# Table of Contents

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

## Adult Mental Health

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keynote Addresses</td>
<td>9</td>
</tr>
<tr>
<td>New ways to Optimise Exposure Therapy for Anxiety Disorders</td>
<td>9</td>
</tr>
<tr>
<td>Understanding Suicide Risk: the Integrated Motivational-volitional model of Suicidal Behaviour</td>
<td>9</td>
</tr>
<tr>
<td>One-Session Treatment, ACT, and Implementation of Research findings in Clinical Practice</td>
<td>9</td>
</tr>
<tr>
<td>Developing and Disseminating Effective Psychological Therapies: an Update on Science, Policy and Economics</td>
<td>9</td>
</tr>
<tr>
<td>New Advances in Schema Therapy</td>
<td>9</td>
</tr>
<tr>
<td>Mindfulness, Early Adversity and Suicidality</td>
<td>10</td>
</tr>
</tbody>
</table>

## Symposia

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation Models of Depression</td>
<td>10</td>
</tr>
<tr>
<td>A giant in the field: A tribute to Lars-Goran Ost on the occasion of his retirement</td>
<td>11</td>
</tr>
<tr>
<td>Treatment Issues in Compulsive Hoarding</td>
<td>12</td>
</tr>
<tr>
<td>Symposium: Can Behavioural and Cognitive Therapies guide TCs and PIEs? (Therapeutic Communities and Psychologically Informed Environments)</td>
<td>13</td>
</tr>
<tr>
<td>Outcomes of Transdiagnostic Interventions Using Control Theory</td>
<td>14</td>
</tr>
<tr>
<td>Individualising CBT Treatment Post Trauma</td>
<td>16</td>
</tr>
<tr>
<td>Putting the spotlight on emotion: a compassion-focused approach to therapy</td>
<td>17</td>
</tr>
<tr>
<td>Imagery in Unexpected Places</td>
<td>17</td>
</tr>
</tbody>
</table>

## Skills Classes

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimizing Exposure Therapy for Anxiety</td>
<td>18</td>
</tr>
<tr>
<td>One Session Treatment for Blood-Injury-Injection Phobia</td>
<td>19</td>
</tr>
<tr>
<td>Evidence based assessment of risks of suicide and self-harm</td>
<td>19</td>
</tr>
<tr>
<td>Managing Endings with Complex Cases: A CBT Approach</td>
<td>20</td>
</tr>
<tr>
<td>Behavioural Couples Therapy for Drug Abuse and Alcoholism</td>
<td>20</td>
</tr>
<tr>
<td>Disentangling Obsessions, Compulsions and Repetitions in People with Autism Spectrum Disorder</td>
<td>20</td>
</tr>
</tbody>
</table>

## Panel Discussions

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Maintains Psychological Distress? A Roundtable discussion of core processes</td>
<td>21</td>
</tr>
<tr>
<td>Adherence versus Innovation in Dialectical Behaviour Therapy. A live Issue</td>
<td>22</td>
</tr>
</tbody>
</table>
DSM 5 - Divisive Devil or Constructive Classification? ................................................................. 22

Posters ........................................................................................................................................ 23

Relationship between Personality styles and coping strategies in undergraduate male students
.................................................................................................................................................. 23

Measuring depression and anxiety among older adults: A randomised control trial .............. 23

Domestic Violence: Prevalence & Mental Health Outcomes in Pakistani Women ..................... 24

Delivering CBT in a case presentation of Trichotillomania and moderate depression ............ 24

Index Offence Analysis: a CBT approach to overcome roadblocks ........................................ 24

Health and vocational outcomes using cognitive behavioural therapy in occupational mental
health liaison service .................................................................................................................. 24

The effectiveness of CBT for adult depression in routine clinical practice: a systematic review. 25

Christopher Rae, ‘Talking Changes’, Improving Access to Psychological Therapies, Tees, Esk and
Wear Valleys NHS Foundation Trust ......................................................................................... 25

A First Stage Evaluation of a Treatment Programme for Women with Personality Disorder in a
Secure Psychiatric Setting ........................................................................................................ 25

Basic Processes and New Developments .................................................................................. 26

Keynote Addresses ..................................................................................................................... 26

Cognitive Bias Modification in Alcohol Dependence .............................................................. 26

Improving Mental Health: Can progress in Cognitive Psychology and Molecular Genetics ...... 26

boost Wellbeing? ....................................................................................................................... 26

Symposia ..................................................................................................................................... 27

Novel uses of technology in therapy ........................................................................................ 27

Emotional Processing in Mental Health: New Developments in Bias Training Interventions ..... 28

Using Smartphone Apps and New Web Technologies in CBT Practice and Research ........... 29

Contextual CBT in the Workplace ............................................................................................. 30

Cognitive processes in worry and rumination: new developments in understanding
perseveration in psychopathology ............................................................................................ 32

CBT skills for non-mental health staff: skills cascade and beyond ....................................... 33

Advances in understnading key cognitive and behavioural processes .................................. 34

Investigating Relationships Amongst Key Cognitive Processes ............................................ 36

Panel Discussion .......................................................................................................................... 37

Developing CBT in Low and Middle Income countries: Is CBT a model of treatment for mental
health problems that can be applied across cultures and contexts? And what can doing this
work teach us about providing CBT to BME communities in the UK? ..................................... 37

Posters ....................................................................................................................................... 38

Efficacy of a Self- Help Approach in the Treatment of Obsessive Compulsive Disorder ........ 38
A new decentering and perspective broadening training intervention for recurrent depression
........................................................................................................................................38

**Behavioural Medicine**....................................................................................................39

**Keynote Addresses**........................................................................................................39

Designing and Evaluating Interventions to Change Behaviour using ‘The Behaviour Change
Wheel’ ......................................................................................................................................39

CBT for Medically Unexplained Symptoms and Long Term Conditions: Are they any different? 39

**Symposia**..........................................................................................................................40

The treatment of Chronic Fatigue Syndrome in adolescents .................................................40

The cognitive behavioural treatment of chronic fatigue syndrome: Interventions and
mechanisms of change..........................................................................................................41

Advances in the Treatment of Health Anxiety ..................................................................43

Diabetes and Eating Problems: Exploring the Overlaps and Intervention Options ............44

Sex, Sexuality & HIV: how Shame shapes us ......................................................................45

Working at the Interface Between Physical and Mental Health .........................................46

**Clinical Roundtable** .......................................................................................................47

Weaving CBT, CAT, ACT and Compassion Focused Therapy into the Tapestry of Chronic Pain... 47

**Posters**..................................................................................................................................48

Cognitions, Culture and Chronic Pain: Do people from different countries think differently about
pain? .......................................................................................................................................48

Making every contact count – does patient-centred care improve in diabetes consultations after
training in psychological skills? ..................................................................................................48

The Pain Management Plan: a cognitive behavioural self-management programme for chronic
pain .......................................................................................................................................49

**Child and Adolescent** .....................................................................................................49

**Keynote Addresses**........................................................................................................49

Anxiety Disorders in Children: Risk Factors for Development and Poor Treatment Outcome .... 49

Separation Anxiety Disorder in Childhood as a pathway to mental disorders? - Under Estimated
and Under Researched ..............................................................................................................50

**Symposia**..........................................................................................................................50

Parenting, callous-unemotional (CU) traits and antisocial behaviour in children and adolescents:
Developmental pathways and treatment response .................................................................50

Understanding barriers in CBT for obsessive-compulsive disorder in youth: implications for
clinical practice ..........................................................................................................................51

Vulnerability to Mood Disorders and Preventive Measures in Adolescents ............................53
How is CBT different with Older People? ................................................................. 87
Mind the gap: a consideration of the services available to Older Adults with severe Mental Health difficulties, and the impacts for clients, services and mental health practitioners. .............. 88

Severe and Enduring Problems .................................................................................. 89

Keynotes Addresses ..................................................................................................... 89
Trauma and Psychosis: a Dangerous Duo ................................................................. 89
Reward Sensitivity in Bipolar Disorder: When, Where, and Why Might Mania Occur .......... 89

Symposia ...................................................................................................................... 89
“Something for everyone?” A range of new ways to help people manage mood swings .......... 89
The treatment of traumatic symptoms in psychosis .................................................... 91
’Low Intensity’ CBT for Psychosis ............................................................................. 92
Formulating Psychosis: How do the Clinical Cognitive Models work in Practice? ............... 93
Attachment and Metacognition: establishing a developmental understanding of affect regulation and recovery from psychosis ........................................................................ 94
Exploring psychological processes & co-morbidity in bipolar disorder: New advances ....... 96
Recognition and psychological interventions of early onset bipolar disorder ................. 96
Acceptance and Commitment Therapy, Psychological Flexibility and Psychosis: New Research and Developments .................................................................................. 100
Compassion and psychosis: developing an understanding of mechanisms underpinning recovery ........................................................................................................... 102
Cognitve and Affective Approaches to Understanding Psychotic Experiences .................. 103

Skills Class .................................................................................................................... 105
Metacognition-Oriented Social Skills Training for social recovery of individuals with schizophrenia ............................................................................................................. 105

Posters ......................................................................................................................... 106
Mindfulness-based Cognitive Therapy in Treatment Resistant Depression: a Randomized Controlled Trial in a Psychiatric Outpatient Setting ......................................................... 106
Outcome on Discharge and Follow-up of Inpatient Therapy for Severe-Treatment Refractory Obsessive Compulsive Disorder associated or not with OCPD/Perfectionism ............... 106
A Cost-Effectiveness Evaluation of CBT for Psychosis in a Specialist Outpatient Clinic (PICuP). 107
Improving Access to Psychological Therapies for People with Psychosis and their Carers: the South London and Maudsley (SLaM) IAPT-SMI Demonstration Site for Psychosis .............. 108
Social Perception in People with Eating Disorders .......................................................... 109
Therapist Experiences of Delivering Two Psychological Therapies to Patients with Anorexia Nervosa: A Qualitative Study .................................................................................. 109
"Groups – more than the sum of the parts? Engagement and empowerment; illustrations and reflections from groups with people with learning disabilities" ................................................................. 109

Pole to Pole – The Collaborative Development of a Resource for Exploration in Bipolar .......... 110

Exploring the past experiences of intimate relationships of lesbian, gay and bisexual services users whilst being treated on adult acute inpatient wards: the role(s) of intimate relationships in recovery. ................................................................. 110

Training and Professional Issues ........................................................................................................ 111

Keynote Addresses .................................................................................................................................. 111

The Dissemination of Psychological Treatments ...................................................................................... 111

“Learning is not a spectator sport” (anon). Is it true that Experience is Essential for the Effective ................................................................................................................................. 111

Acquisition of Knowledge and Skill? ....................................................................................................... 111

Symposia ....................................................................................................................................................... 112

What can qualitative research tell us about CBT? A showcase of the contribution of qualitative methodologies to advance our understanding of the development and application of CBT interventions................................................................. 112

The Art and Science of CBT - Becoming Metacompetent................................................................. 113

A Tough Nut to Crack: Adaptations to CBT Training in Primary Care ......................................... 114

Current Issues in CBT Implementation across Services .......................................................................... 114

New Developments in the Training and Assessment of Health Professionals Delivering CBT... 116

Skills Class .................................................................................................................................................. 118

Improving your Chances of Getting your Submissions accepted for presentation at BABCP Conferences .................................................................................................................................................. 118

Posters ......................................................................................................................................................... 118

Developing Clinical Leadership in CBT Practitioners ........................................................................... 118

Training Health Practitioners To Use The Pain Management Plan ................................................. 119

CUDAS: Coventry University Depression and Anxiety Support. Improving access to psychological care for people with long term conditions ......................................................................................... 119

Training and Supervision Developments in Evidence Based Psychological Therapies for Psychosis ..................................................................................................................................................... 120

Improving wellbeing for staff working in a Medium Secure Setting using Mindfulness ........ 120

The Psychological Treatment of Comorbid Anxiety Disorders in Clinical Practice: A Clinical Vignette Study ..................................................................................................................................................... 121

Secondary Care Mental Health Practitioners’ Perceptions of the Effect of Intermediate Cognitive Behavioural Therapy Training on their Clinical Practice ........................................................................... 121

Therapeutic Techniques ............................................................................................................................ 122

Symposia ..................................................................................................................................................... 122
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adaptations of CBT for Specific Populations</td>
<td>122</td>
</tr>
<tr>
<td>Innovations in Treatment and Delivery</td>
<td>124</td>
</tr>
<tr>
<td><strong>Skills Classes</strong></td>
<td>126</td>
</tr>
<tr>
<td>Cultivating Openness and Acceptance: Working with Difficult Emotions in Mindfulness-Based Cognitive Therapy</td>
<td>126</td>
</tr>
<tr>
<td>Accessing and Incorporating Clients’ Strengths in Case Conceptualisation</td>
<td>127</td>
</tr>
<tr>
<td>Helping Those Who Binge Eat</td>
<td>127</td>
</tr>
<tr>
<td><strong>Posters</strong></td>
<td>128</td>
</tr>
<tr>
<td>Individual Manualised Cognitive Behavioural Therapy for common mental disorders in people with mild to moderate intellectual disability</td>
<td>128</td>
</tr>
<tr>
<td>The effectiveness of Cognitive Behavioural Therapy as a treatment for Generalised Anxiety Disorder in later life compared to adults of working age: A Meta-Analysis and Systematic Review</td>
<td>128</td>
</tr>
<tr>
<td>Mindfulness and Distress Tolerance skills for inpatients in later life?</td>
<td>129</td>
</tr>
<tr>
<td>The impact of an attentional bias modification (ABM) intervention on reducing attentional bias and symptom reporting in women experiencing troublesome menopausal symptoms: an exploratory study</td>
<td>129</td>
</tr>
<tr>
<td>Case Report: Narrative Exposure Therapy in a medical setting</td>
<td>130</td>
</tr>
<tr>
<td>Difficulty in executive control and alertness in trait anxious individuals</td>
<td>130</td>
</tr>
<tr>
<td>CBT for OCD: habituation or cognitive shift?</td>
<td>130</td>
</tr>
</tbody>
</table>
Adult Mental Health

Keynote Addresses

New ways to Optimise Exposure Therapy for Anxiety Disorders
Michelle Craske, University of California, Los Angeles
This presentation will address the augmentation of emotion regulation during exposure therapy for anxiety disorders, using strategies that target the function rather than the content of cognition. Affect labelling, a simple process that involves linguistic processing of emotional responses, activates neural regions that serve to down-regulate the amygdala. Affect labelling is a form of inhibitory regulation of emotion. Individual with anxiety disorders show deficits in such inhibitory regulation. Thus, in training affect labelling may be particularly beneficial as individuals with anxiety disorders undergo exposure to fear producing stimuli. In clinical translation of this work, we have demonstrated the value of affect labelling as compared to cognitive reappraisal during exposure to phobic stimuli. This presentation will cover the basic science of affect labelling and the clinical translation to exposure therapy, in terms of outcomes and mechanisms. Further, the overlap between affect labelling and acceptance-based approaches, and out latest findings regarding acceptance based approaches to exposure therapy, will be presented.

Understanding Suicide Risk: the Integrated Motivational-volitional model of Suicidal Behaviour
Rory O’Connor, University of Stirling
Suicide is a major public health concern with a complex aetiology which encompasses a multifaceted array of risk and protective factors. There is growing recognition that we need to move beyond psychiatric categories to further our understanding of the pathways to suicide. Although a comprehensive understanding of suicidality requires an appreciation of biological, psychological and social perspectives, the focus in this presentation is primarily on the psychological determinants of suicidal behaviour. The overarching aim is to describe and illustrate the integrated motivational–volitional (IMV) model of suicidal behaviour (O’Connor, 2011). This tripartite 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 previous predominant models of suicidal behaviour into an integrated three-phase model of suicidal behaviour. A range of illustrative empirical studies of clinical and non-clinical populations consistent with the model are described. The clinical implications and opportunities for the prevention of suicide will also be discussed.

One-Session Treatment, ACT, and Implementation of Research findings in Clinical Practice
Lars-Göran Öst, Stockholm University
One-session treatment (OST) has become the treatment-of-choice for specific phobias. OST will be described together with a meta-analysis of 30 efficacy studies. Acceptance and Commitment Therapy (ACT) is part of the so called Third wave of Behaviour Therapy and the keynote presents an updated meta-analysis of 50 RCTs showing an overall effect size of 0.53. When applying the criteria of the APA Task Force (1995, 1998) for evidence-based treatment ACT was not well-established for any psychiatric or somatic disorder. It was probably efficacious for OCD, Mixed anxiety, Pain, and Tinnitus. Finally, the keynote reviews effectiveness research of CBT for both children/adolescents and adults. A total of 243 studies show that CBT in clinical routine care yields approximately the same within-group effect sizes as efficacy studies for all adult disorders and all but one disorder for children. In conduct disorder effectiveness studies actually yielded significantly higher effect size than efficacy studies. The conclusion is that CBT works in clinical settings.

Developing and Disseminating Effective Psychological Therapies: an Update on Science, Policy and Economics
David M Clark, University of Oxford
Cognitive Behavioural Therapy (CBT) is in a constant state of flux. Thankfully, each successive generation of CBT therapists aims to build on the achievements of the previous generation in order to develop treatments that are more effective and/or efficient. My talk is divided into two parts. In the first part, I summarise a particular research strategy that our group have found fruitful in our attempts to develop more effective treatments for anxiety disorders. It is hoped that others who are striving to improve treatments may find the strategy of interest. In the second part of the talk I provide an update on the English Improving Access to Psychological Therapies (IAPT) programme. This initiative is probably the world’s largest attempt to disseminate cutting edge CBT to the general public. The achievements of the first four years of the programme and the challenges to come will be considered in detail. Particular emphasis will be placed on ways in which local IAPT services can use their own data to further evolve the offer to their local populations.

New Advances in Schema Therapy
Jeffery Young, Cognitive Therapy Centre of New York
No abstract.
Mindfulness, Early Adversity and Suicidality
Mark Williams, University of Oxford

Suicidality is a common and distressing symptom of major depression. Recurring ideas about suicide and suicidal behaviour are one of the risk factors for eventual death by suicide. Like other aspects of depression, when a person is no longer feeling depressed, the suicidal urges subside. This means that, following treatment, it is difficult to determine which patients are now resilient to future low moods, and who remains at risk.

Using the cognitive reactivity model we have shown that people who have been depressed and suicidal in the past (and are now well), reveal an on-going vulnerability under mood challenge conditions: they show a significant decline in their ability to imagine a positive future and to solve interpersonal problems. Further research shows that this vulnerability, together with the tendency to ruminate or avoid negative moods predicts drop-out from treatment.

There is a problem here: the high risk associated with such thoughts such as “This world would be better off without me” or “I am a burden to my family” mean that, when someone is currently suffering from an episode of suicidal depression, it is not only the suicidal person who does not like these thoughts and tries to find ways to reduce them; with the best of intentions, clinicians do so too, and may thereby unwittingly help to maintain the very symptoms that they wish to help reduce.

Mindfulness-based cognitive therapy (MBCT) was specifically designed to be offered when people are between episodes and so not showing symptoms. The talk will review evidence that MBCT has an important role to play in reducing risk of depression in the most vulnerable patients, and weakening the vicious circle between suicidal thoughts and the impulses that have been associated with them.

Symposia

Regulation Models of Depression
Convenor and Chair: Stephen Barton, Newcastle CBT Centre and Newcastle University

Goal pursuit and adjustment as predictors of depression over 10 years
Rebecca Kelly, Manchester University

Previous research has demonstrated the importance of both tenacity and flexibility in goal pursuit for well-being. This research tested whether these tendencies interact to predict changes in well-being and health-related outcomes, in adults in mid to late life. A large cohort of people (n = 5666), initially aged 55-56, completed measures of flexibility, tenacity, health-related outcomes (physical health, depression, hostility), as well as demographics. Participants provided follow-up data on all measures 10 years later. Moderation analysis was used to test whether flexibility and tenacity interacted to predict changes in outcomes over the period. The interaction between tenacity and flexibility significantly predicted changes in depression, hostility and physical ill-health symptoms over 10 years, such that individuals who were both highly flexible and tenacious experienced the largest decreases in symptoms of depression, hostility, and physical ill-health. The combination of flexibility and tenacity in the pursuit of personal goals may mean individuals can enjoy gains associated with goal pursuit without the detrimental effects of persevering in blocked goals. Clinical implications of these findings will be discussed.

Depressive rumination and personal goal discrepancies
Henrietta Roberts, Exeter University, Edward Watkins, Exeter University, Andy Wills, Plymouth University

Response Styles Theory (RST; Nolen-Hoeksema, 1991) conceptualises depressive rumination as trait style of responding to depressed mood involving persistent focus on negative emotions. Control theories of rumination (CT; e.g., Martin & Tesser, 1996) focus on repetitive thought regarding personal goal progress and predict that the detection of goal discrepancies initiates rumination. There is a lack of experimental evidence evaluating this prediction, investigating proximal causes of rumination, or considering the ways in which trait depressive rumination might interact with personal goal progress to predict susceptibility to state rumination. Two studies examined un instructed state rumination in response to the cueing of resolved and unresolved idiographic personal goals in unselected samples using a novel measure of state rumination. State rumination was assessed through thought probes inserted into a repetitive task that is designed to elicit mind wandering. Consistent with CT, cueing an unresolved goal resulted in greater recurrent intrusive ruminative thoughts about the goal than cueing a resolved goal. Individual differences in trait rumination and brooding moderated the impact of goal discrepancies on state rumination: individuals who had a stronger tendency to habitually ruminate in an unhelpful manner were more susceptible to state rumination in response to goal discrepancies. The interaction of trait rumination with personal goal discrepancies to predict state rumination suggests potential for the integration of RST and CT to develop a more detailed account of rumination that considers both proximal, contextual factors, and aspects of personality and early experience that might contribute to instances of prolonged rumination.

Depressed people are not less motivated by personal goals but are more pessimistic about attaining them
Joanne Dickson, Liverpool University, Peter Kinderman, Liverpool University; Nicholas Moberly, Exeter University
Goal motivation has rarely been examined in clinical depression, despite its theoretical importance and personal relevance. In this study we investigated whether clinically depressed persons (n = 23) differ from never-depressed persons (n = 26) on number of freely generated approach and avoidance goals, appraisals of these goals, and reasons why these goals would and would not be achieved. Participants listed approach and avoidance goals separately and generated explanations for why they would and would not achieve their most important approach and avoidance goals, before rating the importance, likelihood and perceived control of goal outcomes. Compared to never-depressed controls, depressed persons did not differ on number of approach and avoidance goals or on rated goal importance. As expected, depressed individuals, relative to controls, judged approach goal outcomes as less likely to happen and tended to judge avoidance goal outcomes as more likely to happen. Furthermore, although controls generated more pro reasons than con reasons for goal achievement, depressed participants did not. Our results suggest that depressed persons do not lack valued goals but are more pessimistic in their goal explanations and appraisals.

**Integrative model of depression based on self-regulation theory**

*Stephen Barton, Newcastle CBT Centre & Newcastle University*

This paper introduces a new self-regulative model of depression based on self-regulation theory. It integrates the strengths of a number of established approaches including Beck's treatment, Behavioural Activation and Rumination-Focused CT. It is unlikely a single treatment approach can match the needs of all depressed patients not least because of the heterogeneity of the disorder. It is equally unlikely that extant approaches have entirely unique modes of action and more likely they share some common treatment effects and some unique processes. The integrated model uses self-regulation theory to make sense why some patients respond best to a contextualist approach, targeting overt behaviour and environmental reinforcement, while others respond best to a cognitive focus that targets, modifies or compensates internal processes and products. In each case it depends which goals, values and self-representations have been disrupted, and continue to be disrupted, by the maintenance of the disorder. The integrative approach encourages therapists to individualise treatment according to the clinical formulation, but to do so systematically, collaboratively and responsively based on the model, rather than through ad hoc drifting or disjointed movements between alternative approaches. A brief summary of research findings that shaped the model will be followed by some clinical cases to illustrate the application of the model in therapeutic practice.

**A giant in the field: A tribute to Lars-Goran Ost on the occasion of his retirement**

*Chair: Roz Shafran, Institute of Child Health, University College, London*

**Lars Göran Öst and the understanding and treatment of anxiety: Why his Applied Relaxation is not a paradox**

*Paul Salkovskis, University of Bath*

Lars Göran Öst has blazed a trail in the understanding and treatment of anxiety disorders. There is, however, an apparent paradox. On the one hand he has championed the elimination of avoidance and safety seeking behaviours, particularly in the rapid elimination of specific phobias. On the other, he has developed and championed the use of coping strategies, as embodied by applied tension in Blood Injury phobia and applied relaxation in just about everything. From a theoretical view these are apparently contradictory strategies. In this presentation I will explain why this might be regarded as paradoxical but why it should not be so regarded. I will also consider why Lars Goran is rightly considered a Giant in the field.

**Whatever happened to specific phobias? The significant contribution of Lars Göran Öst to specific phobia research and treatment.**

*Graham Davey, University of Sussex*

This paper will review the contribution of Lars Goran Öst to specific phobia research and treatment. The story begins in 1978 and covers all variety of specific phobias, including spiders, snakes, thunder, lightning, blood and dental phobia, claustrophobia, and flying phobia. His early contribution to aetiology was to highlight the various ways in which specific phobias could be acquired. His 1981 paper on this with Kenneth Hugdahl was one I carried around with me for some time, and had a significant impact on my own conceptualization of how phobias were acquired. More recently Lars Goran’s contribution has been to refine and evaluate brief exposure treatments for a range of phobic disabilities, and these will be briefly reviewed. I will end by asking why specific phobia research seems to have had a very low profile over the past 10 years – has Lars Goran Ost given us all the answers?

**Combining attention training with cognitive-behavior therapy in Internet-based self-help for social anxiety: a randomized controlled trial**

*Per Carlbring, Department of Psychology, Johanna Boettcher, Department of Clinical Psychology and Psychotherapy, Freie Universität Berlin, Berlin, Germany; Jonas Hasselrot, Department of Psychology, Umeå University; Erik Sund, Department of Psychology, Umeå University; Gerhard Andersson, Department of Behavioural Sciences and Learning, Linköping University, Linköping, Sweden*
Guided Internet-based cognitive-behavioral therapy (ICBT) has been found to be effective for social anxiety disorder (SAD) by several independent research groups. However, since the extent of clinically significant change demonstrated leaves room for improvement, new treatments should be developed and investigated. A novel treatment, which has generally been found to be effective, is cognitive bias modification (CBM). This study aims to evaluate the combination of CBM and ICBT. It is intended that two groups will be compared; one group randomized to receiving ICBT and CBM towards threat cues and one group receiving ICBT and control training. We hypothesized that the group receiving ICBT plus CBM would show superior treatment outcomes.

Participants with SAD (N = 133) was recruited from the general population. Mean Liebowitz Social Anxiety Scale score at pre treatment was $M=73.8$ ($SD=17.6$). A composite score combining the scores obtained from three social anxiety questionnaires served as the primary outcome measure. Secondary measures included self-reported depression and quality of life. All treatments and assessments were conducted via the Internet and measurement points will be baseline, Week 2, post-treatment, and 4 months post-treatment. By the time of the BACCP-conference all data will be available and presented.

Lars Göran Ost: Inspiring the next generation of clinical researchers
Anna Coughtrey, University College London
Over the course of his career, Lars Göran Öst has inspired many new researchers to follow in his footsteps and conduct thoughtful, rigorous and clinically relevant research. This talk will focus on the influence Lars Göran Öst has had on the next generation of clinical researchers. It will highlight his work taught to trainee clinical psychologists, his role in the development of low intensity interventions based on his work in self help and single session treatments and a discussion of how his work on randomised controlled trials applying to clinical settings has influenced training. The talk will conclude with a summary of future directions.

Treatment Issues in Compulsive Hoarding
Convenor and Chair: Victoria Bream Oldfield, South London and Maudsley NHS Trust and Olivia Gordon, Royal Holloway, University of London & South London and Maudsley NHS Trust

A new formulation for hoarding – introducing the Vicious Shamrock
Victoria Bream Oldfield, South London and Maudsley NHS Trust and, Elizabeth Forrester, Independent Practice
The cognitive model of hoarding devised by Steketee, Frost and colleagues has emerged after decades of diligent research and clinical practice. This provides a rich understanding of hoarding relevant beliefs, information processing problems, and the role of early experiences. However this model has certain limitations for those of us accustomed to formulation-driven CBT focused on belief change. A new model is proposed – the ‘Vicious Shamrock’ – incorporating beliefs about acquiring, discarding, and ‘stuckness’.

Experiences and Beliefs in Hoarding
Olivia Gordon, Royal Holloway, University of London, Paul Salkovskis, University of Bath; Victoria Bream Oldfield, South London and Maudsley NHS Trust
Recent research suggests that hoarding problems may be relatively heterogeneous, which may account for poor outcomes in treatment for hoarding. It is likely that this differential response is due to the strength of different belief domains in each individual with hoarding problems (i.e. seeing the utility of objects / not being wasteful vs. feeling very sentimental or emotionally attached to objects). The role of these hypothesised belief dimensions in hoarding was evaluated in this study, together with the association between compulsive hoarding and OCD on several clinically relevant variables. The comparison of the clinical presentation of participants across groups lends further support to the notion that hoarding should be considered a distinct clinical syndrome from OCD.

A Case Series of CBT for Hoarding Problems – What a Mess
Victoria Bream Oldfield, Alice Deale, Alice Kerr, Tracey Taylor, South London and Maudsley NHS Trust
The new classification of ‘hoarding disorder’ in DSM-5, separate from OCD or OCPD, requires moving on from trying to treat hoarding as an OCD problem, but without shedding all useful elements of OCD treatment. A small case series is presented that provides clinical reflections on what a ‘mess’ treatment can become. The case series illustrates the usefulness of using a maintenance formulation, eliciting and testing idiosyncratic beliefs, and gives examples of the tenacity involved in making progress.

What is the shape of change in hoarding during CBT - and do home visits help?
Steve Kellett, University of Sheffield, L. Pollock, University of Sheffield; P. Totterdell, University of Sheffield
This study evaluated the effectiveness of cognitive-behavioural therapy (CBT) for hoarding disorder. An ABC with extended follow-up N=1 single-case experimental design (SCED) measured discard incidence/frequency/volume and associated...
cognitions, behaviours and emotions in a time series. Following a 4-week baseline (A), CBT was initially delivered via out-patient sessions (B) and then out-patient sessions plus domiciliary visits (C). Total treatment duration was 45 sessions (65 weeks) and follow-up was 4 sessions over 23 weeks. Results show significant increases in the incidence, frequency and volume of discard, with reliable and clinically significant reductions in hoarding. The addition of domiciliary visits did not significantly improve discard ability. The clinical utility of domiciliary visits whilst treating of hoarding is discussed and study limitations noted.

Symposium: Can Behavioural and Cognitive Therapies guide TCs and PIEs? (Therapeutic Communities and Psychologically Informed Environments)

Convenor and Chair: David Veale, King’s College London

A Compassion Focussed and Contextual Behavioural Environment: a new Therapeutic Community

David Veale, Institute of Psychiatry and South London and Maudsley Trust

Social relationships and communities provide the context and impetus for a range of psychological developments. It suggests a need to think about the therapeutic changes and processes that occur within a community context and how communities can enable therapeutic change. However, the ‘therapeutic communities’ that have developed since the Second World War have been under-researched. We suggest that the concept of community, as a changing process, should be revisited within mainstream scientific research. I will briefly review the historical development of group psychodynamic therapeutic communities and critically evaluate their current theory, practice and outcomes. I then draw attention to recent research on the nature of evolved emotion regulation systems, the way these are entrained by social relationships and the importance of affiliative emotions in the regulation of threat. Concepts from Compassion Focused Therapy, Social Learning Theory and Functional Analytical Psychotherapy are drawn on. Conclusions included: living in structured and affiliative orientated communities, that are guided by scientific models of affect and self-regulation and positive reinforcement, offers potential therapeutic advantages over individual outpatient therapy for certain client groups and should be investigated further in controlled trials.

Measuring the Therapeutic Environment

Iona Naismith, Institute of Psychiatry and South London and Maudsley Trust

Background: The therapeutic environment of a mental health service can have a significant impact on treatment outcomes. Therapeutic communities in particular aim to harness this environment for therapeutic intent. Unfortunately, existing measures of the therapeutic environment are limited as they focus predominantly on outcomes rather than psychological processes. This limits their clinical and research use. We describe here the development of a new self-report questionnaire, the Therapeutic Environment Scales (TESS), which measures the processes that may occur within an therapeutic environment. Method: The TESS was developed by drawing on social learning theory and compassion-focused therapy. There are various subscales that relate to the respondent’s experience of their environment (for example compassionate care, positive reinforcement or punishment). Seventy participants were recruited from three clinical settings – a traditional psychodynamic therapeutic community, an in-patient ward, and a residential unit with a strong focus on compassionate mind and positive reinforcement. Participants completed the questionnaire and two related measures, in order to assess its reliability and validity. Results: The TESS was found to have good test-retest reliability; high convergent validity; good inter-item reliability between factors, and is sensitive to differences between services. Conclusions: The results provide initial evidence of the psychometric qualities of the TESS and its suitability for use in clinical practice and research. This measure has the potential to support research into which components of the therapeutic environment mediate or moderate outcomes, and to help services identify areas to attempt to alter in their therapeutic environment.

CBT for Culture Change; Formulating Teams to Facilitate Psychologically Informed Environments

Katherine Newman Taylor, University of Southampton & Southern Health NHSF Trust

Overview: Cognitive behavioural formulation can be used to develop psychologically informed environments. This paper presents the conceptualisation of anti-therapeutic interactions between staff and service users on an in-patient unit. Preliminary data suggest that interventions based on this conceptualisation may have facilitated a more psychologically informed and recovery focused environment, with benefits for service users and staff. Background: Increasingly, clinical psychologists and CBT trained clinicians work with and within teams. The cognitive model enables us to formulate the processes maintaining distress, and work with people to effect change. The model tends to be used to understand individuals’ difficulties, but may be effective in making sense of problems within teams. Aims: This study aimed to (i) explore the value of the cognitive model in formulating key staff-service user relationships; and (ii) determine whether such an approach would yield useful team based interventions. Method: The cognitive interpersonal model was used to develop an idiosyncratic conceptualisation of key staff-service user interactions in an inpatient setting. This then informed management team planning aimed at improving provision for service users, and staff experience. Additionally, frequency of challenging behaviours and levels of staff burnout were assessed before and after service changes, as preliminary outcome data. Results: The team formulation was effective in (i) making sense of interactions contributing to the maintenance of service users’ challenging behaviours and staff burnout, and (ii) deriving systemic interventions likely to effect change. This was then used to guide service development planning in
line with a recovery agenda. In support of a CBT approach to understanding and intervening with teams, preliminary data indicate that staff burnout and incidents of challenging behaviours reduced over time. Conclusion: The cognitive interpersonal model can be used to formulate relationships within teams and guide systemic change. This is likely to improve recovery based practice, with benefits for service users and staff.

Psychologically Informed Environments
Nick Maguire, University of Southampton
Recent ideas about the engagement of excluded populations have centred around the concept of Psychologically Informed Environments. Many third sector organisations run buildings-based and outreach services for homeless people and rough sleepers. NHS provision of psychological services is for many reasons not accessed by this population, so alternative methods of providing some form of psychological input are necessary. It is proposed that enabling third sector organisations to bring a psychological perspective to the way that they work may enable more long-term change by training staff to use basic psychological models to reflect on their experience and engage clients in the process of change. Issues such as rough sleepers’ transition to structured living, which are often not detailed, may be considered in terms of service users’ behaviours which result in eviction, and staff beliefs and emotions which contribute to this process. A broader perspective on psychologically informed environments takes into account the form of the physical environment, making use of evidence based design concepts. This presentation will discuss the contribution that psychologically informed environments can make to the engagement of rough sleepers in structured care and health services. It will cover formulation and change techniques found useful in a CBT / DBT staff training package, informed by research findings implicating specific psychological factors in the causation and maintenance of homelessness. Evidence of the efficacy of a training and supervision package will also be presented.

Outcomes of Transdiagnostic Interventions Using Control Theory
Convenor and Chair: Timothy Bird, University of Manchester

The evidence base for transdiagnostic cognitive therapy: Results from two trials examining the effectiveness of the Method of Levels
Sara Tai, University of Manchester
Method Of Levels (MOL) is a transdiagnostic form of client centred cognitive therapy that aims to facilitate people becoming aware of their own new perspectives of their problems. The MOL therapists’ role is to redirect awareness to increase exposure to those parts of the problem that are attended to only fleetingly, a process which is likely to be observed in any 'helpful' therapy. However, MOL focuses solely on this process, excluding other structural or stylistic elements of therapy that are not directly involved in mobilising awareness. The emerging evidence base for MOL is good. A small number of pragmatic open trials have demonstrated it to be an acceptable and feasible approach, achieving good effect sizes (e.g. Carey & Mullen, 2008; Carey et al., 2009). The current presentation reports on two further studies that further test the acceptability and effectiveness of MOL. Study One is a pilot RCT in which 29 people referred for psychological therapy within a primary care service chose to receive either up to 8 sessions of MOL (N=17) or treatment as usual, including CBT (N=12). Symptom measures were obtained at baseline, 3 and 6 month follow up, which demonstrated that effect sizes for the pre/post change were greater for MOL compared to the control condition. Study Two examined whether previous results could be replicated by novice therapists trained to use MOL, using a case series of 12 patients. Results from this study, based measures obtained at baseline, 6 week and 6-month follow-up will examine the impact of therapy on core transdiagnostic processes -- specifically emotion regulation strategies and flexibility of awareness; the effect of the intervention on depression, anxiety and general functioning; and the feasibility and acceptability of this approach from the patient’s perspective. These two studies provide further evidence that MOL is an acceptable and effective approach for a range of psychological difficulties. The clinical implications of delivering and implementing MOL as a transdiagnostic intervention – both the benefits and limitations will be discussed.

Manage Your Life Online: A Web-Based Randomised Controlled Trial Evaluating a Novel Computer Based Problem Solving Intervention
Timothy Bird, University of Manchester, Warren Mansell, University of Manchester, UK; Sara Tai, University of Manchester
Computerised interactive self-help programs can help to increase the accessibility of psychological interventions and can also provide advantages in terms of the flexibility and ease of use of the intervention. A program called Manage Your Life Online (MYLO), which seeks to emulate Method of Levels (MOL) therapy, has recently been developed. A small-scale, lab-based pilot study showed that the program was associated with reductions in distress, depression, anxiety and stress scores over a two-week follow-up for healthy volunteers struggling with resolving a current problem. We designed a study to further test the efficacy of MYLO as a problem-solving program for healthy volunteers using a much larger sample of individuals accessing the intervention entirely online. Participants were randomly assigned to either use MYLO or a comparison program (ELIZA) and completed measures of distress, problem resolution and symptoms at pre intervention, immediately post-intervention and a two-week follow-up. Our findings indicate that both MYLO and ELIZA were generally useful with helping people to think about and resolve their problems, with reductions in distress and symptom ratings for
both programs. However our results indicate that MYLO was associated with larger reductions in problem-related distress and higher ratings of problem resolution than ELIZA. The findings provide support for the acceptability and usefulness of MYLO as a web-based problem solving tool for individuals seeking help with resolving a relatively mild long-standing problem.

An outcome study of the Take Control Course, a transdiagnostic intervention
Lydia Morris, University of Manchester, UK; Warren Mansell, University of Manchester, UK; Phil McEvoy, Six Degrees Social Enterprise, UK; Rachel Bates, Six Degrees Social Enterprise, UK; Emma Pistorius, Six Degrees Social Enterprise, UK

Anxiety and depressive disorders are common and often co-morbid. A number of reviews have identified processes that maintain psychopathology across a range of disorders (transdiagnostic processes). Previous research into transdiagnostic groups has focused on specific client populations, e.g. clients with anxiety disorders, with promising outcomes. However, a group aimed at clients with a broader range of presenting problems has practical advantages given high co-morbidity levels. Advantages of transdiagnostic interventions include increased ease of implementation by clinicians due to a reduced need to teach numerous disorder specific protocols. This study reports an initial outcome study of a transdiagnostic group intervention (Take Control Course; TCC), which has been primarily offered to clients with issues with anxiety and depression, but that utilizes techniques that target maintenance processes common across disorders. Although different, in content, format and theoretical underpinnings, the TCC have been influenced by the innovative service model (STEPS), and courses, developed by White and colleagues. The TCC is both time-limited and is adapted according to weekly client feedback, therefore increasing client control over their support and recovery. Furthermore, it is based on a cohesive functional transdiagnostic model, Perceptual Control Theory (PCT), which is a universal theory of psychological functioning. PCT is a self-regulatory theory that proposes generic mechanisms that account for psychopathology across disorders. Therefore, the Course does not focus on interventions that are targeted at specific disorder groups. In the current study participants accessed the TCC or treatment as usual (low intensity CBT). The TCC is six sessions that last an average of 1 hour. Sessions are designed to be stand-alone, meaning that clients can look at an overall description of the different session themes and choose to attend relevant sessions. Outcomes measured were anxiety (Patient Health Questionnaire Generalised Anxiety Disorder Scale- 7; GAD-7), depression (Patient Health Questionnaire Depression Scale- 9; PHQ-9), and work and general functioning (Work and Social Adjustment Scale; WSAS). Process outcomes were also measured. The study is currently ongoing, but the full analysis will be available at the conference. Interim analysis on an incomplete dataset found significant pre-post reductions in PHQ-9 and WSAS scores in those who accessed the TCC, with effect sizes of d=1.37 and d=1.60 respectively. Pre-post scores on GAD7 were not significant.

