useful basis for intervention. We highlight structure for clinical intervention based on promoting agency and motivation and a positive identity and specific behavioural experiments. We describe current outcome data and ongoing trials and the potential use of this type of intervention in the detection and prevention of social disability at an earlier stage of the disorder.

Working with the consequences of childhood sexual abuse in adults with psychosis
Elaine Hunter, King's College London

Recent epidemiological studies have shown that there are relatively high rates of reported childhood trauma, including childhood sexual abuse (CSA), in clients with a diagnosis of a psychosis spectrum disorder. Moreover, some studies have found associations between reported CSA and positive symptoms of psychosis such as voice hearing and paranoia. Although there are existing CBT approaches for working with the sequelae of CSA in adults, these have not been adapted for clients with psychosis. A protocol for working with clients who have a history of CSA and current psychosis will be outlined, with use of case examples. This will suggest ways of managing the complex interaction of affect, dissociation and negative schema as well as symptoms of trauma and psychosis. Working in such an integrated way with trauma and psychosis allows clinicians to
help their clients make links between their CSA and their symptoms of psychosis, and can offer an alternative, trauma based, explanation for their distress.

A Case Example of Cognitive Behavioural Therapy for co-morbid PTSD in Psychosis
Ben Smith, North East London NHS Foundation Trust; Craig Steel, University of Reading; Kim Mueser & Jennifer Gottlieb, Dartmouth Medical School, New Hampshire, USA
Recent research shows clear and meaningful links between traumatic events, PTSD and the nature of psychosis (e.g. Mueser et al 2004; Campbell and Morrison 2007). This research suggests that in clinical settings a thorough assessment of an individual's trauma history and PTSD symptoms and the impact of these on their beliefs, assumptions, and thoughts will be important when conceptualizing their psychotic symptoms. Similarly, Mueser and colleagues have recently been successful in treating PTSD symptoms directly in the context of psychosis. Despite this work, there are only a few existing accounts of how to conduct such a clinical intervention (e.g., Callcott, Standart, & Turkington, 2004; Kevan, Gumley, & Coletta, 2007) and these focus on treating psychosis rather than PTSD. On this basis the case example presented here aims to describe the process of cognitive behavioural therapy for PTSD in a case in which psychosis is also a key part of the formulation. We illustrate how understanding and validating experiences of trauma and the use of cognitive restructuring can shape the CBT intervention. The case shows how CBT techniques developed for post-traumatic stress disorder (PTSD) can be applied despite psychosis.

CBT for individuals at high risk of developing psychosis: A case example describing assessment, formulation and various intervention techniques
Nicola Smethurst, University of Manchester
In 1998, Yung et al. published highly influential research detailing operational criteria to identify at-risk mental states (ARMS) and their findings that 40% of individuals identified as ultra-high risk made transition to psychosis over a nine-month period. Since that time there have been a number of randomised controlled trials looking at preventing psychosis, reducing the severity of symptoms and reducing distress (McGorry et al., 2002; Morrison et al., 2004; McGlashan et al., 2006; Amminger et al., 2010; Addington et al., 2011). Recently, Morrison and colleagues carried out a large multi site randomised trial investigating cognitive therapy vs. enhanced monitoring (EDIE-2) with promising results. Here, a case example representing an amalgamation of clients will be presented, moving through assessment, formulation and a range of intervention techniques used with this client group.

Cognitive therapy for people at high risk of developing psychosis: Findings from a multicentre RCT
Convenor: Tony Morrison, University of Manchester
At risk mental state for psychosis or at risk mental state for mental health problems: Baseline characteristics of a sample of people at high risk of psychosis
Paul French, GMWMHFT and University of Manchester, and the EDIE-2 group
Background: Recent trials suggested that the early identification of individuals with an at risk mental state for psychosis may be useful in identifying emerging psychotic symptoms experienced by young help-seeking adults. This strategy has major implications for the prevention of conditions such as schizophrenia and other mental health problems. We report a baseline characteristics from a large multisite randomised controlled trial in this population. Methods: This single-blind trial randomly assigned participants (stratified by site) at high risk of psychosis (aged 14-35 years) in a one-to-one ratio to CT plus monitoring or monitoring only at five UK sites. Measures include the Comprehensive Assessment of At-Risk Mental States (CAARMS), Structured Clinical Interview for Diagnosis (SCID), Beck Depression Rating Scale (Primary care version), Manchester Short Assessment of Quality of life (MANSA) and the Social Interaction and Anxiety Scale (SIAS). This study is registered as International Standard Randomised Controlled Trial number 56283883. Results: 288 participants were recruited. Interpretation: On the basis of our findings, as well as being at risk of psychosis this is a troubled group with high levels of psychological distress across a number of measures.

The evolution of emotional dysfunction and psychotic-like experiences in people at risk of psychosis
Max Birchwood, University of Birmingham, and the EDIE-2 group
In this paper I will present data on the ‘natural course’ of psychotic and affective symptoms seen in the UHR or ‘at risk mental state’ using data from both the MRC EDIE2 trial and the EU EPOS study of the UHR in 4 countries. I will present data in relation to the following questions: 1. The stability of the UHR status over time 2. The nature of affective disorder present at baseline, and its stability or change 3. The cross-sectional and longitudinal link between affective and psychotic experiences I will argue that the UHR paradigm accesses a population of individuals in their late teens and early adulthood who have a single or episodic affective based psychopathology which can put the individual at risk for other disorders and also which can be of no long term pathological import. These data have implications for the emerging focus on youth mental health and its prevention.

The relationship between self-stigma, depression and social anxiety in young people at risk of psychosis
Melissa Wardle, University of Manchester and GMWMHFT, and the EDIE-2 group
Background: Research indicates that people with at risk mental states also experience other psychological difficulties such as depression and social anxiety, with associated distress and risk of transition to a first episode of psychosis. Little is known regarding stigma in young people meeting criteria for ARMS and the relevant contribution of self-stigma to depression and social anxiety in this population. Aims: This study aims to investigate the relationship between self stigma, depression and social anxiety in young people considered to be at risk of developing psychosis. A secondary aim of this study was to validate a revised version of the personal beliefs about illness questionnaire. Method: 288 participants with ARMS were recruited as part of the Early Detection and Intervention Evaluation Trial 2 (EDIE 2), a multi site Randomised Controlled Trial of Cognitive Behavioural Therapy for people with ARMS. Results: Exploratory factor analysis revealed two subscales on the PBEQ; negative appraisals of experiences and perceived social acceptance of experiences. Significant positive correlations were found between negative appraisals of at risk experiences, depression and social anxiety. Significant negative correlations were also found between perceived social acceptance of experiences, depression and social anxiety. Regression analysis revealed that negative appraisals of unusual perceptual experiences contributed significantly to depression at 6 months
Cognitive Deficit and Cognitive Remediation in Schizophrenia: Genetic Background, Predictors and Outcomes
Marta Bosia, San Raffaele Universitary Scientific Institute Hospital, Milan, Italy; Adele Pirovano, San Raffaele Universitary Scientific Institute Hospital, Milan, Italy; Enrico Smeraldi, San Raffaele Universitary Scientific Institute Hospital, Milan, Italy; Roberto Cavallaro, San Raffaele Universitary Scientific Institute Hospital, Milan, Italy

Schizophrenia is a disease of the brain that is characterized by psychosis, apathy, and a distinct array of domain-specific cognitive impairments. Such neurocognitive deficits are recognized as core features of schizophrenia and have important implications for functional outcome, being correlated with poor functional abilities. Although identification of specific underlying mechanisms remains unknown, the important contribution of genetic factors to the development of cognition is widely acknowledged. Given a variety of evidence implicating the prefrontal cortex and mostly its dopaminergic circuits in cognitive processes impaired in schizophrenia, most of the research conducted to date has focused on genes regulating dopaminergic functions. Among these, the most consistent results, that will be reviewed, have been observed for the catechol-O-methyltransferase (COMT) gene polymorphism, involved in prefrontal dopamine’s availability regulation. However other neurotransmitters circuits have been implicated in modulation of cognitive functions, particularly several lines of evidence from pharmacological manipulation pointed a role for serotoninergic transmission. Among genes regulating serotonergic function, promising candidates that will be discussed are serotonin transporter (5-HTT) and serotonin 1A receptor (5-HT1A) polymorphisms. More recently, research has focused also on genes involved in more complex neurodevelopment and neurodegeneration mechanisms, and among these the salthain (STH) gene, suggested to be implicated in several neurodevelopmental disorders, seems to play a role also in cognitive functions in schizophrenia. Concentration of efforts to understand the underlying mechanisms of cognitive deficits is of the greatest importance in order to find the best therapeutic strategy for each patient. Up to date, the most promising therapeutic tool to improve cognition

follow up. Conclusions: These findings suggest that self-stigma may contribute to the development and maintenance of emotional dysfunction, and depression in particular, in young people meeting criteria for ARMS.

Negative schemas and the course of paranoia in at risk mental states
Conley, D., White, R., Hodgakens, J. (University of East Anglia) and the EDIE-2 group

Cognitive models suggest that symptoms of paranoia may arise from extreme negative thinking about self and others. There is already considerable evidence to show that extreme negative beliefs about self and others are associated cross sectionally with paranoia and a recent longitudinal study indicates a potential causal role for negative schemas on the maintenance of paranoia in chronic patients. Here we build on a recent cross sectional study showing that negative schemas are pervasive in the at risk mental state to investigate the longitudinal association with paranoia in young people with at risk mental states. We also highlight work examining the potential protective role of positive schemas on social recovery.

A qualitative exploration of the experience of monitoring and therapy in a randomised controlled trial (‘EDIE 2’)
Rory Byrne, University of Manchester and GMWMHFT, and the EDIE-2 group

Aim: To evaluate participants’ experiences of both monitoring and treatment (CBT) within an RCT for the prevention of psychosis. Method: A ‘qualitative grounded theory’ approach was used, with semi-structured interviews administered following completion of participants’ involvement with the trial. Participants: 10 young people were interviewed; 6 male and 4 female, with a mean age of 26.2. 9 participants identified themselves as white British and 1 black British. Results: We found that both monitoring and CBT conditions were experienced positively, and participants in both treatment conditions commonly highlighted the value of being able to discuss their difficulties with trial staff, identifying ‘normalisation’ of their concerns as a central positive outcome of such discussions. However, notable elements of CBT involvement were also consistently highlighted which suggest additional benefits associated with randomisation to the CBT arm of the trial (such as improving coping skills and understanding of the maintenance of psychological difficulties, and recovery from these).

Cognitive Remediaion for Psychosis
Convenors: Til Wykes and Vyv Huddy, Institute of Psychiatry, King’s College London

Cost-effectiveness of cognitive remediation therapy for schizophrenia
Anita Patel, Institute of Psychiatry, London

Cognitive deficits associated with schizophrenia can have serious effects on patients’ everyday functioning. They can also be predictive of future care and affect psycho-social treatment outcome. We evaluated the cost-effectiveness of a psychological therapy, cognitive remediation therapy (CRT). 85 people with schizophrenia were recruited from UK health centres into a randomised controlled trial comparing CRT with standard care. Assessments at baseline, 14 weeks (post-therapy) and 40 weeks (6 months after therapy) measured clinical/social factors and retrospective health/social care/clinical justice system resource use. Costs were attached to resource use. We examined baseline data using structural equation models to explore whether there was a relationship between cognition and costs. We then linked follow-up costs with outcomes (proportion of participants improving their working memory since baseline) to explore the cost-effectiveness of CRT. Average costs at baseline were £15114 (6 month period). Cognition as a single summary measure was negatively associated with costs (estimated loading -0.393; t 2 =124.9; p=0.06). A separate model with three separate elements of cognition (verbal working memory, response inhibition speed and cognitive flexibility) suggested none were individually associated with costs. There were no significant differences in total health/social care or societal costs between the two groups at 14 or 40 weeks. An additional analysis in the CRT group improved their working memory at both follow-ups (14 week 95% CI: 0-41%; 40 week 95% CI: 2-41%). When placing these cost and outcomes in hypothetical scenarios concerning how much policymakers would pay for another 1% of participants improving their working memory (for values ranging £0 to £5000), there was more than an 80% chance that CRT would be cost-effective compared to usual care at 14 weeks but no more than a 30% chance of cost-effectiveness at 40 weeks (due to greater savings at 14 weeks compared with 40 weeks). To bring about reductions in costs, interventions may need to improve cognition overall, rather than individual components of it. Although cost-effective in the short term, CRT may have limited potential to save costs in the medium term because it could increase take up of some services. This could actually confer important longer term benefits in terms of improved social functioning and less reliance on services. CRT can improve memory among people with schizophrenia and cognitive deficits at no significant additional cost but longer follow-ups need to confirm whether cognition outcomes can be sustained and whether medium term increases in service take-up ultimately result in less reliance on services.

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and global functioning in schizophrenia appears to be the use of cognitive rehabilitation programs. Recent studies showed that cognitive remediation is effective in improving both several domains of cognition and, most important, patient’s global functioning and quality of life. However, complexity of results suggests that there is a lot more to know about cognitive remediation for future developments. In this view, efforts should be put to identification of patient’s characteristics (both genetic and environmental) that predict good outcome.

**What is cognitive remediation therapy doing to the brain in neuroconnectivity terms?**

Rafael Penades, Hospital Clinic de Barcelona, University of Barcelona, IDIBAPS-CIBERSAM
cognitive Remediation Therapy (CRT) is being increasingly used as a part of the multimodal treatment of schizophrenia. Effects on cognition and functional outcomes have been reported in recent meta-analytic studies. However, it still remains relatively unknown how this therapy would affect brain functioning. Previous research based on neuroimaging procedures has shown some changes in functional activity, more specifically on the lateral prefrontal cortex (PFC), and some related regions although connectivity patterns has not been sufficiently studied. A randomised and controlled study has been carried out in order to investigate structural alteration as well as functional connectivity patterns before and after the neurocognitive rehabilitation therapy, especially the frontotemporal circuitry, allocating patients to CRT or psychological control therapy. Before and after the treatment, brain images produced by 3D, DTI and fMRI scans were taken in order to study functional connectivity. Scanning was conducted within an activation paradigm in a blocked design with a working memory (2-back) task and a control (0-back) task. A healthy control group was also assessed on the same conditions. The preliminary results show that following training, the functional connectivity pattern on fronto-temporal areas significantly shifted, normalizing towards the pattern observed in controls. Additionally, a significant increasement in Fractional Anisotropy in the Corpus Callosum was found. Those patterns of activation dynamics were associated with cognitive performance improvements.

**Cognitive Remediation in an Early Intervention Service**

Richard Drake, University of Manchester; Christie Day, University of Manchester; Claire Press, University of Manchester; Nutrat Husain, University of Manchester; Max Marshall, University of Manchester

cognitive Remediation (CR) appears efficacious in rehabilitation settings. In these patients it also translates into better social function but benefits are less clear for other groups. Since schizophrenia is associated with increases in the course of illness it is attractive to treat first episode sufferers in ways that integrate into NHS early intervention services. We aimed to evaluate the efficacy of CR as a preparation for CBT in this setting. We recruited patients on waiting lists for CBT after first episodes of non-affective psychosis into a randomised controlled trial of CR. CR was computer based, with 40h of exercises over 12 weeks. Time-matched supportive social contact was the control condition. Neuropsychological and symptomatic change was assessed by blind raters. After the CR phase CBT was delivered by NHS psychologists during a 30 week period, before final follow-up. A parallel feasibility study examined adaptation of CR for South Asian ethnicity. 66 were recruited to the RCT, 61 were eligible and randomised after 4 refusals and one exclusion (61% male; 80% white; mean age 24.6, SD 4.8). All have completed CR and follow-up is in its final stages. At baseline it was noted that metacogntion, insight and self esteem had a complex relationship. Further data will be available for presentation. 10 were recruited to the cultural adaptation feasibility study, which showed high ratings of acceptability and had 2 drop-out. Neurocognition improved in several domains. Delivery of computer-based CR via the web or CD is feasible in early non-affective psychosis, including adaptation to South Asian ethnicity. As an incidental finding, insight appeared related to metacognitive and self esteem in this group.

**Informing interventions for relatives of people with psychosis**

Convenor: Laura Wainwright, Spectrum Centre for Mental Health Research, Lancaster University

**Types of controlling behaviour and attributions of control in high and low Expressed Emotion (EE) relatives of people with recent-onset psychosis**

Debora Vasconcelos e Sa, University of Manchester

There is evidence that high EE relatives of patients with long-term mental health problems tend to behave in a more controlling manner, when compared with low EE relatives. This study investigates the extent to which high EE relatives of patients with recent-onset of psychosis attribute the patient’s illness to factors within the patient’s control and engage in different types of controlling behaviour. Two types of controlling behaviour are considered: 'direct influencing' and 'buffering'. The controllability scale assesses the extent to which relatives believe patients to be able to control their behaviour/symptoms, and the behavioural control scale measures the types of controlling behaviour towards patients. The present study also explores whether controlling behaviour or attributions of control are better predictor of poor clinical outcome than the EE measure itself. These findings may benefit clinical and family interventions with recent-onset sample. This work is supported by the Fundação para a Ciência e Tecnologia (FCT), Portugal.

**What do relatives experience when supporting someone in Early Psychosis? A qualitative focus group study**

Laura Wainwright, Spectrum Centre for Mental Health Research, Lancaster University; Fiona Lobban, Spectrum Centre for Mental Health Research, Lancaster University; Gillian Haddock, The University of Manchester; David Glentworth, Greater Manchester West NHS Foundation Trust; Ros Bentley, Preston Therapy Centre; Wainwright, L., Lobban, F., Haddock, G., Glentworth, D., & Bentley, R. & the REACT team

This presentation will explore relatives’ experiences when caring or supporting someone with psychosis via a qualitative analysis of data from four focus groups. The four focus groups were conducted as part of the process of designing the REACT intervention in Phase 1 of the study. A previous paper reported the key points drawn from a content analysis of transcripts of the focus groups and how these informed the design of the intervention. The aim of this presentation is to provide a secondary analysis of the data to explore and report relatives’ experiences when caring or supporting someone with psychosis. Four key themes were identified from the data: (1) Psychosis from the relatives’ perspective; (2) The relatives’ fight with the mental health ‘system’; (3) Is anybody listening? Does anyone understand? and (4) Relatives’ coping. These themes can be used to inform the ongoing development of interventions and support for relatives’ of people with psychosis and the day to day clinical practice within the NHS services.
Supporting relatives of people with psychosis: A systematic review to identify the key components of effective family interventions.

Fiona Lobban, Spectrum Centre for Mental Health Research, Lancaster University; David Glentworth, Greater Manchester West NHS Foundation Trust; Vanessa Pinfold, Rethink; Graham Dunn, University of Manchester; Laura Wainwright, Spectrum Centre for Mental Health Research, Lancaster University; Lobban, F., Glentworth, D., Pinfold, V., Dunn, G., Wainwright, L., Clancy, A., Postlethwaite, A., Haddock, G & The REACT team

In this paper we will present the findings of systematic review of studies evaluating psychological interventions aimed at improving outcomes for the relatives or carers of people with schizophrenia or psychosis. The aim is to identify the key components of effective interventions. Only studies which were published in peer reviewed journals, described an intervention to support relatives, reported outcome data for the relatives, and compared outcome to a viable control group were included. All studies were rated for quality of trial design using the Clinical Trials Assessment Measurement (CTAM). Authors were contacted and asked to complete a questionnaire measure about the content of the interventions.

A summary of the studies identified will be presented, along with a detailed examination of the key components of effective interventions. This information can be used to inform clinical practice and the ongoing development of effective ways to support relatives.

Staff-patient relationships and outcomes: The role of staff attributions and psychological explanations

Katherine Berry, University of Manchester; Lynsey Gregg, University of Manchester; Vasconcelos e Sa Dehora, University of Manchester; Haddock Gillian, University of Manchester; Barrowclough Christine, University of Manchester

Introduction. Positive staff-patient relationships might be more sensitive indicators of relationship quality and therefore better predictors of outcomes than traditional measures of relationships, such as Expressed Emotion. Staff attributions and ability to explain patient problems in psychological terms may play a role in the development of more positive staff-patient relationships. Method. Participants were 204 patients participating in a randomised controlled trial of Motivational interventions for Drug and Alcohol misuse in Schizophrenia or psychosis (MIDAS), and their care co-ordinators. We assessed relationship status (positive versus neutral), staff attributions of control and staff psychological explanations using Five Minute Speech Samples collected at baseline. We examined associations between baseline data and outcomes on the Positive and Negative Syndrome Scale and Global Assessment of Functioning Scale at 12 months. Results. Dyads with positive relationships had significantly lower PANSS total scores and GAF total scores at 12-months. As predicted, care co-ordinators with positive relationships made less controlling attributions and had higher levels of psychological explanations. A positive relationship between patient and care co-ordinator made a significant independent contribution to 12-month PANSS total scores, when other potential confounds were controlled in a multiple regression analysis. Discussion. The findings highlight the potentially important role of positive staff-patient relationships in outcomes. Our findings are also in line with the hypotheses that staff attributions and ability to generate psychological explanations may contribute to the development of more positive relationships. However, the direction of these associations needs to be determined by further research.

Posters

A pilot study investigating psychiatric staff response to normalizing psychotic symptoms

Akiko Kikuchi, National Institute of Mental Health, National Center of Neurology and Psychiatry; Keiko Asano, Musashino University; Sayaka Iwasaki, National Institute of Mental Health, National Center of Neurology and Psychiatry Hospital; Chihiro Asanami, National Institute of Mental Health, National Center of Neurology and Psychiatry; Takayuki Okada, National Institute of Mental Health, National Center of Neurology and Psychiatry

The use of normalizing is considered an integral component of cognitive behaviour therapy for psychosis (CBT). When CBT is provided in inpatient settings, the extent to which the psychiatric staffs’ attitude toward psychotic symptoms is supportive of and can influence the generalization of skills acquired during CBT sessions. Seventy three psychiatric nurses participated in a 3 hour training on CBT which involves thought experiences with emphasis on normalizing psychotic symptoms. An uncontrolled, pre-post design was used. Staff perceptions of psychological barriers to address psychotic symptoms were measured using Likert scales. Response to the thought experience using examples of “transient disruptions of ordinary mental life which may mirror the cognitive processes underlying psychosis” (Garrett et al., 2009) were collected three times during the training. The Stigma scale (Link, 1987) was used to clarify the effects of stigma. There was a significant decrease in staff perception of psychological barriers to address psychotic symptoms (Wilcoxon rank sum test p<.000 for all seven items). The first response to the situation depicted in the scenario was mainly that of internal attribution, which was then taken over by external attribution after which situational attribution increased. Negative external attribution increased throughout the three points. Stigma was not significantly related to any measurements. In ambiguous situations where additional information is not available, negative external attribution can increase in those without psychosis even in thought experiences. Professional education and training seemed to have more effect on normalizing attitude than stigma. Incorporating such exercises in CBT training may be effective in disseminating the normalizing rationale in psychiatric staff. Hospital ward environment and staff-service user relationship are associated with relapse and recovery. Implications for the science and practice of CBT: The study shows that CBT training with emphasis on normalizing can improve staff attitude toward addressing psychotic symptoms.

Adapting CBT for psychosis: Creative ways with people with cognitive impairments

Sophie Holmes, Surrey and Borders Partnership NHS Foundation Trust; Rowena Rossiter, formerly Surrey and Borders Partnership NHS Foundation Trust; Jo Jennison, Surrey and Borders Partnership NHS Foundation Trust; Julie Nixon, formerly Surrey and Borders Partnership NHS Foundation Trust

Research shows that cognitive impairments are more common in people with psychosis than the general population (effects of psychosis and/or medications for psychosis; recognised learning difficulties; prevalence of psychosis in people with learning disabilities is 3 times higher). Legislation (e.g., Disability Discrimination Act) and policy (e.g., IAPT, No Health without Mental Health) requires that accessible, appropriate services are provided. A literature review (older age adults, learning disabilities, cognitive impairments) was combined with existing Trust clinical guidance and resources for CBT for psychosis and CBT for people with learning disabilities and anxiety, depression or anger to develop psychosis specific guidance. 3 case examples illustrate simplified and visual approaches to formulation, psychoeducation and individually tailored therapeutic interventions/materials for people with psychosis and cognitive impairments with complex histories and
presentations. One uses the diagrammatic formulation approach outlined by Kirkland (2007) with a 35 year old, the second anchors the intervention around visuals of a cartoon character created and drawn by a 21 year old for "socialisation", formulation and intervention (based more closely on Haddock/Garety model), whilst the third presents these in an innovative, more personalised, visual, narrative format, which seemed appropriate for the comprehension level and interests of a 16 year old. This Intervention also contains visual prompts for personalised ‘distress tolerance’. The outcomes presented incorporate clinical and behavioural data. The practical lessons learned, e.g., considering the both family context and professional network carefully in developing both the materials and the intervention to maximise success, will be discussed. In addition to the above, we will highlight general issues in the adaptation and provision of CBT with people with psychosis and cognitive impairments. We will draw particular attention to issues in obtaining valid, reliable measures of change in this group. Implications for the science and practice of CBT: Despite significant cognitive impairments being associated with psychosis, CBT interventions can over emphasise verbal dialogue. This poster and case illustrations demonstrate how CBT can be made more accessible and effective for these service users/carers and more rewarding for practitioners.

**Therapeutic Techniques**

**Keynote**

**How EMDR Works**
Professor Marcel van den Hout, Utrecht University, Netherlands

Outcome studies and stringent meta-analyses show that eye movement desensitization and reprocessing (EMDR) is effective in the treatment of PTSD. Observations from controlled laboratory experiments corroborate the clinical findings. Making eye movements during recall of an aversive memory reduces its vividness and emotionality; not only during recall with eye movements, but also during later recollections, without eye movements. We took the opportunity to experimentally test some hypotheses about how EMDR works. The findings are surprisingly consistent. First, effects of EMDR are not merely due to imaginary exposure: a short period of “recall only” does not affect negative memories, but a short period of “recall with eye movements” does. Second, proponents of EMDR suggest that the bilateral stimulation, inherent in horizontal eye movements, is essential. Data indicate it is not as vertical eye movements are as effective as horizontal eye movements. Furthermore, various “dual tasks” that do not involve eye movements do the same job. Working memory theory provides a third explanation as it survived a series of critical tests. Data have implications for the application of EMDR, the use of auditory stimulation versus eye movements, eye movements during the recall of positive memories, and individual differences in the impact of eye movements etc. In the keynote, we will clarify conceptual notions, present data from laboratory and clinical studies, and suggest implications that are potentially surprising and clinically relevant.

**Symposia**

**ACT research in the UK**
Convenor: Jo Lloyd, Goldsmiths, University of London

The impact of ACT on transformational leadership

Frank Bond, Goldsmiths, University of London

ACT’s theory of mental health is encapsulated by the construct of psychological flexibility: the ability to move toward valued goals even when experiencing difficult internal events (e.g., unwanted thoughts, feelings, and physiological sensations). This talk will show how psychological flexibility also has implications for health and performance at work. In particular, it will describe a randomised controlled trial that examined the ability of ACT to enhance leadership skills in financial traders. One group of traders was taught how they could use ACT techniques to enhance their use of the leadership skills that they were taught during a leadership training course. The other group had four days of the same leadership training, but on the fifth day, they were taught about financial trading laws instead of ACT skills. Results showed that traders in the ACT group ran teams that made significantly more money in trading over the following six months than did those in the control group. This difference was mediated by an improvement in the ACT leaders’ transformational leadership skills, as rated by team members. Furthermore, an increase in the ACT leaders’ psychological flexibility mediated this increase in their transformational leadership skills.

Investigation of the relationship between depression, rumination, metacognitive beliefs and cognitive fusion

Eleonore Sian Kerr, NHS Grampian; David Gillanders, University of Edinburgh; Sam Aitcheson, NHS Grampian

It has been found that both depressed patients and patients who have recovered from depression report more rumination and hold more meta-cognitive beliefs about the benefits of rumination than never-depressed controls. Furthermore, it is suggested that a ruminative cognitive style predicts the onset, length and severity of depressive episodes. Within an ACT (Acceptance and Commitment Therapy) perspective on depression, it is suggested that rumination in depression is a verbal reason-giving behaviour used to ‘solve’ the problem of depressed mood. However, it is proposed that an individual’s fusion with these verbal reasons (i.e. cognitive fusion) perpetuates rumination and impedes the adoption of more functional behaviours. In this paper we present a study investigating the relationships between depression, rumination, cognitive fusion and positive beliefs about rumination. A between-groups design was used comparing currently depressed adults (n = 26), recovered depressed adults (n = 21) and never depressed adults (n = 27) on a battery of self-report measures for depressive symptomatology, rumination, positive beliefs about rumination and cognitive fusion. Data were analysed using ANOVAs, post hoc comparisons, and path analysis: an extension of multiple regression. Significant differences were found in rumination and cognitive fusion between all three groups, with higher levels of rumination and cognitive fusion found in both the currently depressed and recovered depressed groups compared to never depressed controls. Significant differences in positive beliefs about rumination were found only between the currently depressed group and the never depressed group. Results also indicated that depression severity was best predicted by rumination and cognitive fusion rather than positive beliefs about rumination. Furthermore, the relationships between the variables of cognitive fusion and rumination (r² = 0.76, p < .001), and cognitive fusion and depression (r² = 0.66, p < .001), were stronger than the relationships between any of the
other variables included in this study. Surprisingly, the relationship between beliefs and rumination and rumination itself was significant but relatively weak ($r^2 = .18, p < .05$) and the relationship between beliefs about rumination and depression was not significant ($r = -.10, n.s.$). Overall, the findings suggest that cognitive fusion and rumination are very strongly related and more so than cognitive content variables such as positive beliefs about rumination. It does also appear that the presence of depression may be a context that encourages cognitive fusion. Theoretical and clinical implications will be discussed.