The Method of Levels: Effective and efficient
Timothy Carey, Centre for Remote Health, Flinders University & Charles Darwin University, Australia

With limited financial resources and long waiting lists in many places it is important to provide treatment efficiently as well as effectively. In fact, treatment efficiency should be an inherent component of treatment effectiveness. The Method of Levels (MOL) is a transdiagnostic cognitive therapy which provides appointments according to a patient-led system of service delivery. A two year evaluation of an MOL clinic in a public mental health service in a remote town in Australia was conducted. Of 92 patients referred to the service, 51 attended more than one appointment (M = 3.6; median = 3; range = 2 - 11). The results of the evaluation were compared with other practice based evaluations published in the literature including statistics related to reliable change and clinical significance. Also, an efficiency ratio was calculated as the ratio of treatment effect size with average number of sessions attended. Results indicated that MOL was effective and efficient when compared with other studies. It is suggested that MOL might be an important option for services to consider in order to make the best use of limited resources and the efficiency ratio may be a useful way of evaluating services to ensure that patients are receiving effective and efficient treatments.

Dementia care: Using empathic curiosity to establish the common ground that is necessary for meaningful communication
Phil McEvoy, Six Degrees Social Enterprise

Over the past two decades the advocates of person centred approaches to dementia care have consistently argued that some of the negative impacts of dementia can be ameliorated in supportive social environments and they have given lie to the common but unfounded, nihilistic belief that meaningful engagement with people with dementia is impossible. These developments are welcome, however relatively little is known about how best to train carers to deal with the specific challenges of communicating with people who have dementia. This paper takes up this issue, by exploring how carers can use empathic curiosity to establish the common ground that is necessary to sustain meaningful engagement with people who have mild to moderate dementia. The approach is informed by Perceptual Control Theory and makes use of approaches that have been developed in the fields of linguistics and communication studies. Three case examples taken from the literature on dementia care are used to illustrate what empathic curiosity looks like in practice and illustrate the potential impact that adopting this relational stance may have.
Life after Death: Individualising CBT for PTSD linked to traumatic bereavement

Jen Wild, University of Oxford, Anke Ehlers, University of Oxford

Posttraumatic stress disorder (PTSD) following traumatic bereavement is common, and difficult to treat. Following spousal bereavement by illness, PTSD rates are as high as 10% (Zisook, Chentsova-Dutton, & Shuchter, 2004). Following traumatic loss, PTSD can be as high as 39%. The National Institute for Health and Clinical Excellence recommend an extension of the suggested 8 to 12 sessions of trauma-focused psychological therapy for PTSD when an individual presents with traumatic bereavement. Imagery techniques have been evaluated as effectively treating distress linked to traumatic memories (Wild, Hackmann, & Clark, 2007; 2008) and are a key component of cognitive behavioural therapy for PTSD. This talk presents the results of a case series of six patients who suffered PTSD linked to traumatic bereavement and shows how CBT for PTSD was individualized for this population, paying particular attention to key maintaining factors and cognitive themes that consistently emerged in treatment.

Working with auditory hallucinations in PTSD

Chris Brewin, University College London

Recent research has identified that auditory pseudo-hallucinations are common in PTSD, particularly in more complex cases. The symptom consists of patients hearing their thoughts in the form of a particular voice or voices that may be supportive or, more often, critical. The symptom is similar to voice-hearing in psychosis but is probably dissociative in nature, with patients fully aware these are their own thoughts. If voices are present they are likely to be actively involved in the therapeutic process by commenting on the therapist and what is happening in the session. Individual attention needs to be paid to voices to identify their content and possible effect on therapy. Pilot work suggests it is important to have patients describe and interact with their voices, and test out predictions based on what they say. Essentially this involves adapting standard cognitive therapy techniques such as Socratic questioning and having patients interrogate their own voices.

The Truculent Client

Michael Scott, Sheffield Hallam University

Irritability and avoidance of conversations about the trauma are diagnostic symptoms of PTSD and may make it difficult for a therapist to engage a client in trauma focussed CBT (TFCBT). In routine practise only 57% of clients complied with audio taped exposure treatment [Scott and Stradling (1997)]. A coping skills (CS) programme, modelled on Meichenbaum’s Self-Instruction Training (1985) can help resolve possible therapist-client conflicts and there is limited evidence for its effectiveness as a stand-alone intervention [Bisson and Andrew (2009)]. The CS programme Scott (2012) is presented as a ‘better way’ of handling the traumatic memory and has four components i) preparing to encounter the reminder/flashback ii) encountering the reminder/flashback iii) coping with being overwhelmed by the reminder flashback and iv) reflection on coping strategy. In addition the CS can be used to directly address the client’s irritability. The CS programme can make clients more amenable to TFCBT and offers a way forward for clients who do not wish to undergo TFCBT. At the outset a DSM V based cognitive model of PTSD [Scott (2012)] is presented, this suggests that the hallmark of PTSD is a state of ‘terrified surprise’. The model is individualised to present a cognitive formulation of the client’s difficulties which is then used as the basis for treatment.


Are there differences in treating women and men after trauma?

Emma Warnock-Parkes, University of Oxford

Women have a greater chance of developing Post Traumatic Stress Disorder (PTSD) after traumatic events and report different patterns of symptoms compared to men. It has been suggested that cognitive factors play a role in explaining these sex differences (Olff et al., 2007). Some studies have also found gender differences in treatment outcomes (Tarrier et al., 2000; Karatzias et al., 2007). However, a recent trial of Cognitive Therapy for PTSD (CT-PTSD) (Ehlers et al., 2005) found men and women benefitted equally from this treatment. The purpose of this study was to investigate whether there are differences in treating women and men after trauma, in terms of the cognitive themes, maintaining behaviours and coping strategies targeted in CT-PTSD. Rating manuals, based on the treatment manual of CT-PTSD (Ehlers et al., in press), were developed with high inter-rater reliability. Treatment notes of a consecutive sample of 251 PTSD patients (110 men, 141 women) were then coded using the manuals. We found some differences in the ways in which men and women were treated in CT-PTSD. Specifically, more women worked on cognitions concerned with negative interpretations of symptoms and had more sessions that targeted an overgeneralized sense of danger. Conversely, men spent more sessions working...
on preoccupation with unfairness and revenge. More women than men addressed avoidant coping in their treatment. Results will be discussed in terms of the treatment implications for both men and women suffering with PTSD.

**Putting the spotlight on emotion: a compassion-focused approach to therapy**

**Convener and Chair: Asmita Palmer, East London NHS Foundation Trust & University of Derby**

---

**Group Compassion Focused Therapy for emotional recovery from psychosis**

**Christine Braehler, University of Glasgow**

Recovery after psychosis is hindered by the ongoing activation of internal and external threats including feelings of shame, stigma, entrapment, fear of recurrence and social isolation, which have all been associated with increased rates of emotional dysfunction and reduced quality of life. Compassion focused therapy (CFT) aims to stimulate capacities for soothing and affiliation to self and others as a way to regulate the threat system. CFT has been adapted to be used as a group therapy to help promote emotional recovery in people with psychosis. Preliminary data suggest that CFT is beneficial to this client group. The goal of the CFT group therapy is to counteract defeatist, self-attacking and avoidant attitudes by developing compassion relating to self and others. Key therapeutic tasks, processes and clinical outcomes are illustrated using case examples from a feasibility trial. Core interventions involve the gradual desensitisation to compassion using experiential exercises, interpersonal learning, the building of peer attachments, and the integration of psychosis via narrative tasks. Facilitation of group process and personal practice by therapists will be discussed as important therapeutic factors.

**Learning from the inside: developing skills in Compassion Focused Therapy**

**Asmita Palmer, East London NHS Foundation Trust/University of Derby, Justin Miller, South London & Maudsley NHS Foundation Trust/University of Derby**

The process of undergoing training in Compassion Focused Therapy (CFT) is described from both a personal and professional perspective by two experienced CBT therapists. Palmer and Miller offer their reflections on some of the challenges they encountered as CBT therapists training in this approach, particularly in learning to pay more attention to the client’s emotional experience. They will also discuss how training in CFT has enhanced their CBT practice with those clients who report difficulties in feeling differently despite being able to identify credible ‘more balanced’ alternative perspectives. The importance of ‘learning from the inside’, with respect to developing one’s own personal practice in compassionate mind training, is emphasised as a crucial aspect of developing skills in this approach.

**Imagery in Unexpected Places**

**Convener and Chair: Katy Price, Oxford Health NHS Foundation Trust**

---

**Intrusive imagery in people with a specific phobia of vomiting**

**Katy Price, Oxford Health NHS Foundation Trust, David Veale, Institute of Psychiatry, King’s College London; Chris Brewin, Research Dept of Clinical, Educational & Health Psychology, UCL**

Specific phobia of vomiting (SPOV) is a chronic, pervasive and debilitating disorder and is clinically regarded as difficult to treat (Veale, 2009). Research into its development, maintenance and treatment has been limited. Imagery has been demonstrated in the maintenance and used in the treatment of a range of other disorders (Brewin, Gregory, Lipton & Burgess, 2010). This study explored the prevalence and characteristics of intrusive mental imagery in people with SPOV. It investigated the relationship between presence of imagery and severity of phobia. Thirty-six participants meeting DSM-IV criteria for SPOV were recruited from online support groups and outpatient clinics. A semi-structured qualitative interview was administered. Twenty-nine (81%) participants reported multi-sensory intrusive imagery of adult (52%) and childhood memories (31%) and worst case scenarios (“flashforwards”) of vomiting (17%). Extent of imagery was significantly related to severity of phobia. Participants primarily fearing others vomiting had less severe phobic symptoms.

Limitations of the study were that no control group was used and a heterogeneous sample of clinical and community participants was recruited. Correlational data comparing extent of imagery with severity of SPOV symptoms were derived from as yet unvalidated measures. The study concluded that intrusive mental imagery is a clinically important feature of SPOV and may contribute to its maintenance. Causality needs to be demonstrated.

In addition to the exploratory study, imagery rescripting was tested as an intervention for SPOV in an AB single case experiment with baseline and follow up. One of two images was randomly selected for rescripting. Imagery rescripting reduced intrusiveness of the image and severity of the phobia. Imagery rescripting may be a helpful intervention for SPOV and should be further empirically investigated. Clinical implications and applications from the study and further research questions will be considered.

**Recurrent Imagery in People Who Stutter**

**Helen Tudor, UCL and NHS**

17
Research completed for the UCL Doctorate in Clinical Psychology thesis will be presented. 21 adult participants who stuttered and 21 matched controls were given a semi-structured interview which explored imagery in speaking situations. Measures for symptoms of anxiety, depression and trauma were also used. Significantly more stuttering participants than control participants presented both recurrent imagery and associated memories. Content analysis revealed themes of disfluency, anxiety, negative social evaluation, self-focus, and pressure to speak that were common to both groups’ reports. Additional themes of helplessness, shame, sadness and frustration were found only in the images and memories of the stuttering group. No group differences were evident for; the number of sensory modalities involved in images and memories; for ratings of their vividness or strength of associated emotions; or on self-reports of depression, anxiety and trauma. Implications for treatment are outlined.

**The development of Imagery MAPP for bipolar disorder: case examples illustrating imagery as an emotional amplifier**

**Susie Hales, Department of Psychiatry, University of Oxford**, Kerry Young, Department of Psychiatry, University of Oxford; Martina Di Simplicio, MRC - Cognition and Brain Sciences Unit, Cambridge; Emily Holmes, MRC - Cognition and Brain Sciences Unit, Cambridge

People with bipolar disorder typically experience episodes of (hypo)mania and depression, but also inter-episodic fluctuations in mood. In a range of laboratory studies, imagery has been shown to have a greater impact on emotional states than verbal thoughts. Patients with bipolar disorder have been found to have high levels of some types of mental imagery compared with both healthy controls (Holmes et al, 2011) and other psychiatric populations (Hales et al, 2011). It has therefore been proposed that mental imagery may act as an ‘emotional amplifier’ in bipolar disorder (Holmes et al, 2008).

Cognitive behaviour therapy (CBT) is recommended by the National Institute of Clinical Excellence (NICE) for bipolar disorder (in particular, for treatment-resistant depression and post-acute mood episodes), but outcomes for randomised controlled trials of CBT in bipolar disorder have been mixed.

The aim of the Mood Action Psychology Program (MAPP) is to develop and evaluate a novel imagery-based approach to target mood instability in bipolar disorder. The theoretical rationale of the MAPP intervention approach is discussed, with reference to recent studies on imagery phenomenology in bipolar disorder. Case studies are presented to illustrate the imagery techniques used and their impact on individual outcome data. Implications for psychological treatment innovation with patients with bipolar disorder are emphasised.

**Emotional Intensity in Imagery Rescripting – Impact on Emotion Regulation and Intrusions**

**Laura Seebauer, University Medical Center Freiburg**, Gitta Jacob, University of Freiburg

Background: Imagery Rescripting (ImRS) is a therapeutic strategy for patients with severe emotional problems. During ImRS the course of a traumatic memory is changed in a direction desired by the patient. There is strong evidence for the positive impact of ImRS in conditions like personality disorders, depression and PTSD, but also on emotions like shame or guilt which are common in all kinds of mental illnesses. ImRS is therefore increasingly used in CBT, yet there is little evidence on how to make ImRS work at its best. Many questions on the procedure remain unanswered. There are some studies suggesting that patients might profit better from ImRS if they are highly emotionally involved during the ImRS exercise. The aim of this study was to approach this clinical question on an empirical level.

Method: The aim of this analogue experimental study was to compare if emotional involvement in ImRS can be experimentally manipulated and whether a high involvement during ImRS makes subjects profit better from ImRS. The sample consisted of healthy students (N=63). For the induction of intense negative emotions the trauma film paradigm was applied. The impact of the ImRS exercise was measured through self-reported emotions on a visual analogue scale (e.g. helplessness, anxiety, anger) and psychophysiology (heart rate, skin conductance). Furthermore self-reported intrusions on the trauma-film in the following week were assessed. Every participant watched the trauma film and was randomised in one of the three following conditions: Intense ImRS, less intense ImRS, no task. Intensity was manipulated by closing eyes or not, taking field or observer perspective and focusing more or less on key feelings.

Results: The trauma film increased negative emotions and decreased positive emotions in all subjects. The psychophysiological and physiological data is being reviewed at the moment. In the presentation first results will be presented and discussed.

Discussion/Conclusion: This analogue study will give hints on how to best conduct ImRS exercises. This is urgently needed since this technique is increasingly used in psychotherapy approaches.

**Skills Classes**

**Optimizing Exposure Therapy for Anxiety**

_Michelle Craske, University of California, Los Angeles_
Exposure therapy is an effective tool for treating anxiety disorders, but some clients drop out, and others do not achieve adequate levels of improvement. Traditional ‘habitation-based’ models of exposure will be compared to inhibitory based models of exposure. The latter models draw from principles of fear learning and extinction, and memory, and depend upon repeated functional analyses of behaviors and cognitions so that each exposure practice maximally addresses ‘what it is that the client needs to learn’. For many clients, it may be essential to learn that fear/anxiety can be tolerated, or that they can function even while anxious. Ways in which various strategies that enhance inhibitory learning/regulation can be implemented in clinical settings will be discussed, such as compound extinction, reinforced extinction, weaning from safety signals, retrieval cues, multiple context exposure, consolidation scheduling of learning trials, as well as affect labelling.

Objectives
Understand difference between habitation models versus inhibitory based models of exposure therapy
Understand principles underlying strategies for enhancing inhibitory learning during exposure therapy
Learn ways of implementing strategies for enhancing inhibitory learning during exposure therapy

References

One Session Treatment for Blood-Injury-Injection Phobia
*Lars-Göran Öst, Stockholm University*

Professor Öst has developed a rapid treatment for specific phobia that is carried out in one single session, which is maximised to 3 hours. This session will be of interest for healthcare professionals who work with people who have a fear of injections, blood or surgical procedures. Many adults and children who need surgical procedures are anxious to the point that they avoid the procedure to the detriment of their health. Alternatively, they may endure the procedure with great distress. This 2 hour session gives a unique opportunity to discuss how to help people who have a fear of blood, injury, injections or surgical procedures with the world leading expert on the effective treatment of such fears. The session will comprise an informal discussion of how such concerns can be understood and methods to help.

Evidence based assessment of risks of suicide and self-harm
*Stephen Briggs, CQSW*

Self-harm and suicidal behaviour are complex behaviours occurring across and commonly encountered in all clinical populations, and thus the task of assessing and responding appropriately to risks is a crucial aspect of clinical work. It is important to include service users presenting suicidal thoughts and those who have harmed themselves as there is now strong evidence that an episode of self-harm significantly increases the risk for repetition and completion of suicide; after an episode of self-harm the chances of suicide are raised between 50 and 100 times. The process of assessing risks requires skilled professional intervention applying current evidence (and also having regard for the limitations of this knowledge). There are also many common misconceptions which can impact on assessment and intervention which the evidence helps to dispel.

The skills class will draw extensively on the NICE clinical guidance to introduce the key evidence for working with self-harm and suicide risks. The skills class will be fully interactive, applying knowledge to clinical situations across the wide range of service users who present suicide risks. The class will address all the key areas including:
- General principles of care including safeguarding issues and service user perspectives
- Conducting risk assessments
- Developing an integrated care and risk management plan
- Psychological interventions

Training and supervision

Objectives: The objectives of the skills class are to
- Engage with current knowledge (and its limitations) in assessing suicide risks
- Understand and apply the key principles of care for assessing risks and providing an integrated care and management plan
- Gain or increase the capacity and confidence to accurately undertake risks assessments in clinical contexts

*Stephen Briggs is Professor of Social Work and Director of the Centre for Social Work Research in the University of East London. He is an experienced clinician, teacher, researcher and writer. He worked for many years in the Tavistock Clinic’s Adolescent Department. He was a member of the NICE Guideline Development Group and Evidence Update Advisory Group for the clinical guideline Self-harm, Longer Term Management (CG133).*

References

Managing Endings with Complex Cases: A CBT Approach

Andrew Eagle and Michael Worrell, CNWL NHS Foundation Trust, London

Successful therapeutic endings are difficult to achieve in cases where there have been poor clinical outcomes, where the therapeutic relationship has been difficult, or where patients’ express dissatisfaction with therapy. In a context of finite resources, patients may feel they do not have any meaningful control over decisions about how and when to end therapy. Equally, therapists’ may be frustrated that they cannot offer more flexible treatment.

The gold standard of criteria for termination of CBT (Jakobsens et al, 2007) are often not achieved in practice and clinicians face difficult decisions about whether to extend, modify or end treatment. This is particularly the case where standard CBT is adapted to meet the needs of a more complex and/or co-morbid client group with significant maintenance factors e.g., long term health conditions, housing/benefits issues and poor social support. As IAPT services are increasingly asked to expand their remit, this is likely to become a more prominent challenge.

This workshop introduces models of endings that have historically underpinned clinical practice. A distinctive CBT approach to ending therapy will be presented. Emphasis will be given to the beginning phase of therapy, because a CBT approach to endings must involve a discussion of treatment planning, treatment goals and termination criteria. Particular attention will be given to the management of difficult or unsatisfactory endings and participants will be given an opportunity to discuss challenging cases from their clinical practice.

Objectives: By the end of this workshop participants will have learnt the following concepts and skills:
- A systematic CBT framework for managing endings including CBT-specific termination criteria.
- Learn to properly plan and review therapy to minimise the possibility of unsuccessful endings.
- Learn to more effectively manage endings in cases with poor treatment outcomes and dissatisfied clients.
- Learn to understand how therapist beliefs may contribute to ineffective management of the ending process.

Dr Andrew Eagle is a Consultant Clinical Psychologist with Central and North West London Foundation NHS Trust (CNWL).
He has a particular interest in the management of endings in therapy and the updating of existing theoretical models to support brief time-limited therapy. He has run numerous workshops and conducted research in this area.

Dr Michael Worrell is Director of CBT Training programmes with CNWL. This includes the High Intensity IAPT Training Programme and the Post Graduate Diploma & MSc. These programmes are accredited with the BABCP and are academically validated by Royal Holloway University of London. Michael is a BABCP Accredited Practitioner, Supervisor and Trainer.

References:

Behavioural Couples Therapy for Drug Abuse and Alcoholism

Andre Geel, The Junction Service

Evidence suggests that the inclusion of a spouse can have a significant impact on treatment and relapse prevention for someone with a substance use disorder. The workshop will give participants a good, general overview of how to conduct BCT sessions, how to use the material in the O’Farrell and Fals-Stewart manual, and how to assess and prepare clients for the treatment. It would be an advantage – but not necessary – if participants have some knowledge or familiarity with behavior therapy, cognitive behaviour therapy, family and marital therapy.

Objectives: The workshop will cover the four stages of the therapy: engagement, managing the substance, improving the couples’ relationship, and ongoing recovery and also inclusion and exclusion criteria and challenging clients and difficult situations.

Andre Geel is a Chartered and Consultant Clinical Psychologist in Substance Misuse with Central and North West London NHS Foundation Trust. He has occupied the position of Sector Lead for some 6 years, being responsible for supervising and overseeing psychologists in the Addictions Directorate in five Central London boroughs. Andre split my clinical time between two Community Drug and Alcohol Services, independent and private work in General Mental Health and lecturing and running workshops.

References

Disentangling Obsessions, Compulsions and Repetitions in People with Autism Spectrum Disorder
Panel Discussions

What Maintains Psychological Distress? A Roundtable discussion of core processes

Chair: Mark Williams, University of Oxford
Discussants: Thorsten Barnhofer, University of Oxford
Eric Morris, Institute of Psychiatry, King’s College London & South London & Maudsley NHS Foundation Trust
Michelle Craske, University of California, Los Angeles
Warren Mansell, University of Manchester
Melanie Fennell, University of Oxford

Throughout the development of cognitive and behavioural therapies, a wide range of processes have been emphasized as responsible for psychological distress, and therefore the target of interventions. These include avoidance, cognitive distortions, worry, rumination, experiential avoidance, thought suppression, safety behaviours, poor attentional control, intolerance of uncertainty, perfectionism, psychological inflexibility, metacognition, and overgeneral memory. Yet, there is increasing evidence that these processes are very closely correlated. What does this mean? Is there a ‘core’ process among these that is maintaining distress? If this were the case, then maybe an intervention could target this process and be more efficient, effective and flexible in its application across disorders (transdiagnostic). Alternatively, it may be important to retain the differences between these processes and map interventions to the process that is most pertinent for the individual or the disorder (e.g. rumination for major depression; worry for generalized anxiety disorder). In this panel discussion, we consider these alternatives, share insights from theory and research to illuminate the answers to these questions, and describe practical clinical applications of these approaches.

The debate has been convened by Nick Hawkes and Warren Mansell and will be chaired by Mark Williams from the University of Oxford. Melanie Fennell, University of Oxford wonders whether this is a genuine either/or and will consider the issue from the perspective of classical cognitive therapy. Michelle Craske, UCLA, will present the view that deficits in safety learning or inhibitory learning is a core risk factor and maintenance factor of excessive and impairing anxiety. Thorsten Barnhofer, from the FU Berlin, will provide perspectives from the cognitive and embodied cognition point of view underlying the rationale of mindfulness-based interventions. He will aim to highlight the importance of understanding the processes involved in the tendency for maintaining processes to become increasingly automatic and habitual. Eric Morris, South London & Maudsley NHS Foundation Trust will provide a contextual behavioural science perspective, describing the language-based processes that result in psychological inflexibility as a risk and maintenance factor for a range of problems and disorders. He will describe how this model provides a rationale for mindfulness and values-based action to promote flexible responding to unwanted experiences and contact with greater life meaning and vitality. Warren Mansell takes a control theory perspective and will put forward that case that a range of cognitive and behavioural processes are only a problem when they draw attention away from conflict between personally important goals, leading to a state of chronic...
loss of control. Effective interventions help people to flexibly shift and sustain attention on their problem to reduce goal conflict and regain control.

The plan of the discussion will involve each presenter sharing the theory, research evidence and clinical implications of their approach, followed by discussion between panel members and an extended discussion with the audience. Rather than debating for or against an argument, we hope that the discussion will provide a range of insights and perspectives for clinical practice, alongside a potential synthesis of common themes.

**Adherence versus Innovation in Dialectical Behaviour Therapy. A live Issue**

**Convener and Chair: Isabel Clarke, Southern Health NHS Foundation Trust**

Speakers: Christine Dunkley, Society for Dialectical Behaviour Therapy
Isabel Clarke, Southern Health NHS Foundation Trust
Pamela Henderson
Catherine Parker, Derbyshire Healthcare Foundation Trust
The success of Dialectical Behaviour Therapy (DBT) for its core client group of people with self-harming and suicidal behaviours (e.g. Linehan et al 2006), has led to its application to a wide range of client groups and in a wide range of settings, backed up by a rapidly expanding research base (see Dimeff & Koerner 2007 for a range of examples). As third wave, mindfulness and skills teaching based, therapeutic approaches, become recognized as the way forward for client groups beyond the current evidence base (e.g. chronic and acute sectors of mental health), the potential of DBT is increasingly called into service (e.g. Clarke 2009). Creative approaches are needed here, and DBT, with its targeting of emotional dysregulation and pragmatic use of mindfulness, has proved to have relevance beyond its original, BPD, client base. At the same time, as the therapy has matured, it has developed the approved paths towards accredited practitioner status and standards of adherence essential for the maintenance of consistency and quality, and these standards cannot be expected to accommodate every diverse application.

DBT, with its concept of holding a dialectical balance between opposing positions that values each equally, is well suited to face up to the conflict inherent in these two divergent directions. Should we exclude the creative applications of ‘DBT informed’ practice from using the DBT term altogether? Should we try to regulate them and bring them into the fold? If excluded, must promising but unproven approaches be banned from deserving settings such as acute mental health inpatient units? If allowed, how do we regulate and ensure standards?

The discussion will be chaired by Fiona Kennedy, who brings rich experience to the task, is BITT trained, and currently provides training and therapy through Greenwood Mentors and Skills Development Service. Christine Dunkley, a national DBT supervisor and trainer in the UK will speak for the adherent pole of the dialectic, and Isabel Clarke, who applies DBT informed approaches in acute care will hold the other pole. These issues are not unique to DBT but apply to any successful and rapidly diversifying field of therapy. This debate will muster the arguments on both sides with the aim of exploring both poles of the dialectic in a spirit of mutual respect combined with passion for the individual’s position. 60 minutes will be sufficient for this discussion.


This discussion grapples with the issues of reconciling the maintenance of standards of excellence that should be expected in clinical practice with the encouragement of innovation and practice development in response to perceived clinical need. On the one hand, offering clients interventions that have been tested by research of the highest rigor, delivered by therapists practicing strictly in accordance with the norms laid down by that research, can only be applauded. On the other hand, the new ideas and creative practice that will inform future improvements must start somewhere; RCTs take time and resources, and there is a danger that interventions that are particularly useful for less popular client groups and settings do not enter the evidence base, thus depriving service users of therapy that might suit their needs. These issues are highly relevant to everyday clinical practice.

**DSM 5 - Divisive Devil or Constructive Classification?**

**Chair: Alan Stein, University of Oxford**

Peter Kinderman, University of Liverpool
Rachel Bryant-Waugh, Great Ormond Street Hospital for Children
Michelle Craske, University of California, Los Angeles

DSM 5 has generated a great deal of controversy with regard to its specific content, the process by which it was generated and the value (or otherwise) of a disease-based approach to mental health problems. The Division of Clinical Psychology within the British Psychological Society produced a consensus statement on psychiatric diagnosis advocating a paradigm shift in how we understand mental distress towards one which is no longer based on diagnosis and a ‘disease’ model. The
had good internal reliability (Cronbach's alpha 0.8) needed, e.g. due to writing or eyesight difficulties, there were no problems in the comprehension of items. Both measures The majority of the sample com quality of life, health and well group; the former inc older people in each of four European countries were randomly assigned to either a control group, or a technology available on these measures among frail older adults. (PHQ 2012). Older people can be at particula health challenge with high costs to individuals, families and societies (Löthgren, 2004; Luppa et al, 2007; Thapar et al, 2012). Advances in medicine and research mean that old age is now a normal human expectation, but quality of life does not experience (Eriksen, Karen, & Kris, 2005) is relatively a new endeavour in understanding the human mind. Personality style assessment can help individuals and practitioners to understand and appreciate human diversity and can complement the quest for personality disorders. The present study attempts to investigate the relationship between personality style, coping strategies and adjustment. It focuses on the coping behaviours of young adults which may have adaptive and maladaptive outcomes and relates predisposing personality styles as contributors to the choice of coping strategies. The Million Index of Personality Styles(MIPS,Millon,1994) and the Ways of Coping Questionnaire(Folkman and Lazarus,1988) were administered on a sample of 146 undergraduate engineering male student volunteers of the age range 18 years to 21 years. Univariate analysis, Multiple regression analysis and canonical correlation were carried out. Results indicate that in the motivation based scale of MIPS the undergraduate males predominantly showed enhancing, modifying and individuating personality styles, and in the cognitive mode scales, introverting, sensing and thinking styles were more dominant. In the case of Interpersonal-behavioral scales retiring, asserting and dissenting styles were predominant. Interpersonal behaviour scales were found to be the best predictor of the coping strategies as compared to the scales related to motivating aims and cognitive modes. A positive correlation between adjustment scores and planful coping has been found. Further, accepting responsibility as a prominent way of coping has also been observed. The findings of this study can be explained in terms of how interactions of an individual in daily dealings may affect and impact his choice of coping strategies. Sociable individuals, showing strong loyalties and attachments tend to focus on acknowledging their roles in problem solving. Further, individuals who exert little effort to alter their lives and circumstances are unable to rouse themselves, and those who often lack initiatives are inclined to shun their responsibility for the problem and act in a passive manner to whatever is happening around them. Those who turn to others to find stimulation and encouragement, draw upon friends and colleagues for ideas and guidance. Thus, individuals who are self-controlled and act spontaneously are the ones who engage in planning as to how to tackle stressful situations while keeping their affects under control and subjective vigilance. The study has implications for the identification and adoption of appropriate therapeutic techniques based on the Personality style of the individual and the way the individual has been coping in stressful situations.

Posters

Relationship between Personality styles and coping strategies in undergraduate male students
Santha Kumari, Thapar University; Santha Kumari
The study of Personality style in terms of the individual subsystem and the constructed approximations of human experience (Eriksen, Karen, & Kris, 2005) is relatively a new endeavour in understanding the human mind. Personality style assessment can help individuals and practitioners to understand and appreciate human diversity and can complement the quest for personality disorders. The present study attempts to investigate the relationship between personality style, coping strategies and adjustment. It focuses on the coping behaviours of young adults which may have adaptive and maladaptive outcomes and relates predisposing personality styles as contributors to the choice of coping strategies. The Million Index of Personality Styles (MIPS, Millon, 1994) and the Ways of Coping Questionnaire (Folkman and Lazarus, 1988) were administered on a sample of 146 undergraduate engineering male student volunteers of the age range 18 years to 21 years. Univariate analysis, Multiple regression analysis and canonical correlation were carried out. Results indicate that in the motivation based scale of MIPS the undergraduate males predominantly showed enhancing, modifying and individuating personality styles, and in the cognitive mode scales, introverting, sensing and thinking styles were more dominant. In the case of Interpersonal-behavioral scales retiring, asserting and dissenting styles were predominant. Interpersonal behaviour scales were found to be the best predictor of the coping strategies as compared to the scales related to motivating aims and cognitive modes. A positive correlation between adjustment scores and planful coping has been found. Further, accepting responsibility as a prominent way of coping has also been observed. The findings of this study can be explained in terms of how interactions of an individual in daily dealings may affect and impact his choice of coping strategies. Sociable individuals, showing strong loyalties and attachments tend to focus on acknowledging their roles in problem solving. Further, individuals who exert little effort to alter their lives and circumstances are unable to rouse themselves, and those who often lack initiatives are inclined to shun their responsibility for the problem and act in a passive manner to whatever is happening around them. Those who turn to others to find stimulation and encouragement, draw upon friends and colleagues for ideas and guidance. Thus, individuals who are self-controlled and act spontaneously are the ones who engage in planning as to how to tackle stressful situations while keeping their affects under control and subjective vigilance. The study has implications for the identification and adoption of appropriate therapeutic techniques based on the Personality style of the individual and the way the individual has been coping in stressful situations.

Measuring depression and anxiety among older adults: A randomised control trial
Ann O’Hanlon, Queens University Belfast; Joanne Finnegan, Dundalk Institute of Technology
Advances in medicine and research mean that old age is now a normal human expectation, but quality of life does not always co-occur with increases in longevity. Depression is a highly pervasive, disabling and distressing modern mental health challenge with high costs to individuals, families and societies (Löthgren, 2004; Luppa et al, 2007; Thapar et al, 2012). Older people can be at particular risk for problems of depression and anxiety. The Patient Health Questionnaire (PHQ-9) and the GAD-7 are commonly used measures of depression and anxiety however comparatively little data is available on these measures among frail older adults. Participants were frail adults aged 65+ years recruited as part of the EU randomised control trial Home Sweet Home. In this trial older people in each of four European countries were randomly assigned to either a control group, or a technology group; the former includes usual care only, while the latter includes a suite of technologies that may impact positively on quality of life, health and well-being. Surveys and interview-data was collected at baseline, and at one year follow-up. The majority of the sample completed both the PHQ-9 and the GAD measures without assistance. Where assistance was needed, e.g. due to writing or eyesight difficulties, there were no problems in the comprehension of items. Both measures had good internal reliability (Cronbach’s alpha over .7) and good external validity with a range of other measures including
Domestic Violence: Prevalence & Mental Health Outcomes in Pakistani Women
Syed Naqvi, Eastlondon NHS Foundation Trust; Syed Naqvi, Eastlondon NHS Foundation Trust

This study was an effort to recognize and estimate the prevalence of domestic violence and its effects on mental health of the women in Pakistan which is an endemic in the country. Cognitive behavior theorists (Beck, Seligman) suggest that feelings of helplessness and hopelessness are a strong predictor of low self esteem and the most severe mental health problem like suicide. Using correlational research design, a sample of 336 women victims was identified through different regions of Pakistan, hypothesizing that the women who are victims of domestic violence would report mental health problems like hopelessness, low self-esteem and suicidal ideation. Indigenously developed Scale for Domestic Violence, Beck Scale for Suicidal ideation, Beck Hopelessness Scale, and Rosenberg Self Esteem Scale were used. Using SPSS, Pearson Correlation, t-Test, ANOVA and Regression Analysis were carried out.

Domestic Violence (Physical, psychological/emotional & economic Abuse) was positively correlated with Suicidal Ideation (BSI) and Hopelessness (BHS) and negatively with Self Esteem (SES). A number of women (71.40 %) in present sample had previously attempted suicide in their lives. The regression analyses revealed that Domestic Violence, Physical Abuse, Psychological/Emotional Abuse, Low Self Esteem and Hopelessness were the strong predictors of Suicidal Ideation, Hopelessness and Self Esteem. On demographic variables like type and duration of marriage, family structure, work status, socioeconomic status, age, education, husband’s mental health, past experience of abuse, t analysis was carried out. It was found that many personal, religious, cultural beliefs and myths with persistent patterns of shame, guilt and self-blame keep a woman into abusive relationship. Implications of the results for women’s quality of life and for policy makers and legislature are discussed. It highlights the idiosyncratic nature of the mental health outcomes of domestic violence in Asian (Pakistani) women victims, helps to build insight for the care planning needs of the target population.

Delivering CBT in a case presentation of Trichotillomania and moderate depression
Sinead O'Connell, St Patrick's University Hospital, Dublin

The following is a complex case presentation to be included in the clinical case presentation stream of the poster category. Trichotillomania (TTM) is a chronic impulse control disorder characterised by the pulling out of one’s own hair, resulting in significant hair loss. Azrin & Nunn (1973) developed Habit Reversal Training (HRT), a behavioural intervention incorporating awareness training, competing response training and relaxation training. Rothbaum (1992) developed a stress management rationale for the treatment of TTM using CBT techniques which included education regarding dysfunctional beliefs, underlying negative cognitions and their subsequent on pulling behaviour. Cognitive re-structuring is also employed in the treatment of TTM.

Most recently estimated prevalence rates suggest it occurs in 1.5% of males and 3.4% of females in a survey of 2,597 college students (Pyle et al, 1991). The impact of TTM can result in decreased psychological, social, academic and occupational functioning. School/college absences can be high in adolescents/young adults affected by the disorder.

The individual in this case study experienced a relapse in TTM symptoms during her second year of third level education resulting in moderate hair loss and mild depressive symptoms. This was her second episode of the disorder and first course of CBT, she had previously been treated with Clomipramine. Experiential avoidance in the individual with TTM is closely linked with relapse/return to pulling behaviour and an account of this was given by the client. Treatment included a combination of HRT and CBT. The Massachusetts general Hospital Hair Pulling Scale (MGH-HPS) a self report measure for hairpulling was used for the TTM. The co-morbid moderate depression was measured using the Beck Depression Inventory (BDI) (Beck,1978).

Index Offence Analysis: a CBT approach to overcome roadblocks
Simone Lindsey, St Andrew’s Healthcare; Henck van Bilsen, St Andrew’s Healthcare

Index offence analysis work is an important component of treatment for people who have committed violent offences however, due to the nature of the work, many of those clients remain reluctant to engage in this work. This case report outlines the use of an adapted group cognitive behavioural index offence analysis treatment programme (van Beek, 1999) used for individual work. The programme addresses key cognitive biases and distortions as well as behavioural and emotional components.

The client is a young white British person who was convicted of Assault with Intent. The client has been diagnosed with paranoid schizophrenia and is detained in a low secure unit. Following a CBT assessment it became apparent that the client...
showed considerable cognitive biases, skills deficits and problematic behaviour patterns which meant that the client could not continue along his care pathway to transition into the community due to a high risk of re-offending. The client has attended 13, 1 hour per week, individual sessions. The client remained unwilling to talk in detail about the offence. A number of CBT techniques appear to have facilitated openness and collaboration regarding the work such as motivational interviewing (Rollnick and Miller 2007), setting SMART goals, problem solving, cognitive restructuring and the Colombo technique (Dawson, 1991). Overall it appears that the client has progressed in their understanding of why they carried out the offence and has developed insight into the acquisition of skills needed in order to prevent re-offending. Overall this case report suggests that there is a case for CBT to facilitate offence analysis work when faced with clients who show extreme resistance to change.

Health and vocational outcomes using cognitive behavioural therapy in occupational mental health liaison service

David Hitt, Cardiff and Vale UHB; David Hitt, Cardiff and Vale UHB; Dr Srinivas Lanka, Cardiff and Vale UHB; Lyndon Davies, Cardiff Council; Tayyeb Tahir, Cardiff and Vale UHB

Mental health problems in the workplace are one of the main causes of reduced productivity and sickness absence (Health & Safety Executive, 2005). Early identification and treatment of common mental disorders may reduce the economic burden (Stansfeld et al, 2012). In spite of evidence for the useful role of liaison psychiatry within Occupational Health settings (Greenberg et al 2005), integrated management of Occupational mental ill health is not the norm. We present the outcomes of CBT carried out by the Department of Liaison Psychiatry, Cardiff and Vale University Health Board for the Occupational Health Service of Cardiff Council under a partnership agreement. A retrospective analysis of case notes from the three years of Occupational mental Health liaison psychiatry service was carried out. Routinely conducted baseline assessment scores (PHQ-9, HADS and WSAS) were compared with end of the treatment scores. The health outcomes were measured with PHQ-9 and HADS. Vocational outcomes were measured by improvements in WSAS and return to work. 51/159 referrals received CBT, 46 completed the treatment. 41/46 were referred to occupational health for sickness absence. Improvements in PHQ (mean: pre-15.02, post-3.12; df=45, t=12.61), HADS (mean: pre-23.84, post-7.72; df=44, t=13.49), WSAS (mean: pre-24.04, post-6.08; df=21, t=4.85) were all statistically significant (p=0.000). These improvements were maintained at follow-up. 42 returned to work during/after intervention. 78.2% are currently employed, of which continue to 16% seek occupational health support for mental ill health. CBT improves health and vocational outcomes in occupational mental ill health. Studies are needed of the efficacy of early identification and management of mental health symptoms in improving organisational outcomes. The introduction of further partnerships that enhance outcome for employees by utilising CBT more specifically tailored to their work alongside occupational health input. Improved outcomes for employees results in less sickness/absence, more presenteeism and ultimately a higher functioning work-force.