Towards a more comprehensive understanding of effective psychological treatments for those with chronic pain
Kevin Vowles, The Haywood Hospital & Keele University
The occurrence of chronic pain is widespread, costly, and is associated with significant suffering. The psychological therapies have a decade long history of assisting those with chronic pain to decrease pain-related interference and improve overall quality of living. The mechanisms by which such treatments work, however, and not just as some of the proposed mechanisms have not been supported within the extant literature. For example, improvements in coping concepts such as pacing, relaxation, and cognitive restructuring or positive thinking do not appear to be necessary for treatment improvement or reliably related to treatment outcomes. Recent developments, principally under the clinical and theoretical model underlying Acceptance and Commitment Therapy (ACT), have examined a set of mechanisms that differ from previous work, where the focus is on decreasing the struggle for pain control, increasing awareness of what is valued, and progressing in areas of meaningful functioning. To date, there is good evidence that the processes specifically targeted within ACT for chronic pain are relevant to treatment outcomes achieved within psychological treatments for chronic pain. This presentation will provide an overview of this area, including an in depth focus on the treatment processes that appear to facilitate more meaningful functioning in individuals with chronic pain.

An RCT Comparison of Acceptance and Commitment Therapy and Treatment As Usual for Treatment Resistant Clients
Susan Clarke, Dorset HealthCare NHS University Foundation Trust, Bournemouth University; Jessica Kingston, University of Southampton; Helen Bolderston, University of Southampton ; Kirsty James, Dorset HealthCare NHS University Foundation Trust, Bournemouth University; Bob Remington, University of Southampton
Comprised of generic processes, Acceptance and Commitment Therapy (ACT) is thought to have diverse applicability to chronic, multiply disordered clients who despite carrying different diagnoses - share a tendency to avoid their unwanted private experience (Kohlenberg, Hayes & Tsai, 1993). We describe a randomized control comparison of an ACT group with a TAU group, which drew on CBT (Beck, 2005). Both groups ran for 16 weeks and included participants who had attended at least one previous therapeutic intervention that lasted 8+ sessions. Exclusion criteria included a current eating disorder, self-harming behavior, substance dependency, psychosis or learning disability. Participants (N=40) completed the SCID-II, BDI, STAI, SCL-90, and the AAQ before and after the intervention and at 6-month follow up. All had Axis I presentations and N = 14 were personality disordered. Preliminary results suggest that both groups show reliable reductions in depression, anxiety and global symptom severity (Truax & Jacobson, 1991). Some changes in personality syndromes have also been observed. However, post-hoc analyses suggested that change was more durable for ACT clients at six month follow-up. These data demonstrate the utility of ACT for reducing Axis I and Axis II symptomatology; and its successful delivery to a trans-diagnostic group.

Complex cases: Theory and research
Convenor: Rob Dudley, Newcastle University

Where is the complexity in complex cases - in the lives of the clients or the minds of the clinicians?
Timothy Carey, Centre for Remote Health (Flinders University and Charles Darwin University) and Central Australian Mental Health Service

Complex cases can frustrate clinicians and absorb disproportionate amounts of service resources. In this presentation, the ways in which complex cases are conceptualised is considered and it is suggested that the conclusion of complexity is largely a feature of our focus on symptom profiles of patients. By focusing more on the subjective distress of patients rather than their presenting symptoms we might be able to arrive at a clearer formulation of their situation with a better understanding of how to proceed with treatment. Complex cases can be defined in different ways. For example, the chronicity of problems, the comorbidity of disorders, or the presence of suicidal or psychotic symptoms can all be considered to be contributing factors to the complexity of cases. The ultimate indicator of complexity, however, is likely to be how quickly we are able to assist the patient in resolving their problems. If our treatments bring about a resolution to the problem in a timely fashion then we are unlikely to define the case as complex irrespective of the patient’s initial presentation. Even if we attribute complexity to the case before treatment begins from, for example, a perusal of the patient’s case history our attribution is likely to arise from a prediction about how straightforward treatment is going to be. Often, it is the symptom profile of patients that leads us to conclusions of comorbidity and complexity. Cases might seem less complex if the focus of treatment is the distress experienced by patients rather than the symptoms they report. Perceptual Control Theory (PCT) describes people as being organised to control events and circumstances in their lives in order to create and maintain certain preferred experiences. From this perspective, the distress of psychological functioning arises when control of preferred experiences is compromised or disrupted. Regardless of a patient’s particular symptom profile therefore, or the chronicity of their problem, understanding psychological distress from a PCT perspective, becomes a matter of discovering what aspects of a person’s life are not currently being controlled in the way they would prefer. The treatment that follows from this understanding is a process of helping the patient find new ways to regain control. This approach can be illustrated in the case of a young man who presented with symptoms of depression and anxiety as well as substance abuse problems and suicidality. These problems had been occurring for a number of years. Over the course of 12 sessions of treatment the patient made important changes in his life including reducing his drug consumption, increasing social activities, gaining part time employment, deciding against suicide, and enrolling in university. The patient was still enrolled at university after 12 months. The application of the principles of PCT enabled treatment to focus on the restoration of control and the complexity that might otherwise have made treatment daunting was not an issue that needed addressing.

Towards a conceptual understanding of comorbidity and complexity
Mark Freeston, Newcastle Cognitive and Behavioural Therapies Centred

The Cognitive Behaviour Therapies rightfully make claims that they are evidence based. However, much of the evidence base is apparently organized around single presentations. This may have two consequences. First, therapists may not be
able to match the patients that they see who do not appear to have single or simple presentations to the evidence base and so may reject it ("my patients are not like the ones in the studies"). Second, therapists may struggle to bring together different parts of the evidence base in a helpful way because the knowledge is separated in the way it is organized, taught and learned. One of the challenges when training therapists is to help them learn to make links between nomothetic knowledge and individualized case formulations so that the treatment delivered can strike the right balance between delivering sufficient of the specific components that are thought to be effective while adapting to the particular characteristics of the patient. Nomothetic knowledge includes disorder specific models, empirical support for the models, the treatment approaches that flow from them, and evidence for the treatments. There are several ways that individual cases are typically represented including problem lists, “hot cross buns” or similar approaches, classic longitudinal formulations in the Beckian tradition, and the highly individualized formulations that resemble “spider diagrams” or “central heating plans”. All of these have a role at different rimes, but also various strengths and weaknesses from different standpoints. However, in the face of comorbidity or complexity, therapists (especially trainees) often struggle to develop clear hypotheses and there is a danger that treatment becomes either overly procedural in one area and does not make the necessary adjustment to the comorbidity, or it becomes increasingly scattered, diffused, and lacking in “dose” in important areas. Given that comorbidity and other types of complexity are the rule in many services rather than the exception, it is important that therapists can continue to access nomothetic knowledge in these cases and bring it together in a useful way that leads to clear hypotheses which can guide treatment. Otherwise there is a danger that treatment in the face of complexity and comorbidity becomes ad hoc, overly procedural, or divorced from the evidence base or indeed some combination of the three. This presentation proposes that an intermediate level of specification in the case formulation allows therapists to more easily recognize different types of patterns of linkage between comorbid entities. It is further argued that there are a relatively small number of basic types of linkage, each of which has different treatment implications, although there is of course an infinite number of ways in which these may be configured across cases. Finally, it is suggested that learning to develop hypotheses about these patterns while linking to nomothetic knowledge provides trainees and therapists with a way of thinking about more complex or comorbid cases that increases the chance of more parsimonious and more focused treatments with a higher proportion of “active ingredients” yet are still tailored to the individual.

The Understanding and Treatment of Complexity in Eating Disorders
Carlos Grilo, Yale University, USA

Studies have reported high rates of psychiatric and personality disorder “co-morbidity” in patients with eating disorders. Methodological limitations and conceptual problems make interpretation of the existing literature, which is highly variable, ambiguous. For example, consideration of base rates and relevant patient comparison groups suggests that the observed diagnostic co-occurrence rates between personality disorders and eating disorders are unlikely to reflect meaningful “co-morbidity” (i.e., shared pathophysiology). This presentation will focus on recent research regarding the understanding of such “eating-disorder patient complexity” “psychiatric and personality disorder co-morbidity and eating-disorder severity. This presentation will summarize what is known about the outcome of eating disorders and the potential role that co-morbidity plays as a predictor and/or moderator of outcomes. Although the primary focus will be on RCT data, relevant findings from prospective naturalistic studies will be integrated. For example, recent findings will be presented showing that the natural course of bulimia nervosa and eating-disorder NOS does not appear to be influenced significantly by the initial presence or by time-varying changes in personality disorder psychopathology. Clinical implications will be discussed with a focus on treatment delivery, including issues pertaining to the use of “combination” treatments and new “enhanced” treatments.

Patient Complexity in the Treatment of Depression
Steve Hollon, Vanderbilt University

The cognitive and behavioral therapies and the antidepressant medications both appear to be efficacious in the treatment for depression. Nearly two-thirds of all patients treated will respond to either type of intervention and up to a third will show full remission. Nonetheless, not all patients will respond and there are indications that those who are more complex are particularly likely to not get better. Patients who are more severe or more chronic or who have depressions superimposed on personality disorders are particularly likely to not get well on either or both of these types of interventions. An earlier placebo-controlled trial focused on more severely depressed patients found that patients with depressions superimposed on personality disorders were less likely to respond to cognitive therapy than to medications during acute treatment (patients free from personality disorders showed the opposite pattern) but that patients with personality disorders who responded to medications were particularly likely to relapse following treatment termination (something not evident among similar patients who responded to cognitive therapy) (Fourrier et al., B JP, 2008). Yet another recent placebo-controlled trial found no differences among patients with less severe depressions but that either behavioral activation or medications were superior to cognitive therapy (which was not superior to pill-placebo) among patients with more severe depression (Dimidjian et al., JCCP, 2006). Moreover, a subset of those nonresponsive patients showed a pattern of extreme nonresponse to cognitive therapy; they were not only more severely depressed but also more complex in terms of having chronic characterological problems consistent with personality disorders (Coffman et al., JCCP, 2007). In still ongoing trial, adding cognitive therapy has been found to enhance recovery relative to medications but only among patients who are more severe and not for patients who are chronic, whereas presence of a personality disorder appears to delay recovery regardless of modality. Among those patients who do recover, preliminary findings suggest that those without personality disorders who were treated with cognitive therapy can discontinue medications, whereas those with personality disorders are well advised to stay on medications regardless of whether they were treated with cognitive therapy or not. It would appear that patient complexity alters the likelihood of response to treatment and the subsequent stability of gains and that severity, chronicity, and co-morbidity all contribute to that process.

Recent advances in CBT self-help delivery
Convenor: Christopher Williams, University of Glasgow

Online self-help resources for carers of individuals with Anorexia Nervosa: Findings from a recent community based pilot evaluation
Louise Ewan, University of Glasgow
Anorexia nervosa is a disorder which affects many women, men and also their families and friends. Due to a lack of availability of specialist eating disorder services within the UK, waiting lists for such services are significant and are often forced to only treat individuals whose condition is severe and life threatening, leaving sufferers with mild or moderate illness without specialist treatment. This leaves individuals being supported by relatives, friends etc who often have limited knowledge and skills as to how to help the person with the disorder. Supporters of individuals with eating disorders often experience high levels of distress. Research has found that the burden of care experienced by family members of people with anorexia nervosa is comparable to caring for someone with psychosis. Parents in particular identify issues around finding help for their child and themselves, sometimes feeling unable to offer support, a lack of resources being available, and a breakdown in family routine. In addition caregiver’s often have high levels of expressed emotion, with emotional reactions such as criticism, hostility, overprotection, guilt and shame influencing the time-course of the illness. Such emotional reactions may cause family and friends to accommodate the illness or be drawn in to enable core symptoms. Thus interventions which have the potential to lower expressed emotion, in turn reducing caregiver strain and impacting the individual with anorexia nervosa positively are needed. One means of overcoming some of these problems is through self-help resources. An online package has recently been created, which focuses on helping supporters. ‘Overcoming Anorexia Online’ aims to help supporters offer effective support, identify problematic responses and better self manage how they cope through education, cognitive behavioural therapy based advice and systemic interventions. This paper will discuss the concept of online CBT based self-help resources for carers, and present the findings from a recent community based pilot study of the package. This study recruited 64 supporters of individuals with anorexia nervosa from community based sources such as carer support groups, and via Google advertisements, in order to try and provide support as early as possible and to the widest network of individuals.

Living Life to the Full: A Northern Ireland Study
Pat Lynch, Head of Services, Aware Defeat Depression; Katrina Collins, External evaluator, Aware Defeat Depression
Aware Defeat Depression has been working since 1996 to provide information and support to all those in Northern Ireland affected by depression. The organisation currently has a network of over twenty self-help support groups which are facilitated by trained volunteers and a range of other services including a telephone helpline. As part of Aware’s commitment to helping those affected by depression the organisation began to develop an educational programme based on CBT in 2006, utilising Dr Chris Williams’s resources. Following the initial success of this programme Aware continued to work with Dr Williams using the Living Life to the Full resources in 2009. To date the course has been delivered to approximately 60 groups across NI. Although originally aimed at people with mild/moderate depression such has been the demand for the course that approximately half of courses delivered have been to other target groups including LGBT, women’s groups, young people, workplace groups etc. The systematic evaluation of the programme using the GHQ12 and pre and post programme questionnaires have provided an evidence base of improvement in the mood of participants on the course. The key learning in delivering the programme in Northern Ireland and associated evaluation findings will be presented in the symposium.

Advancing Towards Evidence Based Prescribing: Common Factors in Self-Help Books for Common Mental Health Problems
Joanne Woodford, Mood Disorders Centre, University of Exeter; Paul Farrand, Mood Disorders Centre, University of Exeter
It has been proposed that common factors within CBT self-help books themselves may be linked to their effectiveness (Richardson et al., 2010). This study seeks to examine the extent to which common factors are demonstrated within publically available CBT self-help books for common mental health conditions for which self-help is effective (Farrand & Woodford, submitted). First, a systematic review of Google Books was undertaken to identify publically available CBT self-help written material for the mental health conditions with a CBT self-help evidence base. A thematic analysis was conducted on identified titles to examine the extent to which material demonstrates a range of common factors as identified within a common factors framework (Richardson et al., 2010). This analysis demonstrates that clinically effective written CBT self-help material varies in the extent to which it contains a range of common factors. This may potentially impact upon the establishment, development and maintenance of a positive therapeutic relationship with the user which in turn may limit the effectiveness of the material. Results from this analysis will feed into developing a comprehensive list of self-help books more closely aligned to the evidence base that could be consulted when choosing CBT self-help materials.

Bounce Back: Reclaim your Health: A Telephone-Supported Cognitive Behavioural Therapy-based Self-Help for Primary Care Patients with Mild-Moderate Depression
Mark Lau, University of British Columbia; Michelle Prostak, Canadian Mental Health Association-BC Division; Gillian Albert, University of British Columbia; Lynn Spence, Canadian Mental Health Association-BC Division
Depression is a high prevalence condition, resulting in significant social and fiscal costs. From a health systems perspective, effective depression management should rely heavily on the primary care sector given the ease of access, the inextricable nature of physical and mental health, and the potential costs avoided in specialist care. For mild to moderate depression, one first-line intervention is cognitive behavioural therapy (CBT). CBT has been shown to be more cost-effective than pharmacotherapy in the treatment of depression, yet it is not readily accessible to the large number of people who might need it. In British Columbia, CBT services are available only on a limited basis through mental health specialists and not readily accessible by primary health care practitioners for their patients, particularly in rural areas. To address this service gap, the Canadian Mental Health Association-British Columbia division implemented the Bounce Back: Reclaim your health (BB) program province-wide in 17 communities across British Columbia. BB is a low intensity telephone-supported cognitive behaviour therapy (CBT)-based self-help program for primary care patients with mild-moderate depression. The purpose of this uncontrolled study was to evaluate the effectiveness of the BB program. Family physicians referred 600 patients with mild to moderate depression to the BB program. Patients’ use of the CBT self-help book ‘Overcoming Depression: a Five Areas Approach’ was supported via 3-5 structured telephone sessions by non-specialists trained and supervised by registered psychologists. Participants completed the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7) and the Quality of Life and Enjoyment Satisfaction Questionnaire (Q-LES-Q) before and after their participation in BB. Patients demonstrated a positive impact of the program on the PHQ-9 (11.7 vs 6.7); GAD-7 (9.1 vs 5.8) and Q-LES-Q (43.7 vs 50.0) after participation in BB (all paired samples t-tests ps < 0.001). These data suggest that BB is both a feasible and promising method to treat mild to moderate depression in primary care. Low intensity interventions, provided outside of the formal care sector, offer an efficient means of addressing unmet need in the alleviation of depression and in reducing the burden of care. Moreover, the telephone delivery model allows patients who would otherwise be unable to access
service to conveniently make use of the program and receive help. Currently, a controlled evaluation of the BB program is being conducted.

Self Help Access in Routine Primary Care - the SHARP project
Mike Lucock, University of Huddersfield & South West Yorkshire Partnership NHS Foundation Trust; Mike Lawson, South West Yorkshire Partnership NHS Foundation Trust

NICE guidance recommends guided self-help approaches for anxiety and depression, provided in a stepped care service model. These interventions are provided within IAPT services and to compliment this, the SHARP (Self-help Access in Routine Primary Care) project was designed to enable primary care practitioners to support patients with mild to moderate anxiety and/or depression to access CBT based self-help information. The project consists of a training course, website and brief self-help leaflets. The SHARP training course enables practitioners to: understand the 5 areas CBT model and how it is used in the self-help leaflets; identify patients who are suitable; engage patients in the guided self-help approach; identify appropriate self-help leaflets; support patients to make use of the leaflets. The leaflets are based on the 5 areas model and provide information on understanding problems, the 5 Areas model and using it to manage problems. Some of the leaflets have been adapted from Chris Williams' books Overcoming Depression and Overcoming Anxiety. All leaflets are one or two pages long and more accessible 'lite' versions are available. The website (www.primarycare-selfhelp.co.uk) is being used to support the training, enable the provision of guided self-help in routine primary care and to allow public access to the leaflets. It also includes links to other self help resources. Training resources and an online forum are also available for practitioners who register. The progress of the project will be described, most recently a 'train the trainers' phase, and examples given of its implementation in practice in the Yorkshire and the Humber Region.

Cognitive-behavioural formulation: Views across specialties
Convenor: Barry Ingham, Northumberland, Tyne and Wear NHS Foundation Trust

Collaborative Psychosocial Formulation in Intellectual/Developmental Disabilities: What difference does it make?
Barry Ingham, Northumberland, Tyne & Wear NHS Foundation Trust; Jenny Riley, Northumberland, Tyne & Wear NHS Foundation Trust

People with Intellectual/Developmental Disabilities (IDD) often exist within systems operating at different levels, especially involving direct care staff. This is particularly the case where they experience significant psychosocial difficulties (e.g. mental health problems, displaying challenging behaviour). The quality of the interaction between the individual and systems around them may impact on the nature of those psychosocial difficulties. Previous research has explored the nature of those interactions, e.g. the impact of staff stress on managing people with IDD who display challenging behaviour. Working with the system around an individual could have a positive effect on those interactions and so may play a significant role in managing psychosocial difficulties displayed by people with IDD. Collaborative psychosocial formulation development workshops have been developed to influence direct care staff. These workshops have been piloted within an IDD service alongside novel quantitative measures to detect changes in understanding and emotional response in relation to the person with IDD with qualitative analysis of these changes. This presentation will outline the initial findings of this pilot evaluation and suggest ways of exploring this further. In particular, staff reported changes in understanding the difficulties presented by, and shift in their emotional responses to, people with IDD. In addition, potential change mechanisms were highlighted and should be fed in to protocols for these workshops. The further development of measures and refinement of protocols with a view to service development and further research will be discussed.

Team formulation of complex and challenging service users in CMHTs
Lucy Johnstone, Cwm Taf Health Board

There is a small but growing literature on formulating in teams, ie supporting and training MDTs to create and use formulations with complex and challenging service users, and the key findings from projects supervised by Lucy Johnstone will be summarised briefly. She will describe her own approach which is based on an integrative model. She will argue that any effective team formulation must include transference and counter-transference, trauma awareness, the meaning of medical interventions such as medication, and a consideration of the way the service user interacts with the psychiatric system as a whole. She will also contend that formulation should be seen as a radical alternative to, not addition to, psychiatric diagnosis, and that as such it can be a powerful antidote to many of the most damaging consequences of psychiatric intervention. She will discuss some of the benefits and challenges of using formulation in teams, and will present her 'one-size-fits-all' formulation for all long-term service users.

Investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis
Katherine Berry, University of Manchester

Introduction: Psychiatric staff play a key role in the lives of people with psychosis and the quality of staff and service user relationships is associated with relapse and recovery. One factor that might determine the capacity of staff to form positive therapeutic relationships is their appraisals of service users' mental health problems. Method: A pilot intervention was implemented with psychiatric staff which involved helping them develop psychological formulations for individual service users. Staff perceptions of service users’ mental health problems were measured before and after the intervention using Likert scales. Data at the two time points were collated for thirty staff. Results: There was a significant increase in staff perceptions of the degree of control service users and themselves had over problems, an increase in the degree of effort they felt service users were making in coping, reductions in blame and more optimism about treatment. Staff also reported an increase in understanding of service users’ problems, more positive feelings towards service users and an increase in confidence in their work. Discussion: Results from this pilot are promising, but findings warrant replication in controlled studies. It is also important to establish whether changes in staff perceptions influence the actual nature of staff-service user relationships. The paper concludes by presenting proposals for and baseline data from an accessibility and feasibility trial of a more intensive formulation-based intervention to improve staff-patient relationships.

Applying Case Formulation with Older Adults: Models and Pitfalls
Ian James, Northumberland, Tyne & Wear NHS Foundation Trust
A number of conceptual models have been produced for older people in order to help direct therapy. Owing to the complexities and longevity associated with old age a tension emerges, whereby clinicians are required to develop formulations that are both comprehensive yet accessible. This presentation examines some of the available models and also the pitfalls associated with using them. In addition, the controversies that emerge within this, the challenges to successful application across systems and ways of measuring and understanding the impact of the varying formulation approaches with older people will be explored within this presentation.

Case conceptualization and socialization to the model: examining the role of key therapeutic components in the therapy process
Convenor: Jo Daniels, University of Bath

Examining the concept of 'socialization to the model' in academic and clinical context: an active component in formulation based psychological therapy?
Jo Daniels, University of Bath

Formulation and socialization to the model are acknowledged to play a key role in the initial phase of treatment in psychological therapy, most notably cognitive behavioural therapy. The term 'socialization to the model' is commonly used to describe a process that occurs in the early stages of therapy whereby the therapist and patient negotiate and maintain a shared understanding and formulation of the presenting difficulty, therefore developing a therapy rationale, deriving therapy goals and providing a theoretical basis for treatment (Roos & Wearden, 2009). This concept had previously received little academic interest despite being ubiquitous in the clinical literature and treatment manuals. The use of the randomised controlled trial design in treatment outcome studies presents the opportunity to isolate key components in therapy, resulting in the proliferation of studies investigating predictors of outcome and mechanisms of change in therapy. The role of socialization to the model, previously undefined yet considered to be of clinical importance has been operationalised and associated with outcome in a randomised controlled trial for chronic fatigue syndrome. The major part of this presentation discusses the conceptual development of 'socialization to the model' as an active component in psychological therapy in context of the interface between clinical practice and academic literature. Findings from studies examining the dimensions and properties of 'socialization to the model' and associated research will be considered in relation the practical applications of enhancing socialization to the model in the therapy process and how this translates to clinical practice.

The Impact of Cognitive Behavioural Case Formulation in the Treatment of Obsessive Compulsive Disorder
Anna Nattrass, University of Sheffield

Case formulation is considered a central component of CBT. It is claimed to enhance the therapeutic relationship, relieve client distress and improve treatment outcome. Despite this however, surprisingly few studies have investigated its use in routine clinical practice. This includes if and how clinicians are using formulation, and importantly, how this relates to therapy process and outcome. This presentation reports findings from a study investigating the content and quality of CBT formulations generated in routine clinical practice, and their impact on treatment outcome. The study used archival outcome data of CBT for OCD offered in a specialist psychotherapy service within the NHS. Data comprised measures that had been collected on a session-by-session basis, including ongoing symptom and therapy process measurement, and audiorecords of each therapy session. Transcripts of formulation sessions were coded for content and quality, using the Case Formulation Content Coding Manual (CFCCM; Eells et al 2005). Findings indicate that clinicians tend to create problem-focused OCD formulations, with an emphasis on symptoms and maintaining factors. Formulation quality ranged from rudimentary to excellent. A significant improvement in client distress and the therapeutic alliance was identified shortly after the presentation of the formulation. However, no significant relationship was found between the quality of the formulation and outcome at any stage in treatment. The study presented appears to have raised more questions than it has answered. Central to this is, what is it about the formulation process that is helpful? And how do we determine a 'good quality' formulation? This will be discussed in the context of ideas for further research.

Bringing Interpersonal processes into the mainstream of CBT
Convenor: Stephen Barton and Peter Armstrong, Newcastle CBT Centre

Tales of the unexpected: Using the CTIP model to formulate patient drop out
Stephen Barton, Newcastle Cognitive & Behavioural Therapies Centre

Even the most rigorous CBT trials report patient drop-out rates of up to 20% and best estimates suggest this is even higher in routine clinical practice. Patient drop out can be disguised by averaging change across patients, focusing only on treatment completers or selecting the most successful cases to persuade supervisors, journals and commissioners. But if we really want to improve the effectiveness of our therapies, a consistent reduction in patient drop-out presents the single biggest opportunity. To achieve that some of us need to "fess up" and take a closer look at the various factors that underlie treatment non-completion, including therapist error. One of my patents in a recent CBT case series unexpectedly dropped out in mid-treatment after eight therapy sessions (Barton et al 2008). The drop out was entirely unexpected - at least by myself. Guided by the desire to understand drop-out better and contribute to its long term reduction, the CTIP model was used retrospectively to explore whether a problem in interpersonal process had contributed to the patient discontinuing treatment. Video records of selected sessions made it clear that it had. The CTIP model was used to conceptualise what had gone wrong and try to explain how it escaped my attention first time round. The key lessons are how to spot process problems prospectively and seek to do something about them before the patient gives up on their CBT. This is something many of us do intuitively on a regular basis; the CTIP model provides a framework to support and conceptualise those intuitions.

Introduction to the CTIP model
Peter Armstrong, Newcastle Cognitive & Behavioural Therapies Centre

All psychotherapeutic modalities agree on the importance of the interpersonal alliance to effective therapy (Horvath & Greenberg 1989). Understanding matters that impair the alliance is therefore of great importance. Insofar as these may be explained in terms of interpersonal pathology, CBT provides a reasonable (if under-developed) framework for understanding unhelpful client-therapist interactions (Safran & Segal 1990); similarly, insofar as they may be understood as a function of deficits in therapist competence, tools are available (Roth & Pilling 2007, Blackburn, James, Reichelt & Milne 2001).
However, in keeping with a number of emergent models having their origin in the Newcastle Cognitive & Behavioural Therapies Centre (Armstrong & Freeston 2006 (supervision), Barton et al 2008 (depression)), it is also possible, and in many cases potentially preferable, to formulate disruptions to helpful functioning in a way that does not presume (whilst not excluding the possibility of) pathology or incompetence. The Cognitive Therapy Interpersonal Process model (CTIP) is intended to give therapists, clients, and others (e.g. trainers & supervisors) a means to analyse interpersonal factors influencing the progress of a given course of CBT in apathological terms.