The effectiveness of CBT for adult depression in routine clinical practice: a systematic review

Christopher Rae, ‘Talking Changes’, Improving Access to Psychological Therapies, Tees, Esk and Wear Valleys NHS Foundation Trust

Cognitive behaviour therapy (CBT) has continued to subject itself to rigorous scientific validation. Though by no means exclusively, a significant body of this research has been conducted through randomised control trials (RCT) which now number in their hundreds. The demonstration of the efficacy of CBT has lead it to be incorporated into numerous clinical treatment guidelines as treatment of choice for many disorders and it is firmly established in evidence based practice. Questions remain however about how generalisable and comparable RCT outcomes are with those in routine clinical practice - there is an important distinction between efficacy and effectiveness. This work seeks to address two key questions, 1) How effective is cognitive behaviour therapy at treating depression in routine clinical practice, and 2) Is cognitive behaviour therapy in routine clinical practice as effective as therapy conducted in efficacy trials? A systematic literature review was conducted to identify relevant literature reporting outcomes of CBT treatment for depression in adults which took place in settings deemed to be representative of ‘real world’ clinical practice. Analysis of the data extracted from the selected papers is presented in terms of uncontrolled effect sizes to measure pre-post change, reliable change index and benchmarked against efficacy trial outcomes. A discussion of the effectiveness of CBT in routine clinical practice as a treatment for adult depression is offered. The benefits and limitations of this work are also highlighted.

CBT is a clinically effective treatment for adult depression when delivered in routine clinical practice.

A First Stage Evaluation of a Treatment Programme for Women with Personality Disorder in a Secure Psychiatric Setting

25
Clive Long, St Andrew’s Healthcare; Olga Dolley, St Andrew’s Healthcare; Clive Hollin, University of Leicester

Women admitted to secure psychiatric settings most frequently have a primary diagnosis of personality disorder (PD), borderline type and a secondary diagnosis. However, with the exception of dialectical behaviour therapy (DBT) studies there have been few evaluations of cognitive behavioural treatment (CBT) programmes. Based on a needs analysis of consecutive admissions, a cognitive behavioural understanding of functioning and a pragmatic application of the outcome literature, this study describes outcomes for PD patients admitted to a medium secure treatment setting for women. Evaluation of a gender specific manualised group treatment programme was based on global change over an amalgam of measures. Pre-post outcome measures were chosen on the basis that they met ‘feasibility’ criteria, were specific to the programme content and would be responsive to ‘a priori’ prediction of direction for change. 56 out 70 consecutive admissions had a primary PD diagnosis; most of these had a secondary diagnosis of substance abuse. Patients who showed a statistically significant pre-post change on one group tended to do so on others. Eighty-five percent of patients had an overall mean positive direction of change score. A preliminary analysis of the differences of those who did and did not benefit from treatment indicated that the former were more likely to be admitted from hospital settings and have previously engaged in therapy. They were also less impulsive, less likely to have a history of substance abuse and more likely to score lower on measures of personality pathology. Findings reflect the importance of providing a broad clinical approach to changing cognitive behavioural functioning within PD patients. The study allows conclusions to be drawn about the relative impact of different therapies and the value of coping skills groups that draw on some components of DBT. Study design limits the extent observed changes can be attributed to the described intervention. The use of a global index of change has the advantage of providing a broad index of change for women progressing through a core treatment programme for PD women with comorbid diagnosis. Further work on initiatives to increase engagement and to address the needs of those that fail to benefit is required.

Basic Processes and New Developments

Keynote Addresses

Cognitive Bias Modification in Alcohol Dependence

Eni Becker, Radboud University Nijmegen, The Netherlands

Cognitive biases play an important role in emotional disorders and addictions, and in many studies, Cognitive Bias Modification (CBM) has been found to change these biases and to reduce clinical symptoms. Most of the successful CBM applications have been reported for anxiety disorders, and to some degree, for depression. The CBMs were mainly attention and interpretation. In contrast, little CBM research has been reported on the modification of automatic approach-avoidance tendencies, and very few studies addressed addictions. This is unfortunate because there is recent evidence that Approach-Avoidance Modification (AAM) may be particularly helpful in addictions such as alcoholism. I will review this evidence by presenting four large clinical studies (involving more than 2300 alcohol-dependent patients) in which a simple, PC-based joystick task was used to train automatic alcohol-avoidance tendencies in alcohol-dependent inpatients, in addition to treatment-as-usual. During each training session (between 4 and 12 sessions in total), patients repeatedly pushed pictures of alcoholic drinks away from themselves, and pulled pictures of non-alcoholic drinks closer. In all studies, AAM contributed to significant relapse prevention, compared to placebo training or treatment-as-usual, relapse rates at one-year follow-up were approx. 10% lower. I will also address additional questions: What is changed by the training? Who profits most from it, and how many training sessions are optimal? How does this AAM compare to a training of attentional bias? How can the training be implemented in everyday practice? And how can it be improved even further?

Improving Mental Health: Can progress in Cognitive Psychology and Molecular Genetics boost Wellbeing?

Elaine Fox, University of Essex

The complexity of the human mind allows for the development of subtle differences in how people respond to threat as well as reward. Evidence is accumulating that these variations can lead to the development of neural circuits that, while malleable, can over time become deeply entrenched, effectively becoming ‘brain habits’. This means that for some people their “fear circuit” can become overactive when confronted with social threat, or their “reward circuit” may be difficult to regulate when faced with pleasure-related cues. This flexibility of neural circuits and their associated cognitive biases ensures that people can navigate the complexities of the social world with a great deal of efficiency. The downside, however, is that when these circuits ratchet out of control psychopathology (anxiety, depression, addictions) can follow. Deeply engrained cognitive biases (the selective interpretation of ambiguous social cues as negative in social anxiety, for instance) are a key feature of such disorders. Recent advances in cognitive psychology have shown that techniques designed to modify and change such potentially “toxic” cognitive biases can be effective in a) reducing these dangerous
biases and b) regulating clinical symptomatology. A particularly exciting development is the integration of these approaches with new findings from molecular genetics. While there have undoubtedly been growing pains, rapid developments in both fields have led to a degree of hope that the fruits of fundamental research may be translated into more individually tailored treatment interventions. The current talk considers whether these ‘cognitive bias modification’ procedures are useful for tackling emotional vulnerability as well as for boosting mental wellbeing and whether incorporating genetic approaches may be a useful way forward in the development of psychological interventions.

Symposia

Novel uses of technology in therapy
Convenors and Chairs: James Kelly, Lancashire Care NHS Trust and Samantha Hartley, University of Manchester

An introduction to experience sampling methodology and intelligent real time therapy
James Kelly, Lancashire Care NHS Trust
Person-centre therapeutic interventions are highlighted as a key target for psychological treatment, although it is often difficult to tailor evidence-based practice to suit individuals. Moreover, clinicians face challenges in promoting the continuation of therapeutic work outside of the confined therapeutic context: in the real world. Real time data collection techniques, such as experience sampling methodology (ESM), could be used to gather information on clients’ current state or early warning signs, which—through the power of machine learning—could trigger the implementation of individualised, in situ interventions. On-going, naturalistic data collection would enable the pathways to be refined at both the person and group level, increasing the sensitivity and effectiveness of the system. Possible mechanisms, designs and applications of this type of approach will be outlined.

Using experience sampling as a therapeutic tool: opportunities and obstacles
Samantha Hartley, University of Manchester
This paper will summarise findings from a recent experience sampling (ESM) study (Psychosis: Assessing Life in the Moment), which may indicate avenues for future momentary intervention strategies when working with people experiencing psychosis who engage in worry and rumination. Participant feedback elicited as part of this study will highlight potential areas of value in using ESM as a therapeutic tool, along with barriers to this in terms of participant engagement. Finally, participant compliance with ESM methodology and predictors of this will be explored.

Contemporary approaches to designing psychological therapies
Patricia Gooding, University of Manchester, UK
Experience sampling is a type of diary methodology which samples thoughts and feelings in real time. This methodology has the potential to provide important innovations which can be harnessed in the development of psychological therapies. These innovations include i) tracking when a therapeutic technique is most optimally used by clients, ii) engaging clients with therapeutic techniques, iii) personalising techniques so that they are varied and tailored to the values of clients, iv) gauging the duration of effective techniques, v) exploring blocks to the effectiveness of techniques in real-time, and vi) synthesising and providing feedback from real-time data to therapists which can be used to promote ‘recovery’. The way in which each of these innovations can be used in therapy development will be discussed in the context of working with people who are experiencing suicidal thoughts, behaviours and feelings. Specifically, developing and testing techniques based on Cognitive Behavioural Therapy approaches to suicidality and Acceptance and Commitment Based therapeutic approaches to suicidality using experience sampling will be illustrated.

A new smartphone software application for the assessment of psychosis
Jasper Palmier-Claus, University of Manchester, Shon Lewis, University of Manchester; John Ainsworth, University of Manchester; Anne Rogers, University of Southampton; Graham Dunn, University of Manchester
Retrospective assessments (e.g. interviews) may be limited by recall biases and averaging, thus clinical information is lost. This paper reports on two remote monitoring systems for psychosis using smartphone and text-message technology. Quantitative and qualitative data was collected to assess the feasibility and validity of the approaches in individuals with non-affective psychosis. Potential clinical applications of the technology will be discussed.

Real-time assessment of affect and activity in people with Asperger’s syndrome: clinical and research considerations
Dougal Hare, University of Manchester

27
This paper will explore the potential applicability of electronically supported ESM-derived techniques as both assessment and intervention techniques when working with people with Asperger’s syndrome/high-functioning autism, a group who have often found the conventional modes of therapy to be problematic due to the high social demand involved. Both existing and future research will be discussed.

Emotional Processing in Mental Health: New Developments in Bias Training Interventions
Convenor and Chair: Sally Adams, University of Bristol

Facing up to faces: Changing biases in face perception to improve emotional processing in depression
Sally Adams, University of Bristol, Ian Penton-Voak, University of Bristol; Marcus Munafo, University of Bristol
We have developed a new paradigm which targets the recognition of facial expression of emotions by initially assessing the balance point for detecting one emotion over another in an ambiguous expression. Results from adults recruited from the general population on the basis of high levels of depressive symptoms on the Beck Depression Inventory ii (BDI-ii) show that this manipulation of the perception of emotion in ambiguous facial expressions, designed to promote the perception of positive emotion over negative emotion, may have therapeutic benefit which persists for at least two weeks. It is notable that the strength of the observed effect of training on positive mood appears to strengthen over time. This is consistent with recent models of the action of antidepressant medication, which suggest that drug treatment has early effects on emotional processing bias including the ability to detect positive versus negative facial expressions. This is argued to result in therapeutic benefit (i.e., improved mood) only after sufficient time has elapsed to allow interaction with others, where alteration in these processing biases gives rise to more positive social interactions. Our intervention aims to target these biases directly through automated behavioural feedback.

"Always look on the bright side of life"
Eni Becker, Radboud University, Mike Rinck, Radboud University
Many disorders are characterized by cognitive biases favoring the processing of negative information: Negative stimuli draw and hold attention, are remembered better, and ambiguous situations are interpreted in a negative way. Quite often, this is accompanied by a lack of attention and memory for positive stimuli. In a transdiagnostical approach, we tried to target the processing advantage of negative stimuli and the disadvantage of positive stimuli with two different Cognitive Bias Modification techniques. An Approach-Avoidance-Training (AAT) was used to induce approach tendencies towards a range of positive pictures and avoidance tendencies for a range of negative pictures. A dot-probe training was used to change the attention bias towards positive pictures and away from negative ones. In the first study with the AAT, we trained in both directions (approach positive/avoid negative or approach negative /avoid positive). After the training, we measured mood before and after a stress task, and attention bias. Although the groups did not differ in their reaction to the stress task, an attention bias towards previously approached pictures had been induced. In a second study with the same approach-positive/avoid negative training, we managed to reduce stress vulnerability particularly in dysphoric participants in an induced negative mood. Thus, the training was beneficial for a vulnerable group. In the third study, we applied a dot-probe training to train vigilance for either positive or negative pictures. Subsequently, participants performed a very difficult memory task in which recognition of pictures from the dot-probe task was tested. A significant training effect on memory was found, with better memory for the pictures previously attended to. The training had no effect on mood after the stress task, but there was a difference in attribution of the performance: Those trained towards positive stimuli showed a more external attribution of their failure in the memory task. All in all, both the approach-avoidance variant and the attention variant of this general positivity training seem to be interesting options for interventions.

Individual variation in response to cognitive bias modification (CBM) procedures: Spider fear as a sample case
Elaine Fox, University of Essex,
Attentional biases in relation to fear-relevant stimuli are thought to play a role in the development and maintenance of specific phobias. The current study tested whether experimentally training high spider fearful participants to avoid spider-related images would ameliorate emotional reactivity in the presence of spider-related threat. People scoring more than 8 on the Spider Phobia Questionnaire (SPQ) were randomly assigned to either an attention training condition to avoid threat (n = 66) or a placebo training condition (n = 61). As expected, those in the active training condition showed greater avoidance of fear-related images following training and this induction of a bias to avoid spiders was related to reductions in the subjective, but not the physiological, fear response to threat. However, the effectiveness of attention training was found to vary depending upon the nature and magnitude of the initial bias for fear-relevant material. Those who were highly vigilant for threat had a better response compared to those who were initially avoidant or who showed no specific bias for fear-relevant material. A follow-up study shows that those who were highly avoidant of fear-related images responded best to a CBM procedure designed to orient attention towards the spider-related images. These results highlight individual differences in the effectiveness of attention-based cognitive bias modification techniques.
Mental imagery-based cognitive bias modification in healthy adolescents

Stephanie Burnett Heyes, University of Oxford, S Blackwell, MRC Cognition and Brain Sciences Unit, University of Cambridge; S Raeder, University of Oxford; A Pictet, University of Oxford; EA Holmes, MRC Cognition and Brain Sciences Unit, University of Cambridge

Mental imagery is the experience of perception in the absence of concurrent sensory input. Clinical interventions harnessing mental imagery, including those based on bias modification techniques, are receiving increasing interest for the treatment of psychological disorders including social anxiety and depression in adults. This is based on evidence that mental imagery (relative to verbal processing) potently influences the experience of emotion in non-clinical samples, and that a number of psychological disorders are marked by abnormalities in mental imagery.

Neurocognitive development during childhood and adolescence may moderate the relationship between mental imagery and emotion at a number of potential loci (Burnett Heyes, Lau & Holmes, 2013). Crucially, this development could impact (1) changes in vulnerability to abnormal or unhelpful mental imagery, such as that which characterises psychological disorders including post-traumatic stress disorder, social anxiety and depression, and (2) the efficacy of mental imagery-based clinical interventions in children and adolescents.

In this session, we first summarise evidence pertaining to developmental changes in the role, content and cognitive sub-components of mental imagery. Subsequently, we present novel empirical data from a mental imagery-based cognitive bias modification paradigm in a non-clinical community adolescent sample (aged 12-15). In this paradigm, participants are presented with an ambiguous picture (e.g. a photo of an adolescent talking on their mobile phone) that is paired with a positive or a negative word (e.g. “popular” or “argument”). These valenced picture-word pairs are then combined as per standardised instructions to form a mental image (Pictet, Coughrey, Mathews & Holmes, 2011). Participants generate positive vs. mixed (half positive, half negative) valence mental imagery (between-subjects factor: Valence) from a field vs. observer perspective (within-subjects factor: Perspective). We discuss effects of mental imagery valence and perspective on downstream measures of mood and interpretation bias. Subsequently, implications for extension of this paradigm to clinical and at-risk adolescent populations are discussed.

We argue that, if proper consideration is given to developmental factors, mental imagery-based techniques may be valuable as a clinical treatment strategy in child and adolescent groups, and as a preventative cognitive “vaccine” (Holmes, Lang & Shah, 2009) in those at risk of emotional disorders.

Using Smartphone Apps and New Web Technologies in CBT Practice and Research

Convenor and Chair: Alex Gyani, University of Reading

Development and Initial Evaluation of an internet version of cognitive therapy for social anxiety disorder

David M Clark, University of Oxford, Richard Stott, King’s College London

Individual cognitive therapy based on the Clark & Wells model is an effective treatment for social anxiety disorder which has shown usually comprehensive differential effectiveness in randomized controlled trials. In particular, it has been shown to be superior to exposure therapy, two forms of group CBT, interpersonal psychotherapy, psychodynamic psychotherapy, SSRIs and placebo medication. The new NICE social anxiety guideline recommends individual CT as a first choice treatment.

In its usual form the treatment involves up to 14 weekly 90 minute sessions (21 hours therapist time). In an attempt to make the treatment more widely available our team has developed an internet version of the treatment. All the key features of the treatment (including video feedback of one’s performance, behavioural experiments, attention training and memory rescripting) are implemented. This presentation demonstrates the programme and reports on an initial pre-post evaluation.

The Development of CBT Phone Based Applications

Lauren Callaghan, themindworks

As mobile technology becomes more pervasive, mobile phones are increasingly being used in the delivery of psychological treatments and promoting positive behaviour change. However, there have been varying degrees of success in treatment gains using mobile phones to date. Nonetheless, as mobile phones are becoming more sophisticated (in particular through the advent of the smartphone), so are the applications that can be used on them on a daily basis. This means that there are increased opportunities for complex psychological-based mobile phone applications to be used as an adjunct to Cognitive Behaviour Therapy (CBT). Current estimates by Ofcom, the independent regulator for the UK communications industries, suggest that 92 percent of the UK population have a mobile phone, and 58 percent of mobile phone users have a smartphone. A smartphone is not only a device that lets you make telephone calls, but also adds features that you might find on a personal digital assistant (PDA) or a computer such as sending emails, browsing the internet, and interacting with various web based applications. A smartphone is based on an operating system that allows it to run productivity applications, such as the BlackBerry OS, iOS, or Windows Mobile. The software of a smartphone is much more complex than a standard mobile phone, and a smartphone includes a QWERTY keyboard, so the keys are laid out in the same manner they would be on your computer keyboard. Given the increased use of smartphones, mobile phones make an ideal platform for the delivery of psychological interventions or as an aide in psychological treatments. There are specific benefits of using mobile phones in therapeutic settings but there has been little research to date on whether they increase
effectiveness of CBT or adherence to homework in CBT. The obvious question is whether these applications help people make treatment gains i.e. do CBT applications for mobile phones increase treatment efficacy in CBT? With the speed in which technology has become available, it seems certain that there is a future in the combination of evidenced based therapies and technology, and research will be necessary to determine how effective CBT-based mobile phone applications are as an add-on to therapy. In this symposium I will discuss a review of the literature using mobile phones in treatment, the development of my own series of specific CBT Apps for the iPhone from a psychological and technological perspective, and I will argue the need for additional research into the use of technological advancements in CBT.

Mood Mate: Can a Mobile Phone Application Encourage Treatment Seeking?
Alex Gyani, University of Reading, Jack Rostron, University of Reading; Sam Allen, University of Reading; Suzanna Rose, Berkshire Healthcare NHS Foundation Trust

The ‘Improving Access to Psychological Therapies’ (IAPT) programme has increased the provision of evidence-based treatments for common mental health disorders. Its introduction of self-referral highlights the fact that the first step of the care pathway is not referral, but treatment seeking. However, self-referral has been found to be under-used. A number of barriers to effective treatment seeking have been identified. These include: an uncertainty of where to find treatment, fear of stigma and they lack recognition that problems could have a mental health origin. Online experience sampling or ‘mood monitoring’ tools are available to help people with common mental health disorders identify low mood and anxiety, and increase treatment seeking. However, the effects of these have not been studied in a randomised controlled trial. Smart phones have shown to be very effective tools for experience sampling and can be used to help people find local services for treatment. The Mood Mate study uses a mobile phone application designed for the iPhone to 1) help people identify their local IAPT services, 2) provide a platform for people to refer themselves to treatment with ease, and 3) evaluate the effectiveness of mood monitoring in increasing treatment seeking, using validated depression and anxiety inventories. In this paper the aims, content and preliminary results of the Mood Mate application will be discussed and the case for the use of new technologies to improve well-being will be argued.

Buddy App: Therapy Services in a digital world
James Seward, Buddy Enterprises Ltd, Syed Abrar, Buddy Enterprises Ltd

We live in a digital world that has transformed society to put consumers in control, but public services (and the NHS and mental health services in particular) have been slow to harness these new tools to empower users so they can become more engaged as active collaborators in their care pathway and thereby achieve a more effective and enduring recovery. Buddy App was developed to begin to address these deficits, not as an intervention but as a tool that can be integrated into the provision of services such as IAPT, harnessing modern digital communications to achieve better user engagement and better outcomes. Buddy uses ubiquitous text-messaging to give users a tool for taking more control of their recovery and as a resource for collaborating with professionals to achieve their goals. Buddy App enables service users to create a digital mood diary by using text messaging linked to a simple web application. This session looks at the emerging evidence of the benefits of using Buddy in three key domains: for service users where greater control, the ability to spot patterns and more user-friendly digital communication tools can be decisive in achieving recovery; for clinicians where the digital mood diary can abolish the unreliable paper-based system by providing a richer insight into clients lives which in turn allows professionals to tailor their sessions more effectively around clients’ needs; for managers of provider organisations where appointment reminders cut down in DNA rates making throughput, caseload and achieving contractually required numbers and outcomes more achievable.

Contextual CBT in the Workplace
Convenor and Chair: Jo Lloyd, University of London

A randomized controlled trial comparing Acceptance and Commitment Therapy (ACT) training to brief Mindfulness training in the workplace.
Vasiliki Christodoulou, South London and Maudsley NHS Foundation Trust, Joseph Oliver, South London and Maudsley NHS Foundation Tust, Paul Flaxman, City University.

Recent surveys in the UK indicate that between 25-40% of the working population maybe experiencing psychological ill health and there is a call for promoting worksite programs for improving staff wellbeing. Empirical work suggests that mindfulness-based interventions in the workplace can help improve staff psychological health, reduce stress, and improve work-related outcomes.

A total of 196 participants working for a mental health NHS Trust were randomly allocated to one of three conditions: (1) a four-session Acceptance and Commitment Therapy (ACT) training conveying mindfulness skills and values-based behaviour (n=66), (2) a four-session Mindfulness training conveying purely mindfulness skills (n=58) and (3) a waiting list condition (n=75).

Intervention efficacy was evaluated through completion of online questionnaire packs assessing psychological health and worksite stress outcomes at baseline (T0), at one-month (T1), at two and a half months (T2), at four months (T3) and six month (T4) follow-up.
It was predicted that both ACT and Mindfulness would benefit participants’ psychological health at post-intervention and at follow-up compared to a waiting list. The study further investigated whether any emergent psychological gains would be mediated by change mechanisms consistent with each model’s underlying theory (e.g., psychological flexibility, mindfulness, increased value-based action).

The presentation will discuss the main findings (pending) and their theoretical implications for implementing ACT training or Mindfulness in the workplace. The presentation will reveal recommendations for developing effective mindfulness-based CBT protocols for the workplace.

**Exploring the discursive reality of change in contextual CBT - how it is constructed and actualised post worksite Mindfulness-Based CBT training**

**Kham Chuan Lee, City University London**

Worksite training programs based on Acceptance and Commitment Therapy (ACT) and Mindfulness Based Stress Reduction (MBSR) on employee wellbeing is showing promising results. They showcase change processes that is consistent with each model’s underlying theory. However at present, no qualitative research exist to explore how this change process is captured, constructed and navigated through the use of language, and how it interacts with institutions and wider dominant discourses.

Semi-structured interviews were held late 2012 to early 2013 with NHS mental health workers following the above worksite training. Foucauldian Discourse Analysis was used to analyse how participants construct and explore change processes, including potential ways of operating, and locate subject positions that were not previously apparent prior to the workplace training program.

The study aims to create better understanding of the linguistic constructions of contextual CBT and their underlying change process. This could then better inform the design and delivery of psychological intervention to facilitate personal change, and begin exploring it’s application in different professional environments.

**Acceptance and Commitment Therapy (ACT) and Psychological Flexibility in Performance-focused Contexts: A Meta-analytic Review**

**Jo Lloyd, Goldsmiths, University of London, Frank Bond, Goldsmiths, University of London; Nigel Guenole, Goldsmiths, University of London; Paul Flaxman, City University**

Introduction: Research from the last 13 years has indicated that interventions based on Acceptance and Commitment Therapy (ACT) can produce improvements within a number of performance-focused contexts (e.g., the workplace, chess playing and competitive athletic environments). Furthermore, research has highlighted key relationships between ACT’s underlying process of change, psychological flexibility, and a number of important indices of performance in these contexts. A meta-analytic review was conducted to summarise this research.

Method and Results: In part one of the review we sought to determine the overall relationship between psychological flexibility and various outcomes in performance-focused contexts. Thirteen studies were included, representing a total sample size of 2613. Results indicated that psychological flexibility showed a moderate to large statistically significant relationship with health (weighted mean r = 0.45); a moderate statistically significant relationship with effectiveness (weighted mean r = 0.29) and attitudes towards clients/customers (weighted mean r = 0.26); and a small statistically significant relationship with attitudes towards work (weighted mean r = 0.19) and perceptions of the work environment (weighted mean r = 0.18). Overall, these findings indicate that higher levels of psychological flexibility are associated with better health outcomes, more behavioural effectiveness, more positive attitudes towards the people with whom you work, more positive attitudes towards work itself, and more favourable perceptions of the work environment.

In part two of the review we sought to determine the overall impact of ACT on outcomes in performance-focused contexts. Ten studies were included, and these represented 13 treatment-comparison condition contrasts, and 31 outcome variables. Total sample size 654 participants at post-intervention and 432 participants at follow-up. All of the studies compared ACT to at least one comparison condition, and three studies compared ACT to two comparison conditions. Five studies compared ACT to waitlist controls, three studies to no contact controls, two to educational programs, and three to alternative treatment programs (multicultural training, innovation promotion program, and stress inoculation training). A combined analysis using weighted average effect sizes indicated that ACT outperformed the comparison conditions at both post-intervention and follow-up assessment points. Specifically, there was a significant small between condition effect at post-intervention (d = 0.284, 95% CI 0.021, 0.546), and a significant small between condition effect at follow-up (d = 0.347, 95% CI 0.165, 0.528).

Discussion: Our findings suggest that ACT-based training may be useful for enhancing outcomes in performance-focused contexts, and furthermore, that psychological flexibility may be an important construct to consider in such contexts. Implications for theory, research, and practice will be discussed.

**Measuring psychological flexibility: why and how.**

**Miles Thompson, Canterbury Christ Church University**

This presentation will focus on the importance and practicality of measuring psychological flexibility in ACT interventions, especially those that take place outside of the health care environment. It will begin by providing a brief overview of the initial development of psychological flexibility measures focusing on the proliferation of the Acceptance and Action...
Cognitive processes in worry and rumination: new developments in understanding perseveration in psychopathology
Convenor and Chair: Frances Meeten, University of Sussex

The role of systematic processing in worry
Suzanne Dash, University of Sussex, Graham, C. L. Davey, University of Sussex
Dysfunctional perseveration is one of the key defining features of pathological worrying yet little is known about the proximal mechanisms that account for perseverative worry. The theoretical and empirical rationale for conceiving of systematic information processing as a proximal mechanism of perseverative worry will be presented. Systematic processing is characterised by detailed, analytical thought about issue-relevant information, and in this way, is similar to the persistent, detailed processing of information that typifies perseverative worry. The key features and determinants of systematic processing and the application of systematic processing to perseverative worry will be reviewed. It will be argued that systematic processing is a mechanism involved in perseverative worry because (1) systematic processing is more likely to be deployed when an individual feels that they have not reached a satisfactory level of confidence in their judgement and this is similar to the worrier’s strive to feel adequately prepared, to have considered every possible negative outcome/detect all potential danger, or to be sure that they will successfully cope with perceived future problems. (2) Systematic processing and worry are influenced by similar psychological cognitive states and appraisals. (3) The functional neuroanatomy underlying systematic processing occupies the same regions as are activated during worrying. This mechanism is derived from core psychological processes and offers clinical implications, such as identifying the psychological states and appraisals that may benefit from therapeutic intervention in worry-based problems.

Worry and thought control processes in young people
Charlotte E Wilson, University of Dublin, Trinity College, Dublin, Ireland
Worry is a perseverative process, characterised by iterative thoughts about anticipated negative outcomes. Children as young as three or four years old can report worries, and by adolescence worry has many of the same characteristics as adult worry. However, much less is known about how worry is initiated, becomes perseverative, and stops, in children and young people. We report on two studies exploring the latter of these processes; how children and young people stop their worries, and how cognitive processes impact on this. In study one we manipulated whether children tried to suppress their worries or whether they just let their mind wander. We found no impact of the manipulation on number of intrusions, but intrusions were predicted by trait worry and negative beliefs about worry. In study two we explore a variety of thought control strategies using the thought control questionnaire and qualitative interview. The qualitative interviews produced nine ways of managing/controlling worry, of which 6 were perceived to be helpful and 3 perceived to be unhelpful. Using a modified TCQ, children reported using distraction most often and worry least often to manage their unwanted thoughts. Furthermore, the strategies of reappraisal and punishment were significantly associated with trait worry and meta-cognitive beliefs. We discuss implications for understanding the impact of development on the cognitive processes involved in worry.

Understanding Depressive Rumination from a Mood-as-Input Perspective
Chris R. Brewin, University College London, Jason C. S. Chan, University College London; Graham C. L. Davey, University of Sussex
This paper discusses the mood-as-input hypothesis account of perseverative rumination in 25 participants with a diagnosis of major depressive disorder and 25 healthy controls. A structured rumination interview was used to facilitate participants’ reflection on two previous depressive incidents while deploying a specific stop-rule for the task (either an “as-many-as-can” or “feel-like-continuing” stop-rule). As predicted by the mood-as-input hypothesis, perseveration exhibited by depressed participants was affected by the interaction between diagnosis and stop-rule, with levels of perseveration being greatest when depressed participants used the “as-many-as-can” stop-rule. Increases in negative mood over the rumination interview were shown to be influenced only by participants’ diagnostic status, regardless of their stop-rule. Compared to healthy controls, depressed participants also reported a preferential use of the “as-many-as-can” stop-rule in response to negative mood states in their daily lives. The findings about the dependence of rumination on stop-rule use within the depressed sample support the use of metacognitive treatment approaches in which patients are encouraged to challenge negative beliefs about the controllability of rumination.
The role of metacognitive beliefs and stop rules in ruminative perseveration

Frances Meeten, University of Sussex, Sarah Brown, University of Sussex; Suzanne R. Dash, University of Sussex; Graham C. L. Davey, University of Sussex

Depressive rumination is a key maintaining factor in major depressive disorder. Individuals who regularly engage in rumination report both positive as well as negative metacognitive beliefs about the utility of rumination. The mood-as-input model predicts that rumination will occur when in a negative mood and employing an "as many as can" (AMA) stop rule. This study examined the relationship between positive beliefs about rumination (PBR) and a behavioural measure of rumination and examined the relationship between PBR and AMA stop rule use in rumination. The sample was a non-clinical undergraduate population, 75% were women, mean age was 21.00 (SD = 2.13) years. Participants completed questionnaires measuring depression, positive and negative beliefs about rumination, and stop rule endorsement, then completed a depressive rumination interview. There was a significant positive relationship between PBR and rumination length; AMA stop rule use did not mediate the relationship between PBR and rumination. However, PBR significantly predicted AMA stop rule endorsement and as predicted by mood-as-input theory, negative mood interacted with AMA stop rule endorsement to predict rumination length. These findings suggest that addressing beliefs about the utility of rumination and modifying stop rule use during rumination bouts may reduce depressive relapse.

CBT skills for non-mental health staff: skills cascade and beyond

Kathryn Mannix, Newcastle upon Tyne Hospitals

Developing the ‘CBT First Aid’ training model

Kathryn Mannix, Newcastle upon Tyne Hospitals NHS FT and Marie Curie Hospice, Newcastle upon Tyne, UK, Christine Baker, Newcastle upon Tyne Hospitals NHS FT, UK; Nigel Sage, Beacon Community Cancer and Palliative Care Service, Guildford, UK; Stirling Moorey, South London and Maudsley NHS FT, London, UK

Emotional distress linked to realistic thoughts and appraisals of disability and death are common in serious physical illness, and access to expert psychological help is often limited. Our research has demonstrated that palliative care practitioners can acquire CBT skills and this enables development of local CBT skills pyramids in which patients’ physical health specialists can take a CBT approach to a variety of challenges including emotional distress, enhancing coping, symptom management/tolerance and end of life planning. CBT experts can thus offer more rapid expert help for more complex problems, whilst helping many more patients via supervision and support to the ‘CBT First Aiders’.

We have developed a cascade model for rolling out this CBT skills training for physical health staff, training new trainers as part of the cascade. Training includes use of trainees’ own cases as learning materials; trainee case work will be presented to demonstrate the level of practice and diversity of uses of the ‘CBT First Aid’ model and its place in a local skills pyramid.

From CBT First Aider to Diploma, trainer and researcher

Kathy Burn, St Christopher’s Hospice, London, Karen Heslop, Newcastle upon Tyne Hospitals

Physical health problems can have a significant impact on patient’s lives, and anxiety and depression are common comorbidities. Providing holistic care for physical and psychological symptoms can be very challenging for nurses working with such patients. Patients with life threatening illnesses may struggle with very realistic negative thoughts such as ‘I am going to die’ or ‘this is my last breath’. This can be very distressing for patients approaching the end of their life and our patients are often severely compromised by their physical condition.

Training in ‘CBT first aid’ provided us with extra skills to use within our daily practice with palliative care patients, and inspired us both to train as CBT therapists at post-graduate level. Having the skills and experience to assess a patient both physically and psychologically is a real advantage. The beauty of the cognitive model is the incorporation of physical symptoms in the formulation. In a physical health setting the CBT model needs to be adapted to the needs of patients who may be physically weak. After developing our own manual of providing care to patients we developed training courses to help others develop CBT first aid skills.

We are both currently involved in training nurses from the physical health setting who work with patients at the bedside or in the clinic. Many of the nurses have gone on to undertake further CBT training themselves. Moorey at al (2009) showed that the addition of CBT skills to the work of clinical nurse specialists significantly reduced the anxiety experienced by terminally ill patients. The clinical nurse specialists valued and were able to use CBT skills in their clinical practice. This workshop will discuss the development of a CBT service in a physical health setting. We will review the various methods used to disseminate these skills, and how we are currently investigating the best methods to disseminate these skills to nurses for use in their everyday work.

Developing and delivering CBT skills training for health care professionals in acute and chronic physical health care services

Nigel Sage, The Beacon Service for community cancer and palliative care, Christine Baker, Newcastle upon Hospitals NHS Foundation Trust; Kathryn Mannix, Newcastle upon Tyne Hospitals NHS Foundation Trust; Stirling Mooray, South London and Maudsley NHS Foundation Trust
There is expanding evidence and recent guidance (as well as financial pressure) directing us to address the psychological distress associated with physical illness. However, current provision of and access to psychological assessment and intervention in physical illness is patchy and often difficult to access. Developing awareness and enhancing the skills of those professionals who have routine contact with patients can have a significant impact on service provision and patient experience and outcome. We have found that CBT ideas and skills prove to be a good fit for many health care professionals working in both acute care and with long term conditions. Evidence-based skills complement and enhance their roles and service provision, enabling a scarce psychological therapy service to provide supervision and to focus on quick access for complex problems. We will present and discuss our experiences of developing and delivering CBT training in local services and in partnership with national organisations.

**Cascading to IAPT: the CanTalk trial**
Stirling Moorey, South London and Maudsley NHS Foundation Trust, Marc Serfaty, University College London

CBT has established itself as an effective intervention for managing anxiety, depression and distressing symptoms such as pain, nausea and insomnia in people with cancer. We now face the challenge of how to make these available to as many patients as possible. The expansion of IAPT into long term conditions presents an opportunity to train CBT therapists who are not familiar with working with physical illness. The CanTalk trial is a multicentre HTA funded RCT led Dr Marc Serfaty, which is comparing CBT plus treatment as usual with treatment as usual for depression in advanced cancer. IAPT therapists are trained in CBT as applied to cancer using a manual developed by Stirling Moorey and Kath Mannix. The trial design will be presented, followed by a description of the manual and training programme. Participants feedback on the training will be discussed.

**Advances in understanding key cognitive and behavioural processes**
Convenor and Chair: Nick Moberly, University of Exeter

**Reducing Emotional reasoning; an experimental manipulation in individuals with fear of spiders**
Miriam Lommen, University of Oxford; Miriam Lommen, University of Manchester; Iris Engelhard, Utrecht University, the Netherlands; Marcel van den Hout, Utrecht University, the Netherlands

Emotional reasoning involves the tendency to use subjective responses to make erroneous inferences about situations (e.g., “if I feel anxious, there must be danger”) and has been implicated in various anxiety disorders. To examine whether emotional reasoning may contribute to the treatment of anxiety, the aim of this study was to experimentally attenuate emotional reasoning, and examine the influence on fear-related cognition and behaviour.

In 58 individuals with fear of spiders this study tested whether a computerized experimental training, compared to a control training, would decrease emotional reasoning, reduce fear-related danger beliefs, and increase approach behaviour towards a fear-relevant stimulus. Effects were assessed shortly after the experimental manipulation and one day later. Results showed that the manipulation significantly decreased emotional reasoning in the experimental condition, not in the control condition, and resulted in lower danger estimates of a spider, which was maintained up to one day later. No differences in approach behaviour of the spider were found.

Reducing emotional reasoning may ultimately help patients with anxiety disorders attending more to objective situational information to correct erroneous danger beliefs.

**Approach-avoidance conflict in spider phobia using force-feedback control of visual images: A novel paradigm for assessing dynamic goal-directed action**
Kate Oliver, University of Manchester; Warren Mansell, University of Manchester

Avoidance behaviour has been thought to negatively reinforce anxiety in specific phobias by preventing exposure to unconditioned aversive experiences (e.g. pain) (Milosevic & Radomsky, 2008; Mower, 1939) or the disconfirmation of harm-related threat appraisals (Davey, 1992; Olatunji, Wolitzky-Taylor, Willems, Lohr, & Armstrong, 2009; Öst & Hugdahl, 1981). Within therapy reducing avoidance through exposure is thought to have its effects either through systematic desensitization, (e.g. Wolpe, 1961), or through challenging beliefs in harmful consequences of the feared object (e.g. Beck, Emery & Greenberg, 1985). The mechanisms, however, that underlie change behaviours within therapy are unclear (Carey, 2011). The present study explores the capacity of avoidance behaviour to conflict with important goals that characterizes anxiety (Gray & McNaughton, 2000; Mansell, 2005) and how people who are afraid of spiders dynamically vary their behaviour in order to attempt to maintain a controlled distance from the feared object, both in the presence and absence of goal conflict.

A series of experimental computer tasks were employed that measured real time data of high spider phobic and low spider phobic participants’ control of virtual images on a computer screen, simulating a virtual reality paradigm to elicit real life approach and avoidance behaviours. Participants completed three tasks in which they were asked to adjust the distance of 60 randomly presented images of spiders, spider-like objects and non-spiders, on screen, in the presence of a disturbance, no disturbance or a goal related task of identifying images.
The results showed that high spider phobic participants maintained a greater distance from spider images than other images or low spider phobic participants, and made fewer correct identifications which the authors concluded to be indicative of the presence of conflict.

The role of this conflict as a mechanism for change is explored and how for fearful individuals, avoidance and exposure may be seen as methods of controlling the internal experience of arousal (Brady & Raines, 2009) and by controlling this variable it may maintain anxiety in spider phobia. Possible explanations are discussed with regards to Perceptual Control Theory (PCT; Powers, 1973, 2005).

The role of conflict as a change mechanism underlying therapy may improve the way in which CBT is implemented. It would offer support to Perceptual Control Theory as “a functional and transdiagnostic approach to the consideration of mechanisms of change” (Carey, 2011). The proposal of reorganisation as a functional learning mechanism in encouraging change behaviours could offer a more parsimonious and effective way of conducting not just CBT, but therapy in general.

Group cognitive behavioural therapy for clinical perfectionism: A randomised controlled trial
Alicia Handley, Curtin University; Sarah Egan, Curtin University; Clare Rees, Curtin University; Robert Kane, Curtin University

The purpose of this study was to investigate the efficacy of group cognitive behavioural therapy (CBT) for clinical perfectionism.

Forty-three individuals (M age = 31.46 years) with clinical perfectionism and mixed diagnoses (anxiety disorders, depression, eating disorders) were randomly allocated to 8 sessions of group CBT for clinical perfectionism or a wait-list control.

Results indicated that participants who had received group CBT for clinical perfectionism had significantly decreased perfectionism, self-criticism, eating disorder symptomatology and rumination, and significantly increased self-esteem and quality of life scores compared to the waitlist group. All effects were maintained at three and six month follow-up periods.

These findings contribute toward establishing group CBT for clinical perfectionism as an efficacious intervention to reduce clinical perfectionism, self-criticism, eating disorder symptomatology, and rumination, and increase self-esteem and quality of life.

These findings suggest that group CBT for clinical perfectionism is a promising intervention to ameliorate a broad range of mental health concerns and increase quality of life.

Rumination, dysphoria and self-regulation: Sampling the experience of everyday goal pursuit
Nicholas Moberly, University of Exeter

Although rumination is often considered to be a problematic clinical phenomenon, theorists have proposed that rumination may be a more general response to unsatisfactory goal progress. Based on control theory, this account suggests that rumination may not be maladaptive if it enables the person to reduce goal discrepancies, via effort mobilization or disengagement. However, this self-regulatory account has rarely been examined empirically, and its applicability to dysphoric individuals is unknown. In this study, experience-sampling methodology (ESM) was used to investigate fluctuations in ruminative thought and affect and their association with progress on personal goal strivings, effort and expectancy during everyday life.

Undergraduate participants (N = 109) completed a self-report measure of depressive symptoms, then nominated one important agentic goal and one important communal goal for monitoring during a subsequent experience-sampling phase. At eight quasi-random occasions every day over the next fortnight, a wrist-worn PRO-Diary unit (Cambridge Neurotechnology, UK) prompted participants to report ruminative thought (goal-relevant and otherwise) and rate their affect. In parallel assessments occurring thrice daily, the PRO-Diary cued participants to record progress on each of their goals, the amount of effort they had invested in each goal, and the progress they anticipated at the next assessment.

Replicating previous ESM findings, momentary ruminative thought was associated with negative affect, especially for dysphoric participants. Ruminative thought on personal goals was associated with greater effort and progress, but not when ruminative thought was more evaluative in content. These associations were not moderated by dysphoric symptom levels. Lagged multilevel analyses will examine whether rumination on goal strivings is associated with subsequent increased effort and/or decreased expectancies, and consequently with greater progress, reduced goal discrepancies, and improved affect.

Results are consistent with an elaborated control theory account of rumination, such that this mode of thought generally predicted favourable self-regulatory outcomes, except when it was more evaluative in nature. It is possible that the self-regulatory concomitants of rumination during everyday goal pursuit may foster mistaken beliefs about the utility of rumination in one specific context when it is actually unhelpful: when the goal is to alleviate depressed mood. These findings underline the importance of understanding rumination as a general phenomenon that is not necessarily problematic. When working with clients, clinicians would be advised to highlight the potential functional role of rumination during the pursuit of many everyday goals, while emphasising that rumination may be a less adaptive response during certain circumstances: when it is more evaluative in content, and when it is deployed as a response to depressed mood.
Investigating Relationships Amongst Key Cognitive Processes
Chair: Craig Steel, University of Reading

The impact of mood on interpretation bias
Craig Steel, University of Reading; George Cochrane, University of Reading; Robyn Martin, University of Reading
The relationship between mood and the interpretation of ambiguous stimuli is a fundamental part of most cognitive behavioural models. In fact, the proposal that a negative mood state will influence appraisal is embedded within the Beckian approach to treating depression. Recent years have seen a focus on the potentially causal role of bias within emotion, with extensive efforts being made to develop training programmes to modify negative biases, i.e. cognitive bias modification (CBM). However, there has been little investigation aimed at clarifying whether mood state is indeed related to bias. A recent study (Standage et al., 2010) suggests that a change in mood is not sufficient for a change in bias within a CBM approach. The current study aimed to directly explore this relationship.

A positive mood induction was used, containing a number of humorous video clips. Bias was assessed using a novel paradigm within which participants were to rate short sound clips in terms of how positively they experienced them. Bias was assessed before and after positive mood induction. The fifty participants also completed a measure of trait depression. There was a significant change in bias after a positive mood induction. Bias change was not associated with trait depression.

Findings are at odds with those of Standage et al., (2010) and support the previously theoretically assumed relationship between state mood and interpretation bias. The novel use of auditory stimuli within a measure of bias appears to be valid, brief and requires minimal participant instruction. Therefore the paradigm is appropriate for use within child or learning disabled populations.

The main implications of the current study are for future research within the field of CBM, which is having a growing impact of clinical practice.

Unhealthy perfectionism, abstract analytic rumination and dysphoria: a moderated mediation model
Monika Kornacka, PSITEC, University of Lille Nord de France; Céline Douilliez, PSITEC, University of Lille Nord de France
Previous research has evidenced that perfectionism and rumination affect the recurrence of mood disorders. Current research now focuses particularly on two dimensions of perfectionism: social-interpersonal and self-oriented intrapersonal perfectionism (Hewitt & Flett, 1991). It has been observed that rumination can serve as a mediator between unhealthy perfectionism and depression. Using a new approach to the study of rumination developed by Watkins (2004), it has been observed that the maladaptive consequences of rumination appear to be caused by an abstract analytic processing mode and not by rumination per se.

The present study is the first to explore the interplay between Abstract Analytic (AA) rumination, social, and intrapersonal dimensions of perfectionism, and their impact on dysphoria in one model. Questionnaires assessing Socially Prescribed Perfectionism (SPP), Self-Oriented Perfectionism (SOP), rumination processing mode, and depressive symptomatology were administrated to 134 participants from a non-clinical sample.

The moderated mediation model computed using a bootstrapping procedure (Hayes, 2012) identified a mediating role of AA rumination between SPP and dysphoria. Additionally, the interaction between the SPP and SOP affected dysphoria independently of rumination level: the SOP influenced dysphoria only in individuals with a low level of SPP.

Interpersonal perfectionism affects depression through rumination; whereas intrapersonal perfectionism affects depression directly in individuals with low social perfectionism.

The maladaptive consequences of interpersonal perfectionism on depression might be reduced through rumination-focused interventions (Watkins et al., 2011). However, an intervention explicitly targeting perfectionism (Fairburn, 2008) may be more appropriate in regards to intrapersonal perfectionism.

An investigation into the relationship between early maladaptive schemas and chronic fatigue syndrome
Dzintra Stalmeisters, University of Derby
The aim of the research was to investigate the relationship between Early Maladaptive Schemas, as described by Young, Klosko and Weishaar (2003), and Myalgic Encephalomyelitis/ Chronic Fatigue Syndrome (ME/CFS). Despite the recognition of characteristics associated with these schemas in people with ME/CFS by clinicians, a review of the literature suggests that research into this relationship has not previously been conducted. This study progresses knowledge in this area by providing a schema-level understanding of ME/CFS and offering insights into the behavioural process from schema to illness.

It employed mixed methods. The quantitative study conducted involved 40 people with ME/CFS and 40 people from a non-clinical population completing Young’s Schema Questionnaire (YSQ-S3), a questionnaire designed to elicit 18 Early Maladaptive Schemas. The qualitative study conducted adopted a mainly classical Grounded Theory approach (Glaser, 1978, 1998). An instrumental case study conducted within a clinical context, concentrated on the experience of a woman with ME/CFS who endorsed several schemas.
Analysis of the data revealed the schemas Unrelenting Standards and Self-Sacrifice were dominant in both groups. Unrelenting Standards was endorsed by 47.5% of the ME/CFS group and by 25% of the non-clinical group at a level of ‘clinical caseness’, whilst the percentage of people that endorsed the Self-Sacrifice schema was similar in each group; 27.5% of the ME/CFS group endorsed this schema and 25% of the non-clinical group. Statistical analysis of the data found a number of associations. Qualitative study: The core category generated from the data termed ‘obscuring’ conceptualised the manner which Early Maladaptive Schemas and the coping style ‘surrender to the schema’ obscured the needs of individuals with ME/CFS. The theory proposed a subtle cycle of ‘obscuring’ within the illness context potentially exacerbating the illness, increasing fatigue. Instrument case study: Measures of mood and schemas were taken throughout the study. The number of Early Maladaptive Schemas reduced once depression had been treated, whilst the schemas Unrelenting Standards and Self-sacrifice remained at a level of ‘clinical caseness’ at the end of therapy, although their scores on Young et al’s Schema Questionnaire (YSQ S-3) had decreased. Not only did the qualitative study and the case study give an insight into the complexity of Early Maladaptive Schemas in relation to the illness, bestowing the ‘figures’ from the quantitative study with real life meaning, together the three studies increased the credibility of the theory.

The studies taken together have implications for Cognitive Behavioural model of ME/CFS (Surawy et al., 1995). It is proposed that Early Maladaptive Schemas have relevance for the model at the predisposing and perpetuating levels, that the theoretical codes, ‘compelling’, ‘curtailing’ and ‘compassionating’, derived from the grounded theory analysis’ are evident at these levels and that the model might benefit by the inclusion of the terms ‘unhelpful emotional responses’ and ‘psychological rewards’.

The conclusion asserts that the information gathered helps to deepen understanding of the role that Early Maladaptive Schemas have in this disabling and unpredictable illness. Integrating Young’s short-version questionnaire may be useful in the assessment process; this may help in reducing drop-out figures and enable clinicians to focus their work at an idiosyncratic level. Treatment plans can be adjusted to accommodate the challenges that the schemas present as cost/benefits of surrendering to the schemas are explored. Furthermore, the therapeutic relationship could be enhanced as both therapist and client appreciate that surrendering to the schema was the client’s creative adjustment to their past context, yet influences their experience of the illness in the here and now.

Exploring Compassion: Systematic review and meta-analysis of the association between self-compassion and psychopathology

Angus MacBeth, University of Aberdeen/NHS Grampian; Andrew Gumley, University of Glasgow

Compassion has emerged as an important construct in studies of mental health and psychological therapy. This has implications for enhancing our understanding of recovery and resilience. In the last 2 decades an increasing number of studies have explored relationships between compassion and different facets of psychopathology. However, there is considerable heterogeneity between studies in terms of sampling, demographic correlates and outcomes. A systematic search identified 20 samples from 14 eligible studies, representing a total sample of n=4007. All identified studies used the Neff Self Compassion Scale (Neff 2003). Meta-analysis was used to explore associations between self-compassion and psychopathology using random effects analyses of Fisher’s Z correcting for attenuation arising from scale reliability.

We found a large effect size for the relationship between compassion and psychopathology of r=0.54 (95% CI=0.57 to0.51; Z=34.02; p<.0001). Large effect sizes were also reported for the relationship between compassion and anxiety, depression and stress. Heterogeneity was significant in the analysis. There was no evidence of significant publication bias.

The discussion will focus on future avenues for developing the evidence base for compassion in psychopathology, and consider implications for the development of intervention models.

CBT models that incorporate a compassionate mind focus may confer benefits to individuals in terms of more adaptive coping strategies for buffering stress and may foster the development of resilience.

Panel Discussion

Developing CBT in Low and Middle Income countries: Is CBT a model of treatment for mental health problems that can be applied across cultures and contexts? And what can doing this work teach us about providing CBT to BME communities in the UK?

Convenor and Chair: Andrew Beck, University of Manchester

Discussants: Rachel Calam, University of Manchester

Nusrat Hussain, University of Manchester

Deborah McNally, Salford Cognitive Therapy Training Centre

Bipasha Ahmed, St George’s Medical School

The majority of the world’s population live in Low and Middle Income (LMI) countries in environments that are rapidly urbanising. There is a widespread recognition that these newly urbanised populations have high rates of unmet mental
health problems and considerable shortfalls in mental health service provision both in terms of numbers of staff available per head of population and training in evidence based interventions. Where interventions for mental health problems are available they are likely to be psychopharmacological and there has been very limited development of CBT and Parenting programmes in the majority of LMI countries. The World Health Organisation has estimated that by 2020 mental health problems will be the second largest cause of disease burden in the world, with the majority of this falling on the newly urbanised populations of China, India and Latin America.

Key learning outcomes for this panel discussion will be to:

- Provide a critical consideration of the acceptability or applicability of disorder specific CBT to presenting problems typically found in different cultures
- Enhance awareness of key cultural differences in the uptake of CBT amongst people with mental health problems in different settings and to consider issues around developing a local evidence base for the efficacy of CBT.
- Enhance familiarity with key differences in the application of CBT in non UK/US/European cultures in ways that inform therapy with UK based immigrants from these cultures

Over the past few years there have been many initiatives aimed at training staff in LMI countries as Cognitive Behaviour Therapists and in cognitive and behaviourally informed parenting interventions. This work has included large scale RCTs of CBT in rural Pakistani populations (Rahman 2008), developing the Triple P parenting intervention (Sanders 2012) and establishing the first CBT course in India in response to a clear identification of the need to develop evidence based psychological therapies in the sub-continent (Mohandas 2009).

These initiatives are not without their problems. The uncritical import of European and US developed models of mental illness, family functioning, training and service specification risks developing services that fail to account for local beliefs, practices and expressions of distress (Fernando 2010).

This panel will comprise of researchers and clinicians directly involved in developing CBT in LMI countries and participants will be encouraged to take a critical and reflective position on challenges in developing therapies away from a UK / USA / European model. Participants will provide short presentations illustrating their experiences and thoughts on this topic followed by a round table discussion addressing the dilemmas, barriers and opportunities that developing CBT in LMI countries in order to share good practice and suggest future directions.

### Posters

**Efficacy of a Self- Help Approach in the Treatment of Obsessive Compulsive Disorder**

Sneh Kapoor, All India Institute of Medical Sciences, New Delhi; Sneh Manju Mehta, All India Institute of Medical Sciences, New Delhi

Obsessive Compulsive Disorder is one of the most prevalent, not to mention disabling, disorders reported. Though treatable, some patients may not respond adequately to pharmacotherapy, and many patients go years without receiving adequate treatment due to lack of information about other modalities of therapy. Within the Indian setup, particularly within the public sector, lack of resources, stigma, geographical barriers and long waiting periods can sometimes be primary factors in reduced treatment seeking, and thereby leave a large section of patients untreated. Hence, the need for self help therapy is more strongly felt. No research has been conducted in this area in the country, nor have any manuals been developed to suit the needs of the Indian population. A self help manual approach is therefore required to bridge this gap, and that is the primary rationale for the present study.

A self help manual to suit the Indian population was developed, primarily employing exposure and response prevention. The manual was developed in English and translated into Hindi following standard protocol. It was then sent out to experts in the area of Obsessive compulsive Disorder and CBT- ERP for review and feedback.

Sixty patients diagnosed with Obsessive Compulsive Disorder would be recruited for the study from the outpatient psychiatric clinic at All India Institute of Medical Sciences, New Delhi. Twenty participants each would be randomly assigned to the three treatment conditions – Self Help (SH), Therapist Directed Intervention (TDI) and Waitlist Controls (WL) for a period of 10 weeks. Baseline, mid- and post- intervention assessments would be done, on a range of tools including Y-BOCS, M.I.N.I, Hamilton Depression Rating Scale, Hamilton Anxiety Rating Scale, Global Assessment of Functioning among others.

The study is currently in progress.

We hope to find results in concordance with literature on the use of self help manuals. The study aims to study their use in terms of feasibility and reduction in symptoms of OCD. Results from a pilot study currently in progress will be discussed.

The use of self help manuals in therapy will greatly reduce burden on therapists’ time and resources, and reduce attrition due to geographical barriers, stigma etc. Patients are free to monitor and pace their therapy at their will. If successful, this approach can yield an important low intensity intervention for OCD, and can be incorporated in a stepped care approach to treatment.

**A new decentering and perspective broadening training intervention for recurrent depression**
Major Depressive Disorder is often characterised by negative thoughts, and the struggle in gaining perspective on those thoughts. We think that two things are likely to be happening when someone feels this way; a loss of sight of the bigger picture, and black and white thinking. Our research is looking at ways of challenging these two aspects of depressive thinking. Firstly, by helping people to step back from situations in order to see the bigger picture – decentering through mental imagery. Secondly, by helping people to use that wider perspective to see situations in terms of shades of grey so that everything isn’t simply all good or all bad – perspective broadening through reappraising.

Participants suffering from Major Depressive Disorder, in remission (Study 1) and in episode (Study 2), took part in a two week decentering and perspective broadening training programme. The programme involved training the new ways of thinking on memories and every day upsetting events. We will be presenting the results from the groups in remission and in episode. In particular we will be focusing on the changes in residual symptoms of depression and thinking styles. The decentering and perspective broadening training programme has the ability to help people to gain perspective on those every day upsetting events that can often accumulate and lead further into depression. It is a compact intervention that needs to be studied further and has the potential to be applied to other emotional disorders.

The decentering and perspective broadening training intervention uses mindfulness and CBT components but in a distilled and compact way. It could one day be used for those on waitlist, in remission, and in conjunction with standard CBT.

Behavioural Medicine

Keynote Addresses

Designing and Evaluating Interventions to Change Behaviour using ‘The Behaviour Change Wheel’
Susan Michie, University College London

How health professionals, patients and the general population behave is crucial to good health. Behaviour lies at the heart of delivering evidence-based practice (e.g. following guidelines), preventing ill-health (e.g. through avoiding harmful behaviours such as smoking and excess alcohol consumption) and managing illness and long-term conditions (e.g. self-management). There is a science of ‘behaviour change’ (shaping and changing behaviour patterns) to inform interventions to improve health. This science is also invaluable when describing interventions and their contexts with a view to evaluating them in ways that inform our understanding of underlying mechanisms – which in turn can help us develop better interventions.

This lecture will describe a framework, ‘The Behaviour Change Wheel’, for researchers and practitioners to use when designing and evaluating behaviour change interventions. The framework was developed from a systematic review of previous frameworks and the observation that none of them covered the full spectrum of mechanisms for behaviour change and a minority linked the choice of intervention strategy to a coherent and comprehensive analysis of behaviour. After specifying the target individual, group or population, the desired behaviour pattern and other behaviours that may facilitate this, compete with it or be beneficially or adversely affected by any change, the framework considers what would need to change in terms of capability, opportunity or motivation for the desired behaviour to be enacted (a COM-B analysis). This leads to selection from nine ‘intervention functions’ (education, persuasion, incentivisation, coercion, training, restriction, environmental restructuring, modelling and enablement) and seven types of policy to enact these (legislation, communication, guidelines development, regulation, fiscal policy, service provision, and environmental/social planning). This framework then leads to identifying specific ‘behaviour change techniques’. It will be argued that this systematic, theory-based approach is more likely to achieve desired behaviour change than the more ad hoc approach currently being adopted.

CBT for Medically Unexplained Symptoms and Long Term Conditions: Are they any different?
Rona Moss Morris, King’s College London

There is increasing acknowledgment across the health sector of the importance of providing better access to psychological treatment for people with long term conditions (LTCs) and functional syndromes (FS, often referred to as MUS). Whilst access is important, wherever possible we need to ensure that the treatments on offer are effective evidenced based interventions. In this talk I will present an overview of the developmental stages or winding road of my research which has focused on contributing to this evidence base. The stages include 1) systematic reviews and empirical studies to develop cognitive behavioural models which help understand the aetiology of FSS and the processes of adjustment to LTCs 2) using these models to develop and evaluate therapist delivered CBT based self-management interventions for people with LTCs and FS; 3) using process analysis to validate and revise the theory and/or intervention 4) exploring methods of expanding
the scope of these treatments by developing web-based or self-help versions of the treatment packages. Discussion will focus on how interventions for these groups may differ from interventions for people with primary mental health problems and the overlap in understanding adjustment and symptom experience in FSS and LTCs. The role of therapist competence will be addressed together with the need for future work which compares both the clinical and cost effectiveness of different modes of treatment delivery.

Symposia

The treatment of Chronic Fatigue Syndrome in adolescents

Chair: Trudie Chalder, King’s College London

Characteristics of parents of adolescents with Chronic Fatigue Syndrome compared to parents of asthma or healthy adolescents

Kate Lievesley, King’s College London, Katharine Rimes, King’s College London

Introduction: Very little is understood about the role parents play in understanding CFS in adolescents. Previous literature has found an association between higher levels of maternal distress and overprotection in CFS compared to healthy controls (e.g. Rangel et al., 2005). The aim of this study was to examine distress alongside other psychological variables in mothers of adolescents diagnosed with CFS.

Method: Eighty five mothers of adolescents with CFS, 78 mothers of healthy controls and 31 mothers of adolescents with asthma were asked to complete questionnaires assessing their own mood, personality and quality of life, and perceptions of their child’s health status.

Results: The mothers of adolescents with CFS reported significantly higher levels of past CFS, past and present depression and current anxiety than the other 2 groups. Mothers of adolescents with CFS reported a significantly worse quality of life, worse general health and significantly more self-sacrificing behaviours than the other two groups. In addition, mothers of adolescents with CFS rated their child significantly higher on all subscales of the Cognitive Behavioural Responses Questionnaire (p=.000); more fear avoidance, catastrophising, damage, all or nothing behaviour and avoidance/resting behaviour. The overall score on the Autism Spectrum Quotient was significantly lower in the CFS group, with 3 significant scales; social skills, attention switching, and communication all significantly lower in the adolescents with CFS as reported by the mothers, suggesting greater difficulties with these skills in the CFS group. Finally, the mood/atmosphere at home was significantly worse in the CFS group, as reported by the mothers on the SCORE40; a family functioning measure where mood/atmosphere is one of the key constructs measured. This ‘significantly worse mood’ in the family supports the finding that distress in the family is an important factor in this condition.

Discussion: This research has shown that there are key health differences between the 3 groups, with current and past health as well as quality of life being significantly worse in the mothers of CFS patients. Further, the mothers’ perception of the child’s health is associated with CFS in the child, as well as the measures suggesting a certain focus on the illness in the CFS group which isn’t necessarily beneficial to the child’s recovery. We have a better clinical picture of the mothers in the CFS group than we did before and indeed the family environment and their responses to illness. This has implications for the delivery of cognitive behavioural therapy, the only evidence based treatment for adolescents with CFS.

The role of cognitive behavioural responses in adolescents with Chronic Fatigue Syndrome

Trudie Chalder, Institute of Psychiatry

Introduction. The aetiology of CFS remains uncertain and controversial (Browne & Chalder, 2006), although it is likely that both the development and perpetuation of the disorder are due to an interaction of cognitive, behavioural, physiological, affective and social factors (Chalder, Tong & Deary, 2002). Very little is understood about the role parents’ play in CFS in adolescents.

Cognitive Behavioural Therapy (CBT) aims to help the individual recover by addressing unhelpful thinking patterns and behaviours that are contributing to the fatigue and/or associated disability. There is preliminary evidence for the effectiveness of CBT for adolescents with CFS (Stulemeijer et al., 2005). However, we remain unsure as to how or why CBT works, as it involves many different components. In order to develop our understanding, we used a measure investigating the cognitive and behavioural responses to symptoms of illness. We hypothesise that the CFS group (adolescents and mothers) will score higher on the Cognitive Behavioural Responses Questionnaire (CBRQ) than the asthma group.

Method. Eighty five adolescents with CFS, 31 adolescents with asthma and all mothers were asked to complete the CBRQ investigating cognitive and behavioural responses to symptoms. The measure includes 41 items, split into 5 cognitive subscales and 2 behavioural subscales; the cognitive – fear avoidance, catastrophising, damage, embarrassment avoidance and symptom focusing. The behavioural subscales are all or nothing behaviour and avoidance/resting behaviour.

Results. The adolescents with CFS and their mothers scored significantly higher across all subscales of the CBRQ (p=.000). These items specifically relate to CBT constructs and support the notion that CBT is the recommended treatment for adolescents with CFS. There is significantly more fear avoidance, catastrophising, embarrassment avoidance, symptom focusing, damage, all or nothing behaviour and avoidance/resting behaviour in this CFS population.
Discussion. There are key differences between the 2 groups, on their response to illness and the mothers’ perception of the child’s health behaviours is associated with CFS in the child. Cognitive behavioural models propose that the way that a sufferer responds to the initial symptoms may inadvertently maintain the symptoms (e.g. Surawy et al., 1995). In younger people, it is believed that the response of the parents to the symptoms may be relevant to the longer term outcome for the child. For example, if the parent and individual fear that undertaking exercise will worsen their fatigue then they may avoid activities which may itself perpetuate the fatigue. This has implications for the delivery of cognitive behavioural therapy in this patient group.

Family-focused cognitive behaviour therapy versus psycho-education for adolescents with chronic fatigue syndrome: Long-term follow-up of an RCT
Samantha Lloyd, Institute of Psychiatry,; Trudie Chalder, Institute of Psychiatry; Katharine Rimes, Institute of Psychiatry

Chronic fatigue syndrome (CFS) in adolescents is associated with serious impairment (Garralda & Rangel, 2004), impacts upon physical, emotional and intellectual development (Royal College of Physicians, 1990) and is associated with significant absenteeism from school (Patel, Smith, Chalder & Wessely, 2003). The aim of this study was to investigate the long term efficacy of family-focused cognitive behaviour therapy (CBT) compared with psycho-education in improving school attendance and other secondary outcomes in adolescents with CFS. A 24 month follow-up of a randomised controlled trial was carried out. Participants received either 13 one-hour sessions of family-focused CBT or four one-hour sessions of psycho-education. Forty-four participants took part in the follow-up study. The proportion of participants reporting at least 70% school attendance (the primary outcome) at 24 months was 90% in CBT group and 84% in psycho-education group; the difference between the groups was not statistically significant (OR = 1.29, p = 0.80). The proportion of adolescents who had recovered in the family-focused CBT group was 79% compared with 64% in the psycho-education, according to a definition including fatigue and school attendance. This difference was also not statistically significant (Fisher’s exact test, p = 0.34). Family-focused CBT was associated with significantly better emotional and behavioural adjustment at 24 month follow-up compared to psycho-education, as reported by both adolescents (F = 6.49, p = 0.02) and parents (F = 4.52, P = 0.04). Impairment significantly decreased in both groups between six and 24 month follow-ups, with no significant group difference in improvement over this period. Gains previously observed for other secondary outcomes at six month follow-up were maintained at 24 month follow-up with no further significant improvement or group differences in improvement. In conclusion, gains achieved by adolescents with CFS who had undertaken family-focused CBT and psycho-education generally continued or were maintained at two-year follow-up. The exception was that family-focused CBT was associated with maintained improvements in emotional and behavioural difficulties whereas psycho-education was associated with deterioration in these outcomes between six and 24-month follow-up.

The psychological wellbeing and quality of life of siblings of children with CFS/ME: a mixed methods study
Sophie Velleman, Paediatric CFS/ME Service, RHNRD, Bath, Esther Crawley, University of Bristol

Chronic Fatigue Syndrome or myalgic encephalopathy (CFS/ME) has a negative impact on a child and their parents, but it is not known what the impact is for the siblings of children with CFS/ME. 18 siblings completed questionnaires concerning depression, anxiety, and quality of life, which were compared to community norms. Nine siblings also participated in semi-structured interviews. Siblings mean score on the Spence Children’s Anxiety Scale (SCAS) were significantly greater than community norms, although similar percentage to norms reach the cut-offs. There were no differences in depression or quality of life scales. Two overarching themes emerged from the interview data: ‘Impact on Family’ and ‘Impact on Siblings’ with a number of sub-themes. The Impact on Family theme was divided into positive and negative factors. The negative factors included restrictions on family life, the ‘not-knowing’, and lack of communication. The positive factors on the family included positive communication, social support and extra activities. The factors which influenced the impact on the sibling included change of role/focus, emotional reactions and social impact. These findings have implications for current practice in CFS/ME paediatric services.

The cognitive behavioural treatment of chronic fatigue syndrome: Interventions and mechanisms of change
Chair: Trudie Chalder, King’s College London

Mindfulness based cognitive therapy for chronic fatigue syndrome: A pilot randomised study
Katharine Rimes, Institute of Psychiatry, King’s College London, ; Janet Wingrove, South London & Maudsley NHS Trust; Chantell Douglas, Canterbury Christ Church University

Cognitive behaviour therapy (CBT) is an effective treatment for chronic fatigue syndrome (CFS), but most individuals do not fully recover. This pilot study investigated the acceptability and impact of mindfulness-based cognitive therapy (MBCT) for people with CFS still experiencing excessive fatigue after CBT. Participants were randomly allocated to MBCT or waitlist (WL). Sixteen MBCT and nineteen waitlist participants completed the study. Questionnaires were completed before and after treatment and at two and six-month follow-up. Thirty participants (from both groups) answered open-ended
Mediation effects in the PACE trial of complex treatments for chronic fatigue syndrome

Trudie Chalder, King's College London, Kim Goldsmith, King's College London; Peter White, Queen Mary’s London; Michael Sharpe, Oxford University

Background: We have previously shown that both cognitive behaviour therapy (CBT) and graded exercise therapy (GET) are superior to adaptive pacing therapy (APT) and specialist medical care (SMC) in reducing fatigue and physical functioning in people with chronic fatigue syndrome (White et al 2011). The aim of this study was to investigate potential mechanisms of change underlying the efficacy of these treatments

Method: We examined a number of cognitive and behavioural mediators such as fearful cognitions, avoidance behaviour and walking. Mediation was assessed using Baron-Judd-Kenny, or BJK methods fitting a series of regression models.

Results: Cognitive and behavioural mediating variables generally showed similar patterns, with the majority of change in the mediators occurring during the treatment phase. There was no change in the mediators between the end of treatment at 24 weeks and follow up at 52 weeks. Beliefs had the largest mediated effect on both fatigue and physical functioning for both CBT and GET. However the effect of these mediators on outcomes in GET was stronger than for CBT.

Conclusion: Both CBT and GET were mediated primarily by beliefs. Both CBT and GET should target specific beliefs through behaviour change in order to change fatigue and disability.
Advances in the Treatment of Health Anxiety  
Chair: Helen Tyrer, Imperial College, London

Clinical outcomes of the CHAMP randomised trial of adapted CBT in medical patients with health anxiety  
Peter Tyrer, Imperial College, London, Helen Tyrer, Imperial College, London; Mike Crawford, Imperial College, London; Paul Salkovskis, University of Bath; David Murphy, Charing Cross Hospital, London

Health anxiety, usually known under its more common synonym, hypochondriasis, is very common in patients attending for medical consultations. Treatment using cognitive behaviour therapy principles has been shown in small studies to have benefit but the longer term benefits and costs are not known.  
28, 991 patients attending five medical clinics in seven general hospitals were screened with a questionnaire (Health Anxiety Inventory (HAI)). Those that scored 20 or more were offered further assessment and if they satisfied the DSM-IV diagnosis of hypochondriasis and other inclusion criteria were randomised to 5-10 sessions of an adapted form of cognitive behavior therapy for health anxiety (CBT-HA) delivered by a nurse, psychologist or other health professional, or to standard care in the medical clinic. 444 patients were randomised and assessments made at 3m, 6m, 12m and 2 years. The primary outcome at one year showed a greater mean improvement in HAI scores of 3.0 (95% CI: 4.34-1.64; P<0.001) in favour of patients treated with CBT-HA and similar improvement was shown after two years. Significant improvements were also shown for generalised anxiety at all time points and for depressive symptoms at 6 months.  
It is concluded that this is now a necessary new treatment to reduce a largely hidden and serious form of morbidity in medicine, and the persistence of its therapeutic effects is particularly noteworthy.

The training and performance of CHAMP therapists  
Simon Dupont, CNWL, Peter Tyrer, Imperial College; John Green, Imperial College; Barbara Barrett, King’s College London

Fidelity to the treatment protocol in clinical research studies is extremely important. In order to draw conclusions that can be applied to other clinical settings, one has to be certain that the research therapist adheres to the accepted procedure reliably. This can become harder to achieve if the research study is multi-centered, with a number of therapists with different professional backgrounds and with a variety of supervisors. One solution is to provide a treatment manual which the therapist applies rigidly with the patient, checked by the supervisor. However, this may interfere with the therapeutic alliance between patient and therapist, to the detriment of the treatment study as a whole. A pragmatic alternative is to train the therapist in the desired treatment area, assess performance via live or audio-taped observation and provide specific feedback. This allows the therapist and patient to vary the pace, depth and length of treatment as well as give room for an individual conceptualization to grow collaboratively.

This paper will examine the impact of applying such an alternative in the CHAMP study. The therapists from all seven centres received two full days training in CBT for health anxiety. At the beginning of the study supervisors sat in the therapy sessions in order to provide direct clinical feedback. All therapists received individual formal supervision every two weeks throughout the study. Fifty percent of the therapy sessions were audio-taped and a random sample of these were independently assessed by supervisors at one of the other centres for fidelity of treatment using a modification of the Cognitive Therapy Rating Scale - Health Anxiety Version (CTRS-HAV) to determine an acceptable level of competence. In addition, an independent researcher assessed a separate random sample of these tapes to determine overall competence. The centres were either based in teaching hospitals or district general hospitals. Therapists varied in their core profession, with some coming from a nursing background whilst others had studied psychology. Practical aspects regarding the training and performance of therapists from the different centres will be considered. Results from the fidelity assessments will be discussed, with specific reference to the core profession of the therapist.

Cost-effectiveness of health anxiety in medical patients  
Barbara Barrett, King’s College London, Hristina Petkova, King’s CollegeLondon; Helen Tyrer, Imperial College, London; Peter Tyrer, Imperial College, London

People with health anxiety place a substantial burden on health services, particularly in secondary care where between 10-20% of attenders have abnormal health anxiety. Previous trials have suggested the efficacy of CBT for health anxiety; in this study we assess its cost-effectiveness over a two-year period.

Patients attending medical clinics in five general hospitals were recruited to the study if they scored at least 20 on the Health Anxiety Inventory and met the DSM-IV criteria for hypochondriasis. Those randomised to CBT were invited to receive between 5 and 10 sessions of CBT with adaptations for health anxiety. During follow-up assessments at 6, 12 and 24 months post-randomisation, alongside clinical outcome measures, information on the services used by the study participants was recorded using the Adult Service Use Schedule (AD-SUS).

We will report the costs and cost-effectiveness of CBT for health anxiety and make recommendations on its role within NHS secondary care.
Psychosocial stress predicts abnormal glucose metabolism and body mass index gain over 5 years: evidence from the longitudinal Australian Diabetes Obesity and Lifestyle (AusDiab) Study

Emily Williams, Imperial College London

Using population-based longitudinal data from Australia, perceived stress and stressful life events were explored as predictors of obesity and diabetes. Perceived stress and stressful life events were measured at baseline, with health behaviour also collected by questionnaire and anthropometrics measured during clinic visits. Oral glucose tolerance tests (undertaken at baseline and five-year follow-up) provided objective classification of abnormal glucose metabolism categories (impaired fasting glucose, impaired glucose tolerance, and type 2 diabetes).

Diabetes: Perceived stress predicted incident abnormal glucose metabolism in women but not men, after adjustment for age, socioeconomic position, health behaviours, adiposity, and metabolic syndrome components. Interestingly, health behaviours appeared to only play a marginal mediating role in the relationship between stress and abnormal glucose metabolism.

Obesity: Among those who maintained/gained weight, individuals with high levels of perceived stress at baseline experienced a 0.20kg/m² greater mean change in BMI compared with those with low stress. Additionally, individuals who experienced 2 or ≥ 3 stressful life events had a 0.13kg/m² and 0.26kg/m² greater increase in BMI compared with people reporting no stressful events, respectively. These relationships differed by sex, age, smoking, physical activity and baseline BMI. Psychosocial stress, including both perceived stress and life events stress, was positively associated with weight gain but not weight loss. These associations varied by sex, age, baseline behaviours and obesity. Additionally, higher perceived stress appeared to be a greater predictor of weight gain than the occurrence of a stressful life event.

Are financial incentives for behaviour change in breast feeding acceptable?

Emily Turton, University of Sheffield

Background: Obesity rates in the UK are rising dramatically but breastfeeding rates are declining. Given growing evidence of a link between obesity and not being breast-fed, there is a need for interventions to address this. Recently, some NHS-based studies have explored the use of positive financial incentives to modify health-related behaviours.

Method: The NOSH scheme (NOurishing Start for Health) explores the potential role of a financial incentive programme to improve breastfeeding rates in key neighbourhoods in Sheffield. A literature review was undertaken and a wide range of stakeholders in breastfeeding (women, midwives, health visitors, breastfeeding support workers, doulas, commissioners/funders of infant feeding services) were consulted using face-to-face interviews, focus groups and a street survey.

Results: The literature review identified 10 relevant studies addressing the ethics of financial incentive programmes in the UK, US and Australia, aimed at: smoking cessation, smoking cessation in pregnancy, medication adherence and obesity. Interventions which were more ethically acceptable were also more effective. The street survey (n= 129) found that 80% approved of the NOSH scheme and would participate if they had a baby in the future. One-to-one interviews and focus groups revealed diverse opinions about the NOSH scheme and concerns about how such a scheme could be policed, but healthcare professionals tended to feel it was worth trying if effective.

Discussion: Despite expressing concerns, many interviewees took a consequentialist approach to assessing the acceptability and the ethics of offering financial incentives to modify a health-related behaviour change such as breastfeeding.

Use of Acceptance and Commitment Therapy (ACT) for weight management issues

Matt Wardley, North East London NHS Foundation Trust

There has been a recent growth in the use of Acceptance and Commitment Therapy (ACT) with an obese population. This is supported with an increasing number of empirical studies indicating the effectiveness of ACT as an evidence-based approach for this client group.

This paper explores an ACT-based group for weight loss within a diabetes service. The group’s aim was to develop acceptance and defusion strategies (such as mindful eating and urge surfing) to help change people’s relationship towards food-related thoughts and feelings alongside clarifying people’s values and developing ongoing committed action. The paper will describe the underlying ACT case conceptualisation for weight management as well as exploring the approaches and exercises used to address people’s difficulties, including an experiential exercise.

Understanding successful weight loss and maintenance and the development of a teachable moments intervention

Jane Ogden, University of Surrey

Using both qualitative and quantitative methods the factors associated with successful weight loss maintenance were explored as a means to develop more effective interventions. The results from these studies highlighted a key role for life events as a trigger for change and a series of sustaining conditions which facilitated the shift from an initial change into
sustained changes in behaviour. As a result of these studies two interventions have been developed designed to convert a life event into a teachable moment. This talk will present both the data on success stories and preliminary data from the interventions.

**Sex, Sexuality & HIV: how Shame shapes us**
**Alexander Margetts, CNWL NHS Foundation Trust**

The role of sex, stigma & shame in HIV health anxiety: the case for a new model.

Alexander Margetts, CNWL NHS Foundation Trust

This paper finds current cognitive-behavioural therapy (CBT) models lacking when formulating HIV health anxiety, due to the unique interface of sex, shame and stigma. A new model for this is presented for further discussion and exploration. Some HIV negative people have an irrational and extreme fear of contracting HIV (aka HIV health anxiety). Whilst few might wish to become HIV+, for some their fear of contracting HIV is so pervasive as to significantly impact on their mood, relationships, and daily functioning, leading to rumination and preoccupation about HIV, with extreme avoidance, checking and reassurance behaviours to regulate their emotions, such as abstaining from sexual contact, searching the internet for HIV related information, repeated HIV testing, and requesting unnecessary medication.

HIV is unique compared to other feared illnesses and diseases because of the history and cultural stigma that has been attached to being HIV+, the connotations with sex and sexuality, notions of responsibility/preventability, contamination and onward infection, and the fact that HIV can be symptomless. With HIV health anxiety it is often the fear of rejection and shame, ‘double disclosures’, and being ‘stupid/reckless’ for becoming HIV+ that clients report and ruminate upon, rather than the illness process itself. Indeed this has changed within a generation from being a ‘death sentence’ of unknown cause in the 1980s, to today being an understood and manageable chronic condition with normal life expectancy providing timely diagnoses and access to treatment is available.