**Does the IAPT program ignore the therapeutic relationship?**

Richard Thwaite, Cumbria Partnerships NHS Foundation Trust
The roll out of the Improving Access to Psychological Therapies (IAPT) program has revolutionised access to CBT over the last three years in the UK. More people than ever are able to access evidence-based talking therapies. However, not everyone is pleased. Quotes such as the following are not uncommon in the media. ‘Everyone knows the limitations of CBT’ (Letter to The Guardian by Professor Samuels, 2007). This is an appropriate point in time to reflect on how the selection, training and supervision of High Intensity Practitioners support the development and refinement of skills in working with interpersonal process: What have we learnt knowledge and skills?)

**Fear and loathing in the clinic: Interpersonal processes in therapy drift**

Glenn Waller, Vincent Square Clinic, Central and North West London NHS Foundation Trust, and Institute of Psychiatry, King's College London
Therapy drift is a widespread phenomenon in CBT and other therapies. Clinicians commonly fail to adhere to the evidence base, drifting into less effective or even harmful practice. There are diverse reasons for this pattern of behaviour on the part of clinicians, but ‘maintaining the therapeutic alliance’ is probably the most commonly cited justification. This presentation will focus on the interpersonal factors that result in therapy drift, and the way that going off course can have adverse consequences for patient and clinician alike. It will consider the wide range of interpersonal relationships that contribute to treatment outcomes (e.g., patient-clinician; clinician-supervisor; clinician-colleagues), and the potential positive and negative emotions and cognitions that might be involved in those relationships. It is important to remember that clinicians value the therapeutic relationship/working alliance as a therapeutic tool, despite the poor evidence that it drives change in structured therapies. Such overevaluation of the working alliance can mean that we work hard to make patients (and colleagues) like us, while reducing the likelihood that the patient will recover. Clinicians need to be aware that they are not the only ones who experience interpersonally-based emotions and cognitions (e.g., social anxiety, anger, hopelessness, shame), and that to try to hide these experiences beneath a veneer of false ‘professionalism’ means that we cannot use those emotions and cognitions to get better at what we do.

**Clinical Roundtable**

**Complex Cases**
Convenor: Robert Dudley, Newcastle University
Speakers: Mike Lambert, Brigham Young University, USA
Mark Lau, University of British Columbia, Canada
Willem Kuyken, University of Exeter

This clinical roundtable is part of a linked symposium on complex cases. Complexity may consist of many overlapping, and interacting processes. For instance, the chronicity of the problems, the number and nature of co morbid difficulties as well as the social and physical context in which the person lives can have an impact on how able we are to help. The linked symposium addresses issues of definition and understanding of what contributes to complexity. Even when we know and understand these factors we are still left with the task of trying to help alleviate the distress that a person with a complex presentation is experiencing. This roundtable particularly focuses on formulation and treatment of complex cases. In this roundtable three expert clinicians outline their formulation and preferred treatment strategies for a complex case. At the beginning of the session there will be a brief presentation (RD) of case material of a person with depression and anxiety and other factors that contribute to complexity. This material was shared with all the contributors a little while before the conference. Each presenter will then outline an understanding of the factors leading to and maintaining the presentation and highlight potential treatment strategies. The purpose of the presentations and the subsequent clinical discussion is to help articulate the way that experienced and knowledgeable clinicians approach the task of working with a complex case. This session would appeal to clinicians working with people with these complex presentations. Also, trainers, supervisors and services need to address issues of complexity as these presentations may not respond to our best efforts to help. It may actually be that they are excluded from services even though they are experiencing distress and disability. Of course, researchers considering how to refine and improve models of disorders may also value discussing how best to help complex cases. We anticipate and hope for considerable discussion on these issues and welcome your contribution to the roundtable.

**Skills Class**

Two Techniques to Improve Well-Being Through Targeting Grateful Schemas: A Positive Clinical Psychology Approach
Alex Wood, University of Manchester
In the last five years the extent to which people experience gratitude has emerged as one of the strongest predictors of well-being and clinical functioning, even after controlling for the presence of negative characteristics and other personality traits. Gratitude naturally leads to well-being over time and prevents the development of disorders such as depression during difficult periods of life. As such, there has been considerable interest in clinical techniques to foster gratitude, both to treat disorder and to build resilience in at risk populations. Of all the Positive Psychology techniques, gratitude has been proposed as having the most promising evidence as being the one that is most adopted in current practice. Two techniques exist to increase gratitude; (a) maintaining lists for things for which one is grateful, and (b) a new approach developed by the class leader which more directly targets the schemas underlying gratitude through an automatic thought monitoring technique. Dr Wood has recently conducted four randomized controlled trials (published in Social Science and Medicine) showing that these techniques decrease depression, body image problems, and stress in clinical and community populations. These trials also consistently suggested that gratitude diaries are as effective as techniques that monitor and change negative thoughts whilst having a lower drop-out rate. Thus the addition of these techniques to existing therapies may reduce clients dropping out of therapy. The key challenge is now to disseminate these techniques and illustrate their correct use to encourage integration with mainstream clinical practice.

Key learning objectives:
1. To understand the relationship between gratitude and well-being, which cognitions underlie gratitude (and how these can be targeted), and the empirical evidence of the effectiveness of gratitude techniques.
2. To be able to confidently use two techniques to increase gratitude.
3. To be able to integrate gratitude and other Positive Clinical Psychology techniques within personal clinical practice.

The session begins with a brief overview the current empirical evidence regarding the effectiveness of gratitude techniques, in keeping with the model of therapist as scientist practitioner. This leads onto the main body of the session, involving participants pairing and taking turns to administer the two techniques on each other. There will be four of these role-playing sessions (acting as both therapist and client for both techniques) which will be with different partners. The session will conclude with a group discussion about their experiences with the techniques and how they may be applied in participants personal clinical practice.

Open Papers

A pilot randomised trial of Acceptance and Commitment Therapy for Psychosis (PACT)
Ross White, Andrew Gumley: University of Glasgow

The experience of psychosis can lead to emotional distress in the form of anxiety, fear and depression. In recent years there has been a move toward incorporating acceptance/mindfulness-based approaches into cognitive-behavioural frameworks to help alleviate distress associated with psychological disorders. Acceptance and Commitment Therapy (ACT) is a mindfulness-based psychological therapy that aims to help people be fully aware of their here-and-now experience, with an attitude of openness and curiosity. It is hoped that this will reduce distress associated with particular thoughts and emotions. In addition, ACT aims to facilitate people to take effective action that is conscious and deliberate, rather than impulsive. The PACT trial was a pilot randomised controlled trial of Acceptance and Commitment Therapy (ACT) for emotional adaptation following psychosis. Twenty-seven participants were randomised in the PACT trial: 14 participants to ten sessions of ACT and 13 to treatment as usual (TAU). Measures used included the: Hospital Anxiety and Depression Scale, the Positive and Negative Syndrome Scale, idiothetic measures of positive symptoms (frequency/believability/distress), the Kentucky Inventory of Mindfulness Skills and the Valued Living Questionnaire. From baseline to 3 months post-baseline, the ACT group showed significantly greater improvement in mindfulness skills, and negative symptoms ($p < 0.05$) than did the TAU group. There were also trends indicating that the ACT group had a greater decrease in depression ($p = 0.051$) and a greater increase in value-consistent behaviour ($p = 0.057$) compared to the TAU group. Participants receiving the ten session PACT intervention appeared acceptable; 100% of the individuals randomized to the ACT intervention completed the trial. In addition, the extent to which participants receiving ACT could work collaboratively with the therapist to identify goals, set tasks, and form a therapeutic alliance was rated very highly by these individuals. The PACT trial demonstrates the merit and feasibility of conducting a larger trial of ACT for psychosis-related distress. In particular, ACT appears to offer promise in reducing levels of negative symptoms and depression in psychosis. Randomised clinical trials have found that Cognitive Behaviour Therapy for psychosis (CBTp) is efficacious for treating residual distressing positive and negative symptoms (see: Wykes et al., 2008). However, the evidence for treating emotional dysfunction associated with psychosis (such as anxiety, depression and hopelessness) is less clear (Birchwood, 2003; Wykes et al., 2008; Tarrier et al., 2006). The PACT trial highlights the potential benefit that may come from integrating acceptance-based approaches and values-based behavioural activation into cognitive-behavioural frameworks to facilitate emotional adaptation following psychosis.

A Randomised Controlled Trial of Person-based Cognitive Therapy Groups for People Experiencing Chronic Depression
Clara Strauss, University of Surrey & Sussex Partnership NHS Foundation Trust; Paul Chadwick, Institute of Psychiatry, Kings College London; Mark Hayward: University of Sussex & Sussex Partnership NHS Foundation Trust

Chronic depression is diagnosed when symptoms of depression persist for two years or longer (Gelenberg et al, 2006). The prevalence rate of chronic depression has been estimated to be between 3% and 5% of the population. People experiencing chronic depression respond less well to the range of depression interventions, including CBT, than people experiencing acute episodes (Keller et al, 2000). Mindfulness-based cognitive therapy (MBCT) is a group intervention aimed at reducing risk of relapse for people who are currently well but who have a history of recurrent, acute episodes of depression (Segal et al, 2002). This form of therapy may be less acceptable to some people who are currently depressed given the focus on lengthy mindfulness meditation practices. MBCT also has little emphasis on traditional CBT approaches as it is designed for people who are currently well. Person-based cognitive therapy (PBCT) is a mindfulness-based intervention that incorporates a traditional CBT approach with brief mindfulness practices (Chadwick, 2006; Dannahy et al, 2011). This presentation reports on a randomised controlled trial of PBCT groups for 27 people experiencing chronic depression. Participants were randomly allocated to either a 12-session PBCT group or to continue with their usual treatment (TAU). At the end of the study, PBCT group participants scored significantly lower on the BDI-II than TAU participants ($p < 0.001$) and reduction in symptoms of depression was associated with improvements in mindfulness skills, as predicted by the theory underlying PBCT. These findings suggest that PBCT groups may be helpful in reducing symptoms of depression for people experiencing chronic depression.
Posters

‘Buying affection’: New goals and new possibilities
Jody Fairhurst, Six Degrees Social Enterprise
A woman in her thirties (known as Jane) was referred with history of anxiety, which had increased prior to referral as a result of severe financial difficulties. Jane identified that she was suffering from anxiety, characterised by excessive worry, rumination, feelings of guilt and poor self-esteem. This anxiety had affected numerous areas of Jane’s life including her relationships and work. Disorder specific self-help was initially used, but Jane’s anxiety prevented her fully engaging with this. A recently developed transdiagnostic CBT model (Mansell et al., under review) was used to formulate how her anxiety was being experienced, its effect on her goals, and her use of inflexible control strategies; such as avoiding confrontation, pleasing others, and in Jane’s words ‘buying affection’. Using guided discovery informed by the Method of Levels approach (Carey, 2006), the therapist encouraged Jane to focus upon underlying goals that may be competing with one another; for example, maintaining secure bonds and friendly relationships with those people she depended upon and ‘selfishly’ looking after her own needs. Jane overcame this tension by adopting the higher-level goal of seeking to be reasonably independent and properly taking care of her own needs. Jane’s confidence improved and much of her anxiety alleviated. Her PHQ-9 scores reduced from 12 to 3 and GAD-7 scores reduced from 14 to 2. She has continued to maintain these gains 6 months after completing the brief therapy. Implications for the science and practice of CBT: The case study illustrates how the Method of Levels approach can be used to help clients work through conflicting goals and to explore adaptive alternatives to inflexible control strategies such as ‘buying affection’. The strategy of focusing on underlying goals has the possibility to be applied across disorders for clients with multiple problems to provide efficacious, yet brief therapy.

Self-help treatment for anxiety disorders: A meta-analysis of effect and a meta-regression of potential predictors and moderators
Thomas Haug, University of Bergen and Western Health region; Tine Nordgreen, University of Bergen; Odd Havik, University of Bergen
Self-help through books or computer and Internet programs show promising results in treatment of anxiety disorders. However, the research literature indicates much heterogeneity in the results. It is therefore of importance to identify potential predictors and moderators of treatment effect to further optimize self-help treatment and identify patients likely to benefit. The present study reviewed the literature on CBT based self-help delivered via books or computer/Internet programs for anxiety disorders. The study aimed to estimate the overall effect of self-help treatment through a meta-analysis and identify potential predictors and moderators through subgroup analysis and meta-regression. Articles were identified through literature searches in databases and hand searches of relevant articles. A mean summary effect size was calculated for primary and secondary outcome measures for all comparisons of self-help treatment vs. a control/comparison group in the included studies. Subgroup analyses were conducted to identify potential predictors and moderators. Moderators with a significant relationship to outcome were included in a multiple meta-regression. 57 articles with 83 RCT comparisons were included in the analysis. The summary effect indicated a moderate to large effect for self-help compared to wait-list or placebo control, and a small effect favouring face-to-face treatment (FTF) when FTF was compared to self-help. Subgroup analyses and multiple meta-regressions indicated that Computer-based self-help targeted at panic, social phobia and GAD was associated with a superior treatment result. In addition, when self-help is compared to FTF, comparison with CBT and high % females in the study sample was associated with a worse treatment result. The results from the present analysis indicate that self-help may be as effective as standard face-to-face therapy, but somewhat less effective than specialized therapy such as CBT. Comparison group, treatment format and diagnosis, but not therapist contact, seemed to moderate the treatment result. The conclusions that can be drawn from the present analysis are however limited by methodological weaknesses and high heterogeneity in the included studies. Implications for the science and practice of CBT: Self-help treatment should be made available for more sufferers of anxiety disorders and should be offered to patients as a low-threshold intervention in primary care.

A single-case study of attention training in Social Phobia: From lab to clinical practice
Alexandre Heeren, Universite catholique de Louvain, Belgium; Pierre Philippot, Universite catholique de Louvain, Belgium
Attention capture for threatening stimuli and difficulties to disengage from these stimuli have been identified as core components in Social Phobia (e.g. Amir et al, 2003). Further, cognitive models of Social Phobia state that attention biases for threatening information contribute to the maintenance of this disorder. Some studies have demonstrated that training social phobics to attend to non-threatening stimuli is related to short-term (Amir et al., 2008) as well as long term emotional changes (e.g., Schmidt et al., 2009). However, to date, no studies have examined the adaptation of an attention training approach within a single-case design. Using an attention training procedure based on a modified dot-poke task, the present single-case study examined whether such procedure enabled a social phobic client to reduce attentional biases and to transfer this rehabilitation to daily functioning. Efficacy of the attention training was assessed with multiple baseline measurements (cognitive, behavioural and ecological). In addition, several self-reported questionnaires were administered to assess the efficacy of the attention training on psychopathological symptoms. Results suggested attention training is an efficient treatment for social phobia. Results will be discussed in terms of cognitive model of social phobia and implications for psychological interventions. Implications for the science and practice of CBT: The poster will present how to adapt the attention training procedure to a single-case approach.