Current mainstream CBT models for health anxiety however focus on physical body checking and death and illness related cognitions, rather than social stigma. Conversely whilst OCD models cover more adequately responsibility and contamination beliefs systems the panic and largely neglect specific health issues and behaviours, and have a limited focus on shame. A new model is proposed therefore, drawing on research literature and clinical experience. It incorporates and prioritises shame and stigma to help formulate the perceived threats and resulting safety behaviours with regards to fear of contracting HIV, with interesting research and clinical implications.

**HIV-related PTSD: The precipitant and maintaining role of shame**
**Anthony Theuninck, Private Practice**

Research has indicated that the experience of shame is strongly associated with the experience of HIV-related PTSD. It has been proposed that HIV-related PTSD may be a more specific shame-based type of traumatic stress disorder as opposed to the more commonly recognised classification of PTSD as an anxiety disorder. This paper will draw on findings from a UK study conducted by the author/presenter that offers data to support a formulation of the relative role of both fear and shame in HIV-related PTSD as an anxiety disorder. The implications for therapeutic tasks and goals will be considered by outlining the precipitating and maintaining role of shame in HIV-related PTSD as an anxiety disorder.

**HIV, Shame and Metacognitive Therapy**
**Bruce Fernie, CASCAID, South London and Maudsley NHS Trust**

In 2007 it was estimated that 33.2 million people were living with the Human Immunodeficiency Virus (HIV). HIV can be considered a chronic disease in developed regions of the world since the introduction of highly active antiretroviral therapy (HAART) in the 1990s. Despite this, people living with HIV often have to endure stigma and, as a consequence, may experience feelings of shame. Shame can be considered as a consequence of perceived threats to the social self. Cognitions thought to contribute to shame have been broadly delineated into internal (negative beliefs about the self) and external (negative beliefs about others’ judgements about the individual) domains. Research has suggested that shame has a significant effect on depression, and that this effect is mediated by rumination. Metacognitive Therapy (MCT) is a type of CBT that focuses on cognitive processes such as rumination that have been implicated in shame. Bruce Fernie will present some case examples of the application of MCT to HIV positive individuals with shame-related issues.

**Best Practice Guidelines for Working Therapeutically with Sexual & Gender Minorities: Applications in CBT**
**Stuart Gibson, BPS Faculty for HIV & Sexual Health**

Working effectively and appropriately with diversity is at the cornerstone of good clinical practice in cognitive behavioural therapy (CBT). In 2012, the British Psychological Society published the Best Practice Guidelines for Working Therapeutically with Sexual and Gender Minorities. Stuart Gibson will present an overview of these guidelines with a view towards discussing how they impact on the practice of CBT. Since today’s symposium is a series on shame associated with sexuality and sex, these guidelines will be useful in developing CBT formulations, making treatment decisions and evaluating their impact. Implications for teaching, supervision and continuous professional development in CBT will also be considered and discussed.
Working at the Interface Between Physical and Mental Health
Convenor: TBC

Are executive functioning and coping style after acquired brain injury (ABI) associated with depression and fatigue?
Fergus Gracey, Oliver Zangwill Centre; Catherine Longworth, Oliver Zangwill Centre; Andrew Bateman, Oliver Zangwill Centre; Jon Evans, Glasgow University; Donna Malley, Oliver Zangwill Centre; Sara Simblett, King’s College London; Tom Manly, MRC Cognition and Brain Sciences Unit
Executive functioning deficits of planning, problem-solving and remembering to put plans into action (‘goal neglect’) are common after acquired brain injury (ABI), and may be associated with poor emotional adjustment. Fatigue is also a major problem affecting psychosocial outcomes following ABI. CBT following ABI needs to be adapted to address acquired deficits such as these. However, relationships between these factors are not well understood. This study tested specific predictions about relationships between executive functioning, coping style, depression and fatigue after ABI as part of ongoing work towards development of an evidence-based cognitive model of emotional adjustment to ABI.

Adults with ABI identified as having executive functioning (EF) problems (N = 78) completed neuropsychological assessments of EF (Hotel Task; Sustained Attention to Response Task, SART) and questionnaires (Coping Inventory for Stressful Situations, CISS; Profile of Mood States, POMS), to evaluate goal neglect, coping style and mood respectively. Multiple regression indicated the Hotel Task total deviation time ($\beta = .183$, p = .008), emotion-focussed coping ($\beta = .53$, p < .001) and fatigue ($\beta = .44$, p < .001) are significant predictors of depression ($R^2 = .69$, $F(5,72) = 31.81$, p < .001). The Hotel Task ($\beta = .19$, p = .03), avoidance coping ($\beta = .19$, p = .03) and depression ($\beta = .71$, p < .001) are significant predictors of fatigue ($R^2 = .5$, $F(5,72) = 14.38$, p < .001). SART variables approached significance as predictors of depression (errors of commission $\beta = .13$, p = .09) or fatigue (anticipatory errors $\beta = .19$, p = .058).

Depression after ABI may be related to specific aspects of executive functioning (‘goal neglect’), coping style and fatigue, suggesting these are important mechanisms to consider in developing interventions. The cognitive-behavioural model of post-ABI depression should include potential interactions between acquired difficulties with ability to engage in goal-directed behaviour, coping style (specifically avoidant coping) and fatigue. Similarly, interventions may need to include ways to help clients identify, plan and implement goals, manage fatigue, and reduce avoidant coping. There may be implications for development of CBT for other neurological conditions where EF is affected.

Exploring the nature of self-esteem after Acquired Brain Injury
Fergus Gracey, Oliver Zangwill Centre; Catherine Longworth, Oliver Zangwill Centre; Joseph Deakins, Royal Holloway; David Rose, University of Surrey; Fergus Gracey, Oliver Zangwill Centre
Acquired Brain Injury (ABI) results in increased rates of low self-esteem, depression or anxiety. Clinical trials of CBT following ABI show encouraging but mixed results, typically focussing on symptoms (e.g. depression, anger) or skills (e.g. coping style). The psychological nature of emotional adjustment, and related to this, the cognitive-behavioural model of post-injury adjustment has received little attention. This study aimed to contribute to development of a cognitive-behavioural approach to post-injury adjustment by 1. identifying and describing the dimensions of self-esteem with this population using the Robson Self Concept Questionnaire (RSCQ) for the first time 2. exploring relationships between specific dimensions of self-esteem, anxiety and depression.

A sample of adults with ABI referred for assessment for outpatient rehabilitation (N = 80) completed the RSCQ and the Hospital Anxiety and Depression Scale. Factor analysis and multiple regression were conducted.

28% of the sample had low self-esteem and this was associated with severity of ABI (lower self-esteem in mild-to-moderate ABI than in severe ABI), and symptoms of depression and anxiety. Factor analysis found four dimensions of self-esteem after ABI labelled ‘self-worth’, ‘self-regard’, ‘self-efficacy’ and ‘confidence’ differing from the factor solution identified in non-ABI. Each dimension had unique significant correlations with anxiety and depression respectively, except for ‘confidence’. The results suggest the RSCQ is a reliable measure of self-esteem after ABI, identifies multiple dimensions which differ from those previously identified, that relate to anxiety and depression in specific ways.

The findings are broadly consistent with application of an established cognitive behavioural model of self-esteem to understanding and treating anxiety and/or depression in the context of emotional adjustment following ABI. Development of interventions with this patient group may benefit from attention to underlying issues with self-esteem and application of existing approaches integrated into rehabilitation aimed at building intrinsic self-worth in the face of lost or altered social roles, negative self-evaluations in the face of acquired disabilities and reduced self-efficacy in the face of increased difficulty fulfilling routine tasks and roles.

Psychological Therapies for Chronic Fatigue Syndrome: an Interpretative Phenomenological Analysis
Laura Turner, University of Sheffield; Steve Kellett, University of Sheffield
There has been considerable contention as to the use of CBT and other psychological therapies in the management and treatment of CFS/ME. The research literature has tended to focus on outcome, with little attention to how those with
CFS/ME experience psychological therapy and whether they find it satisfactory. This is clearly important given that therapy outcome has been linked with satisfaction and engagement with the therapy process. Eight individuals with CFS/ME agreed to participate with semi-structured interviews to explore the experience of therapy utilising an Interpretative Phenomenological Analysis approach. To assess the satisfaction and acceptability of CBT as a therapy to improve quality of life in those with a long term condition e.g. CFS/ME.

Long Term Conditions Learning & Development Programme: working at the interface of physical and mental health

Jennie Conroy, Cambridgeshire & Peterborough NHS Foundation Trust; Maxwell Saxty, Cambridgeshire & Peterborough NHS Foundation Trust; Gunn Ellie, Cambridgeshire & Peterborough NHS Foundation Trust; Vainre Maris, Cambridgeshire & Peterborough NHS Foundation Trust; Walsh Cathy, Cambridgeshire & Peterborough NHS Foundation Trust

The key approach to meet the economic challenge of the increasing numbers of patients with long term physical conditions is for practitioners to support patients in effective self management (Imison et al. 2011). Mental Health problems impact on an individual’s ability to effectively self manage and reportedly increase the economic burden between 45-75 %, the majority of which is in physical health care cost (Naylor et al. 2012). The government has placed IAPT services in the fore for addressing the mental health needs of this population and more recently Liaison Psychiatry services have been highlighted as having a core function of training to improve the detection and management of patients mental health in physical health care settings (NHS Confederation 2012).

Health Innovation and Education Cluster (HIEC) funding was awarded by Cambridge University Health Partners (CUHP) to the Department of Liaison Psychiatry in 2011 to develop and evaluate training in the interface between physical and mental health. The evaluation has been supported by Cambridgeshire CLAHRC. The training programme was designed to complement the care pathway for people living with long term physical health conditions and common mental health problems (NICE CG91; CG123) within a modular framework. It integrated supporting self management of long term physical conditions (LTCs) and the mental health needs of patients within a stepped care model across physical and mental health care settings.

Modules were developed for qualified and unqualified staff; specialist practitioners working with long term physical conditions and IAPT practitioners.

The training team consisted of BABCP accredited practitioners with experience in liaison and IAPT services and a senior psychological wellbeing practitioner.

Evaluation was of our pilot delivery in the acute hospital and community setting. Evaluation methods were principally self reporting through pre, post and follow up questionnaires and the collection of case examples of taught methods in practice.

Physical health care practitioners reported an increase in awareness of the relationship between the physical and mental health of their patients and greater confidence in working with patients; increased use of assessment and screening for mental health problems; use of a range of low intensity psychosocial interventions at Stepped care levels 1 and 2 and greater use of mental health resources and care pathways.

IAPT practitioners reported increased knowledge and confidence in working with patients with long term physical conditions and medically unexplained symptoms and the integration of this into therapy process and formulation. IAPT service data demonstrated an increase in the proportion of patients being seen with an identified LTC.

The outcomes of this pilot delivery indicate the training was well received and the training objectives met. Participants reported increased integration of the physical and mental health care needs of patients with long term physical conditions within the framework of supporting self management and the stepped care model across physical and mental health care settings.

Investing in training can improve the detection and management of patients’ mental health with long term physical conditions in both physical and mental health care settings.

Clinical Roundtable

Weaving CBT, CAT, ACT and Compassion Focused Therapy into the Tapestry of Chronic Pain

Chair: Meherzin Das, Dorset Community Pain Service & Bournemouth University

Meherzin Das, Dorset Community Pain Service & Bournemouth University
Helen MacDonald, University of Sheffield
Frances Cole, Pain Rehabilitation Specialist Leeds Community Trust
Nicole Tang, University of Warwick

Chronic Pain affects millions of people around the UK and traditional approaches featuring CBT have long been the backbone of individual/group based programmes.
While CBT helps people address pain related cognitions, other approaches complement therapists’ understanding of the catastrophic impact pain has on people’s lives. Defences are destroyed, core pain rises to the surface and people are forced to reckon with parts of themselves hitherto disavowed. Cognitive Analytic Therapy helps people acknowledge their unmet needs and unmanageable affect, enabling individuals to arrive at a deeper acceptance of themselves and their long term pain. Staying present ’in the moment’ with the psychological and physical aspects of pain – as per the Acceptance and Commitment Therapy model – and doing so mindfully and with compassionate focus helps people live in accordance with their values. They learn to understand their pain, gain greater self-efficacy, less pain distress and regain control of their lives as they learn to soar above their pain.

This discussion will enhance people’s understanding of the richness of inter-modality functioning and empower therapists’ safe use of these and other platforms while engaging in therapy with people with chronic pain.

**Posters**

**Cognitions, Culture and Chronic Pain: Do people from different countries think differently about pain?**

*Katy Bradbury, Central North West London NHS Foundation Trust; Gary Brown, Royal Holloway, University of London*

Cognitive models generally suggest that our beliefs and cognitions about the world, ourselves and others arise from our experiences in the world and from the culture we are part of. There are several models of chronic pain that describe the impact that cognitions, particularly cognitions around threat, can have on the experience of pain. It could therefore be hypothesized that people from different cultural backgrounds may have different beliefs and cognitions about pain, which may impact on their experience of pain. The current study therefore investigated pain cognitions in participants who experience chronic musculoskeletal pain from different countries of origin.

Seventy seven participants were recruited from a London musculoskeletal service and a health psychology department. They completed questionnaires regarding their catastrophic and self-efficacy pain cognitions. To evaluate catastrophic thoughts the Pain Catastrophising Scale (PCS; Sullivan, Bishop & Pivik, 1995) was used. The Pain Self Efficacy Questionnaire (PSEQ; Nicholas, 2007), was used to assess participant’s beliefs regarding abilities to complete a range of tasks despite being in pain (self-efficacy beliefs).

It was found that those participants from less developed countries of origin demonstrated significantly higher catastrophic beliefs about their pain than participants from more developed countries of origin. No differences in self efficacy beliefs were noted.

The results are consistent with the hypothesis that people from different countries may hold different beliefs about pain. Limitations to the current research and difficulties with conducting research exploring cultural differences are highlighted. Given the fact that it is possible that differences do exist in cognitions regarding pain, it would be prudent for health care professionals (HCPs) to attempt to assess cognitions thoroughly regardless of cultural background, and to assess level of understanding when discussing education about pain. If there are differences in how people from different cultures view pain, then it may be that certain interventions need to be adapted for different cultural groups, to target certain beliefs or cognitions more specifically.

**Making every contact count – does patient-centred care improve in diabetes consultations after training in psychological skills?**

*Leeanne Nicklas, NHS Lanarkshire; Alison McCusker, University of Glasgow; Heather MacDonald, NHS Lanarkshire*

Every contact is an opportunity to improve health (The Healthcare Quality Strategy for Scotland, 2010). This is particularly important in the management of long term conditions (LTCs) such as diabetes where lifestyle issues influence disease progression and person-centred care improves outcomes. This study measured patients’ views on their diabetes consultation and compared the ratings subsequent to training staff in psychological skills that support person-centred interactions using the Consultation and Relational Empathy (CARE) measure (Mercer and Murphy, 2008). The CARE measures the clinician’s ability to understand the patients’ perspective and feelings, to communicate that understanding, and to act upon it in a way that is seen as helpful by the patient.

Patients attending specialist diabetes services in Lanarkshire were asked to complete the 10 item CARE measure after their clinic appointment. Patient and staff identities remained anonymous, other than recording discipline of staff seen. Data were obtained from 300 dietitian, doctor, nurse and podiatry consultations across 3 hospitals. The audit was conducted for a one month period prior to psychological skills training and again five months later when all staff had completed training. The findings will be analysed using t-tests by timepoint and professional discipline.

Statistical analysis in SPSS has not yet been completed but descriptive analysis in excel indicate that ratings of consultation empathy were high overall with positive changes post psychological skills training and the most substantial changes in podiatry session ratings. The poster will display t-test results and bar charts of the mean scores pre and post training.

Findings indicate that:
1) patients felt there were existing high levels of empathy in their diabetes consultations 2) these levels increased following training in psychological skills (significance to be determined)
3) there is the greatest shift in professions who have historically had the least access to training in psychological skills.

The high overall quality of person-centred care in the diabetes clinics is a very positive outcome for patients, staff and management. It demonstrates that training in psychological skills has potentially the most impact when targeted at staff who have lower ratings of empathy in their consultations.

Staff working in LTCs and their patients, can benefit from training in psychological skills that familiarise them with the CBT model and its application in their clinical area.

**The Pain Management Plan: a cognitive behavioural self-management programme for chronic pain**

Frances Cole, Bradford Teaching Hospitals NHS Foundation Trust; Polly Ashworth, Gloucester Royal Infirmary; Patrick Hill, Birmingham Community NHS Service; Eve Jenner, Birmingham Community NHS Service; Bob Lewin, University of York, Robb Hunt, Gloucester Royal Infirmary

The Pain Management Plan (PP) was evaluated in a pilot study in Bradford, Birmingham and Herefordshire & Gloucestershire Pain Management services. Staff were trained in using the PP in process and structure of its use, six hour training period.

The PP consists of an interactive pictorial workbook and a relaxation and stress management CD. Readability analysis shows it to be accessible to people with a reading age of 9 upwards. After a face to face assessment, use of the workbook was supported, either remotely via telephone or face to face by a trained facilitator. Some people may have received other interventions for example, medication advice or a gentle stretch/exercise programme.

Pre and post outcome measures included the Pain Self Efficacy Questionnaire (PSEQ: Nicholas, 2006); where a higher score indicates increased self efficacy, and The Pain Disability Questionnaire (PDQ: Anagnostis et al, 2004); where a higher score indicates greater disability. Data was collected regarding the number and method of sessions.

88 people were assessed of whom 66 (75%) completed the intervention. Reasons for attrition included participant’s needs being too complex, other illnesses and life events.

The mean age was 47.5 (sd 13.5, range 20-78) with pain duration of 10.8 years (sd 10.0, range 1-36). 8% were of Asian origin. For 48% this was their first contact with pain service; 19% had attended a Pain Management Programme.

Comparison of before and after PP outcome measures showed a significant improvement in self efficacy and disability (p<0.001). Participant feedback was extremely positive.

Patients can find that attending intensive multidisciplinary pain management programme to much for their needs or inaccessible for numerous life reasons. Exploring other options such as this specifically designed workbook meant could be used in different ways such as face to face or via telephone was found to be practical for both patients and staff. It seem to engage more patients and required less time predicted to complete and improve self management confidence. Drop out seem linked as found in previous self management approaches to be similar and linked to pain severity and complex life issues. Patient feedback collected indicated its value and role and some short falls.

This CBT based workbook programme offers flexible options face to face, telephone and group based options in this long term condition. It is ideal for lower intensity IAPT staff with one to two days training and easily implemented into front line clinical practice in diverse populations as this study showed across multiple sites.

---

**Child and Adolescent**

**Keynote Addresses**

**Anxiety Disorders in Children: Risk Factors for Development and Poor Treatment Outcome**

*Jennie Hudson, Macquarie University, Australia*

Anxiety disorders are increasingly recognized for their substantial costs to society as well as significant personal suffering. Such impacts have been found throughout the lifespan, with research increasingly focusing on child populations. Effective prevention and intervention strategies need to be informed by evidence regarding risk. Although knowledge of risk factors for anxiety disorders has not been as extensive as it has for some other problems, there is growing evidence for the importance of several factors (such as parenting, temperament) in the development of anxiety disorders. I will present recent data from our own centre examining early predictors of anxiety disorders from the preschool years through to middle childhood. I will also review recent research examining genetic, clinical and demographic predictors of outcome for children receiving cognitive behavioural treatment for anxiety disorders. The potential implications of this research for the treatment of children with anxiety disorders will be discussed.
Separation Anxiety Disorder in Childhood as a pathway to mental disorders? - Under Estimated and Under Researched
Silvia Schneider, Ruhr-Universität Bochum, Germany
Each young child goes through a phase of anxiousness towards strangers and separation anxiety during its childhood development. For some children, however, this development can be the starting point of one of the earliest mental disorders, Separation Anxiety Disorder. The presentation will discuss the characteristics of Separation Anxiety Disorder in childhood and explore further the following questions: What course does this disorder take? What do we know about its etiology and causes? Which treatment options are available to us? Should this disorder be treated at all?

Symposia

Parenting, callous-unemotional (CU) traits and antisocial behaviour in children and adolescents: Developmental pathways and treatment response
Chair: Jennifer Allen, Institute of Education, University of London

Childhood Callous-Unemotional Traits Moderate the Relation Between Parenting Distress and Conduct Problems Over Time
Luna Centifanti, Durham University, Kostas Fanti, University of Cyprus
Parenting distress and involvement have been associated with child problem behavior as well as with callous-unemotional (CU) traits. However, research on whether parenting distress and involvement changes over time with high levels of child conduct problems (CP) is lacking, particularly with regard to CU traits. Objective: The present short-term longitudinal study (N= 656; 53.4% girls) examines the bidirectional effects among paternal-reported and maternal-reported involvement, distress and CP in children ages 7-12 years with CU traits as a potential moderator. Method: We used clinical cut-off criteria to identify groups with low (57.7%), moderate (30.5%), or clinically significant (11.9%) CU symptoms. A cross-lagged model using structural equation modeling was used to estimate the bidirectional effects between CP and parenting variables, and these effects were compared across the CU groups. Results: Children meeting clinical criteria for CU traits were at higher risk to exhibit CP, and were more likely to experience low parental involvement and high parental distress. Findings from the bidirectional model suggested that high levels of CP predicted increases in parenting distress, and this was shown for youths with high levels of CU traits. Parental-reported distress predicted increases in CP for children scoring low on CU traits. Maternal involvement was negatively related to CP for children scoring low on CU traits but positively related to CP for children scoring high on CU traits. Discussion: The present short-term longitudinal study extends cross-sectional research (Fite et al., 2008) showing parents become distressed by CP behaviors, particularly when accompanied by high CU traits. Controlling for prior parenting-related distress, CP predicted increases in parenting distress among those with children high on CU traits (compared to the low and moderate groups). We conversely examined the effects of parenting distress on CP. In this case, parenting-related distress predicted increases in CP for children low on CU traits, as compared to those moderate or high on CU traits. Together, these findings suggest there are child-driven effects that depend on the degree of concern children show while displaying CP. Further, the findings dovetail with research suggesting reduced parent-driven effects for those high on CU traits (Edens et al., 2008; Wootton et al., 1997). The socialization context between mother and child was expected to be stronger than for the father-child relationship (Kochanska, Aksan, Prisco, & Adams, 2008), but only maternal involvement was found to have unique effects on changes in CP over time. In particular, high maternal involvement predicted stronger decreases in CP over time, and this significant finding was specific to the group low on CU traits. Surprisingly, a trend was found for high maternal involvement to predict higher levels of CP in children high on CU traits. Prior research shows children with CU traits may be sensitive to parental involvement and may perceive involvement as overcontrolling behavior (Tilton-Weaver et al., 2010). Conclusion: The present short-term longitudinal study extends cross-sectional research showing parents become distressed by CP behaviors, particularly when accompanied by high CU traits.

Bidirectional associations between parental warmth, deceitful-callous behavior, and conduct problems in high-risk preschoolers
Rebecca Waller, University of Oxford, Frances Gardner, University of Oxford; Essi Viding, University College London; Daniel Shaw, University of Pittsburgh; Melvin Wilson, University of Virginia
Research suggests that parental warmth and positive parent-child interactions predict development of conscience, empathy, and internalization of social norms in children. Recent studies also suggest that among older children and adolescents, affective dimensions of parenting, including parental warmth, are associated with lower conduct problems in youth with high levels of CU traits. Emerging evidence also suggests that CU behaviors may confer unique risk for conduct problems by shaping parenting behavior. The current study examines reciprocal associations between parental warmth, CU behavior, and conduct problems among toddlers. Methods: Data from mother-child dyads (N=731; 49% female) were collected from a multi-ethnic, high-risk sample at ages 2 and 3. CU behavior was assessed using a previously validated measure of deceitful-callous behavior (Hyde et al., 2013). Models were tested using two measures of parental warmth, the
first derived from direct observations of warmth in the home, the second coded from five-minute parental speech samples. Results: Two- and three-way cross-lagged, simultaneous effects models showed that parental warmth uniquely predicts child CU behaviors, above and beyond associations with conduct problems. Child CU behaviors predicted parental warmth for the directly observed measure only. Conclusions: There were cross-lagged associations between parental warmth and child CU behavior, suggesting these behaviors show some malleability during the toddler years and that parenting appears to reflect some adaptation to child behavior. The results have implications for models of early conduct problems and preventative interventions for young children.

Preventive effects of improved parenting across childhood on adolescent callous-unemotional traits and subsequent antisocial outcomes

Dave Pasalich, Institute for the Reduction of Youth Violence, Simon Fraser University, Robert McMahon, on of Youth Violence, Simon Fraser University; Katie Witkiewitz, Department of Psychology, University of New Mexico; Conduct Problems Prevention Research Group

Callous-unemotional (CU) traits (e.g., lack of empathy and guilt) are important in the conceptualisation of developmental models of antisocial behaviour because they identify unique characteristics of youth most at risk of following a trajectory of severe and chronic conduct problem and delinquent behaviour (Frick, 2012). CU traits assessed in early adolescence are a robust predictor of later antisocial outcomes (e.g., delinquency, antisocial personality disorder), even after controlling for initial conduct problem severity (McMahon et al., 2010). Considering that CU traits become increasingly immutable throughout adolescence, it is important for the design of future preventive interventions to understand factors in childhood that are implicated in the development of these traits. Toward this end, a growing body of research has demonstrated significant relationships between dimensions of parenting—including harsh discipline and warmth—and CU traits, both concurrently and longitudinally (e.g., Frick et al., 2003; Pasalich et al., 2011). Moreover, results from treatment studies suggest that levels of CU traits can be effectively targeted by parent management training and that improvement in parenting accounts for some of the observed changes in post-treatment levels of CU traits (McDonald et al., 2011). Thus, taken together these findings support a conceptual model wherein the quality of parenting received in childhood affects the development of CU traits in early adolescence, which in turn underpins the emergence of antisocial and delinquent behavior in later adolescence and early adulthood. In this paper we aim to test this model in the form of an experimental manipulation involving the cascading effects of the Fast Track prevention program on parenting, CU traits, and antisocial outcomes, assessed at pivotal stages in child and youth development. Fast Track was a large US-wide prevention program aimed at child conduct problems, and followed a high-risk sample of children from urban and rural communities from kindergarten through age 25. The multicomponent intervention (e.g., parent management training, school-based social-emotional skills curriculum) began in Grade 1 and finished in Grade 10. Our study includes participants from both the Fast Track randomised intervention (n = 445) and high-risk control (n = 446) groups. Measures of parents’ discipline and warmth, CU traits, and antisocial outcomes (e.g., conduct disorder symptoms, juvenile arrests) come from direct observations of family interaction; teacher, parent, and youth reports; and official court records. We discuss our results in relation to developmental theories of CU traits and conduct problems, and the design of tailored family-based interventions for children at high-risk of developing CU traits.

Personalising treatment for antisocial children with callous-unemotional (CU) traits: Preliminary findings from a randomized controlled trial

Jennifer Allen, Institute of Education, University of London, Mark Dadds, University of New South Wales, Sydney, Australia; Stephen Scott, Institute of Psychiatry, King’s College London, UK; Matt Woolgar, Institute of Psychiatry, King’s College London, UK

Callous-unemotional (CU) traits in children are characterised by low empathy, guilt and emotionality. CU traits are highly heritable and predict a particularly severe and persistent pattern of antisocial behaviour. Children with CU traits show deficits in attending and responding to emotional or distress cues, particularly the emotion of fear. Fear recognition deficits are associated with reduced gaze to the eye region during computer-based facial emotion recognition tasks and ‘real-life’ interactions with parents. This paper will describe the development and evaluation of an innovative new adjunct to parent training (PT) aimed at promoting children’s eye contact during emotional interactions with their parents. Method: Fifty children aged 3-8 years diagnosed with Oppositional Defiant Disorder (ODD) and their parents were randomized to receive either PT+ emotional engagement (EE) or to PT + a control adjunct. All families participated in a manualized 8-session individual family PT intervention. Families completed a structured diagnostic interview, questionnaires and observational measures of parent-child interaction prior to and following treatment. Parent-child interactions were coded by independent raters blind to CU status and treatment stage. Results: Families showed significant improvements, with significant reductions in ODD diagnostic status and clinical severity ratings, reductions in conduct problems and improved empathy at post-treatment. Conclusions: Preliminary findings suggest that an innovative new adjunct targeting child eye contact during warm, fun interactions with parents has the potential to improve treatment outcomes for antisocial children with CU traits.

Understanding barriers in CBT for obsessive-compulsive disorder in youth: implications for clinical practice
Convenor and Chair: Georgina Krebs, National Specialist OCD Clinic for Young People, South London and Maudsley NHS Foundation Trust

‘Mum, I’m a paedophile’: Sexual obsessions in paediatric obsessive-compulsive disorder
Faye Barrow, South London and Maudsley NHS Foundation Trust, Lorena Fernández de la Cruz, King’s College London, Institute of Psychiatry; Koen Bolhuis, King’s College London, Institute of Psychiatry; Chloë Volz, South London and Maudsley NHS Foundation Trust; David Mataix-Cols, King’s College London, Institute of Psychiatry

Background: Sexual obsessions are common in adults with obsessive-compulsive disorder (OCD), cause great distress, and are sometimes misinterpreted as indicating risk to others. Little is known about the prevalence, clinical correlates, and prognosis of such symptoms in young people. However, some studies conducted among adult samples have suggested that patients with sexual obsessions respond less well to cognitive behaviour therapy (CBT).

Methods: Three-hundred and eighty-three patients referred to a specialist paediatric OCD clinic were administered a series of measures at initial assessment and, for those treated at the clinic, again after completing a course of CBT, delivered with or without concomitant medication. Patients with and without sexual obsessions were compared on socio-demographic and clinical characteristics. Mixed model analyses of variance compared treatment outcomes in both groups.

Results: A quarter of patients had sexual obsessions at baseline (age range 8-17); they had slightly more severe OCD symptoms and were more depressed than those without sexual obsessions. Crucially, no differences in treatment outcome were found between the groups.

Conclusions: Sexual obsessions are common in paediatric OCD, even among young children. They do not show poorer treatment response compared to other presentations of OCD. The occurrence of sexual obsessions in children should be recognized and these symptoms understood as ordinary, non-threatening OCD symptoms, which pose no risk to others. Case examples will be discussed in relation to this. Sexual obsessions respond to the standard, evidence-based treatment strategies, so children and families should receive the usual message of optimism regarding the chances of recovery.

Outcomes of cognitive-behavioral therapy for obsessive-compulsive disorder in young people with and without an autism spectrum disorder
Kim Murray, Institute of Psychiatry, King’s College London, Georgina Krebs, South London and Maudsley NHS Foundation Trust; Faye Barrow, South London and Maudsley NHS Foundation Trust; Amita Jassi, South London and Maudsley NHS Foundation Trust

The most common forms of co-morbid disorders present in young people and adolescents with autism spectrum disorders (ASDs) are the cluster of anxiety disorders, with obsessive-compulsive disorder (OCD) being 3 to 8 times more prevalent in this population. Cognitive-behavioural therapy (CBT) is a well established therapeutic intervention for pediatric OCD, but the evidence base for its efficacy in youth with an ASD is still in its infancy. Clinical features associated with ASDs have often been considered as potential obstacles to this population engaging with and responding to CBT for OCD. Consecutive referrals (N = 387) to the National Specialist OCD clinic were reviewed and those who met diagnostic criteria for both an ASD and OCD (ASD+OCD) were identified. Young people within this ASD+OCD group who received CBT treatment (N = 22) were then individually matched to a group of young people who received an OCD diagnosis, but did not have an ASD (N = 22) and finally compared to a subgroup who held a dual diagnosis of both Tourette’s Syndrome (TS) and OCD (N = 25).

The results of the study will be presented and implications of the findings will be discussed in relation to clinical considerations, treatment modifications and future research when assessing and treating pediatric OCD in the context of ASDs.

The impact of depression and maternal distress on cognitive-behavioural therapy response in pediatric obsessive-compulsive disorder
Hannah Brown, King’s College London, Amita Jassi, South London & Maudsley, NHS; Georgina Krebs, South London & Maudsley, NHS

Both depression and parental psychopathology have been suggested to be associated with treatment-resistance in OCD but there has been little systematic investigation of these factors, especially in young people. Depression is one of the most common comorbidities in paediatric OCD. Emerging evidence suggests that children with comorbid depression show lower remission rates following a course of cognitive behaviour therapy (CBT) than those without depression (Storch et al., 2008). Furthermore, there is some evidence that depression is associated with poorer treatment response and remission rates in adults (e.g. Abramowitz & Foa, 2000; Overbeek et al., 2002). However, overall the findings are mixed and other studies have found no effect of depression on treatment outcomes (e.g. Storch et al., 2010). Similarly, there has been limited investigation into the impact of maternal psychopathology on treatment outcome in childhood OCD. This is surprising given that anxiety disorders are common in parents of youth with OCD (Cooper et al., 2006) and maternal anxiety has been shown to impede treatment outcome among young people with non-OCD anxiety disorders (e.g. Creswell et al., 2008). Overall, the existing literature relies on relatively small sample sizes and/or diagnostic as opposed to dimensional measures of psychopathology, and focuses largely on non-OCD anxiety disorders in youth or adult samples.
The current study examines CBT outcomes in a large cohort of young people with OCD (N= 102; 50% female; mean age = 15 years 1 month; range = 10-18 years) and their associations with dimensional measures of child depressive symptoms and maternal depression, anxiety and stress. We will explore whether comorbid depressive symptoms and maternal distress predict poorer treatment outcomes with respect to OCD symptoms. We will also explore whether children’s depression and mother’s distress reduces over the course of treatment in-line with reductions in OCD symptoms. Clinical implications of the study will be discussed, including suggestions for treatment.

**Vulnerability to Mood Disorders and Preventive Measures in Adolescents**

**Convenor and Chair: Stella Chan, University of Edinburgh**

**Social anxiety and interpretation bias in adolescence - findings from a novel interpretation bias measure**

Simona Paula Haller, University of Oxford; Kathrin Cohen Kadosh, University of Oxford; Jennifer Lau, University of Oxford

Social anxiety often has its onset between late childhood and adolescence. Cognitive models of social anxiety disorder postulate that biases in early and late processing stages (e.g. threat, interpretation) are at the heart of the development and maintenance of the disorder (e.g. Clark & Wells, 1995; Rapee & Heimberg, 1997). In this talk, we present pilot data from a series of studies that aims to validate a novel pictorial measure of interpretation bias in adolescents. We discuss how the tendency to interpret social scenes negatively is linked to social anxiety symptoms as well as putting forward a new hypothesis that may help explain why adolescence is a particularly volatile period for the onset of social anxiety. Specifically, we suggest that the growing sophistication in social-cognitive and affective abilities, which corresponds with late childhood and adolescence, makes social interactions increasingly complex and also increasingly ambiguous. This additional ambiguity may provide a vehicle for the expression of interpretive biases. Implications for devising new interventions that target interpretation biases are also discussed briefly.

**Cognitive bias modification in healthy and vulnerable adolescents**

Stella Chan, University of Edinburgh, Shirley Reynolds, University of Reading

Cognitive Bias Modification (CBM) is a computerised training programme that involves participants reading ambiguous social scenarios and resolving them in a positive or non-negative way. This has been shown to be effective in reducing interpretation biases and improving mood in adults, including those who suffer from anxiety or depressive disorders. However, most CBM research was conducted in adult populations. At the time of writing there have only been five studies on adolescents. Although these studies have established evidence for the use of CBM in this age group, they have not demonstrated a consistent effect on mood, in part due to the lack of use of standardised questionnaires. Notably, none of them has measured the effects on stress reactivity or vulnerability to mood difficulties.

**Aims**

This study therefore aimed to investigate the effects of CBM on the interpretation bias, mood, and stress reactivity in adolescents including some who have an elevated risk for developing depression.

**Methods**

Adolescents with varying levels of neuroticism, a personality risk factor for depression, were recruited. They were randomised into receiving either two sessions of CBM or control intervention. Their interpretation bias and mood were measured before and after the intervention. Stress vulnerability was assessed using a novel experimental stressor; participants were also asked to report their daily mood and stressful events over one week. Feedback was collected.

**Results**

The CBM group showed a greater reduction in negative affect than the control. In addition, the CBM group did not show the increase in state anxiety as seen in control participants. However, CBM did not show superior benefits in other outcome measures. Both groups displayed an increase in positive interpretations, a decrease in negative interpretations, and a reduction in depressive symptoms. The two groups did not differ in their responses to stress. Participants with higher scores on neuroticism showed higher levels of negative interpretation bias, mood symptoms and stress vulnerability. However, there was no evidence to suggest that neuroticism acts as a moderator of training effects. Feedback from participants was mostly positive.

**Conclusion**

Overall, this study has not yielded strong supportive evidence for the use of CBM in healthy or vulnerable adolescents. Instead, it has highlighted that the effectiveness of CBM in the younger population is far from robust and hence the need for further research in this age group. This study also represents an important step in exploring CBM as a preventive intervention for vulnerable adolescents.

**The Potential Role for Developing Compassion in Adolescents: Suitability as a Preventative Measure for Mood Disorders**

Fiona Ashworth, Anglia Ruskin University, Stella Chan, University of Edinburgh; Matthias Schwannauer, University of Edinburgh; Amna Khalid, University of Edinburgh

It is estimated that 20-50% of adolescents report sub-syndromal symptoms of depression and there is also a major increase in the rate of depression from mid to late teens. Given this significant increase and the developmental stage of
adolescence, it seems a particularly appropriate time to build on or enhance coping skills associated with protective factors in mental wellbeing. One such construct is that of self-compassion (Gilbert and Procter, 2006; Neff and McGhee, 2010). This presentation will discuss the potential for developing interventions based on Compassion Focused Therapy (CFT) as a preventive tool for adolescents at risk for developing depression. Within the CFT approach it is proposed that affective disorders have in common certain emotional experiences and responses including shame and self-criticism; CFT is a therapeutic approach that aims to reduce shame and self-criticism through increasing self-compassion. Training in self-compassion has been found to be beneficial for adults with a variety of mental health problems where heightened self-criticism and shame have been identified (Gilbert & Irons, 2005; Lucre & Corten, 2012). Previous studies have almost exclusively been conducted in the adult population although Neff and McGhee (2010) found that self-compassion predicted wellbeing in an adolescent population. The current study will therefore focus on looking at the link between self-compassion and mental health wellbeing in the younger population. In building on previous research in this area, this study will examine the role of self-criticism and shame as well as relevant factors such as attachment, mental health symptomatology and the relationship with self-compassion in an adolescent population. The study will also investigate the association between parent and child self-compassion. More recently, research has highlighted that fear of compassion may make individuals more resistant to self-compassion (Gilbert, 2010) which has implications for therapeutic intervention. In trying to understand the potential feasibility of this approach with adolescents, we also explore fear of compassion in this adolescent group. The findings of the analysis will be presented and discussed with regards to the potential role that CFT may have as a preventative tool for adolescents at risk for developing depression.

The Role of Parenting in the Development of Rumination
Jessica Douglas, University of East Anglia, Shirley Reynolds, University of Reading

Rumination is associated with depression and recent research suggests that rumination may also be related to other mental health problems. Little research has explored how this tendency develops, although the role of parenting has been hypothesised to play a causal role. This study investigated the relationship between rumination in adolescent females and their mothers. Additionally, the mothers of adolescents in upper and lower quartile rumination groups were selected to provide a Five Minute Speech Sample (FMSS), which was coded for the frequency of positive and critical comments. The findings showed that the mothers of high rumination daughters made half as many positive comments about their daughters as the mothers of low rumination daughters on the FMSS. This finding was statistically significant and remained significant after controlling for mother and daughter affect variables. The rate of critical comments on the FMSS was too low for meaningful analysis, although there was a trend for the mothers of high rumination daughters to be more critical. Finally, the results revealed that rumination was not correlated in mothers and daughters, contrary to predictions that this tendency may be modelled by mothers to their children. Overall these finding suggest that low maternal positivity is linked to rumination in adolescents and may implicate positive parenting programmes in ameliorating adolescent depression.