Group Behavioural Activation treatment for Depression
Ingrid Huijbregts, Talking Change Primary Care Therapy Service; Lisa Butler, Talking Change Primary Care Therapy Service; Samantha Milner, Talking Change Primary Care Therapy Service
Jacobson et al.’s (1996) component analysis of Cognitive Behavioural treatment showed BA can be an effective treatment for depression. Clinical Behaviourists view depression as a direct consequence of an individual’s learning history. Behavioural reduction in depression is seen as a loss of or reduction in access to positive reinforcement and the affective components of depression as responses to these losses or reductions. BA assumes that direct contact with contingencies of negative reinforcement can initially establish and later maintain avoidance repertoires. Therefore, more flexible repertoires of depression. This encouraging finding will be discussed in terms of increasing access to evidence-based psychological therapies for chronic depression.
problem solving and repertoires based on positive reinforcement are either extinguished or never developed. Escape and avoidance from aversive internal and external stimuli lead to a further decrease in positive reinforcement and depressive symptoms are therefore maintained. Developing more proactive alternative coping behaviours to replace these patterns is the primary focus of BA. BA treatment uses the full arsenal of behavioural techniques to achieve behavioural activation targeting specific areas of passivity and avoidance that have been identified ideographically. BA is principle based, encouraging the use of any intervention techniques consistent with their underlying principles, rather than a manual approach. This suggests BA intervention is recommended on an individual rather then group basis. A 10 (90 minute) session group programme based on BA was developed and delivered to a group of ten individuals as a step 3 intervention. Participants included 6 males and 4 females with an average age of 41.8. Participants were selected using the IAPT minimum data set to identify moderate to severe depression (measured on PHQ9). Entry requirements were depression scores 10+ (measured on GAD7). Exclusion criteria were a risk score >2 (measured on CORE 34). All clients agreed to group treatment. The participants are still currently being treated and therefore final outcomes cannot yet be given. However, results at session 10 as measured by the IAPT minimum data set, CORE 34 and BDI-2 show clinically significant change in 6 of the 10 participants. Follow-up data will also be reported. Implications for the science and practice of CBT: Our findings to date suggest that BA could be effective if delivered in a group format. Due to high demands on Primary Care psychological services and the emphasis on IAPT recommended interventions, group interventions are becoming more important. More research is needed to determine the effectiveness of BA treatment delivered in group format and the effective components of this type of intervention.
relationships by talking together. They learned assertiveness theory, and they notice the importance of valuing it in reference to themselves. Through role play, appropriate self-expression is learnt. These factors may be connected to the reduction of stress.

**Group substance abuse treatment for women in secure services**

Clive Long, St Andrew's Healthcare; Barbara Fulton, St Andrew's Healthcare

Gender differences in the presentation of substance abuse problems requires gender sensitive treatment approaches. The treatment effectiveness of a manualised CBT substance abuse treatment programme for women in secure settings is described. Pre-post changes following treatment were assessed using substance-specific and other outcome indicators. Positive outcomes were identified for treatment completers (n=23) in terms of improved substance-related self-efficacy, lower perceived costs, and greater benefits of change. These differences, which were not evident in the non-completers group (n=11), were paralleled by positive clinical changes in symptomatology, need, and increased general self-efficacy. Treatment was successful in engaging two thirds of patients to complete treatment in readiness for conditions of lower security and potential exposure to alcohol and other drugs. Differences between completers and non-completers raise issues about the timing and intensiveness of treatment at stages in treatment paths for women in secure settings. Future research might aim to develop and test interventions for specific sub-groups of women given the complex treatment needs of this group.

**Socialization to the model: An active component in the therapeutic alliance? A preliminary study**

Jo Daniels, University of Bath; Alison Wearden, University of Manchester

Therapeutic alliance has been found to be a significant predictor of outcome in psychotherapy yet what constitutes therapeutic alliance remains unclear. Examining the common constructs of therapeutic alliance, it is possible that there may be a conceptual overlap between active components of therapeutic alliance and socialization to the treatment model. Aim: To investigate the relationship between socialization to the model and therapeutic alliance. Participants (N = 43) were taken from the active treatment arm in a RCT for the treatment of chronic fatigue syndrome (CFS/ME). Therapeutic alliance was measured using a 5-item questionnaire (brief CALPAS) and socialization to the model was extracted from therapy tapes using a novel coding system. Key findings were that when patients and therapists agreed about goals of treatment, there were higher levels of concordance, less evidence of applying principles incongruent to the model, and less resistance during the treatment sessions. The outcome of this preliminary study contributes to the potential understanding of active components in the therapeutic alliance, and supports further research to achieve a more detailed picture of “non-specific” factors in therapy, including the active process of socialization in therapeutic alliance. Implications for the science and practice of CBT: Implications are furthering the understanding of therapeutic alliance and socialization to the model, moreover understanding the non-specifics of therapy which can promote better practice and inform the therapy process.

Note. This study is in press in *Behavioural and Cognitive Psychotherapy*, and complements a symposium convened by the lead author.

**Training and Professional Issues**

**Keynotes**

**Acronyms and the Information Revolution : Support for Research and Treatment in the NHS**

Professor Til Wykes, Institute of Psychiatry, King's College London

Research in the UK took a large leap following the formation of the National Institute for Health Research (NIHR) as this provides the structure of support for research involving patients. NIHR provides grants for research, but in addition it provides infrastructure support for studies of mental health, and this structure is known as the NIHR Mental Health Research Network (MHRN). These two acronyms have changed the way that mental health research is carried out, and in particular the MHRN has as an objective to ensure that high quality research studies involving the NHS recruit to time and target. Lack of recruitment due to poor feasibility prior to study start and poor patient engagement during the study have both been issues that have prevented studies from answering the key scientific and clinical questions. They also undermine the confidence of funders when making decisions about the viability of some projects. This paper will provide researchers with an overview of what help is on offer from the MHRN as many researchers are still not taking advantage of additional support. In addition, we will touch briefly on new ideas for collecting clinical and trial data which will reduce the time and increase the feasibility of our studies. These new ways of working must be supported by service users, and may not only be able to improve mental health research but also provide service users with further empowerment in the research process.

**What Shall We Do About the Fact That There are Supershrinks and Pseudoshrinks?**

Professor Michael Lambert, Brigham Young University, USA

While cognitive behavioral theory and practice place major emphasis on specific interventions to facilitate recovery from psychological disturbance, it is clear that a major contributor to psychotherapy outcome is the specific provider of services, especially in routine care. A summary of research documenting the size of this effect will be provided, along with evidence about the factors that contribute to variability in patient outcome due to the therapist. Methods of taking action in this area in order to maximize patient outcome will be discussed. The roles of training, treatment adherence, and competence will be contrasted with the importance of interpersonal relationships. Obstacles to identifying outcome as a function of individual therapists will be highlighted and suggestions made for using therapist outcome variability to improve treatment will be made.

**Symposia**

**Examples of service delivery, clinical outcomes and the development of CBT competencies within IAPT services**

Convenor: James Gregory, Rightsteps Bristol, IAPT, Turning Point
Outcome effect sizes in clinical studies are often smaller than those attained in randomised control trials (e.g. Weisz, Weiss, & Ham, 1995), with therapist training and competence being cited as some of the important reasons for this difference. Within the context of the IAPT initiative, Roth and Pilling (2008) developed a framework of evidence based CBT competencies. This covers generic, basic and specific CBT competencies across and within disorders and has been developed into a self assessment tool. The curriculum of IAPT CBT training diplomas largely aim to support High Intensity (HI) trainees in developing the competencies comprising the Roth and Pilling (2008) framework. The present study describes the changes in CBT competencies of six HI trainees using the Roth and Pilling self assessment tool at the beginning, middle and end of training. The implications of these findings and recommendations for the future are discussed.

The development of an ‘in-house’ continuous professional development programme for Psychological Well-being Practitioners

Jane Mallard, Rightsteps Bristol, Turning Point

Since 2007, the Department of Health has trained 3660 new cognitive behavioural therapists in the roles of psychological well-being practitioners (PWP) and high intensity therapists (HI). No formal PWP top up training has been provided by the DOH to follow the initial IAPT training programmes, although IAPT has recognised the potential benefit of such a scheme. Within Bristol Rightsteps, PWP's reported a need for continuous professional development to maintain and develop their PWP competence. This paper describes the development, delivery and evaluation of a hi in-house training programme designed to maintain and develop PWP competence, whilst being conscious of mid-intensity drift. The method was a user centred design which involved the PWP's in the requirement analysis and the planning stages of the training programme. The training was delivered by HI qualified therapists to a PWP workforce comprising each of the four waves of IAPT PWP training programmes; the first of which completed in May 2009, the last in January 2011. Evaluation measures included adoption of the Roth & Pilling (2007) competencies framework and a user evaluation form. Preliminary findings from the project are discussed, including problems encountered, and recommendations for the future.

An ‘in-house’ training programme for new recruits without prior PWP training.

Abigail McCormack, Outlook South West

The presentation discusses the background and rationale for the development of an in-house PWP training course within a provider of IAPT services. The training is aimed at new recruits who have not attended a commissioned PWP training course. The stages of the development of the course are discussed, as based on national IAPT guidelines, as well as the integration of local developments such as a telephone triage project. Course content, teaching styles and assessment methods are all outlined and discussed as well as lessons learned. The question of BABCP accreditation is addressed.

The implementation and audit of a stress control group within an IAPT service

Paul Adkins, Bristol Rightsteps, Turning Point

Since 2007, the Department of Health has trained 3660 new cognitive behavioural therapists in the roles of psychological well-being practitioners (PWP) and high intensity therapists (HI). No formal PWP top up training has been provided by the DOH to follow the initial IAPT training programmes, although IAPT has recognised the potential benefit of such a scheme. Within Bristol Rightsteps, PWP's reported a need for continuous professional development to maintain and develop their PWP competence. This paper describes the development, delivery and evaluation of a hi in-house training programme designed to maintain and develop PWP competence, whilst being conscious of mid-intensity drift. The method was a user centred design which involved the PWP's in the requirement analysis and the planning stages of the training programme. The training was delivered by HI qualified therapists to a PWP workforce comprising each of the four waves of IAPT PWP training programmes; the first of which completed in May 2009, the last in January 2011. Evaluation measures included adoption of the Roth & Pilling (2007) competencies framework and a user evaluation form. Preliminary findings from the project are discussed, including problems encountered, and recommendations for the future.

An exploration of the effectiveness of low intensity interventions for depression in a multi cultural and ethnically diverse population

Lucy Brett-Taylor, City and Hackney Primary Care Psychology Service

The IAPT programme has transformed the way psychological therapy is delivered in the UK. This evaluation aims to assess the effectiveness of Behavioural Activation, a low intensity intervention for depression, within an inner city IAPT service. Outcome data from 108 clients treated by a cohort of six psychological well being practitioners was collected across twenty-one months from the inception of IAPT in October 2008. Effectiveness was measured by pre to post-treatment improvement in depression and anxiety symptoms, functional impairment and employment and benefit status. Client satisfaction was also included as a measure of effectiveness. The extent to which the service provides equitable access to the diverse population is also evaluated by comparing the current sample with the local demographic. Results showed BA to be effective at reducing symptoms of depression and anxiety and levels of functional impairment with effect sizes of .47, .38 and .30 respectively. Of the sample, 47.8% ‘moved to recovery’ with respect to depression, 40.5% for anxiety, 39% for functional impairment of the therapist have been nationally developed. Furthermore, national curricula and accreditation processes have been set to ensure equal standards and a high quality provision of training is delivered. However within clinical skills education there is insufficient comprehensive evaluation to date that measures the impact of clinical skills delivered in educational settings from the classroom through to the individual, the organisation and on patient outcomes. To date systematic reviews have focused upon learner responses which provide only a limited and impressionistic understanding.
Within the IAPT Low Intensity CBT programme at The University of Nottingham a multi-method approach to evaluating education using Barr’s Framework is being used across six domains: learner reactions, modification of attitudes and perceptions, acquisition of knowledge and skills, changes in individual behaviour and changes in organisational behaviour and benefits to patients. Preliminary findings from the evaluation will be presented.

**CBT Supervision: Measuring Competence**

Pamela Myles, University of Reading; Derek Milne, Newcastle University; Melissa Snith, University of Reading

High-quality supervision is generally acknowledged as being a key component of training aimed at developing practitioners’ competence in using a CBT approach with patients. The Cognitive Therapy Scale™ Revised (CTS-R) developed by Blackburn and colleagues is commonly used to measure competence of learners but no such instrument is commonly used to measure competence of the supervisors of these developing therapists. The Supervision: Guidance and Adherence Evaluation (SAGE) developed by Milne and Reiser (2008) is an instrument designed to measure the competence of supervisors and trainers. A newly adapted version of this instrument (SAGE-R) is in the early stages of development. The instrument will be described with some preliminary findings on its usefulness in the clinical and training setting.

**Can therapists learn CBT through the Internet? A pilot study of online CBT training**

James Bennett-Levy, University Centre for Rural Health, University of Sydney; Russell Hawkins, Department of Psychology, James Cook University; Helen Perry, University Centre for Rural Health, University of Sydney; Paul Cromarty, PRAXIS CBT, Northumberland Tyne and Wear NHS Foundation Trust

The internet now provides a medium for learning CBT skills. For mental health professionals who have difficulty accessing face-to-face training due to issues of cost, distance and time off work (e.g. small training budgets, limited time for training, work in rural/remote communities), online training may hold particular promise as a means of disseminating skills. Accordingly, we undertook a pilot study with mental health professionals, the majority of whom live in rural/remote regions of Australia, in order to answer the following questions:

1. Does online training make a difference to self-report of knowledge, skills, confidence and CBT utilisation in clinical practice and to objectively measured CBT knowledge?
2. Does a minimal level of practitioner support by telephone or Skype (15 minutes every 2 weeks, on 5 or 6 occasions) make a difference to program completion and outcomes, compared with no practitioner support?

The results of the study showed statistically significant positive changes in all measured parameters and give grounds for optimism that online training may be a useful resource for training mental health professionals. However, there are limitations both to the study and to the mode of delivery, which require more research before online training can be unequivocally endorsed.

**Teaching excellence in CBT on a pluralistic clinical psychology training course**

Sue Watson, University College London

The notion of CBT as an approach to helping people overcome psychological difficulties elicits polarised reactions amongst mental health professionals. Within the current zeitgeist, it is both idealised as the route back to happiness and gainful employment and demonised as a mechanical and technique-driven approach to human distress which does not take account of complexity. At UCL, we do not engage in these dominant discourses but we do present CBT to our trainees as an empirically validated approach, which, in the interests of both clinical excellence and political expediency, they need to be competent to practise. In this presentation, I describe what we teach our trainees within our CBT unit and how we teach it. I review various ongoing CBT projects in which we are engaged and I present a model for CBT training and supervision in the clinical environment.

**Expanding CBT capacity through training mental health workers from diverse professional backgrounds in CBT**

Convenor: Metka Shawe-Taylor, Surrey and Borders Partnership NHS Foundation Trust

**CBT Training Courses and Outcomes within an NHS Trust: A Case Study**

Metka Shawe-Taylor, Surrey and Borders NHS Foundation Trust; Katie Broome, Surrey and Borders NHS Foundation Trust

The National Institute for Health and Clinical Excellence (NICE) guidance recommends CBT as the psychological treatment of choice for a broad range of mental health problems. The NICE guidelines also recommend that CBT should be delivered by suitably trained and supervised clinicians. All these recommendations have put considerable pressure on NHS mental health providers to increase access to good quality CBT provision. In order to meet this demand CBT is increasingly delivered by a range of mental health professionals including those that have not been traditionally trained in psychological therapies. This development presents a new challenge for CBT training and supervision. This paper will describe how this challenge is being addressed by one mental health and learning disability NHS Trust. It will describe different levels of CBT provision that were adopted by the organisation and the internal training model that has been developed in order to support this type of CBT provision. The paper will give an overview of the different courses offered within the organisation and will provide training outcome data, including long-term follow-up information on CBT progress of the participants on these courses.

**CBT training for staff working with people with learning disabilities**

Karen Dodd, Surrey and Borders NHS Foundation Trust

This paper will describe the rationale, development and implementation of CBT training for qualified staff working with people with learning disabilities. The intention of the training was to develop staff CBT skills that they could incorporate into their daily practice to help them understand and work more effectively with people with learning disabilities. A six session training course was devised together with a follow-up session. Outcome data was collected both pre and post course through a knowledge questionnaire, and through participants keeping a reflective diary. Evaluation of the course was completed for each session and from overall course feedback. Results were very positive. The attendance rate was very high, with all but one attendee completing the course. Sessions were rated as very positive. The questionnaires indicated that most participants had improved their knowledge. Information from the reflective diaries demonstrated positive effects on the participants’ skills and knowledge, their work with people with learning disabilities and their understanding of systems and working together as staff teams. The presentation will describe the course design and content; quantitative and qualitative outcome data; the challenges presented in helping staff to work in a CBT framework with people with learning disabilities; and proposals for future training.
Introductory Training in Cognitive Behavioural Therapy for staff within Surrey's Children and Young People's Service: Benefits and Challenges
Kate Danvers, Surrey and Borders NHS Foundation Trust; Beth Johnson, Surrey and Borders NHS Foundation Trust; Rachel Sweetingham, Surrey and Borders NHS Foundation Trust
Evidence for the efficacy of CBT with children and adolescents has been growing rapidly and NICE now recognises it as the treatment of choice for several disorders, but many staff in Child and Adolescent Mental Health Services nationally lack CBT skills. As part of the Trust's CBT training strategy, a new training programme was developed to provide basic skills for working with children and adolescents with mild to moderate depression and anxiety problems: the first course ran in Spring 2009 and was attended by 12 clinicians from a range of disciplines working within the local Children and Young People's Service. The course outline was similar to that developed within the Trust for training clinicians working with adults, but adapted for children, adolescents and families. It was designed and delivered by Clinical Psychologists trained and experienced in the use of CBT with children and families, with newly created content based on resources from our own training and clinical practice and previous training courses we had delivered. The course covered basic CBT skills, assessment and formulation skills, behavioural techniques, techniques for identifying negative thoughts, cognitive restructuring, behavioural experiments and relapse prevention. Attention was paid to using child-friendly language and materials, ensuring intervention skills taught were age-appropriate, and including parents in CBT formulations and interventions. The 10 day course consisted of 12 teaching sessions and 8 group supervision sessions (two to three hours each) spread over three months. Course participants carried out two pieces of supervised case work during this time. Participants showed extremely high levels of satisfaction with the course content, indicated by questionnaires completed at the end of each session and at the end of the course. Outcome was evaluated via questionnaire measures at the beginning and end of the course and at 6-month follow up: the course generally increased participants' knowledge of CBT, the frequency of their use of CBT techniques, and their confidence in using CBT techniques. It was more difficult to assess the long-term impact of the course, as only five participants returned follow-up measures, but those who did so appeared to have maintained their learning. The course resulted in some participants carrying out CBT with families who previously would have been seen by psychologists. We had planned to provide ongoing supervision after the course, but in some areas this proved challenging due to staff mobility, job role changes and time pressures. Limitations of our evaluation methods included possible positive bias in reporting satisfaction with the course, the use of a multiple-choice format to assess knowledge, and the use of self-report measures rather than objective observations of changes in clinical skill level. Participants often appeared to struggle with role-play exercises carried out during the training: it would be valuable to explore the possibility of using objective measures of CBT competence (such as the CTS-R²) to evaluate future training courses. 1. Staallard et al. (2007), Behavioural and Cognitive Psychotherapy, 35: 501-505; 2. Blackburn et al (2001), Behavioural and Cognitive Psychotherapy, 29: 431-446

Consultation as a Model of Training in Acceptance and Commitment Therapy
Katherine May, Surrey and Borders NHS Foundation Trust; Lorraine Nanke, Surrey and Borders NHS Foundation Trust; Rebecca Isherwood, Surrey and Borders NHS Foundation Trust; Melanie Orchard, Surrey and Borders NHS Foundation Trust; Cara Galligan, Surrey and Borders NHS Foundation Trust
This paper will describe the design and delivery of an Acceptance and Commitment Therapy Consultation into an existing service. The present a series of recent developments in guideline development from the United States and Europe which aim to better present a series of recent developments in guideline development from the United States and Europe which aim to better evidence based practice but they can be costly to produce and implementation remains patchy. This panel discussion will address these two issues.

Panel Discussions

The future of stepped care: Triage versus LIFT (Least Intervention First Time)
Convenor: Alex Stirzacker, IAPT South West Alison Sedgwick-Taylor, 2gether NHS Foundation Trust
Speakers: Mandy Cole, University of Exeter
Liz Howells, Avon and Wiltshire Mental Health Partnership NHS Trust
Annette Law, Swindon and Wiltshire Primary Care Psychology
Barbara Stapleton, Swindon and Wiltshire Primary Care Psychology
Jackie Freeman, Swindon and Wiltshire Primary Care Psychology

There has been a lot of discussion about the future of IAPT. Some Primary Care Trusts have withdrawn funding and it remains to be seen whether GP consortia will replace this funding. IAPT is widening its remit to include a far broader client base and a wider range of conditions. Some services have remained true to IAPT e.g., with its target group of mild to moderate anxiety and depression and with a workforce dominated by high intensity therapists. Other services have widened their remit and retained the high qualifications (and pay) of their workforce others have increased the proportion of step 2 work. However, most services are struggling with a waiting list. There are two types of stepped care LIFT and Triage. It has been suggested that triage will always produce waiting lists and there may be a trade off between capacity and outcome and that cost effectiveness will be different. This discussion will address these two issues.

Making clinical guidelines more useful for clinicians: International perspectives
Convenor: Steve Pilling, University College London
Speakers: Steve Pilling, University College London
Steve Hollon, Vanderbilt University, USA
Tony Kendrick, Hull York Medical School

Clinical guidelines are one of the best developed and widely used means to support the dissemination and implementation of evidence based practice but they can be costly to produce and implementation remains patchy. This panel discussion will present a series of recent developments in guideline development from the United States and Europe which aim to better engage clinicians, improve on the development process and bring about improved outcomes for patients; the emphasis will be on psychological interventions. The discussion will provide an opportunity not only to hear about new developments but also to contribute to the shape of these developments.
Skills Classes

How to make best use of the CTS-R in terms of assessment, training and supervision

Ian James, Northumberland, Tyne and Wear NHS Foundation Trust

The CTS-R was developed in the 1990s to assess competence in CBT, and to assist with training and supervision. It is now widely used as an assessment tool throughout the country, and is employed routinely on many IAPT courses. The scale has numerous critics who do not consider it to be a reliable or valid tool. However, frequently such critics have not received training in the proper use of the CTS-R, and are unaware of the associated documentation—particularly the training manuals. This short workshop reviews the scale, and the supporting documentation, providing information on how to make ‘best use’ of the scale.

Case Management Supervision for Psychological Wellbeing Practitioners - How to do It

Pamela Myles, Charlie Waller Institute, University of Reading, Faye Small, University of Exeter, Sarah Gibbons, Berkshire Healthcare NHS Foundation Trust

Supervision is a key activity which is central to the success of the IAPT programme. Psychological Wellbeing Practitioners (PWPs) require access to experienced supervisors to consult on assessment and risk issues. Clinical decisions to either step up, step down or step out must be discussed within regular case management supervision. Case management supervision (CMS) refers to the regular review of practitioners’ caseloads. These practitioners provide low intensity interventions within IAPT services. CMS takes place regularly (usually weekly) and is informed by automated IT-based case management systems (i.e., E-PAS, IAPTUS etc). CMS is unlike traditional models of clinical skills supervision which is why training in this type of supervision is essential. Typically, large numbers of cases are discussed in any one supervision session. Discussions in CMS always include supervisee presentations of patients at pre-determined stages in their care pathway and/or who have particular clinical characteristics which ensure that all cases will be taken to CMS. It is structured to enable efficient support and shared decision making by PWPs and their supervisors.

Participants will:

- Become familiar with national guidelines for PWP supervision
- Recognise what is Case Management supervision and how it compares with Clinical Skills supervision
- Recognition of how to select cases for discussion in CM supervision
- Demonstrate an understanding of Supervisee and Supervisor responsibilities
- Consider some of the main challenges of CM supervision

This experiential workshop will use a range of teaching methods including discussion, small and large group work and role-play. Implications for the science and practice of CBT: Case management supervision is essential to the clinical methods employed by PWPs. These supervisors help ensure that all patients are reviewed according to specific clinical and organisational criteria in order to make effective clinical decisions, often relating to the stepping up of treatment intensity or offering alternative low intensity treatments and this has been shown to have a positive effect on patients’ clinical outcomes, therefore appropriate training of these practitioners is vital. Pamela Myles is Head of Training for both Psychological Wellbeing Practitioner and High Intensity training at the University of Reading and was co-editor of A Complete Guide to Primary Care Mental Health (2007); Sarah Gibbons is a senior Psychological Wellbeing Practitioner working in clinical practice at Berkshire Healthcare NHS Foundation Trust; Faye Small is an Associate Training Fellow on the Low Intensity training course at the University of Exeter and a senior Psychological Wellbeing Practitioner working in clinical practice at Devon Partnership Trust.


Open Papers

Clinicians’ views on the use of session measures and whether these change as procedures become established.

Stephen Linacre, University of Leeds; Samantha Tucker, South West Yorkshire Mental Health NHS Trust

When monitoring feedback systems (MFS) are implemented in therapy services, client outcomes are improved. Some clinicians perceive MFS as a threat to their own clinical effectiveness. This, alongside practicalities can make them difficult to implement. This project investigated clinicians’ views regarding the implementation of a MFS called “SIGNAL” at Dewburns Adult Psychiatric Service. A predominantly qualitative design was adopted due to interviewing clinicians over the telephone using a semi-structured interview schedule. A follow up questionnaire was distributed approximately 6 months after the interviews to assess whether any changes in opinion had occurred. Descriptive statistics and a thematic analysis were used to identify the clinician’s views and highlight the perceived strengths and weaknesses of “SIGNAL”. There did not appear to be any substantive changes in opinion between the interviews and follow up. The results identified that clinicians felt that improvements to the system are required and that protocols need to be established. The majority of clinicians did see the potential of MFS but suggested that as yet, the benefits were not being seen. A number of recommendations were proposed that included better communication, clinician training, equipment changes and mnemonic aids. It was suggested that further evaluation of clinicians’ views would be beneficial once “SIGNAL” was fully operational e.g. feedback being given to clinicians.

The reliability of the Cognitive Therapy Scale across different client groups

Kenneth Gordon: University of Southampton

As training in CBT becomes more structured, and accreditation more vital to clinical practice, we place great emphasis on the judgement of therapist competence. The revised Cognitive Therapy Scale (CTS-R) is a major tool for assessing CBT skills. However, there are concerns about its reliability in practice (Gordon, 2007). This study investigates the routine use of the
in order to maximise the likelihood of the ‘Processes of Change in ACT’ occurring). This study highlights the complexity of
themes were considered (e.g. some of the moderating factors identified in ‘Aids and Hindrances…’ may need to be present
facilitating change in ACT for anxiety and depression. In their narratives, clients talked about the multi-faceted nature of
diagnoses of severe and enduring anxiety and/or depression. The interviews were transcribed and analysed using
and Hindrances to Change in ACT’ and ‘Non-Specifics of Therapy’. Hypotheses about the possible interactions between the
requirements as well as an adapted supervision options grid (Padesky, 1996), to capture all methods used within supervision.
A pre-pilot was undertaken, prior to the pilot with IAPT students. Two audit tools were designed, one for supervisors and
one for the supervises themselves. The aim was to test whether the use of a structured supervision record sheet would
encourage supervisors to use evidence-based methodologies, e.g., role-play, within their clinical supervision. Because of the
small scale of this project (3 supervisors, 6 students), qualitative feedback was also included. Supervisors were asked
questions relating to ease of use, impact on interactive methods, and whether trainees were more or less likely to bring a
DVD to supervision. Scores ranged from 2.5-5 for ease of use, and 3-5 for impact on use of a range of supervisory methods.
Students answered questions relating to ease of use, impact on methods chosen by them, and on homework completion.
They also ranked methods in order of usefulness. Scores ranged from 0-5 for ease of use, and to 4-5 for impact on use of a
range of methods, and the benefit of this. It appeared that the development of the supervision sheet did impact on the
frequency of DVDs being brought to supervision. In addition, the use of the supervision options grid did encourage both
supervisors and supervisee to use more interactive methods. A less clear response was obtained with regard to the third
expectation, that the tool would enable supervisors to carry out clear action points and prepare more thoroughly for
supervision. Although positive feedback was received, there were also suggestions for improvements, to capitalise on the
process of capturing action points at the end of each supervision session and reviewing them, at the start of the following
supervision. The findings of this project have implications for future practice, and the following recommendations are made:
A session should be provided at the start of each new CBT programme aimed at providing information and guidance to the
supervisee. A standardised supervision record should be used in each supervision session containing the following: Basic
information e.g. name, date, individual/group and the duration of supervision as well as supervisor and supervisee
signatures; whether a DVD is played; a supervision question (with a prompt about previous action points/agenda items); a
content of supervision section (with clarification about individual and group elements of supervision); a grid indicating what
the supervision mode and focus was; and risk issues. More training should be made available to support supervisors in
ensuring that they are adhering to EBCS. A larger scale study is required to see if these findings are replicable.