Maternal anxiety, verbal information transmission and child play representations in the context of starting school
Laura Pass, University of East Anglia, Kiki Mastroyannopoulou, University of East Anglia; Helen Dodd, University of East Anglia

Anxiety is one of the most common psychological problems in childhood, can predict long-term impairment in functioning, and is associated with other mental health difficulties. Anxiety aggregates in families, and while the causes are still unclear, environmental risk factors including parental information transfer are likely to be important. Maternal influences may be particularly significant, as a stronger link has been found between mothers and child internalising problems than for fathers. These factors may start to operate very early in childhood, so it is crucial to investigate such processes at a young age to understand vulnerability factors and consider preventative work. However, reliably accessing a young child’s cognitions and emotions can be difficult. Using a developmentally appropriate measure, such as a play task, can overcome some of these difficulties, but designing a tool that could be used in routine clinical work with families remains a challenge. This talk will present data from a community sample of mothers and their pre-school children, assessed in the context of an upcoming, universal (and potentially anxiety-provoking) real-life transition; starting school. Mothers were asked to speak to their child about starting school (coded for verbal information transmission), and children completed ambiguous school social scenarios presented using toy props (coded for interpretation biases and responses). Mothers reported on their own anxiety and depressive symptoms, as well as on fears of negative evaluation from others regarding themselves, and their child. Preliminary findings from the ongoing research will be presented, and areas for future work discussed. It is hoped that this research will add to the literature on vulnerability factors for emotional difficulties in children and adolescents, and provide evidence on the clinical utility of streamlined play assessment measures for young children.

'No health without mental health': The psychological needs of children in a specialist children's hospital
Convenor and Chair: Daniela Hearst, Great Ormond Street Hospital for Children

Brief Interventions for Children and Families in a medical setting
Kristina Soon, Great Ormond Street Hospital for Children
Working in an acute medical setting means that access to patients can be time limited and the need for psychological change immediate. This presentation will describe how we have adapted the way in which we provide psychological interventions based on a CBT model to the Dermatology Service at Great Ormond Street Hospital in order to meet these challenges.

Cognitive behavioural interventions in children and young people with heart conditions.
Kate Hawkins, Great Ormond Street Hospital for Children; Kate Hawkins, Great Ormond Street Hospital for Children
There is a significantly higher incidence of psychosocial dysfunction in children with Congenital Heart Disease compared to healthy children. Children with CHD have been found to be more withdrawn, have more social problems and engage in fewer activities. The literature suggests that up to 42% of adolescents with severe or cyanotic CHD meet DSM criteria for psychiatric problems, typically anxiety disorder and dysthymic disorder, with one third rated as having serious dysfunction. Children with less severe or acyanotic conditions are still more vulnerable than their healthy peers, with 27% of adolescents meeting DSM criteria and 4% having major psychiatric disorder. A more conservative estimate of the impact of CHD on psychosocial functioning still found that 19% of adolescents with CHD had significant psychological symptoms, most with internalising disorders such as anxiety and depression. Children with inherited cardiac conditions typically first present to cardiac services following the sudden death of a family member. ICCs are associated with significant morbidity and mortality and are a leading cause of sudden cardiac death in young individuals, including children and adolescents. The literature on inherited cardiac conditions suggests that children with ICCs and their families are far more likely to present with health anxiety than their peers with CHD.

Mental health problems: detection and intervention in children with neurological disorder
Isobel Heyman, Great Ormond Street Hospital for Children
Children with neurological disorder are known to have up to 7 times the rates of mental health problems of children in the general population. Most studies have shown that the problems they present with are the common child mental health problems, such as anxiety, depression, attention deficit-hyperactivity disorder and oppositional/defiant disorder. Little is known about responsiveness to evidence-based treatments in children with brain illnesses, but clinical experience suggest that these children may be doubly disadvantaged in that 1) their mental health needs may cause as much or more impairment than their neurological illness 2) they fail to access child mental services as their physical illness diverts attention. 3) there seems to be poor identification and targeting of treatable mental health problems with short, focussed evidence-based interventions. We will present some example of brief cognitive-behavioural interventions in children with neurological illness, and ideas for more systematic study and evaluation of outcomes in this group.

Personality, Learning and Predictors in Child and Adolescent Mental Health
Convenor and Chair: Cathy Cresswell, University of Reading

The effects of vicarious learning on the fear emotion in children
Gemma Reynolds, Kingston University; Gemma Reynolds, Kingston University; Andy Field, University of Sussex; Chris Askew, Kingston University
Research with children has shown that vicarious learning can result in changes to two of Lang’s three anxiety response systems: subjective report and behavioural avoidance, but is yet to explore the effect of vicarious learning on Lang’s third system, physiological responses. It has been well-established that anxiety or self-reported fear, in children and adults, are commonly associated with physiological changes, such as increased heart rate in feared real or imaginary situations (e.g., Lang, 1971; Sartory et al., 1977; Weems et al., 2005). Therefore, the current study aimed to extend previous research by exploring the effects of vicarious learning on physiological responses. Additionally, a wealth of research has indicated faster detection of threatening stimuli, and a bias towards processing ambiguous situations or information as threatening, in clinically anxious children (e.g., Hadwin et al., 1997; Mogg, Millar, & Bradley, 2000; Schippell, Vasey, Cravens-Brown, & Bretveld, 2003; Taghavi, Moradi, Neshat-Doost, Yule, & Dalgleish, 2000). Research has increasingly demonstrated that parents can transmit cognitive biases to their children (e.g., Creswell et al., 2006). A link between vicarious learning and information processing biases to threat has yet to be established (Muris & Field, 2008) therefore the current study also investigates this.

The study uses the vicarious learning procedure developed by Askew and Field (2007) with children aged 7 to 10 years. Heart rate was taken during a behavioural avoidance touch box task and attentional bias was measured using a visual search task. It is likely that learnt responses need to be fairly robust for actual phobias to develop; therefore follow-up measures of fear beliefs, avoidance preferences and attentional bias were taken one week and one month later. Trait anxiety was also measured as attentional biases are known to be related to general anxiety levels (Haddock et al., 2006). The results demonstrated fear-related increases in children’s cognitive, behavioural, and physiological responses. Cognitive and behavioural changes were re-tested one week and one month later and remained elevated. However, a visual search task found no evidence that vicarious learning creates attentional bias for threat-related animals, directly after learning, one week, or one month later. Trait and state anxiety also did not predict response times to locate animals.
The findings represent the first evidence in children that vicarious learning leads to changes in all three of Lang’s anxiety systems and hence provides compelling experimental support for the vicarious learning pathway to fear acquisition during childhood. Moreover, changes in fear beliefs and avoidance preferences were still present at follow-up one week and one month later, supporting previous longitudinal evidence demonstrating the robustness of vicariously learnt responses (Askew & Field, 2007). Given the detrimental effects of anxiety for children and adults, understanding the processes of fear-acquisition is fundamental in order to develop effective interventions. Understanding how and why vicarious learning occurs, and what its effects are on the wider fear emotion (e.g., physiological responses) can help us find ways to prevent and reverse fears. The current study is important in broadening our understanding of the effects of vicarious learning. The results help us to better understand how children’s fears develop and could therefore lead to the development of more effective treatment interventions.

Vicarious fear learning in childhood: fear-relevant vs. fear-irrelevant stimuli

Chris Askew, Kingston University; Gemma Reynolds, Kingston University; Andy Field, University of Sussex

Enhanced learning has typically been observed for prepared, fear-relevant stimuli such as snakes and spiders in laboratory conditioning procedures with adults (see e.g. Öhman & Mineka, 2001). This study aimed to investigate whether fear-relevance is also a factor influencing vicarious fear learning in children. In an adaptation of Askew and Field’s (2007) vicarious learning procedure, three groups of children (aged 6 to 9 years, N = 82) saw pictures of snakes, worms or marsupials together with pictures of scared faces (scared-paired) or no faces (unpaired control). Children’s fear beliefs and avoidance preferences for animals were measured before and after the learning procedure. Self-report measures of cognitive, behavioural and physiological fear responses for the animals were also taken. Fear-related learning was observed for stimuli children had seen with scared-paired faces compared to control stimuli. Learning was similar for marsupials and snakes and appeared to be independent of stimulus fear-relevance. Learning for worms differed from the other stimuli on three measures: increases in fear beliefs, fear-related cognitions, and self-reported avoidance were greater for marsupials and snakes than for worms. However, increases in self-reported physiological responses and avoidance preferences were similar for all stimuli. These findings support similar research comparing learning for flowers, caterpillars and marsupials. Together they suggest that stimulus preparedness may not be particularly influential for children in this age group during observational learning of fear from adult models.

Understanding how fears develop during childhood can contribute to the development of early interventions.

Identifying Early Targets for Intervention in Child Behaviour Problems

Jill Domoney, Academic Unit of Child and Adolescent Psychiatry, Imperial College, London; Katie Aumayer, Academic Unit of Child and Adolescent Psychiatry, Imperial College, London; Vaheasha Sethna, Institute of Psychiatry, King’s College, London; Lynne Murray, 3Winnicott Research Unit, School of Psychology, University of Reading, Reading; Andreas Giannakakis, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford; Haido Vlachos, Milton Keynes Community Health Services, Standing Way, Eaglestone, Milton Keynes; Paul Ramchandani, Academic Unit of Child and Adolescent Psychiatry, Imperial College, London

Child behavioural disorders are associated with a range of poor outcomes which represent a considerable health and social burden. Early parent-child interactions have been identified as important risk factors in the development of behaviour problems and represent a potential target for preventive interventions. This study examined the association between father-child interaction and child behaviour across the first two years, including identifying aspects of interaction important in predicting behaviour and exploring the direction of effects between paternal interactions and child behaviour. A sample of 155 families was visited at home at 3 months, 1 year and 2 years post-partum. Child behaviour was assessed by maternal report questionnaires at all three time points. Fathers were observed interacting with their child at 3 months and 2 years. Correlation analyses were used to examine the stability of key variables across time and investigate cross-lagged associations between paternal interactions and child behaviour. Disengaged paternal interactions at 3 months predicted child externalising behaviours at 1 year. This association attenuated when looking at child behaviour at 2 years although there was a strong correlation between child behaviour at 1 and 2 years. Child behaviour at all time points did not predict the quality of parental interactions at 2 years.

There is some evidence that early disengaged paternal interactions are associated with later child behaviours, while no evidence was found for the opposite pattern. This suggests that paternal behaviours may be a potential target for early preventive intervention.

A longitudinal study of child sleep in high and low risk families

Sarah Halligan, University of Bath; Andrew Sheridan, Oxford University Hospitals NHS Trust; Lynne Murray, University of Reading; Peter Cooper, University of Reading; Michael Evangelii, Royal Holloway, University of London; Victoria Byram, Royal Holloway, University of London; Sarah Halligan, University of Reading

The study aimed to investigate whether sleep disturbances previously found to characterise high risk infants: a) persist into childhood; b) predict cognitive and emotional/behavioural functioning; and c) are influenced by early maternal settling strategies.

56
Mothers experiencing high and low levels of psychosocial adversity (risk) were recruited antenatally and longitudinally assessed with their children. Mothers completed measures of settling strategies and infant sleep postnatally, and at 12- and 18-months infant age. At 5-years, child sleep characteristics were measured via actigraphy and maternal report, and IQ and child adjustment were also assessed. Sleep disturbances observed in high-risk infants persisted at 5-years. Poorer 5-year sleep was associated with concurrent child anxiety-depression and aggression, but there was limited evidence for an influence of early sleep problems. Associations between infant/child sleep characteristics and IQ were also limited. Maternal involvement in infant settling was greater in high risk mothers, and predicted less optimal sleep at 5-years. Early maternal over-involvement in infant settling is associated with less optimal sleep in children, which, in turn, is related to child adjustment. The findings highlight the importance of supporting parents in the early development of good settling practices, particularly in high-risk populations. The importance of flexibility in parenting style is highlighted, in order to optimise child sleep. This is particularly key among mothers who themselves experienced high levels of stress during pregnancy, are of low socioeconomic status, and have a history of mental health problems.

**Treatment Issues in Child and Adolescent Mental Health**

Convenor and Chair: Silvia Schneider, Ruhr-Universität Bochum, Germany

---

**Adapted cognitive behaviour therapy for young people with autism spectrum disorder and anxiety: a pilot evaluation**

Jacqui Rodgers, Newcastle University; Helen McConachie, Newcastle University; Eleanor McLoughlin, Northumberland, Tyne and Wear NHS Foundation Trust; Vicki Grahame, Northumberland, Tyne and Wear NHS Foundation Trust; Helen Taylor, Northumberland, Tyne and Wear NHS Foundation Trust

Anxiety is a significant challenge for many children with autism spectrum disorders (ASD). Adapted cognitive behaviour therapy (CBT) can be effective. The ‘Exploring Feelings’ program (Attwood 2004) originally developed in Australia, was modified for clinical use in the UK. A pilot randomized study was undertaken to investigate acceptability and feasibility. Thirty-two children (9 to 13 years) were randomised to immediate or delayed therapy over 7 weekly sessions. Child and parent sessions were run in parallel. The primary blinded outcome measures addressed changes in overall functioning after 3 months and in the primary anxiety diagnosis. At follow-up both parents and children in the immediate therapy group were more likely to report a reduction in anxiety symptoms and severity of primary diagnosis. Fidelity of delivery was high, and attendance was 91%. This pilot trial indicates that randomisation was acceptable to families, format and content were feasible for use within a CAMHS setting and the outcome measures were appropriate for use in a future fully powered trial. Results suggest adapted group-based CBT for children with ASD and high anxiety in middle childhood has the potential to be beneficial.

This abstract describes independent research commissioned by the National Institute for Health Research (NIHR) under the Research for Patient Benefit programme (PB-PG-0408-16069). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

---

**A meta-analysis of cognitive behavioural therapy in the treatment of child and young person anxiety disorders**

Donna Ewing, University of Sussex, Falmer; Jeremy Monsen, East London Consortium of Educational Psychologists, London; Ellen Thompson, University of Sussex, Falmer; Sam Cartwright-Hatton, University of Sussex, Falmer; Andy Field, University of Sussex, Falmer

Although systematic reviews and meta-analyses of CBT for adults with anxiety disorders have recently been conducted (Rodrigues et al., 2011; Smits et al., 2008), the most recent meta-analysis of CBT for children and young people with anxiety disorders was published in 2004 and only included studies dated up to 2001 (Cartwright-Hatton et al., 2004). This paper aims to provide an updated meta-analysis of the efficacy of cognitive behavioural therapy (CBT) for children and young people with anxiety disorders. The analysis included randomised controlled trials using CBT for children and young people formally diagnosed with an anxiety disorder, and who were randomly assigned to either a CBT intervention group or a control group. An electronic search was conducted, and the studies identified from this search were screened against the inclusion and exclusion criteria. 22 studies were identified as appropriate for inclusion in the current meta-analysis. Risk of bias of these studies was assessed. Findings indicated significantly greater odds of anxiety remission for those engaged in the CBT intervention than those in the control group. Risk of bias was not correlated with study effect sizes. CBT seems an effective intervention in reducing symptoms of anxiety in children and young people. Further research is required to investigate the efficacy of CBT for children under the age of 6 and over the age of 15. CBT was found to be more effective than no treatment for reducing anxiety in children and young people with anxiety disorders. CBT was also effective across the range of disorders and child ages included in this meta-analysis.
Topic specific low-intensity group parenting programmes: Are they acceptable to parents of 5-8 year olds?
Melanie Palmer, University of Auckland and MRC Social and Public Health Sciences Unit; Louise Keown, University of Auckland; Matthew Sanders, University of Auckland; Marion Henderson, MRC Social and Public Health Sciences Unit

Evidence-based parenting programmes are recommended to treat childhood psychosocial problems and should be made more accessible for parents. As a consequence, topic-specific low-intensity parenting programmes have been developed. The aim of this paper is to describe parents’ satisfaction with topic-specific low-intensity parenting groups. Parents took part in a randomised control trial (RCT) examining the effects of attending a one-off topic-specific parenting group in comparison to four topic-specific parenting groups. Depending on group allocation parents attended groups on Disobedience, Positive Parenting, Fighting and Aggression, Chores, and Self-Esteem. After each group session, attendees (59 parents from 42 families with a 5-8 year old child who displayed elevated levels of behaviour problems) completed a questionnaire to measure participant satisfaction. Child and parenting outcomes were also measured at pre-intervention, post-intervention, and 6-month follow-up to examine change over time.

Parents were generally satisfied with the help they received, the content, and the format of the groups. Participants also reported a high level of intent to use the strategies introduced in the sessions and felt they had sufficient knowledge to implement the strategies. The Fighting and Aggression group was rated most favourably followed by Chores, Self-Esteem, Positive Parenting, and Disobedience, although there was very little difference on overall satisfaction scores. Comments about the groups indicated satisfaction with the topics and strategies introduced in the sessions. Change over time in outcome measures for the RCT will also be presented.

Overall, topic-specific low-intensity group parenting programmes appear to be acceptable for families with a child aged between 5 and 8 years. Topic-specific low-intensity parenting programmes are a promising option for intervention as practitioners are potentially able to reach more parents with a brief intervention when compared to a more intensive delivery mode. Furthermore, these programmes appear to be an acceptable form of parenting support for parents with a 5-8 year old child.

MBCT Adapted for Adolescents—What Works and Why
Brenda Davis, Brighton & Hove CAMHS, Sussex Partnership NHS Foundation Trust; Brenda Davis, Brighton & Hove CAMHS, Sussex Partnership NHS Foundation Trust; Lana Jackso, Brighton & Hove Community CAMHS Service, Brighton & Hove City Council

There exists a strong evidence base for MBCT for adults with anxiety and depression (Teasdale et al, 2000), (Ma & Teasdale, 2004). MBCT has now also been extended for use with adults with other disorders such as cancer patients (Foley et al, 2007), suicidal behaviour (Williams et al, 2006) and bipolar disorder (Williams et al, 2008). There is now an emerging evidence base for child and adolescent clinical populations, the most robust being that by Bogels (2009), Biegel (2009) and Oord et al (2011). Burke (2009) and Harnett et al. (2012) provide comprehensive reviews of the current evidence base for clinical and non-clinical populations, both of which indicate that, although there are increasingly encouraging results, what is lacking is evidence about the mechanisms of change involved.

We have been delivering MBCT groups modified for adolescents with anxiety and depression, to 14-18 year olds referred to two CAMHS services in Sussex, on a termly basis for the last two years (Summer 2011-present). Number of sessions and session length are less, and practices are shorter and include more age appropriate activities using music, technology etc. Group size is 8-12 young people and parents are included in screening and first orientation session and in the evaluation. Course content and delivery has been modified in accordance with feedback.

We conducted evaluation pre and post group and at 3 and 6 month follow-up, using standardised measures of anxiety (SCARED) and depression (MFQ) - parent and child versions, an adolescent measure of Mindfulness (CAMM), and the CORC goal based measure. We also gathered qualitative information post-group via structured interview about what aspects of the group were most useful and what had changed as the result of attending the group. We now have data from 6 groups on over 40 young people such that numbers are sufficient to show statistically significant improvements overall in anxiety and low mood (group mean level) and clinically significant levels of improvement (RCI for each participant) in both. There was also a statistically significant move towards the young people achieving their goals. There was, however, greater improvement in low mood than in anxiety, including a reliable move from above to below clinical cut off for depression. This was also in the event of higher levels of severity being referred to the groups over time. We have also found a correlation between high levels on the mindfulness measure and reduced levels of both anxiety and depression. The qualitative information, particularly from follow up groups, included information about particularly anxiety still being experienced, but reducing quicker/causing less concern.

We now have sufficient quantitative data, including some at 3 and 6 month follow up, to show some statistically and clinically significant improvements. We also have qualitative data about what worked well to compare with this. Hence we are now in a position to make some preliminary hypotheses about what sorts of interventions work for which young people, which we would like to present for discussion, and which will form the basis of the next stage of our research. This work will inform other CAMHS services about how MBCT can be successfully adapted to intervene with adolescents, as well as beginning to identify the active ingredients of change.
Prevention effects in a universal, transdiagnostic school-based intervention: 12-month follow-up of the Healthy Minds program

Thomas Nehmy, Flinders University; Tracey Wade, Flinders University

Given the need for more effective school-based prevention programs for mental health problems, the Healthy Minds program was developed as a transdiagnostic preventive intervention for high-school age adolescents. Unhelpful perfectionism was targeted along with cognitive and emotion regulation skills to prevent the future onset of depression, anxiety and shape and weight concerns, a key marker of eating pathology.

1051 high school students (Year 8–10) from three independent schools and one Catholic school in Adelaide, South Australia participated. Approximately half the sample comprised of an intervention group, receiving eight classroom lessons over eight weeks. Lessons focused on reducing unhelpful perfectionism and its related characteristics by teaching such concepts as: flexible, realistic thinking; emotional awareness and regulation strategies; media literacy; gratitude; and self-compassion. The control group received regular classroom lessons.

At baseline, lower levels of perfectionism were associated with lower levels of depression, anxiety, stress, shape and weight concerns, and higher levels of self-compassion. Using multi-level modelling, girls who had low levels of psychopathology at baseline showed a significant prevention effect for the onset of symptoms of depression and anxiety at six-months. Results for eating disorder symptoms were approaching significance. These effects were no longer evident at 12-month follow-up.

Results will be discussed in terms of the viability of the Healthy Minds program as a new and cost-effective way to prevent multiple psychological problems in adolescents. Its application as a transdiagnostic psychological skills program for schools will be discussed in the context of the extant research literature.

This study informs our understanding of how CBT concepts can be applied in a preventive, school-based context to reduce the rate of onset of multiple clinical conditions.

Clinical Roundtable

Working with Parents in CBT for Children and Young People

Chair: Shirley Reynolds, University of Reading

Jennie Hudson, Macquarie University, Australia
Sam Cartwright-Hatton, University of Sussex
Polly Waite, University of Reading

This roundtable discussion will focus on how and when to involve parents in CBT with their child. Our knowledge base in this area is still developing. For example it is not clear when parental involvement is helpful or even necessary and the evidence is mixed. We know that there are many innovative CBT therapists working with children and young people and hope that they will contribute to the discussion. The presenters will illustrate their discussion with their own clinical examples and research experiences. The Key themes which we hope to explore and discuss include:

- Development issues
- Different ways to involve parents in therapy
- Dealing with parents’ own mental health concerns and problems
- Impact of parental cognitions and behaviours on their children
- Integration of system/development/cognitive factors in treatment
- Key research directions and priorities

Posters

‘Look at me, sweetheart’: Eye gaze of antisocial children with callous-unemotional (CU) traits during a parental display of affection

Sara Dawson, Institute of Psychiatry, King’s College London; Jennifer Allen, Institute of Education, University of London

Introduction: The deficits in emotion recognition and empathy characteristic of antisocial children with callous-unemotional (CU) traits has been attributed to reduced gaze to the eyes of caregivers when emotion is being expressed (Dadds et al., 2012). However, this research was conducted in a small sample (n = 24) and relied on parent self-report to assess parent feelings towards the child, which may provide an alternative explanation for eye gaze deficits in high CU children. This study aims to redress these limitations by examining eye gaze in a larger sample and incorporating observational measures to assess potential confounds.

Method: Children with oppositional defiant disorder (n = 59) and healthy control children (n = 40) were observed during a display of affection from their primary caregiver. Eye contact, verbal and physical affection was assessed during a parental
display of affection; parental sensitivity and expressed affect was assessed during free play. Parents completed questionnaires assessing child CU traits and comorbid problems.

Results: High CU children (n = 12) showed significantly less eye contact than low CU children and controls during a display of affection. No significant group differences were found for parent eye contact or affection. The relationship between CU traits and reduced eye contact was not accounted for by child comorbidity, parental feelings or sensitivity towards the child.

Discussion: This study suggests that reduced eye contact during parent-child emotional interactions may be a marker of high CU traits in antisocial children, and this appears to be independent of comorbid difficulties and parenting. Findings suggest that strategies promoting eye contact during warm, emotional parent-child interactions and their integration into current best-practice treatment may help to overcome emotion deficits in antisocial children high with CU traits.

Is the Current View tool a reliable way of collecting assessment information to inform the development of Payment by Results in CAMHS?

Katy Hopkins, The Anna Freud Centre

The Current View tool has been widely used for CYP-IAPT assessments and has recently been adopted as a data collection tool for CAMHS Payment by Results (PbR). This study examined inter-rater reliability on the Current View following training to assess the potential for generalising information from CAMHS PbR pilot sites to the rest of CAMHS. Clinicians from 23 CAMHS (tiers 2-4 including specialist services) were given training in completing the Current View and a manual detailing the definitions and rating guidance for each item. Immediately following training, all clinicians filled in the Current View for a vignette. A second vignette was given out via a website 1-3 months following training, the results from this will be used to further examine the reliability of the tool. Intra-class Correlation was used to calculate within- and between-site inter-rater reliability as well as agreement with the ratings of the trainers. If the remaining analyses are in line with the preliminary findings, these results support the use of the Current View tool to collect assessment information to inform the development of PbR for CAMHS. Following training and provision of a manual, the Current View is completed in much the same way by clinicians from different teams and services, suggesting that the assessment information captured is broadly comparable across sites. Analysis is underway and will be complete in May 2013. Preliminary results show post-training inter-rater reliability for the first 10 sites to be in the good to excellent range. Reliable, standardised measurement of assessment information, along with tracking of treatment types and outcomes is vital for understanding the effectiveness of treatments (including CBT) for different types and severities of presenting problem.

CBT based brief intervention in Adolescents with substance use disorder

Manju Mehta, All India Institute of Medical Sciences, New Delhi; Renu Sharma, All India Institute of Medical Sciences, New Delhi; Anju Dhawan, All India Institute of Medical Sciences, New Delhi

Substance abuse in adolescents is increasing in India (Ray, 2004). This has negative impact on academic and interpersonal relationships. Psycho-social factors contribute in precipitating and maintaining drug abuse. Preventive and intervention strategies based on cognition and behavioral model has been found to be effective. In Indian set up socio cultural beliefs and practices also need to be linked to the therapy.

Psychological and familial variables among adolescent substance users were assessed using various structured standardized tests. These were - Motivation to quit the drug, self esteem, coping strategies, Stressful life events, Intelligence, Personality and Behavior problems (co morbidity) The familial variables were assessed using a semi-structured interview schedule. A clinical sample of 50 drug using male adolescents in an age group of 11-19 years was selected using convenient sampling technique from drug de-addiction treatment centre, and psychiatry OPD of All India Institute of Medical Sciences, New Delhi. Sample was drawn irrespective of the child’s education level, socio-economic status, and parent’s occupation functioning.

A brief CBT based treatment module was developed consisting of 6 individual sessions: Motivation enhancement and Psycho education, Relapse Prevention, Identification of high risk situations, coping skills, craving management, social skills training and Family member were provided counseling. The module was administered on 10 adolescent substance users coming from different socio-economic status. Pre and post assessment was done using Teen Addiction Severity Index (T-ASI) and WHO-Quality of life scale.

Results obtained were analyzed using descriptive and inferential statistics. Both qualitative and quantitative analysis was done. Findings revealed that these adolescents faced a number of potential high risk situations like peer pressure, craving, positive and negative emotional states, severe punishment by parents and were having a tendency to experiment. They were having poor motivation to quit the drugs, Poor coping skills, negative self esteem, inadequate coping skills, poor academic performance, high externalizing problems, significant stressors in their life and an average intellectual functioning. The impact of treatment module was assessed through pre and post assessment. The findings show high acceptance for therapy, family involvement, reduction in addiction severity and enhanced treatment retention rate among adolescent substance users. Patients also reported having positive attitude towards therapy.
CBT was effective in terms of reducing relapse rate, managing craving and behavior problems, improvement in academic and social skills and family support. The treatment module was also found to be feasible to use with these adolescent substance users as treatment outcomes have shown reduction in severity, frequency and days of drug use. The study provides insight regarding the various psychological aspects and family functioning of substance using adolescents in Indian setting. The present module is the first initiative in India and is feasible to use with adolescents having substance use disorder. The finding also provides guidelines to the novice researchers for the treatment of adolescent substance users.

Eating Disorders and Impulse Control

Keynote Addresses

DBT in the Treatment of Eating Disorder: How, Why and With Whom?
Lucene Wisniewski, CaseWestern Reserve University and Cleveland Centre for Eating Disorders
Dialectic Behavior Therapy (DBT) was originally designed to treat chronically suicidal patients diagnosed with borderline personality disorder. Recent empirical evidence suggests that DBT may be an effective treatment for some eating disorder (ED) patients. This keynote address will review the empirical support, rationale and existing models for using DBT to treat patients suffering from disordered eating.

Sex, Cognitions and Behaviour
John Green, Imperial College London
The predominant everyday model of human sexual behaviour emphasises instinct over cognition. The scientific basis of such an approach is at best shaky. In part it is based on a misapprehension that sexual behaviour in animals and humans is stereotyped and genetically fixed. In fact evolutionary theory suggests that sexual behaviour in particular should be flexible and adapted to the environment, as indeed it is. The model has led to an unfortunate failure to address the importance of cognitions in sexual behaviour. I will look at two key areas in sex, risky sexual behaviour and sexual dysfunction. There is a large literature on risk behaviour, but it is remarkably uninformative about the processes underlying risk taking. I will argue that our lack of understanding of the cognitive basis of sexual risk behaviour is a major barrier to the development of better interventions. In the case of sexual dysfunction the evidence base is much smaller and there is a dearth of outcome studies. That is surprising given the acknowledged importance of psychological factors in the development and maintenance of sexual dysfunction.

Symposia

Cognitive Remediation Therapy for Anorexia Nervosa: Current evidence and future research directions
Convenor and Chair: Kate Tchanturia, King’s College London
A case study of CRT with an inpatient with anorexia nervosaCaroline Fleming, South London and Maudsley NHS Trust
This presentation will initially focus on providing background information to the case incorporating a CBT informed assessment and formulation conducted after patient’s admission to the ward. The presentation will continue by reflecting on the work of CRT within the context of the formulation. A “bigger picture” perspective will be taken, exploring the process of some of the exercises but focusing in more detail on the reflective process and behavioural experiments conducted between sessions. There will be an opportunity to demonstrate one of the exercises within this. Primary and secondary outcomes will be presented before and after CRT. Finally, there will be reflection on the experience of working with this particular patient, and how the learning of CRT informed further therapeutic intervention.

Applying Cognitive Remediation Therapy Skills to Support Patients with Eating Disorders at Different Stages of Recovery
Amy Harrison, King’s College London, Institute of Psychiatry and South London and Maudsley NHS Foundation Trust
This presentation aims to use a series of case studies to explain how CRT can be used in an individual format to support the cognitive skills of adult patients at various stages of recovery. Initially, the talk will use a case study to focus on how CRT can be used to engage and enhance the cognitive functioning of an adult patient and will explore how to explain the treatment and its possible benefits to severely ill patients and how to adapt sessions if necessary for extremely low weight patients. Next, on the basis of a second case study, the talk will then explore how to support patients in a day care programme to develop flexible and bigger picture thinking skills alongside a preference for detail. At this stage, ways to help patients take CRT knowledge and apply it to everyday functioning will be explained and evaluated. Finally, the talk will explore how small individual improvements in cognitive flexibility and global thinking can be disseminated to the wider clinical team in an outpatient department and used to further treatment gains in this context.

A cognitive remediation therapy group for adolescents with anorexia nervosa

Natalie Pretorius, South London and Maudsley NHS Foundation Trust

Cognitive remediation therapy (CRT) has shown some promising results when carried out with adults with anorexia nervosa (AN) in individual and group formats, however evaluation of CRT with adolescents in this population is very limited.

Methods: A total of 30 adolescents with AN completed four weekly CRT groups. Seven groups were run in total. Adolescents’ cognitive flexibility and motivation was assessed before and after the group and they completed qualitative questionnaires after the group to determine their perceptions. Results: There was a small effect size in self-reported cognitive flexibility post group. Adolescents reported the group was interesting and useful however some wanted more support with application to real life. Conclusions: More research is needed to determine if CRT is beneficial for young people with AN. We are currently in the process of evaluating an eight session CRT group for adolescents with AN to examine whether increased number of sessions of CRT is associated with greater improvements in cognitive flexibility.

Family-based cognitive remediation therapy

Bryan Lask, Great Ormond St Hospital and University of London

Involvement of the family in the treatment of child and adolescent anorexia nervosa is standard practice, with reasonable evidence to support its effectiveness. However it is not a panacea, and its main value seems to be in supporting the re-feeding process. It does not tackle the underlying cognitive deficits so common in this population, and which seem to contribute to the pathogenesis and maintenance of the illness. Cognitive remediation therapy (CRT) is being increasingly used as an adjunct to treatment for anorexia nervosa in all age groups. It is logical to consider involving the family when utilising CRT for the younger population, both because it helps parents better understand the difficulties their daughter is facing and because the cognitive deficits often appear to be shared by other family members. This paper presents the key elements of family-based CRT illustrated with case examples.

Cognitive approaches to understanding eating disorders: New directions

Convenor and Chair: Maxine Howard, Department of Clinical, Educational and Health Psychology, University College London

Implicit food attitudes in dieters and non-dieters

Alisa Anokhina, Dept of Clinical, Educational and Health Psychology, UCL, Lucy Serpell, Dept of Clinical, Educational and Health Psychology, UCL

Implicit attitudes can be defined as valenced associations in memory which are automatically activated in response to an attitude object. Research suggests that implicit attitudes are better predictors of spontaneous or impulsive behaviour, while explicit (self-reported) attitudes are more closely associated with rational or controlled behaviour. The present study was concerned with the role which implicit attitudes play in dietary restraint. We hypothesised that explicit, but not implicit, food attitude change in a state of dietary restraint, which may then contribute to dietary restraint failure via diminished self-control capacity in a state of ego depletion. Female participants (N=125) completed an IAT to assess implicit attitudes towards high fat (HF) and low fat (LF) food and a series of questionnaires to assess pathology and eating habits. Participants not dieting at the time of the study had a significant implicit preference to HF over LF food (M=.25), t(80)=4.8, p=.000. However, contrary to hypothesis, current dieters did not have a significant implicit preference for either food type (M=-.12), t(42)=−1.7, p=.10. Both dieters and non-dieters explicitly reported a preference for HF food. Further analyses were conducted between non-dieters, successful dieters and unsuccessful dieters: a two-way ANOVA yielded a significant main effect of group on IAT-D score, F(2,91)=5.90, p=.004. However, post-hoc analyses suggest that this was driven by the difference between non-dieters (M=.30) and unsuccessful dieters (M=−.10) only, p=.004. Both successful and unsuccessful dieters reported elevated levels of eating disorder pathology compared to non-dieters. Overall, the results suggest that typical implicit preference for HF food is absent in dieters; this may potentially be a consequence of restrained eating behaviour, particularly of the type associated with repeated dietary restraint failure. While these findings do not support the ego depletion account, they do suggest that some cognitive strategies used to facilitate dietary restraint may affect cognition on an implicit level.
The Neuropsychological Functioning of Children at High Risk of Developing an Eating Disorder: Moving Away from Diagnostic Categories and Towards Observable Phenotypes

Radha Kothari, Eating Disorders and Adolescent Mental Health Research Team, Behavioural and Brain Sciences Unit, UCL Institute of Child Health. Janet Treasure, Psychological Medicine, Section of Eating Disorders, Institute of Psychiatry, King’s College London.; Nadia Micali, Eating Disorders and Adolescent Mental Health Research Team, Behavioural and Brain Sciences Unit, UCL Institute of Child Health

Background: Evidence suggests that diagnosis of an eating disorder (ED) is associated with differential cognitive functioning. It is not clear however whether the differences observed in clinical and recovered groups are present prior to onset, possibly contributing to development of an ED. Our team has previously investigated neuropsychological functioning of children at high risk of developing at ED, due to being born to a mother with a lifetime ED, in comparison to children not at high risk. Results showed that children at risk due to being born to mothers with lifetime AN showed higher intelligence, superior working memory, and superior visuo-spatial functioning; but decreased attentional control in comparison to children not at risk. The children at risk due to being born to mothers with lifetime BN showed comparatively poor visuo-spatial functioning. The diagnostic groups of AN, BN and EDNOS may not be effective for research however, and it has been suggested that observable behaviours/symptoms will be more closely associated with cognitive functioning. Due to this, we investigated neuropsychological functioning in children at risk using maternal ED symptoms over lifetime to define high risk status in children.

Methods: Participants were drawn from a large general population cohort called the Avon Longitudinal Study of Parents and Children (ALSPAC). Mothers were interviewed retrospectively about the presence of ED behaviours over their lifetime as part of a two-phase prevalence study (Kothari, Treasure and Micali, in preparation). Children completed neuropsychological assessments between 8 and 10 years of age. Data was available on approximately 600 to 800 mother-child pairs.

Results: The children of mothers with a lifetime ‘Restricting’ phenotype exhibited superior verbal intelligence in comparison to children not at risk. The children of mothers with a lifetime ‘Purging’ phenotype exhibited comparatively poor attentional capacity, particularly sustained attention. The children of mothers with a lifetime ‘Bingeing and Purging’ phenotype exhibited comparatively poor visuo-spatial functioning, but superior working memory capacity.

Conclusions: Findings suggest that differences in neuropsychological functioning may be present prior to onset of an ED, possibly contributing to development of the disorder. In addition, it appears that lifetime ED phenotype of the proband could be a precise and effective predictor of neuropsychological functioning in high risk groups. Findings are extremely important in relation to the identification of vulnerable individuals, and in furthering our understanding of which cognitive profiles are linked to susceptibility for ED. Further research is required to confirm and extend these findings; however such lines of enquiry will inform the design of prevention, early intervention, and treatment strategies in the future.

Impulsive and compulsive behaviour in disordered eating: The role of short term fasting in a non-clinical sample

Maxine Howard, Research Department of Clinical, Educational and Health Psychology, University College London; Jonathan Roiser, Institute of Cognitive Neuroscience, University College London; Lucy Serpell, Research Department of Clinical, Educational and Health Psychology, University College London

Research has shown increased impulsivity in individuals with Bulimia Nervosa (BN) or Anorexia Nervosa binge/purge subtype (AN-B), and increased compulsive behaviour in Anorexia Nervosa (AN). These impulsive and compulsive traits can be observed prior to the onset of an Eating Disorder (ED); however the dysfunctional eating patterns are thought to be worsened by increased dietary restraint.

Recently, diets that involve either complete short term fasting or a significant reduction in daily calories have been promoted by the media. These diets involve the cycling of high dietary restraint and normal eating, and could serve as a precursor to the development of an ED. Recent research indicates that short term fasting exacerbates compulsive behaviour, akin to the perseveration deficits shown in AN. However, the degree to which fasting could lead to increased impulsivity, and consequently dysregulated eating, has yet to be established. Therefore this study was designed to examine the causal influence of short term fasting on measures of impulsivity and compulsivity in a non-clinical sample.

A within-subject, repeated measures design, with separate neurocognitive tasks assessing impulsivity and compulsivity was conducted. Participants (N=33) attended two testing sessions, once after fasting for twenty hours, and once when satiated.

Results indicated no difference in performance between fasting and satiated conditions on the neurocognitive tasks assessing impulsivity. However, in line with previous research, there was a significant difference found for measures of compulsivity. Specifically, fasted individuals showed a significant deficit when switching between rules on a novel set shifting task.

Overall, this research suggests that short term starvation has an impact on cognitive functioning, and the promotion of such fasting diets should be reconsidered. The specific deficits shown as a result of fasting seem to resemble, to a degree, the perseveration difficulties shown in individuals with an ED. The potential for these diets to exacerbate existing disordered eating should be considered.

Clinician and practice characteristics influencing delivery and initial outcomes of the early part of outpatient cognitive behavioral therapy for anorexia nervosa
Amy Brown, Institute of Psychiatry, King's College London, Vicki Mountford, Institute of Psychiatry, King's College London & South London and Maudsley NHS Foundation Trust; Glenn Waller, Department of Psychiatry, University of Sheffield

Objective: In the light of recent evidence that cognitive-behavioral therapy (CBT) can be effective for anorexia nervosa, this study examined evidence that clinician characteristics and practice can influence the effective implementation of that therapy with this patient group.

Method: The study used a cross-sectional mixed correlational and comparative design. The participants were 100 qualified clinicians who routinely offered outpatient CBT to adults with anorexia nervosa. The clinicians completed a survey of their demographic characteristics, level of anxiety, clinical practice in CBT for anorexia nervosa, and beliefs about the relationship between weight gain and therapeutic alliance in the early part of such treatment.

Results: Several factors were associated with better reported levels of weight gain, including the use of manuals, an early focus on weight gain as a target, structured eating and a belief that weight gain precedes a good working alliance. Factors associated with less improvement were clinician anxiety and an early focus on the therapeutic alliance rather than structured eating. Clinicians all reported seeing the alliance as necessary for change, but a minority saw it as sufficient for change (though they reported that their patients did not make the same changes as clinicians who worked with both structured eating and the alliance).

Conclusions: These conclusions need to be tested within clinical and research settings. However, they suggest that clinicians should be encouraged to use manual-based approaches when treating anorexia nervosa using CBT, as the focus on techniques might result in the best possible outcome in this early part of treatment.