Introducing a custom developed supervision record sheet: The impact on clinical supervision with students undertaking
training in Cognitive Behaviour Therapy
Megan Edwards, University of York
Clinical supervision is an integral part of training in Cognitive Behaviour therapy, with a comprehensive framework and an
emerging evidence base for best practice. Although methods for evaluating supervision have been developed, much less is
written on the day to day documentation of supervisory processes, and in particular what methods were used. The aim was
to devise a more structured supervision record. A new supervision record sheet was developed, incorporating supervision
recommendations as well as an adapted supervision options grid (Padesky, 1996), to capture all methods used within supervision.
A pre-pilot was undertaken, prior to the pilot with IAPT students. Two audit tools were designed, one for supervisors and
one for the supervises themselves. The aim was to test whether the use of a structured supervision record sheet would
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ensuring that they are adhering to EBCS. A larger scale study is required to see if these findings are replicable.

What clients tell us about Cognitive Therapy: A Systematic Review of Qualitative Research
Ann Meaden: Worcestershire Mental Health Partnership NHS Trust
CBT has a large evidence base supporting its use (Padesky & Beck, 2003). However, much of this work seeks to test
therapists’ hypotheses, and there is a paucity of studies which look at therapy from the client's point of view (Manthei,
2006). For example, Hardy and Beck (1999) make a case for studying therapy from clients’ perspectives, both because the
research tends to show that clients disagree with therapists about what works and because mental health professionals’
control of the research agenda has lead to a deficit in what is known about something, which is after all, a shared process.
This paper used a qualitative synthesis technique based on Interpretive Phenomenological Analysis to systematically review
the qualitative research literature to gain an understanding of clients’ experiences of cognitive therapy. Ten papers were
found which met the review criteria. Seven sub-themes emerged during the meta-synthesis. Three were linked to a
therapeutic relationships theme; the trusted listener, power and authority and others like me. Four were linked to an
impact of cognitive therapy theme; empowering information, analysing the problem, thinking differently and doing things
differently. Of interest to researchers and therapists are client perspectives on; the importance and nature of the
therapeutic relationship, the complexities of the unequal power relationship between therapists and clients and the way in which
CBT concepts are distorted when recalled. These results suggest that therapeutic outcome may be improved paying
more attention to the intricacies of the therapeutic relationship within CBT and what precisely, clients learn in therapy.

What works for whom? A qualitative exploration of the process of change in Acceptance and Commitment Therapy for
anxiety and depression
Melanie Orchard, Dale Van der Watt, Mary John: Surrey and Borders NHS Foundation Trust
Studies in the ACT literature have consistently employed qualitative methods to investigate change processes, thus
ignoring quantitative accounts of change from the perspectives of those who have experienced it. This study aimed to
establish clients’ perspectives of the mechanisms of change in ACT for anxiety and depression. Semi-structured interviews
were conducted with eight clients. Each had attended an ACT therapy group at a Community Mental Health Team. All had
diagnoses of severe and enduring anxiety and/or depression. The interviews were transcribed and analysed using
and Hindrances to Change in ACT’ and ‘Non-Specifics of Therapy’. Hypotheses about the possible interactions between key
themes were considered (e.g. some of the moderating factors identified in ‘Aids and Hindrances…’ may need to be present
in order to maximise the likelihood of the ‘Processes of Change in ACT’ occurring). This study highlights the complexity of the
process of change and suggests specific (to the ACT model), moderating, and non-specific factors are responsible for
facilitating change in ACT for anxiety and depression. In their narratives, clients talked about the multi-faceted nature of
ACT and the elements of the model that resonated with them on a personal level. ACT is not a prescriptive intervention and so can be readily tailored for the individual. There may be less scope for this in group settings, but clinicians should ensure that they provide even coverage of the core processes and actively encourage feedback from clients.

Are client’s expectations of psychological therapy related to initial attendance?
Richard Cosway, Carol Duncan: NHS Lothian

The beliefs or expectations of psychological therapy that clients hold prior to attending have an important influence upon subsequent engagement and outcome (Greenberg et al, 2006). Those clients who do not become engaged in the therapeutic process may cancel or miss appointments, or drop out from treatment. This can affect the efficiency and effectiveness of services and lead to increased waiting times. Two types of client expectation of therapy have been identified: role expectations, which are related to how the client expects to interact with their therapist and be open in talking about their problems; and prognostic expectations, which are related to how much the client expects the therapy to help them with their problems. Client expectations have been found to be linked with therapeutic alliance and positive outcome in cognitive behavioural therapy (Constantino et al, 2005). Numerous studies have investigated client attendance patterns for psychological therapy with a view to designing services to optimise attendance. Research in Edinburgh found that non-attendance of either of the first two appointments was strongly linked with poor overall attendance (Austin, 2007). The aim of this study was to investigate the relationship between client expectations prior to psychological therapy and initial attendance. Participants, referred to Primary Care Mental Health Liaison Teams for psychological therapy, completed questionnaires at opt-in, prior to being offered a first appointment. In addition to demographic data, information about the presenting problems and initial attendance (those who attended both initial appointments vs those who missed at least one initial appointment), the following expectations were assessed: role expectations - the Psychotherapy Expectancy Inventory Revised (Bleyen, et al, 2001) has four factors, relationship, audience, approval and advice. Prognostic expectations - The Expectation of Improvement and Suitability of Treatment Form (Agras et al, 2000) has two factors, success and suitability. Data collection continues but initial analysis with data from fifty-four participants has indicated that those who attended both initial appointments had a significantly higher PEI-R Relationship score (p<0.03) than those who missed either of their first appointments. Individuals who expect to be free and open in expressing themselves within the context of the relationship with their therapist demonstrate better initial attendance. Findings and implications for addressing expectations prior to therapy or in the early sessions in order to improve subsequent engagement will be discussed. Beliefs and expectations about CBT and therapy may be important to address prior to therapy (or in the initial stages) in order to optimise client attendance and engagement. This may also have a subsequent influence upon outcome.

Posters

Joint working between Wandsworth Community Learning Disability Team and IAPT
Becca Salmon, Wandsworth Community Learning Disability Team; Britta Nagel, Wandsworth Community Learning Disability Team; Vicky Vidalaki, Wandsworth Psychological Therapies and Well Being Service; Sharon Roscoe, Wandsworth Community Learning Disability Team; Sarah Gibson, Wandsworth Community Learning Disability Team; Herjoyt Ubhi, Wandsworth Psychological Therapies and Well Being Service; Gemma Ellis, Wandsworth Community Learning Disability Team

There is a requirement for NHS mental health services, such as IAPT, to make services accessible to people with learning disabilities and to make reasonable adjustments to enable this. No PCTs (Primary Care Trusts) on the IAPT website report a special interest in learning disabilities, and the Department of Health’s document (2010) detailing the full roll-out of IAPT services makes no mention of learning disabilities. A partnership working party was formed between WCLDT and WPTWbS to address this requirement. A local service user involvement group gave us feedback on the mainstream IAPT step 2 model in use locally. They concluded that the processes of referral, screening and intervention were not accessible in their current form. Therefore we began a pilot to develop a joint working and consultation protocol and worked in partnership across our services to develop a referral pathway, create new materials accessible to people with learning disabilities and consult service users in developing materials (screening tools and intervention materials). Issues of risk and governance have been important to address especially due to our partnership working across services and Trusts. We are currently monitoring how many people with learning disabilities have been referred, screened and seen by IAPT. We are now offering Step 2 interventions to clients with learning disabilities using the protocol we have developed which has been adapted at all stages from point of referral to post session evaluation. We are monitoring the outcomes of screening assessments and of our interventions using adapted measures. In our discussion we have considered the experience of working in partnership, the difficulties and learning opportunities created and how the model and materials could potentially be applied to people without a learning disability.

What does complex mean? Factors contributing to complexity in clinical presentations in CBT
Thomas Reeves, Northumberland Tyne and Wear NHS Trust

The term ‘complex’ is often used to describe a variety of clinical presentations in mental health services. When a clinical case is described as being complex this can potentially have serious implications for the service user and the treatment they may or may not be offered. There are many papers in the clinical literature which speak of complex cases, complex mental health problems and complex needs. There is also limited literature on assessing suitability for psychological approaches such as CBT, yet there is little information on what constitutes complexity. This study aimed to draw upon the experience and opinion of a selected group of highly experienced clinicians, researchers and writers in the field of CBT in order to begin the process of identifying the key factors which influence complexity in clinical presentations. A Delphi method was used in order to try to develop consensus on the key factors influencing/contributing to complexity. This study is in progress and results will be reported in the poster presentation. Implications for CBT practice: Greater clarity and/or a shared understanding of complexity in clinical presentations may lead to improvements in the decision making process in developing referral criteria for mental health services, better access to the right treatment at the right time for all patients, and better understanding of the training needs of teams working with specific populations.

Innovations in delivering CBT for women in secure services
Clive Long, St Andrew’s Healthcare; Barbara Fulton, St Andrew’s Healthcare

Women admitted in secure psychiatric care prove a significant and recovery challenge for reasons that include a primary diagnosis of personality disorder, comorbidity, disturbed behaviour, early onset of illness, failure to benefit from previous
Improving access to psychological interventions in inpatient acute settings
Emese Csipke, King’s College London ; Rumina Taylor, King’s College London ; Til Wykes, King’s College London

Providing psychological therapies on acute wards is sometimes said to be impossible due to the lack of access to psychologists; the perceived inability of nurses to implement therapies, and the acuity of patients’ symptoms. We aimed to increase the access of inpatient service users to psychological therapies by providing training to nurses to give them the skills and confidence to provide these. Every six months, wards taking part were randomised and two allocated to the treatment arm, and this process was repeated until all received treatment. Preceding each randomisation, the project team collected data concerning the atmosphere of the ward from both nurses’ and service users’ perspectives. Following data collection, a psychologist provided training in groups such as problem-solving skills, hearing voices, emotional-coping skills.

The psychologist then demonstrated these groups on the wards, and co-facilitated them until the nurses were able to run them independently. The project demonstrated that nurses are able to deliver these interventions. The view that this would be beyond the abilities both of the nurses and their skills, and suggests a more complex model in which nurses’ training would sensibly be recommended. The uptake of the therapeutic groups also demonstrates the receptiveness of acutely unwell people to such interventions. The uptake of these interventions by both staff and service users demonstrates the feasibility of psychological therapies in an acute inpatient service. We look forward to presenting further data, when it becomes available, which demonstrates whether implementing these interventions leads to a significant improvement in ward atmosphere, patient and staff perceptions. Implications for the science and practice of CBT: It is demonstrated that CBT based interventions can be delivered on inpatients wards successfully.

Styles of humour and secondary traumatic stress among mental health workers
Lucy Czwartos, Devon Partnership NHS Trust

Sense of humour is seen as beneficial for mental health (Forssen, 2007; Miller, 2003), especially when faced with life stressors such as diagnosis of cancer (Dowling et al., 2003), exams (Kuiper et al., 1993) or difficult working environment (Scott, 2007). Professionals such as police officers, paramedics and mental health workers are particularly at risk of being affected by secondary traumatic stress; “stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1999, p. 10). The aim of this study was to explore whether there was a relationship between different aspects of humour and secondary traumatic stress among mental health workers. The Secondary Traumatic Stress Scale (STSS) (Bride et al. (2004), which measures symptoms of Intrusion, Avoidance, Arousal, and the Humour Styles Questionnaire (Martin et al., 2003) were used. The former questionnaire consists of 4 subscales, measuring both “positive” and “negative” aspects of humour: affiliative, self-enhancing, aggressive and self-defeating style of humour. Scores obtained from 81 participants were included in data analysis. Results of Pearson’s r correlation and Multiple Linear Regression Analysis indicate that styles of humour are related to levels of secondary traumatic stress and that the direction of the relationship differs depending on which of the four humour styles is considered. For example: higher levels of self-enhancing humour style were associated with lower symptoms of Arousal & Intrusion. Thus, self-enhancing humor may be protective factor preventing the increase of Arousal (e.g. sleep disturbances, hypervigilance, irritability, difficulty focusing attention) and reducing less conscious ways of dealing with trauma such as nightmares, flashbacks or intrusive thoughts (Intrusion). Implications for the science and practice of CBT: It is possible that self-enhancing humour style buffers against stress by facilitating Cognitive Restructuring. Potentially traumatic life events are far less terrifying if seen through the lenses of humour, which exaggerates and amplifies them to the point of absurdity and in this way leads to putting the situation back into perspective.

CBT through an interpreter to treat Depression and Animal Phobia: A case study presenting clinical outcome and trainee therapist learning
Laay MoIfrad, Talking Changes, Durham and Darlington IAPT Service

There is a lack of evidence to support CBT when delivered through interpreters. Difficulties can occur in obtaining appropriate information at assessment and establishing the cultural meaning of problems. A 35 year old Egyptian woman, experiencing moderate depression compounded by animal phobia, was referred to an IAPT service. Shared understandings were gradually developed using written functional analyses translated in session. Activity scheduling was integrated with graded exposure to increase access to positive reinforcement. Questionnaires and subjective data indicated a reduction in phobic avoidance and functioning increased. Despite the complexity of working as a triad, a positive therapeutic relationship was achieved with increased mutual cultural understanding. Indirect communication led to difficulties maintaining guided discovery and focus. IAPT recommendations suggest ‘staff reflect the community’ (Jassi, 2008); County Durham has one of the lowest “foreign born populations” (ONS, 2011) in the UK, indicating that IAPT services may be ill-prepared to work with ethnic minorities. Learning points for the trainee were: maintain simplicity, take time to formulate incorporating cultural difference, and translucalent interventions are key. The interpreter brought advantages: providing means of communication and understanding cultural differences. Disadvantages were the potential for bias or lost information (Farooq & Fear, 2003), increased time and complexity of delivering therapy. This case indicates a deficit in high intensity training and lack of evidence to support CBT through interpreters. In this poster I will present key clinical issues and outcome and reflect on trainee therapist learning related to the challenges of delivering culturally sensitive CBT in a setting such as County Durham.