Psychological aspects of bariatric surgery

Convenor and Chair: Denise Ratcliffe, CNWL NHS Foundation Trust, Chelsea & Westminster NHS Foundation Trust & Phoenix Health

Getting Ready for Bariatric Surgery: A pre-surgery behaviour change workshop

Bariatric surgery is an effective method for weight loss, with dramatic results initially. However, a proportion of patients (up to 30%) who have undergone surgery can regain weight after 18-24 months (Brandenburg & Kotlowski, 2005). This weight regain has been attributed to the dramatic behaviour change required and/or insufficient lifestyle changes pre-surgery. In a qualitative study examining patient explanations for poor weight loss following surgery, Zijlstra et al. (2006) noted that a number of interviewees recognised the need to make behavioural changes but had difficulty implementing these goals and transferring them into actions. A similar qualitative interview found that failed bariatric patients reported unplanned eating, difficulty implementing new behaviours and poor self-control following surgery which impeded weight loss (Zunker et al., 2012). A number of studies have investigated the effectiveness of offering pre-surgery workshops although these have varied significantly in content and approach and have subsequently generated inconsistent findings (e.g. Brandenburg & Kotlowski, 2005; Leahey et al., 2009).

The current paper evaluated the effectiveness of pre-bariatric surgery workshops focused on behaviour change and skill development, and draws upon CBT and MI approaches. The workshops aimed to increase participant’s awareness of behaviour change required for surgery to work, increase readiness and develop skills to counteract potential challenges which may affect weight loss outcomes. The intervention consists of two workshops, one month apart, as part of the pre-surgical intervention at Chelsea and Westminster Hospital. Participants completed measures of locus of control (Weight Locus of Control; Saltzer, 1982), as well as continuum ratings of confidence, readiness, preparedness, knowledge and motivation. Individual’s weights were taken at both workshops. The workshops consisted of psycho-education and exercises around the importance of regular eating, self-monitoring, identifying and managing emotional eating, mindful eating and managing setbacks. In addition, there was input from the bariatric team’s dietitians and expert patients.

The results indicate that participant’s weight decreases between the two workshops and from weight at initial assessment with the team. Continuum ratings demonstrated positive shifts. Furthermore, a subset of data looking at the differences between those who attended the group versus non-participants (who subsequently had surgery) in terms of weight loss will be highlighted. Participants rated the workshops highly and meeting other pre-surgery patients was beneficial. The results of these workshops will be discussed in terms of using cognitive behaviourally informed interventions to expedite maximum change within a time constraint, as well as the psychological benefits of attending such groups.

The Modification of Eating Behaviour Prior to Bariatric Surgery: The Case for and Against
Jackie Doyle, University College Hospital London, Sri Steinmo, University College Hospital London

Maladaptive eating patterns such as such as binge eating, ’grazing’, disinhibited and emotional eating are common in patients presenting for bariatric surgery. The question of how pre-operative eating behaviour might impact on surgical
outcomes is debated throughout the literature, with some researchers suggesting that disordered eating (DE) is a poor prognostic indicator of weight loss (WL) (Canetti et al., 2009; Kalarchian, et al., 2002; Niego et al., 2007; Sallet et al., 2007; van Hout et al., 2005), whilst others argue that it is post-operative, not pre-operative eating behaviours that are significant (Burgmer et al., 2005; Busetto, et al., 2005; Larsen et al., 2004; Saunders, 2004; Wadden et al., 2011). Whilst the pre-operative DE/WL relationship is equivocal, the negative impact of pre-operative DE on other important outcomes (e.g. psychosocial factors such as HRQL, psychiatric disturbance, depression, and social function, as well post-operative eating disturbances including BED, night eating and ‘grazing’ with loss of control) is clearer (Busetto et al., 2005; Colles et al., 2007; de Man Lapidoth et al., 2011; Green et al., 2004; Saunders, 2004), suggesting there may be a role for pre-operative psychological intervention.

In this paper we describe the development and content of a series of Cognitive Behavioural Therapy workshops with the aim of modifying unhelpful eating patterns prior to bariatric surgery. A continuous improvement model was deployed and data from two phases of the programme are presented. Patients were given a range of questionnaires pre and post workshops to measure depression, eating restraint, incidence of binge eating, regular eating, and eating in the absence of hunger in response to internal/emotional and external triggers. Changes to these key variables and weight in kilograms are presented from Phases 1 (n=50) and 2 (n=31) of the workshops as well as a comparison of excess weight loss at one year in a selection of patients who had completed Phase 1 versus a non-treatment control group. The complexity of evaluating pre-operative psychological change and the significance of short term change and longer term outcome are discussed. This presentation aims to add to the debate about the role of psychology in this fast developing area.

**Weight Loss Surgery at the Intersection of Obesity and Addiction**

Stephanie Sogg, Massachusetts General Hospital Weight Center; Harvard Medical School, Ida Hatoum, MGH Weight Center and Obesity, Metabolism & Nutrition Institute, Massachusetts General Hospital; Sarah Turbett, Massachusetts General Hospital; Lee Kaplan, MGH Weight Center and Obesity, Metabolism & Nutrition Institute, Massachusetts General Hospital

Increasing evidence is emerging that obesity and addiction share several behavioral, psychological, and neurobiological similarities (Volkow et al., 2013). In both conditions, personality characteristics such as impulsivity and disinhibition, impaired sensitivity to reward, and novelty-seeking have been observed (Barry, Clarke & Petry, 2009; Davis & Carter, 2009; Davis & Fox, 2008). Neurobiologically, it has been demonstrated that highly palatable foods have a similar impact on brain reward pathways as do substances of abuse such as drugs and alcohol (Johnson & Kenny, 2010; Wang, Volkow & Fowler, 2002). Further, individuals with obesity and those with substance use disorders (SUD) both exhibit perturbations in brain systems related to hedonic reward, inhibitory control, and emotion/memory (Loeber et al., 2012; Stice et al., 2010; Stoeckel et al., 2010). Recently, an increasing number of reports have documented an increased risk for new-onset SUD - particularly alcohol use disorders (AUD) – among individuals who have undergone Roux-en-Y gastric bypass (RYGB) (King et al., 2012; Consone et al., 2012). As RYGB is one of the most prevalent bariatric procedures being performed today in Europe and the US, a risk of alcohol misuse after surgery is a cause for significant concern.

In order to examine the prevalence of alcohol misuse before and after RYGB, our group administered a telephone survey to patients who had undergone RYGB at our center at least 18 months before the start of the study. Additional demographic and other clinical data were extracted from the electronic medical record. "Problem drinking" (PD) was defined as consuming >3 drinks/day on >4 days/week, or >5 drinks/day on >2 days/month. The prevalence of PD in this cohort at any time before surgery was 30.4%. PD during the 6 months immediately before RYGB was reported by 9.4%, with 41% of this group reporting PD after surgery. Importantly, among patients with no previous history of PD, 7% reported developing this behavior de novo after RYGB, an incidence far greater than would be predicted for this predominantly middle-aged population. We did not identify any clinical characteristics associated with new-onset PD after RYGB.

These findings demonstrate that RYGB is associated with a risk of developing new-onset PD. In addition to the clinical implications for pre- and post-surgical evaluation and screening, these results represent additional support for the connections between obesity, addiction, and the neurobiological mechanisms underlying both conditions.

**The impact of pre-operative disordered eating on weight loss outcomes 12 months after bariatric surgery.**

Denise Ratcliffe, CNWL/Chelsea & Westminster Hospital, Rukshana Ali, CNWL/Chelsea & Westminster Hospital; Mahbuba Khatun, CNWL/Chelsea & Westminster Hospital

Binge eating disorder is common amongst individuals seeking bariatric surgery (de Zwaan, 2005) yet the evidence regarding its relationship with post-operative weight loss outcomes is inconsistent (Kalarchian et al., 2008; Sallet et al., 2007). The bariatric surgery literature has tended to focus on binge eating disorder yet many individuals have subclinical patterns of emotional eating which are not captured by this diagnosis. It is unclear how emotional eating patterns may impact on weight loss outcomes (or interact with binge eating disorder). Furthermore, it is not clear whether these pre-operative eating patterns may have a differential impact depending on the type of bariatric surgical procedure (e.g. gastric band or Roux-en-Y bypass (RYGB)).

In this paper we present data from over 200 bariatric patients who either had a gastric band inserted or RYGB. All patients completed a pre-operative screening tool to identify binge eating and emotional eating patterns. Cluster analysis was used to identify groups based on the eating screening tool and the following groups were identified: a) binge + emotional eaters b) emotional eaters and c) neither binge or emotional eater. No binge only cluster emerged. We investigated the impact of
these eating patterns on weight loss one year following surgery (using % excess weight loss (%EWL) as the outcome measure) separately for men and women. Our data show that a history of disordered eating influences the weight loss outcomes of men and women who have gastric bands and RYGB differently. Amongst female patients who had a RYGB, those with a pre-operative history of binge eating plus emotional eating have a greater %EWL than emotional eaters or those without disordered eating. The opposite pattern of results was found for men who had RYGB, with those individuals without pre-op disordered eating having greater %EWL. In relation to weight loss outcomes following gastric band insertion, another reverse pattern of results was found between men and women. Women with a pre-operative history of binge eating plus emotional eating have poorer %EWL outcomes whereas men with this eating profile have greater %EWL than emotional eaters or those without disordered eating.

There are distinct differences between men and women in the impact of disordered eating on the weight loss outcomes following gastric band versus RYGB. These data have implications for pre-surgery psychological assessment and the information given to patients in order to facilitate informed decision making about the type of bariatric surgical procedure they choose. Clearly further research is needed to identify the psychological mechanisms of action driving these different effects. We will consider the role, and timing, of targeted psychological interventions to address and ameliorate the impact of these eating patterns.

Interacting Vicious Circles: A cognitive behavioural thematic analysis of post bariatric psychological difficulties

Nick Hawkes, Barnet, Enfield and Haringey Mental Health NHS Trust

Obesity is a major problem and bariatric surgery is especially effective, therefore there is significant interest in understanding post bariatric psychological problems to aid in assessing and ameliorating risk. Different approaches exist, including focus upon specific behaviours or outcomes (eg weight regain, substitution of other addictive behaviours, suicide attempts), psychiatric diagnoses as predictors or outcomes, and focus on intermediate mechanisms (eg emotional eating). This paper contributes a thematic analysis of a large sample of post bariatric psychology referrals focusing upon aspects of vulnerability factors, the nature of the stressor, and post surgery presenting problems that were used to inform differential diagnosis and cognitive behavioural formulation. The data are the case notes, correspondence and recollections of cases therefore the analysis is highly subjective. Specifically it is argued that after surgery patients present with a variety of maintaining cycles typical of different disorders, leading to emotional eating and/or emotional avoidance of food. Of particular note are features characteristic of anorexia-like and bulimia binge-eating-like eating disorders, somatisation/hypochondriasis and low mood/depression. Also found were features of body dysmorphia, adjustment/PTSD and rarer outcomes such as psychosis. The most severe negative outcomes in this sample seemed to arise when there were a larger number of problems of greater severity interacting, especially anorexia-like, somatisation and mood problems on top of probable avoidant, dependent or histrionic temperamental vulnerabilities. This paper will present descriptions of the emerging themes, describing how they appeared to operate and interact, and illustrating this with case examples.

Process and Treatment Issues in Eating Disorders
Convenor and Chair: Ulrike Schmidt, King’s College London

Social Perception in People with Eating Disorders

Beth Renwick, King’s College London; Beth Renwick, King’s College London; Hannah De Jong, King’s College London; Martha Kenyon, King’s College London; Nelman Samarawickrema, King’s College London; Rachel Loomes, Oxford Health NHS Trust; Ulrike Schmidt, King’s College London

Social perception (SP) is a key aspect of social cognition (SC) which has not yet been investigated in eating disorders (ED). Poor social cognitive abilities have a negative impact on treatment outcome and prognosis in these severe and often long-term conditions. Interventions that enhance social cognition may therefore improve quality of life in chronic illness. This study aimed to investigate SP in individuals with anorexia nervosa (AN) and bulimia nervosa (BN).

Outpatients with AN (restricting subtype (AN-R): n=51; binge-purge subtype (AN-BP): n=26) or BN (n=57) and Healthy Control (HC) (n=50) participants completed the Interpersonal Perception Task (IPT-15). This is an ecologically valid task consisting of 15 video-clips depicting complex social situations relating to intimacy, status, kinship, competition and deception. Participants assess relationships between protagonists based on non-verbal cues.

Overall, there was no difference between groups on IPT total and subscale scores. Group differences on the Intimacy subscale approached significance so post hoc comparisons were carried out. AN-R participants performed significantly worse than HCs in determining the degree of intimacy between others.

SP is largely preserved in ED patients. Film scenarios allow individuals to be a social observer and tap into cognitive rather than emotional SC, making the task less difficult for patients. However, individuals with AN-R do show impairments in identifying intimacy in social situations, this may be due to lack of relationship experience.

Conclusions: Further research into different aspects of social cognition is required to establish the link between interpersonal difficulties and ED psychopathology.
The implications would be to enhance the understanding of social cognitive functioning in individuals with anorexia nervosa and bulimia nervosa. Social cognition can be an important aspect of CBT in the treatment of Eating Disorders.

Patient Experiences of Two Psychological Therapies for Treatment of Anorexia Nervosa: A Qualitative Study
Anna Lose, Institute of Psychiatry, King's College London; Anna Lose, Institute of Psychiatry, King's College London; Lotty Davies, Institute of Psychiatry, King's College London; Bethany Renwick, Institute of Psychiatry, King's College London; Martha Kenyon, Institute of Psychiatry, King's College London; Daniella Waterman-Collins, Institute of Psychiatry, King's College London; Ulrike Schmidt, Institute of Psychiatry, King's College London.

Anorexia Nervosa (AN) in adults is a serious, long-term mental disorder, with a great need for novel treatments with better outcomes. The Medical Research Council recommends including the perspectives of patients, clinicians and other stakeholders in the design, development and dissemination of any novel treatments. In the field of eating disorders few studies have explored patient treatment experiences. The Maudsley Outpatient Study of Treatments for AN and Related Conditions (MOSAIC) is an ongoing Randomised Controlled Trial (RCT) which aims to determine the efficacy of two treatments, the Maudsley Model for Treatment of Adults with AN (MANTRA) and Specialist Supportive Clinical Management (SSCM). The current study, embedded in the MOSAIC RCT, utilised a qualitative approach to gain an understanding of patients' experiences of these two therapies.

17 semi-structured interviews were conducted with adult AN and EDNOS-AN trial participants receiving either MANTRA or SSCM. The interviews were recorded, transcribed and analysed thematically. Patient responses yielded five themes: positive and helpful aspects, benefits, less helpful aspects of treatments, possible treatment improvements, and factors contributing to the therapeutic outcome. There were both distinct and shared characteristics of MANTRA and SSCM in terms of patients' therapeutic experience. MANTRA patients highlighted structure, flexibility and tailoring of treatment, whereas SSCM patients valued the practical and proactive approach. These findings are discussed in terms of their implications for clinical practice, therapist training, further treatment development, and in the context of therapist perceptions of the treatments. This study provides valuable clues on the possible ways of improving therapy, and desired therapist characteristics as described by patients. These treatment and therapist characteristics can be used to inform clinicians in relation to their everyday practice when engaging such a complex group of patients with Eating Disorders.

Exploring voluntary participation in mental health interventions aimed at young adults: Findings from a body image initiative
Melissa Atkinson, Flinders University; Tracey Wade, Flinders University.

It is imperative to not only establish efficacious interventions aimed at improving mental health but to disseminate them effectively. We aimed to determine reasons for non-participation in a body image initiative, due to a low response rate to a randomised controlled trial of two freely offered group programs. Female students studying first-year psychology (N = 124, Mage = 19.30, SD = 1.55) were recruited to complete an online survey including measures of eating disorder risk factors, presentation of a flyer outlining the research trial, and questions regarding interest and likelihood of participation. Participants were also randomised to receive a set of cognitive dissonance-inducing questions prior to the flyer presentation to determine the capacity of dissonance to increase interest in participation.

Results showed limited interest and likelihood of participating overall and indicated time to be the most commonly endorsed explanation. Those high on weight concerns were more likely to cite the group format as a deterrent. A greater belief in the helpfulness of such programs and higher personal ineffectiveness were significant predictors of interest in participation, providing two avenues to emphasise when promoting interventions. No significant group differences were found between those who did and did not receive the dissonance induction. These findings highlight the importance of ensuring that mental health initiatives are amenable to uptake in the population of interest, particularly for prevention work where people are not necessarily seeking help, and for young adults, where there is no easy avenue for mandatory participation. The findings also give insight into factors behind limited help-seeking and not engaging in therapeutic services. Also sheds light on uptake into interventions delivered in a group programs.

Is mindfulness a worthwhile pursuit in eating disorders prevention? Results from a randomized controlled trial of mindfulness and dissonance-based programs
Melissa Atkinson, Flinders University; Tracey Wade, Flinders University.

The primary objective of this study was to evaluate a mindfulness-based prevention program against an established dissonance program with regard to reducing risk for disordered eating. Adolescent girls (N = 379, Mage = 15.70, SD = 0.77) from four high schools were randomly allocated by class to receive either a mindfulness or dissonance-based program, delivered universally, or lessons as normal (assessment-only control).
Standardized measures of eating disorder behaviors and related risk factors were completed at baseline, post-program, 1-month and 6-month follow-up. Controlling for baseline, results showed significant group differences over time for weight concerns (F (6, 663) = 3.74, p = .001), with both dissonance and acceptance groups showing a greater reduction than control. No other variables demonstrated significant interactions, however main effects of time for dietary restraint, mindfulness, self-compassion, emotion dysregulation, negative affect, escape-avoidant coping, and media internalization indicated overall improvement across groups. Improvements evident within the control group may suggest the presence of cross-contamination between classes or an impact of assessment. Further analysis is required to account for significant missing data across time points; however, these preliminary findings validate continued evaluation of mindfulness in this context. This study evaluates the worth of adopting mindfulness techniques when applied to body image disturbance and other risk-factors for disordered eating common in adolescence.

Posters

Social Anhedonia and Work and Social Functioning in the Acute and Recovered Phases of Eating Disorders
Amy Harrison, King's College London, Institute of Psychiatry, Section of Eating Disorders, London, UK and Eating Disorder Inpatient and Outpatient Services, South London and Maudsley NHS Foundation Trust, London, UK; Vicky Mountford, Eating Disorder Inpatient and Outpatient Services, South London and Maudsley NHS Foundation Trust, London, UK; Kate Tchanturia, King’s College London, Institute of Psychiatry, Section of Eating Disorders, London, UK and Eating Disorder Inpatient and Outpatient Services, South London and Maudsley NHS Foundation Trust, London, UK

Mental ill health is associated with difficulties with work and social functioning (WSF). A multi-site European study of 969 adults found people with eating disorders (EDs) or personality disorders reported greater social disability than those with schizophrenia, depression and anxiety (Rymaszewska et al., 2007). WSF play an important role in successful recovery from an ED (Noordenbos, 2011).

This cross-sectional study investigated WSF and social anhedonia (SA) in women with anorexia nervosa (AN; n=105), bulimia nervosa (BN; n=46), women recovered (4 years post-illness) from an ED (n=30) and age and IQ matched non-ED controls (n=136) using the Work and Social Adjustment Scale (Mundt et al., 2002) and the Revised Social Anhedonia Scale (Eckbald et al., 1982).

There were large sized differences for the AN and control groups across all domains of WSF (D=5.45) and SA (D=1.4) and for the BN and control groups for WSF (D=2.7) and SA (D=1.4). Recovered participants reported more WSF difficulties (D=1.39) and higher SA than controls (D=1.44), but fewer WSF difficulties (D=3.11) and less SA than acute participants (D=0.57). A subgroup of recovered individuals (n=9) who continued to score in the clinical range (>12) for SA reported significantly poorer WSF (D=2.76) than those outside the clinical range. Lifetime severity (lowest ever BMI) and current symptom severity (EDE-Q Global score) were significant predictors of WSF problems.

Interventions which encourage patients to seek out small pleasures, increase social contact and develop social networks and employment or training opportunities may be beneficial. Helping patients to target behavioural activation at behaviours which involve contact with others and vocational opportunities may be a way of intervening at the level of a reduced drive to seek out social contact. Having small successes in these experiments may help patients to experience more pleasure around social interaction. Using problem solving skills may be a way of helping patients to brainstorm how they can practically and realistically make improvements in their work and social functioning. For example, exploring potential options, breaking down goals into small steps and working towards the goals and evaluating what worked well and what could be changed for next time. This may be a way of enhancing people’s subjective experience of how well they are functioning in their work and social lives.

IAPT and Primary Care

Keynote Addresses

Preparing for a Modern IAPT NHS
Ian McPherson, Improving Health and Wellbeing, UK
The Improving Access to Psychological Therapies (IAPT) Programme has revolutionised interest in as well as the availability of psychological therapies in ways that few of even the most committed advocates could have imagined. While IAPT has not been without controversy, the major level of investment over the last three years supported by all main political parties has resulted in more than 600,000 people completing therapy and almost 4,000 new psychological therapists. Strategically this has moved psychological interventions into the mainstream of health provision. However, the changing NHS climate with clear moves away from centrally led and funded programmes towards local determination of priorities and responses to these will raise challenges to sustaining the momentum and growth that has occurred under IAPT.

Further, it is not only policy and structures that are changing, but all of this is occurring in a context of unprecedented financial pressures in the NHS with the need to take at least £20 billion of resources out of existing services over the next 3 years. This paper will explore what this might mean for those who wish to maintain the growth in psychological therapies and in particular the need to develop different tactics to cope with the political realities of a post IAPT NHS.

**Does Computer-delivered CBT really Work for Depression?**

*Simon Gilbody, University of York*

Computer-delivered CBT forms an important component of NHS psychological therapy services. Many assume that the effectiveness and efficiency of this mode of delivery are already proven. Others have questioned whether people with depression engage with the technology and derive benefits without the direct input of a therapist.

Several years ago NICE recommended that a large scale independent trial of this technology be conducted. The Randomised Evaluation of the Effectiveness and Acceptability of Computerised Therapy (REEACT) is the largest UK trial to date, and was commissioned by the National Institute of Health Research (NIHR). Using a pragmatic design we recruited and randomised 690 participants with depression. The design, challenges and preliminary results of this trial will be presented by Professor Simon Gilbody on behalf of the REEACT collaborative (Universities of York, Manchester, Sheffield, Bristol, Birmingham and Exeter).

**Symposia**

**The new NICE Guideline for the assessment and treatment of social anxiety disorder.**

*Convenor and Chair: David M Clark, University of Oxford*

**Why a Guideline is needed?**

*David Clark, University of Oxford*

Starting in 2004, NICE has issued a series of Guidelines on the assessment and treatment of depression and different anxiety disorders. The only major anxiety disorder that is not yet covered is social anxiety disorder. This presentation covers the nature, prevalence, and natural course of the condition and highlights the multiple ways in which it can interfere with people’s lives.

**Analytic methods used to inform the Guideline recommendations**

*Evan Mayo-Wilson, University College London, Stephen Pilling, University College London*

NICE uses a wide range of methodologies to analyse available evidence to inform the recommendations in a Guideline. This presentation provides an overview of the process and describes in some detail the network meta-analyses and cost-benefit analyses that contributed to the recommendations.

**Recommendations for working with people with social anxiety disorder**

*Nick Hanlon, UCL, Gareth Stephens, UCL*

People with social anxiety may be reluctant to come forward for treatment and may find the interactions involved in attending a treatment service particularly stressful. A series of recommendations for working with people with social anxiety disorder are outlined.

**Recommendations for identifying anxiety disorder in adults, children, and adolescents**

*Stephen Pilling, University College London*

Social anxiety disorder is under-recognised in both primary and secondary care. Recommendations for improving the identification of the condition are outlined, with particular reference to the questions and screening instruments that clinicians are likely to find helpful.

**Recommended interventions for adults**
Lusia Stopa, University of Southampton, David M. Clark, University of Oxford
The psychological and pharmacological interventions that are recommended are outlined. Ways of delivering these interventions are described in detail. Interventions that are NOT recommended are also highlighted.

Recommended interventions for children and adolescents
Cathy Creswell, University of Reading, Sam Cartwright-Hatton, University of Sussex
The psychological and pharmacological interventions that are recommended for children and adolescents are outlined. Ways of delivering these interventions are described in detail. Interventions that are NOT recommended are also highlighted.

Transfer of Training in CBT: Do CBT training actually transfer or do we train and evaluate in vain?
Convenor and Chair: Marie Chellingsworth, The Institute of Mental Health, University of Nottingham

Measuring the transfer of training into practice
Marie Chellingsworth, The Institute of Mental Health. The University of Nottingham
Transfer of training is a phrase used to describe the link between classroom based training and the replication of the knowledge and skills into the ‘real world’ setting of the trainee over a sustained period of time. It has been proposed that there is no point to training apart from transfer, yet the problem of transfer evades researchers across disciplines. This is commonly referred to as the ‘transfer problem’. Within CBT training, the clinical skills and theoretical knowledge gained within Cognitive Behavioural Training (CBT) transfering into patient and service outcomes is a key return on investment for all stakeholders, yet little empirical work has been undertaken in this area to date. Within the wider transfer literature it has been predicted that between only ten to forty per cent of the content of training may result in behavioural change in the workplace. Knowing that CBT training produces competent clinicians and positive patient outcomes is a key priority, not least with the new landscape of payment by results and against the backdrop of increased CBT training programmes being delivered. Do we really know enough about which components of training predict better transfer and what hinders the transfer of CBT training into practice? A research protocol for CBT training transfer evaluation using a mixed method sequential explanatory design will be presented.

Evaluating and Demonstrating the Value of CBT training: A Critical Review
Michael Townend, University of Derby, Marie Chellingsworth, University of Nottingham; Wendy Wood, University of Derby; Gemma Wilson, University of Nottingham
In this paper the findings from a critical review will be discussed that concern how CBT training has been evaluated and how effective the evaluation has been. A hermeneutic approach was used make sense and interpret of papers that met the inclusion criteria. Sixteen published papers were identified and read using the framework of Freeth, Hammick, Koppel, Reeves & Barr (2002) as a data extraction tool. Findings suggest considerable variability on the quality of training in the field, suggestions for future practice and research will be made.

IAPT, Linking Training and Patient Outcome
Amanda Branson, 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. A substantial part of the government investment of £400 million is to train new therapists, yet little is known about the efficacy of such training programmes (Kean and Freeston 2008). The current investigation aimed to explore the relationship between training and patient outcomes.
Patient outcome data were collected from five IAPT services for patients treated by Psychological Wellbeing Practitioners (n=46) and High Intensity Therapists (n=36) trained at the University of Reading between 2008 and 2011. Analyses revealed that whilst the outcomes of patients treated by trainee PWP and HIs were comparable to national data (Gyani et al, 2010), assessments of clinical skill (such as the Cognitive Therapy Scale Revised and Observed Structured Clinical Examination), and academic knowledge (such as written examinations and case reports) were largely unrelated to patient outcome. However, when mean performance on clinical assessments was ranked by quartile a significant association was observed between clinical performance and reliable change in symptoms of anxiety and depression, and on rates of recovery. More patients than would be expected by chance alone, who were treated by PWP and HIs in the top quartile of clinical performance, experienced a reliable improvement in their symptoms and reached reliable recovery. Conversely more patients than would be expected by chance showed a reliable deterioration in their symptoms, and fewer patients reliably recovered when treated by PWP or HIs in the bottom quartile of performance. The implications of these findings, and future lines of research will be discussed.
Training the wider workforce in guided CBT self-help— the SPIRIT (Structured Psychosocial Interventions in Teams) Training course

Christopher Williams, University of Glasgow, Rebecca Dafters, NHS Greater Glasgow and Clyde; Lisa Ronald, NHS Greater Glasgow and Clyde; Rebeca Martinez, University of Glasgow

The use of CBT self-help materials for depression is recommended by NICE and is an integral part of the IAPT programme. Such resources can be delivered by both specialist workers (such as the IAPT services in England), or by introducing this style of working into an existing workforce.

The SPIRIT course consists of 38.5 hours of workshops, and 5 hours of clinical supervision in the use of guided CBT (CBT self-help). We describe the evaluation of the effectiveness of the course when offered to community and inpatient mental health staff from a wide range of adult and older adult mental health teams in Greater Glasgow Mental Health Division (267 practitioners from 16 adult and 1 elderly multi-disciplinary team).

Training led to both subjective and objective knowledge and skills gains at the end of training and were largely sustained three months later. At that time point, 40% of staff still reported use of CBSH in the last week. Satisfaction with the training is high using validated rating scales. The SPIRIT training has gone some way to increasing access to guided CBT in everyday clinical practice.

Reference:

Is the level of reflective ability within self-practice self-reflection (SP/SR) blogs a predictor of clinical competency?

Marie Chellingsworth, The Institute of Mental Health. The University of Nottingham, Paul Farrand, The University of Exeter; Nicola Sloan, The University of Nottingham

The benefits of Self-Practice/Self-Reflection (SP/SR) within Cognitive Behavioural Training (CBT) have been well documented in the literature. The process of SP/SR has been deemed to be central to a trainee’s knowledge and skill development enabling trainees to practice CBT techniques and reflect on their practice. Trainees have highlighted the benefits of SP/SR in aiding them to develop a greater sense of empathy, an increased understanding of the role of a therapist and better communication of CBT techniques. Research has also highlighted how the process of sharing SP/SR with other trainees has benefits in normalising their personal experience and seeing how CBT techniques work differently for different people. Due to such benefits SP/SR is currently used in training for Psychological Wellbeing Practitioners (PWP) at some institutions as part of the roll out of Improving Access to Psychological Therapies (IAPT). Reflection is assumed to be an element associated with a competent practitioner however little evidence has looked at the extent to which this is the case. There is a lack of research into the extent to which reflective capacity may predict competency in clinical skills. This study aimed to assess whether there is a relationship between the level of reflective analysis and competency scores in Psychological Wellbeing Practitioner training. The study used discriminant function analysis to examine the extent to which the trainees rating given to the quality of their reflective process was predictive of their score on the competency assessments. We predict that the higher the level of reflection on a participant’s SP/SR blog, the higher their results will be on the patient role-play competency assessment of clinical skill. Preliminary results of the study will be presented.

Computer-delivered and Tecnological-mediated CBT

Convenor and Chair: Simon Gilbody, University of York

Qualitative insights into the use of computer-delivered CBT

Sarah Knowles, University of Manchester

Cognitive Behaviour Therapy (CBT) has generally been regarded as a pragmatic set of clinical interventions based on a materialistic view of the context in which these interventions occur. The real world is a place of facts where an individual’s reactions to these “facts of life”, the situation in which they find themselves depressed or anxious, for example, provides the solution to their problems. This model has served CBT well in the mainstream groups with which it has traditionally been involved. However, the rigours of universal access to psychological therapy through the IAPT programme and the advance of “third wave”, metacognitively based therapies have exposed this model to some challenges. This paper provides a brief exploration and clinical examples of the application of additional, more postmodern principles to the practical task of delivering CBT in a non-standard CBT environment; to the psychological problems of ageing.

With the review of and recommendations for age equality in IAPT services comes the challenge of actually making it happen. We know that CBT works with older people but the constructed mental context within which it is delivered is also important. New models based on the experience of anti-discriminatory practice are proposed as additions to clinical practice and are explored in this paper. The implications of addressing self-stigmatisation in CBT socialisation and
institutional ageism in service development are examined. A proposal is made for integrating everyday CBT practice into working effectively with the psychological problems of ageing.

What level of support is needed to engage with computer-delivered CBT: insights from the REEACT trials
Simon Gilbody, University of York, Liz Littlewood, University of York
For computer delivered CBT (cCBT) to be effective, there needs to be good engagement with and uptake of computer-based materials. Computer-delivered CBT can be offered with varying levels of support to help achieve this. The authors have conducted some of largest independent trials of cCBT to date, and will give their insights drawn from the UK REEACT 1 trial. In this trial, uptake was lower than expected despite the provision of telephone support. The results of this trial will be considered alongside the results of other trials in this important area and other low intensity forms of Self Help.

Moderators of outcome in cCBT
Peter Bower, University of Manchester
Although evaluation of the effectiveness of interventions through randomised controlled trials remains the bedrock of clinical guidelines, such methods provide limited evidence concerning those patient groups who are best served by particular interventions. This places significant limitations on the ability of services to deliver care that is both evidence-based and personalised to patient needs, preferences and aptitudes. Rigorous analysis of moderation in trials (i.e. identifying patient factors associated with variation in comparative benefit) is critical to overcome the limitations of current evidence and to provide a better evidence base concerning ‘what works for whom’.

We conducted analysis of moderators in the NIHR HTA REEACT trial of CCBT for depression. We identified a small set of moderating variables based on practical, clinical and theoretical criteria, including age, gender, initial severity of depression, and patient preferences. We tested the degree to which they predicted comparative benefit from the CCBT interventions in the REEACT trial. We consider the results in the context of published data from existing CCBT trials, and an individual patient data meta analysis of ‘low intensity’ interventions for depression.

Analyses are ongoing and the completed results will be presented at the conference. We will outline the methodological challenges in making appropriate use of analyses of this type, to ensure that findings are replicable and enduring. We will consider the possible clinical and service delivery implications of the findings for depression care in the NHS.

Therapist-delivered therapy via computer and email – the IPCRESS trial
David Kessler, University of Bristol; David Kessler, Glyn Lewis, Surinder Kaur, Nicola Wiles, Michael King, Scott Weich, Debbie J Sharp, Ricardo Araya, Sandra Hollinghurst, Tim J Peters
Summary
Background Despite strong evidence for its effectiveness, cognitive-behavioural therapy (CBT) remains difficult to access. Computerised programs have been developed to improve accessibility, but whether these interventions are responsive to individual needs is unknown. We investigated the effectiveness of CBT delivered online in real time by a therapist for patients with depression in primary care.

Methods In this multicentre, randomised controlled trial, 297 individuals with a score of 14 or more on the Beck depression inventory (BDI) and a confirmed diagnosis of depression were recruited from 55 general practices in Bristol, London, and Warwickshire, UK. Participants were randomly assigned, by a computer-generated code, to online CBT in addition to usual care (intervention; n=149) or to usual care from their general practitioner while on an 8-month waiting list for online CBT (control; n=148). Participants, researchers involved in recruitment, and therapists were masked in advance to allocation.

The primary outcome was recovery from depression (BDI score <10) at 4 months. Analysis was by intention to treat. This trial is registered, number ISRCTN 45444578.

Findings 113 participants in the intervention group and 97 in the control group completed 4-month follow-up. 43 (38%) patients recovered from depression (BDI score <10) in the intervention group versus 23 (24%) in the control group at 4 months (odds ratio 2.43, 95% CI 1.23–4.46; p=0.01), and 46 (42%) versus 26 (26%) at 8 months (2.07, 1.11–3.87; p=0.023).

Interpretation CBT seems to be effective when delivered online in real time by a therapist, with benefits maintained over 8 months. This method of delivery could broaden access to CBT.

Funding BUPA Foundation.

Patients With Long Term Conditions: Year 1 Findings from Four DH Pathfinder Sites
Convenor and Chair: June Dent, Oxford Health NHS Foundation Trust

Buckinghamshire Breathe Well: Developing Integrated Physical and Psychological Care For People With COPD
John Pimm, Oxford Health NHS Foundation Trust, Bronwyn Taylor, Oxford Health NHS Foundation Trust
Patrick Kennedy-Williams, Oxford Health NHS Foundation Trust; Clare Stafford, Oxford Health NHS Foundation Trust

72
People with Chronic Obstructive Pulmonary Disease (COPD) are 3 times more likely to experience common mental health problems than the general population. This co-morbidity results in poorer clinical outcomes and increased costs for the NHS. The aim of this pathfinder site is to implement and evaluate an integrated physical and psychological stepped care pathway for COPD. Working together the IAPT service and primary and community respiratory services have developed a range of innovative evidence based interventions delivered in GP practices, community rehabilitation programmes and home based settings. Results from over 153 participants, mean age 70 years (range 38–94 years), 55% male will be presented. For the step 2, low intensity, breathlessness intervention there were significant improvements in depression, anxiety, phobia and confidence to manage COPD. For the step 3, high intensity, modified pulmonary rehabilitation programme there were significant improvements in depression, anxiety, physical function and work and social adjustment. Implications for integrated stepped care management of COPD, training, service development and research will be discussed.

Oxfordshire Heart2Heart: Implementing A Stepped Care Pathway For Anxious And Depressed Patients In Cardiac Rehabilitation
June Dent, Oxford Health NHS Foundation Trust, Heather Salt, Oxford Health NHS Foundation Trust, Marion Elliot, Oxford University Hospitals NHS FT, Clare Stafford, Oxford Health NHS Foundation Trust, Patrick Kennedy Williams, Oxford Health NHS Foundation Trust

Early research and service development work showed that patients who had had a myocardial infarction and who also were anxious or depressed had benefitted from being offered very brief psychological interventions from a highly trained and specialised psychological therapist working within a cardiac rehabilitation service. The current DH Pathfinder Site in Oxfordshire built on this work and investigated whether an integrated stepped care model was a feasible alternative. By working together care was modified and delivered by cardiac nurses and exercise physiologists at step 1, IAPT staff at steps 2 and step 3, and by specialist psychological therapists at step 4. Training, consultation and clinical supervision in CBT was provided across all steps by an experienced clinical health psychologist and reciprocal training, consultation and supervision in cardiac rehabilitation was available throughout the year from the cardiac specialists. The study also investigated whether care could be extended to new patient groups who have heart failure and other cardiac diseases. The progress of the first 86 patients seen in year one (mean age 59 years, age range 19 – 85), will be presented. The clinical outcome data is very promising showing significant improvements on measures of anxiety, depression and work and social adjustment by the end of treatment. Further analyses of quality of life and economic data will be presented and lessons learned about ways to develop fully integrated services will be discussed.


IAPT: Is the best yet to come?
Convenor: Pam Myles, University of Reading
Chair: David M. Clark

Developments in High Intensity Therapies for Depression and Anxiety Disorders
David M Clark, University of Oxford

Some recent developments in high intensity therapies for depression and anxiety disorders are described and their possible relevance for IAPT services is considered.

Future of IAPT – the PWP Role
Steve Pilling, University College London

The Psychological Well-being Practitioner (PWP) is essentially a product of the IAPT programme and has been central to the effective delivery of the IAPT programme. Over the past 5 years the role of the PWP has developed, driven in part by new evidence as it emerges but also by the demands of the service. The implications of these developments, both good and bad, for the future role of the PWP are discussed along with the outcome of a recent review of the PWP national curriculum and associated materials. Taken together these suggest a new theoretical framework for the work of the PWP and a revision to the role of the PWP not only in existing IAPT services but in the expansion of IAPT services into acute health care and long-term conditions.

CYP IAPT: Challenges and opportunities for the future?
Peter Fonagy, University College London, Kathryn Pugh, NHS Improving Quality, NHS England

The Children and Young people’s element of the IAPT programme has always been highly ambitious and fast moving. In its third year, the programme will expand its current service transformation programme geographically and through offering new training curricula. CYP IAPT works with existing CAMHS to support collaborative practice between our young service
users, their families and professionals through routine outcome monitoring and participation in service feedback and design, embedding evidence based practice and strong case management. The addition of training in interpersonal psychotherapy for adolescents with depression and working systemically with families will further support the development of comprehensive, reflective and responsive CAMHS but as the project moves forward it is identifying organisational development needs and further training needs in local services. What gaps have been identified so far, and how might the current vision and reality of the project and its interaction with services evolve over the next four years?

How does the current work programme fit with the NHS quality improvement initiatives? Does the way CYP IAPT unfolded yield principles that may lead to service improvements elsewhere?

IAPT and Older People
Marie-Claire Shankland, NHS Education for Scotland

Despite IAPT services being open to all adults there is a considerable under representation of older people amongst the population accessing IAPT. The estimated prevalence of common mental health disorders for adults over the age of 64 in England is 18% (Adult psychiatric morbidity survey, 2007). Access rates to IAPT nationally for this group is an average of 5.2% compared with a rate of at least 12% set out in the ‘Talking therapies: four year plan of action’ (DOH 2011).

There is a considerable body of research evidence indicating that talking treatments are as effective in addressing anxiety and depression in older people as other age groups. NICE guidance on the treatment of anxiety and depression makes no variation in its recommendations relating to age. An analysis of a sub-set of the national data for IAPT indicates that there is no difference in recovery rates for those aged over 64 years. Some IAPT services have reported finding higher recovery rates for those over 64 years, and a trend towards older people being more likely to complete a full course of treatment.

National Initiatives
• The IAPT Workforce Education and Training Group, in conjunction with experts in psychological treatments for older people, have produced a Competence Framework and an Indicative Curriculum for working with older people. This will form the basis of future Older People training on IAPT courses and will be available to provide top up training for existing IAPT staff.
• An IAPT ‘Compendium’ is available bringing together examples of initiatives that IAPT services have undertaken that increase access for older people.
• Promoting talking treatments to older people – joint campaign with Age-UK.
• Older people should constitute around 50% of those presenting with Long Term Conditions. The IAPT pathfinder site data will be analysed separately for those over 64 years to give a clear insight into how targeted LTC interventions affect outcomes for older people in IAPT.
• Targeting specific populations of older people who have higher rates of anxiety and depression e.g. supporting the Alzheimer’s Society trial of cCBT for carers of people with dementia.

There will be discussion of what local services can do to improve access for older people and the potential to expand the vision for access to psychological therapies by addressing the needs of older people.

IAPT for SMI: The Story so Far
Alison Brabban, County Durham and Darlington Priority Services

In 2012, the Schizophrenia Commission reported that despite the NICE recommendation that everyone with psychosis should be offered CBT, only 10% of those with psychosis have access to this intervention. Moreover, for those with a diagnosis of Bipolar Disorder or a Personality Disorder access to evidence based therapy is even more limited. To address this unacceptable level of provision, the IAPT for SMI project is working to identify and address barriers to implementing therapy for those with complex mental health problems within current mental health services. The presentation looks at the current level of therapy provision for those with an SMI and considers why it is so low. It then highlights how this has influenced the focus of the IAPT SMI project, what has been done to date and what still needs to be done if access to therapy is to become universal.

Long Term Conditions and Medically Unexplained Symptoms
André Tylee, King’s College London

This talk will provide an overview of the Long term Conditions and Medically Unexplained Symptoms (LTC/MUS) Programme within IAPT. In the first phase of the LTC/MUS workstream, just over £2m has been spent on supporting 15 National Pathfinder sites across the country to examine a variety of models to improve care for people with LTCs (e.g. coronary heart disease, chronic onobstructive pulmonary disease, diabetes etc) and MUS (e.g. chronic fatigue, irritable bowel, fibromyalgia etc). Models include those that involve providing additional training for IAPT workers in how to manage long term conditions and MUS within their services, the provision of additional psychological support and also related training in psychological skills for medical services (e.g. pulmonary rehabilitation, diabetes services, coronary heart disease services etc), additional training and provision of psychological services in primary care for people with LTC and MUS etc mindfulness groups for people with MUS in a primary care setting). Many of the Pathfinder projects are improving access for a range of people with LTC/MUS and these will be described. Preliminary findings from an external evaluation will be discussed as will plans for further phases in the LTC/MUS workstream.
Evidence suggests that up to 70% of MUPS patients also suffer from depression or anxiety, suggesting that between 20% - 30% of all consultations in a primary care setting are with people experiencing MUPS. A MUPS can sometimes be unexplained after an appropriate medical evaluation (Richardson and Engel, 2004). Research suggests that between 20%- 30% of all consultations in a primary care setting are with people experiencing MUPS. Evidence suggests that up to 70% of MUPS patients also suffer from depression or anxiety, and a MUPS can sometimes be associated with a higher suicide risk. It is therefore important that people with MUPS are carefully assessed and offered appropriate treatment.

Diversity section of the course at Reading University has tried to address these challenges, and it will look at areas for PWP clinical educators, as well as PWPs wishing to improve their cultural competence. This focus is given the evidence that certain groups, including those from BME backgrounds, face disproportionate barriers in access to services and outcomes by sexual orientation is not well understood and information is under-collected. In addition, there is disproportionately poor data gathering and analysis on sexual orientation and avoidable harm in comparison to some other protected characteristics. Therefore, a better understanding of how services and PWP working can be improved to meet the needs of LGB individuals is needed. This is the primary aim of this talk and will include suggestions for improving care. This is particularly important to consider when reviewing research that states LGB individuals are at higher risk of experiencing anxiety and depression compared to heterosexual individuals (Mind, 2013). Another area of interest is reducing rates of self-inflicted injury and suicidal ideation/behaviour among LGB individuals (Department of Health, 2011). Jorm, Korten, Rogers, Jacomb and Christensen (2002) found that homosexual and bisexual individuals were significantly higher on suicidality measures compared to heterosexual individuals. Similarly, Ferguson, Horwood and Beautrais (1999) reported LGB individuals (self-reported) to be 5.4 times more likely to have suicidal ideations and 6.2 times more likely to have suicidal attempts than heterosexual individuals (self-reported). In PWP working, a critical element of training and practice is how to conduct a risk assessment. This talk reinforces the importance of this with any and all individuals, particularly within a LGB population. Furthermore, insight into the limits of PWP working and the usefulness of signposting is a key skill to grasp. A wide range of resources (ranging from information leaflets, support groups, physical exercise groups and helplines) can be accessed which are often absent from resource manuals in PWP working. This talk will cover organisations in the UK that support LGB individuals with mental health problems to improve collaborative working. Overall aims of the talk are to a) increase awareness of sexual diversity in PWP working, b) review the importance of data collection within IAPT services for protected characteristics (focus on sexual orientation), c) improving standard of care offered to LGB individuals, and d) awareness of risk rates in LGB populations.

Considering diversity within IAPT: how to improve access and treatment at Step 2
Convenor and Chair: Allán Laville, Charlie Waller Institute, University of Reading

Considering sexual diversity in PWP working
Allán Laville, Charlie Waller Institute, University of Reading

Diversity is about the recognition and valuing of difference and creating a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and the individual (Department of Health, 2011). Sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes (APA, 2008). Sexual orientation (lesbian, gay, bisexual (LGB)) is a protected characteristic under the Equality Act (2010) and therefore deems it unlawful to discriminate, harass or victimise an individual on the grounds of their sexual orientation. NHS organisations are listed as public authorities covered by the general duties. These duties include the advancement of equality of opportunity. Data collection and reporting is therefore a critical function for ensuring effective delivery of equality objectives and for improving access to psychological therapies (IAPT Data Handbook, 2011). The Department of Health (2011) comment that access to services and outcomes by sexual orientation is not well understood and information is under-collected. In addition, there is disproportionately poor data gathering and analysis on sexual orientation and avoidable harm in comparison to some other protected characteristics. Therefore, a better understanding of how services and PWP working can be improved to meet the needs of LGB individuals is needed. This is the primary aim of this talk and will include suggestions for improving care. This is particularly important to consider when reviewing research that states LGB individuals are at higher risk of experiencing anxiety and depression compared to heterosexual individuals (Mind, 2013). Another area of interest is reducing rates of self-inflicted injury and suicidal ideation/behaviour among LGB individuals (Department of Health, 2011). Jorm, Korten, Rogers, Jacomb and Christensen (2002) found that homosexual and bisexual individuals were significantly higher on suicidality measures compared to heterosexual individuals. Similarly, Ferguson, Horwood and Beautrais (1999) reported LGB individuals (self-reported) to be 5.4 times more likely to have suicidal ideations and 6.2 times more likely to have suicidal attempts than heterosexual individuals (self-reported). In PWP working, a critical element of training and practice is how to conduct a risk assessment. This talk reinforces the importance of this with any and all individuals, particularly within a LGB population. Furthermore, insight into the limits of PWP working and the usefulness of signposting is a key skill to grasp. A wide range of resources (ranging from information leaflets, support groups, physical exercise groups and helplines) can be accessed which are often absent from resource manuals in PWP working. This talk will cover organisations in the UK that support LGB individuals with mental health problems to improve collaborative working. Overall aims of the talk are to a) increase awareness of sexual diversity in PWP working, b) review the importance of data collection within IAPT services for protected characteristics (focus on sexual orientation), c) improving standard of care offered to LGB individuals, and d) awareness of risk rates in LGB populations.

Training culturally competent PWPs: Challenges and opportunities
Matthew McNaught, Charlie Waller Institute, Reading University/italk, Solent Mind,

Training Psychological Wellbeing Practitioners (PWPs) to be culturally competent is a clear priority in the IAPT PWP curriculum, reflected in the fact that a whole module of the course is dedicated to culture and diversity. This focus is given the evidence that certain groups, including those from BME backgrounds, face disproportionate barriers in accessing services (NIMHE, 2003). However, the issue of cultural competence is vast and complex, and while there is a consensus that something should be done, there is still debate about how cultural competence should be conceptualized, taught and tested (Dogra & Karim, 2005). Some have questioned the assumptions implicit in this kind of training, arguing that it can sometimes present an overly simplistic and unhelpful view of culture and cultural competence (Kumas-Tan, Beagan, Loppie, MacLeod and Frank, 2007). Others have noted the relative lack of empirical evidence for cultural competence training and culturally adapted practice (Sue, Zane, Nagayama-Hall and Berger, 2009). In addition, most guidance on cultural competence is aimed at high intensity therapists and psychologists rather than low-intensity practitioners such as PWPs. All of this presents challenges for PWP clinical educators, as well as PWPs wishing to improve their cultural competence. This talk will look at the challenges inherent in training PWPs to be culturally competent. It will look at some of the key debates and guidance from the literature and their implications for PWPs. It will discuss the ways in which the Culture and Diversity section of the course at Reading University has tried to address these challenges, and it will look at areas for further development and improvement.

Medically Unexplained Symptoms from a PWP perspective
Gemma Brisco, University of Reading

Medically Unexplained Physical Symptoms (MUPS) may be defined as physical symptoms that prompt the sufferer to seek healthcare but remain unexplained after an appropriate medical evaluation (Richardson and Engel, 2004). Research suggests that between 20%- 30% of all consultations in a primary care setting are with people experiencing MUPS. Evidence suggests that up to 70% of MUPS patients also suffer from depression or anxiety, and a MUPS can sometimes be associated with a higher suicide risk. It is therefore important that people with MUPS are carefully assessed and offered...
appropriate treatment wherever possible (IAPT Positive Practice Guide, 2008). Cognitive Behavioural Therapy (CBT) has been shown to be an effective intervention in improving quality of life and wellbeing in people experiencing MUPS (Speckens, Hemert, Spinshoven, Hawton, Bolk and Rooijmans, 1995; Kent and McMillan 2009; Sumathipala, Hewege and Hanwella, 2013). Therefore, MUPS is now a particular focus within IAPT and is currently being treated using both Step 2 and Step 3 interventions in some services. However, there is currently a lack of research and guidance regarding working with MUPS from a Step 2 perspective.

This talk will look at the clinical experience of a PWP who has had the opportunity to work with this client group by facilitating a symptom management programme as part of a Department of Health pathfinder project. The key focus of the talk will be to provide information and consideration points for PWPs working or hoping to work with people with MUPS within an IAPT setting. Brief details will be provided of the clinical content. Emphasis will be placed on the clinical skills required for engagement and how this fits with the PWP training; this will include adaptations to common factor skills directly from the personal perspective of a PWP that has ‘been there and done it’. Consideration will be given to developing engagement using the Hot Cross Bun CBT model specifically at step 2. The aim is to highlight useful skills required when working with this client group and also difficulties encountered by PWPs throughout treatment. Through the presentation the audience will be able to identify some of the ‘top tips’ and potential pitfalls of engaging with MUPS as a PWP. Finally, the talk will highlight potential training needs and considerations PWPs may wish to reflect upon when working with this client group.

Improving Access and Quality of Treatment for Older People at Step 2
Katy Figus, Charlie Waller Institute, University of Reading, UK. Healthy Minds, Buckinghamshire, Oxford Health NHS Foundation Trust, UK

High levels of common mental health problems are reported within the older adult population, with clinical symptoms of depression found in approximately 25% of older adults (Older People Positive Practice Guide, 2009) and clinical symptoms of anxiety in 15.3% (Kessler, Berglund, Demler, Jin, Merikangas & Walters, 2005). Despite this, outcomes show older adults are under-represented in IAPT services (IAPT, 2011). There is a legal responsibility to demonstrate that older people and other protected groups are safe from discriminatory practices and health professionals are expected to make reasonable adjustments to remove barriers (Equality Act, 2010), therefore the talk will look at how Psychological Wellbeing Practitioners (PWPs) can make appropriate modifications in their low intensity practice, as well as how IAPT services can reduce barriers in accessing treatment for this population.

The talk will highlight both the importance of existing clinical elements of step two practice such as using common and specific factor skills (Richards & Whyte, 2011) and following a patient centred approach, as well as making adaptations to incorporate additional clinical skills (where appropriate) including using aids to assist memory and reduce anxiety, applying wisdom enhancement (Laidlaw, 2010) and considering strategies based around Selection Optimisation and Compensation (Freund & Baltes, 1998; Baltes & Smith, 2002).

Other modifications will concentrate on new step two initiatives aimed at increasing referrals from older adult populations, such as Cognitive Behavioural Therapy for insomnia (CBT-I), Cognitive Behavioural Therapy group for carers of people with dementia and clinics for individuals with long-term conditions, who may have co-morbid symptoms of depression and/or anxiety.

Finally the talk will end with recognising some of the barriers in engaging this population including assumptions that common mental health problems are attributable to age, stigma and cohort beliefs, and will consider ways to overcome these barriers.

Transforming CBT in Primary Care
Chair: Pam Myles, University of Reading
Discussant: Ian McPhearson, Improving Health and Wellbeing, UK

Early changes, attrition and dose-response in low intensity psychological interventions
Jaime Delgadillo, Primary Care Mental Health Service, NHS Leeds Community Healthcare, Dean McMillan, University of York; Mike Lucock, South West Yorkshire Partnership NHS Foundation Trust and University of Huddersfield; Chris Leach, South West Yorkshire Partnership NHS Foundation Trust and University of Huddersfield; Simon Gilbody, Hull York Medical School and Department of Health Sciences, University of York

Objectives: To investigate if early symptom changes in brief low intensity psychological interventions (guided self-help and psycho-education using CBT principles) are predictive of final treatment outcome.

Design: Retrospective cohort data analysis.

Method: Clinical records for 1850 patients who screened positive for depression and/or an anxiety disorder were analysed. Reliable and clinically significant improvement (RCSI) on depression (PHQ-9) or anxiety (GAD-7) outcome measures after treatment was the primary outcome. Change scores ≥6 on PHQ-9 and ≥5 on GAD-7 were taken as indicative of reliable improvement (RI). The model assumed that RI in the earliest treatment sessions would be predictive of RCSI post-treatment. Predictive accuracy was assessed by calculating the area under the curve (AUC), as well as positive and negative predictive values. Diagnostic odds ratios were also estimated, adjusting for confounders such as baseline severity, use of medication and pre-treatment symptom change.
Results: AUC estimates for session-to-session change scores ranged between .62 – .88, indicative of moderate to high predictive reliability. Predictive accuracy was higher for patients who had 4 or more treatment sessions, with more than 70% of patients with RCSI being accurately identified as early as sessions 1 to 3. Attrition rates were significantly associated with poor outcomes. Results suggest that at least 4 therapy sessions are necessary to achieve more than 50% RCSI rates, and the dose-response effect appears to decline in treatments longer than 6 sessions.

Conclusions: Patients showing RI early in treatment were at least twice as likely to fully recover compared to those without early RI.

**CBT for Anxiety Disorders in Primary Care**

**Michelle Craske, UCLA**

Anxiety disorders are highly common and yet often poorly treated in primary care. The CALM study evaluated the effectiveness of (a) cognitive behavioral therapy, psychotropic medication recommendations, or both compared to (b) treatment as usual, for anxiety disorders in primary care. Cognitive behavioral therapy for multiple anxiety disorders was computer/internet assisted, in order to increase fidelity of CBT in the hands of novice clinicians. Computer-assisted CBT and its effects will be presented. In addition, methods for training novice clinicians in computer-assisted CBT, the acceptability of the program, and the role of therapist adherence/competency in treatment outcomes will be described. Also, the role of ethnicity, income, and age as moderators of outcome will be presented. Finally, the role of engagement in CBT and self efficacy and outcome expectancy as mediators or treatment outcomes will be described.

**CBT Developments in Primary Care**

**Steve Pilling, University College London**

Primary care has always been, and will remain, the primary focus of care for the vast majority of mental health care. The advent of the IAPT programme has seen an expansion in the availability of CBT based interventions but little variation in the model or style of delivery of CBT. This is a major missed opportunity. New models and modes of delivery are required which allow more people to engage with CBT (e.g. those with long-term conditions), are based on much closer working relationships with other providers of healthcare (e.g. GPs or practice nurses), engage more imaginatively with new technologies ( e.g. moving beyond the limited CCBT models available) and engage the wider community in the delivery of interventions (e.g. the workplace). Primary care should be the hub around which this new model is built. How this might be achieved and what we need to know to implement it effectively will be discussed.

**Improving Access to Treatment: Novel CBT Models and Pathways of Care**

**Convenor and Chair: Steve Kellett, University of Sheffield**

**Evaluation of the Psychological Well-being Practitioner Role in the NHS**

**Olivia Adams, University of Surrey; Nimmi Hutnick, University of Surrey; Serenia Yip, ; Olivia Adams, University of Surrey; Gemma Nash, University of Surrey**

Little research to date has been conducted into the role of a Psychological Wellbeing Practitioner (PWP). The PWP role was established within the Improving Access to Psychological Therapies initiative to provide Low Intensity CBT interventions to people suffering mild to moderate depression and anxiety. PWPs treat a high volume of people in a short space of time via face to face or telephone interaction or a combination of these. Working with such a high volume of patients providing short term interventions may be inherently unsatisfying. We describe how PWPs feel about undertaking high volume low intensity work and how they evaluate their role. 18 PWPs filled in a PWP Satisfaction Questionnaire (PWPSQ). These were Content Analysed. The PWPSQ revealed that PWPs are happy and proud to be PWPs because they are able to help patients change. However, they were unhappy with the high volume case load and limited time with patients leading to perceived poor quality patient care. Also, they feel their role is undervalued by other service professionals and that there were few career progression opportunities within the role, leading to PWPs moving on to other jobs. The primary reasons for a lack of satisfaction in the role related to the nature of the task itself; high caseloads, exhaustions and burnout and the target driven nature of services. The PWP role needs some modification in order to ensure the retention and well-being of PWPs themselves.

**A brief model of CBT appropriate for acute care**

**Emily Turton, University of Surrey /Sussexpartnership NHS foundation Trust; Dr Bree MacDonald, Sussexpartnership NHS Foundation Trust; Dr Paul Davis, University of Surrey**

Crisis Teams are part of acute care and aim to prevent / reduce hospital admissions by providing care and support in the community. The British Psychological Society (BPS) published a paper (2008) on the role of Clinical Psychologists in Crisis Teams, which recommended that CBT might be a helpful intervention to draw upon but did not identify any evidence of how it should be delivered. Similarly the BPS recently (February 2013) published a paper on delivering Clinical Psychology in acute care, stressing that psychological interventions should be provided, but did not identify how or what a model for...
interventions in Crisis Teams might look like. CBT techniques are currently being used in Crisis Teams in West Sussex, and there is some evidence that CBT informed techniques are being used elsewhere in Crisis Teams (Brunetti, 2008). This study aimed to describe the model of CBT techniques used in Crisis Teams. A qualitative study was carried out to understand the experience of five staff using CBT techniques in Crisis teams and identify some common themes. The Project is ongoing with a finish date of May 2013.

The discussion will include an analysis of similarities and differences of CBT techniques used in the Crisis Team setting compared to those used in acute inpatient, or in the community. A model outlining appropriate use of CBT techniques in Crisis Teams will be proposed. Using CBT techniques in this way is a new area of work and is interesting theoretically. How CBT techniques can be transferred to patients in a Crisis Team, informing Crisis Team services and the study will identify future training needs for individuals working in Crisis Teams. Clinically psychological work in Crisis teams is predominantly short term, for example formulation and assessment based work. The proposal of a therapeutic model specific to Crisis Teams aims to consolidate short pieces of therapy within these teams and encourage the development of other short-term therapies appropriate to crisis settings.

‘Get out of Jail Free Card’ Offender IAPT Project, taking Improving Access to Another Level
Kim McConnachie, 2gether Foundation NHS Trust; Habibah Moolla, 2gether Foundation NHS Trust

The Offender Improving Access to Psychological Therapies (IAPT) project went live on the 22nd October 2012, to work with offenders who are experiencing primary care mental health problems; a topic which is under researched and at an embryonic stage.

The Bradley Report (2009) suggested the Criminal Justice System was failing offenders with mental health problems. The ‘Alternative to Custody’ project aims to address this gap in services by offering an IAPT intervention to offenders who are at the point of being sentenced to custody and thus divert them away from prison.

Solomon & Rutherford (2007) stated that the ‘Level of emotional needs that may be directly related to criminal behaviour of those serving community sentences in 2005 – 2006 was 43%’ yet only 1% of offenders in the community are being referred for mental health treatment (DOH 2010).

The Offender IAPT project, supported by the local 2gether NHS Foundation Trust, has taken the concept of ‘Improving Access’ to the hard to reach client as one of the fundamental requirements of any IAPT service. Practitioners in this project were drawn into unknown territory and this paper discusses the challenges and rewards in combining mental health interventions with the criminal justice system sentencing processes.

Methodology is based on the PDSA Cycle: Plan, Do, Study Act (Deming, 1993) with practitioners reflecting on the following three questions to aid development of the project: What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in an improvement?

Evaluation will be via use of both qualitative and quantitative data.

This paper will demonstrate key issues for the implementation of the ‘Offender IAPT Pilot Project’ for both the criminal justice system and the IAPT services. Implications and experiences for IAPT practitioners and service users will also be discussed and evaluated.

At the time of writing this is the only project of its type in England and our findings will hopefully prove of value in the future as IAPT organisations begin to expand services to include this challenging client group.

Improving Access to Psychological Therapies for people with Chronic Obstructive Pulmonary Disease
Kristina Fletcher, NAViGO CIC; Judy Humphrey, NAViGO CIC; Jan Kirkby, NAViGO CIC; Stacey Whyte, NAViGO CIC

NAViGO CIC provides the improving access to psychological therapies (IAPT) service in North East Lincolnshire and was awarded a Burdett Trust grant to develop integrated pathways for people with chronic obstructive pulmonary disease (COPD).

COPD is the second highest cause of emergency admission to hospital. Up to 67% of people with COPD experience depression and anxiety (DOH, 2011). This psychological co-morbidity can increase hospital admissions and significantly reduce quality of life (Yohannes et al, 2010).

In line with evidence for talking therapies in long term conditions (King’s Fund, 2012), pathways were developed for assessing and treating depression and anxiety; integrating cognitive behavioural therapy (CBT) with acute and community COPD services. Organisations working collaboratively across the hospital community interface; offering sessions in hospital wards, the community and people’s homes.

Outcomes include monitoring reductions in health care use e.g. hospital admissions, primary care appointments and Accident and Emergency (A&E) attendances. Improvements are also measured for depression, anxiety, functioning, quality of life and satisfaction.

During the first nine months 105 people were assessed. Results indicate that 88% of those completing treatment reached recovery for depression and anxiety and have achieved life changing improvements in quality of life and functioning. 65% completing the evaluation indicated they can now manage anxiety and breathlessness at home without phoning an ambulance or going into hospital, where previously they had used emergency services.

We present the results, challenges and conclusions from the first year and discuss potential to extend this integrated service to other long term conditions.
Potential implications include replicability and further development of integrated services providing CBT to people with long term physical health conditions including COPD.

The Sheffield LTC/MUS Pathfinder site; a mixed methods service evaluation

Stephen Kellett, NHS and Sheffield University; Kim Keane, NHS

In February 2012, Sheffield achieved Pathfinder status in terms of developing services for patients with LTC/MUS in Primary Care. This triggered a major training initiative in Primary Care and the development of a new stepped care model for LTC/MUS patients. GPs have been trained in more effective recognition at step 1, PWPs in pacing at step 2, CBT therapists in ACT at step 3, with a team of Health and Medical Psychologists offering a consultation/specialist treatment service at step 4. New supervision and clinical governance structures have therefore been put into place. This paper reports on the clinical and organisational impact of the Sheffield Pathfinder initiative for the first six months of the project (September 2012-March 2013).

In a mixed methods approach N=10 patients and N=10 staff were randomly selected and interviewed concerning their experience of receiving and providing psychological care, with data analysed using thematic analysis. Use of the IAPT minimum dataset has enabled N=1016 LTC/MUS patients to be tracked through the stepped care model since the start of the Pathfinder. The results will be reported via a CONSORT type analysis of patient flow, which reports rates of drop-out, recovery and harm for both LTC and MUS patients.

In comparison to generic IAPT referrals, LTC/MUS patients tend to be the same ethnic mix, but more likely to be male and older. Caseness is high (>80%) for both anxiety and depression across LTC and MUS patients. The stepped care model means that 81.81% of LTC/MUS patients are treated at step 2 by PWPs. Overall, 15.16 % of LTC/MUS patients are stepped-up, equally distributed across LTC and MUS. The recovery rate for LTC/MUS patients is lower than generic IAPT referrals across step 2 and step 3, but harm is a very rare outcome. Patients reported six key themes including the importance of the therapeutic relationship. Staff reported six key themes including an increased awareness of the emotional needs of LTC/MUS patients.

The paper will be discussed in terms of the organisational impact of the Pathfinder site, methodological limitations and the challenge of developing robust/integrated services for LTC/MUS patients within IAPT.

Patients with LTC/MUS are common in Primary Care and are often referred for low and high intensity interventions.

Skills Classes

Creating Lean, Mean Fighting Machines: Low-Intensity Services in the age of Austerity

Jim White, STEPS, Greater Glasgow and Clyde NHS

With budget restraints and increasing demand, low-intensity services must look at providing the most efficient and effective services possible. This class will look at ways of providing innovative and comprehensive approaches to common mental health problems and to look at ways of tackling common difficulties such as attrition (Richards and Borglin, 2011).

The class will focus on the six-level Glasgow STEPS model – individual therapy, groups/classes, single contacts, non-face-to-face contacts, working with others, population-level (White, 2008).

Objectives: By the end of the class, participants will have looked at options to:

a) offer greater choice to service users.

b) substantially increase the number of people offered a service while, at the same time:

c) allow clinicians to use a wider range of skills and, by doing so, reduce the risk of burnout in clinicians who, otherwise, may feel pressure to provide ‘more of the same’ in an attempt to keep waiting times low.

d) offer early intervention/prevention interventions at the population level.

e) offer a range of services more suited to areas of deprivation.

Jim White is a consultant clinical psychologist and leads the Glasgow STEPS primary care mental health team, a Scottish Government Exemplar Project. He is a co-editor of the Oxford Guide to low-intensity CBT (Bennett-Levy et al, 2010) and is the creator of Stress Control, a large class CBT approach, increasingly used in IAPT services (White, 2010).


Utilising CBT Techniques in Practice with Clients with a Long term Condition who Experience Depression and/or Anxiety

Simon Reay, Gateshead and South Tyneside IAPT Service & Carrie Davies, Gateshead and South Tyneside IAPT Service
People with Long Term Conditions (LTC) are two to three times more likely to experience depression and/or anxiety (DOH 2011). The CSIP paper Long Term Conditions and Depression (2006) identified the increased risk of depression in people with a LTC and that this impacts on outcomes, disability and health resource utilisation. It is claimed that effectively treating anxiety and depression within this client group serves to provide a range of clinical and financial benefits (Department of Health, 2008). Treatment of Anxiety and Depression helps improve quality of life and prognosis (Department of Health, NICE Guidelines for COPD 2010). CBT is recognised in NICE guidance for treatment of anxiety and depression and also recommended in NICE Guidance for treatment of LTC’s (Dept. of Health 2010). In response Gateshead and South Tyneside IAPT Service has recently trained all 50 Community Matrons in CBT Techniques and supported this by providing all trainees with monthly Clinical Supervision as part of an interagency Pilot to working with Long Term Conditions. The workshop will focus on the relationship between LTC’s and depression and anxiety. How CBT can be effective in working with LTC’s, using the cognitive model to incorporate physical and mental health as part of formulation and how sharing the CBT model with patients and explaining the role of thoughts, feelings and actions in chronic illness can help to educate patients and increase the likelihood of engagement in the active management of their illness. Overcoming maintenance of problems, identifying goals and implementing cognitive and behavioural treatment interventions will conclude the session.

Objectives: At the end of the class participants will have the skills, knowledge and understanding to
1) Define, recognise, assess for and formulate symptoms of anxiety and depression in clients with a Long Term Condition
2) Collaboratively identify client goals
3) Plan, develop and deliver cognitive behavioural techniques with clients with a Long Term Condition

Simon Reay is Clinical Lead and Cognitive Behavioural Therapist (Post Grad Diploma in CBT) with Gateshead and South Tyneside IAPT Service. Simon has worked in mental health for over 20 years, initially as an RMN Level 3 and also has a BSc Hons Degree in Mental Health. Simon also currently facilitates the IAPT Service Long Term Conditions Group which has recently conducted a Pilot designed to train health staff (50 locality Community Matrons) in implementing CBT Techniques working with clients with Long Term Conditions, and supporting the development of all trainees through monthly clinical supervision.

References: Kunik et al (2007) COPD education and cognitive behavioural therapy group treatment for clinically significant symptoms of depression and anxiety in COPD patients: a randomised controlled trial, Psychological medicine, 38, pp.385-396
Mannix et al (2006) Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners, Palliative medicine, 20, pp. 579-584

Posters

A group based intervention for those with depression and co-morbid diabetes
Deniz Kemal, KCA; Pavlo Kanellakis, KCA; Karl Williams, KCA
Living with a long term health condition can be further distressing for an individual when there is co-morbidity with depression and/or anxiety. Depression in these individuals is known to be associated with poor compliance to diabetes control (Gonzalez et al. 2010), increased risk of complications from diabetes and is known to be mainly treated with pharmacological intervention.

The long term conditions positive practice guide published by IAPT (2008) highlights the importance of better links between IAPT services and physical health services in order to reduce the suffering experienced by the individual and also to reduce costs of additional health services from those experiencing co-morbid depression and/or anxiety.

The aim of this study is to determine the efficacy and appropriateness of offering a group intervention tailored for those with diabetes within a Step 3 IAPT service compared to a waiting list control group.

A 10 session weekly CBT based depression group was developed with a specific focus on diabetes control.

Participants: Participants were recruited from the current waiting list and local diabetes service.
Measures: For those recruited to the group, the IAPT minimum data set was used at each session, including the PHQ-9 as a measure of depressive symptoms, GAD-7 as a measure of anxiety symptoms. For those on the waiting list, measures were taken at the start and end. Outcomes will be taken again 3 months after treatment.

Measures of glycemic control were requested from the GP at the beginning, end and at follow up where possible.

Intervention: Based on the NICE guidelines for depression in adults with a chronic health problem (2009), a structured CBT group-based intervention was developed with a focus on diabetes psycho-education and management. The group met for 10 meetings with four participants, including a follow up.

The results from the study indicate good patient satisfaction.

There was a 75% moving to recovery rate (3 out of 4).

There were no drop outs indicating that participants were happy to engage in this type of treatment.
We will aim to conduct another group before the Conference and could therefore, produce further results by then. Long term health conditions are an increased focus of IAPT services. This study aimed to investigate the effectiveness of using a group-based CBT intervention for those with diabetes and co-morbid depression. Previous research had shown individual CBT to be effective in improving the symptoms of depression in participants with co-morbid diabetes and depression but had received mixed results on improving diabetes management (Gonzalez et al. (2010), Khalida et al. (2004)). Therefore, this study aimed to investigate the effectiveness of a group based approach. These preliminary results may provide evidence for the acceptability, feasibility and potential utility of CBT groups for diabetes and other long term conditions within IAPT services. The results of the study will be discussed further upon completion of the study. It is anticipated that if the group based intervention is showed to be effective for co-morbid depression and diabetes then it is possible that further studies can be conducted and/or randomised controlled trials set up to investigate the efficacy further. Furthermore, a group based intervention is likely to be utilised within IAPT services and physical health services as a way of treating higher numbers of those awaiting therapy and also as a way of driving forward specific interventions for long term conditions.

Mindfulness-based Cognitive Therapy in IAPT
Peter Smith-Howell, Suffolk Wellbeing Sevice.

It is sometimes difficult to see how MBCT could be implemented into an IAPT service in view of the fact that there is so much emphasis on recovery rates. Nevertheless, with a move towards the commissioning of Wellbeing Services and a greater focus on prevention and the maintenance of mental wellbeing, IAPT services should be considering the provision of MBCT. With funding of psychological therapies in primary care being spread more thinly, resulting in many IAPT services moving towards the increased use of group-based CBT and a 6-8 session individual CBT model for High Intensity Therapists, MBCT is one way of filling in the gaps that may appear. In the Suffolk Wellbeing Service, we currently run groups for the prevention of relapse amongst those with Recurrent Depression and the prevention of developing anxiety disorders among those who have a propensity to Worry. We are developing a group for the prevention of Post-natal Depression amongst pregnant women considered to be at greater risk of developing depression post partum. We have also run groups aimed at maintaining the wellbeing of staff using a MBCT model of stress. Future developments will focus on the implementation of MBCT in other areas, particularly physical health issues, including Long Term Conditions and Chronic Pain.

8-week MBCT Group for Recurrent Depression using the ‘Green Book’ protocol. 11 participants. 8 completers. Effectiveness: A simple pre-post design was used to show the effectiveness of the group. 4 measures are used here to demonstrate effectiveness. Firstly, the PHQ9 and GAD7 which are standard IAPT measurements for depression and generalised anxiety. Secondly, and perhaps more important for the purposes of an MBCT group are the Five-Facet Mindfulness Questionnaire or FFMQ (Baer et al, 2006) and the Self-Compassion Scale or SCS (Neff, 2003). Statistically significant decrease in levels of depression and anxiety and a statistically significant increase of levels of mindfulness and self-compassion by the end of group. Acceptability: As well as using the attrition rates to demonstrate a sense of participant acceptability, at the end of the group clients were asked to state how important the course had been to them on a scale of 0-10 (0 being “not at all important” and 10 being “extremely important”) (as per the Green Book, p.295). In terms of developing an effective referral pathway, important lessons were learnt. From the perspective of running the groups, discussion about the Importance of Embodying Mindfulness and Staying Present. Other issues: use of language; safety; perfection and posture; religion.

Consideration of how MBCT may be incorporated into existing IAPT services to ensure compliance with the 2009 NICE guidelines that make this a priority intervention for implementation as well as the use of MBCT more generally within an IAPT service.

The Effectiveness of group CBT for Low Self-Esteem in Primary Care
Stuart Pack, Oxleas NHS Foundation Trust; Emma Condren, Oxleas NHS Foundation Trust

Low Self-esteem is widely acknowledged to be associated with the phenomenology of a number of mental health diagnoses including those which are treated under the umbrella of IAPT services (McManus, Waite & Shafran, 2009). This study aimed to evaluate the effectiveness of Group CBT based on the work of M. Fennell (Fennell, 1997) to treat Low Self-Esteem, and associated Anxiety and Depression.

50 participants attended a 10 week group programme; Pre- and post-group measures of depression, anxiety and self-esteem were analysed using Mann-Whitney U tests. The results indicated there was a statistically significant and clinically meaningful change across all measures. Mean post-group measures indicated levels of depression and anxiety which were below caseness and a healthy level of Self-esteem. Results also indicate that gains were well maintained at 3 month follow-up.

The results from this study highlight the effectiveness of group based CBT for Low Self-Esteem and contribute to the limited existing evidence base. Results were discussed with consideration of the existing evidence base, implications for practice and future research.

Reference.

We believe that this offers further support to the current evidence base for the value of offering Self-Esteem groups based on CBT in primary care IAPT services.

**Preliminary findings from a DBT skills group in IAPT**

Claire Eagles, iCOPE/Islington IAPT Service, Claire Goodwin, iCOPE/Islington IAPT Service; Aysha Begum, University of East London.

Clients who report significant difficulty regulating intense emotions and impulsivity (traits of BPD). Suitability will be assessed via a telephone screening assessment. Before starting the group, clients will attend an individual session aimed at orientating them to the group. The DBT skills will be taught in a modular fashion and include mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness skills. It will be an open group where new clients join at the start of each module. Clients will complete the IAPT minimum data set, the Borderline Evaluation of Severity over Time (BEST) and the DBT Ways of Coping Checklist.

As it will be a rolling group that is in progress, the results presented will relate to the 5 clients that have finished the group, 9 clients who have completed 2/3, and 2 clients that have completed 1/3 of the group.

A DBT skills group may provide a useful model of treatment for clients with emotion regulation difficulties and impulsive behaviours that are managed within primary care. Furthermore, a modular approach to the group will be useful in meeting IAPT targets of instant access to therapy.

How to best help clients with traits of BPD within an IAPT service.

**'Improving Self Esteem' in an IAPT Service**

Rachel Shephard, TalkPlus IAPT Service (Rushmoor and Hart); Janice Budd, TalkPlus IAPT Service (Rushmoor and Hart); Nigel Sage, TalkPlus IAPT Service (Rushmoor and Hart);

Freda McManus has demonstrated the value of running courses based on Melanie Fennell’s book ‘Overcoming Low Esteem Self Help Course’.

We devised a CBT group intervention delivered within IAPT service for adults (mixed gender) identified as having low self esteem.

We included a mixture of presentation, discussion, group work, homework.

We assessed outcomes of 5 ‘Improving Self Esteem’ courses from Sep 2012 to April 2013.

We compared 6 and 8 week evening courses of 1.5 hours duration.

We recruited participants from within an IAPT service identified as having low self esteem – referred by Step 2 and Step 3 Therapists, Counsellors and Clinical Psychologists.

Participants experienced a variety of common mental/ co morbid health problems such as depression and/or anxiety disorders typically seen in an IAPT service.

The groups were facilitated by 2 (High Intensity) CBT therapists.

The Robson Self Concept Questionnaire was used as a pre and post measure.

Statistical analysis of 6 and 8 session groups

Pre/post Robson scores

Dropout rate

Qualitative data

Participants’ evaluation

Referring therapist feedback

Preliminary results suggest:

both 6 and 8 session groups provide an efficient and therapeutically beneficial service.

there is no evidence of additional therapeutic gain by having a longer group of 8 sessions.

Qualitative data suggests patients preferred the longer group.

Anecdotal material from a pilot course and a 9 week course will also be discussed.

Findings are limited by lack of follow up data at this time.

Group CBT delivered in six weekly sessions based on Melanie Fennell’s ‘Overcoming Low Self Esteem Self Help Course’ can be an effective and therapeutic intervention for improving self esteem for clients within an IAPT service.

**Conceptualizations guiding Computer Assisted Cognitive Behavior Therapy for Adolescents with Depression**

Paakhi Srivastava, All India Institute of Medical Sciences; Manju Mehta, All India Institute of Medical Sciences; Rajesh Sagar, All India Institute of Medical Sciences; Atul Ambekar, All India Institute of Medical Sciences.

Adolescent depression is associated with adverse psychosocial outcomes in adulthood, and its prevalence rates are high in the Indian context. Despite these factors, the majority of depressed adolescents in India does not receive treatment or receive it when the psychopathology has become entrenched and chronic. High case load per clinical psychologist in
primary care centers is manifest in India. Innovations in treatment delivery and disseminations are desired to ensure effective treatment strategies to greater numbers of depressed adolescents in need with greater efficiency. The present study is an endeavor to develop a computer assisted cognitive behavior intervention to adolescents with depression. The objective of the paper is to present the results of the focused group discussions held with adolescents with depression to assess the phenomenology of depression in Indian context, evaluate the need, feasibility and acceptability, possible treatment barriers of a computer assisted intervention. Focused group discussion data from 14 participants was submitted and developed theory method. A conceptualization of depression among adolescents in Indian context was developed that guided the development of intervention module.

The conceptualization suggested that among Indian adolescents, depression is experienced in context of relationships rather than as an individual subjective state. The degree of functional impairment is a major concern among adolescents. Other significant themes included grief over loss of mental health, distress with negative cognitions, and desire for support from parents, academic stress, high degree of hopelessness and desperation for help. Need and acceptance of computer assisted intervention were expressed with a preference for a software program rather than an internet based intervention. Lack of ‘human like qualities’ in a computerized intervention was a proposed barrier, against which occasional therapist assistance was recommended.

Results are discussed in the context of highlighting key differences in phenomenology of depression in adolescents in Indian context. Need for such intervention programs in India, along with how understandings derived from this study would be incorporated into development of a cognitive behavior therapy module.

The relevance of the study lies in renewing understanding phenomenology of depression among Indian adolescents. The expressed preference for and acceptance of computer assisted intervention in view of logistics, overcoming stigmatization and reduction in case burden per therapist may go a long way in delivering effective treatment services.

Using Guided Self-Help to treat the impact of a Traumatic Brain Injury: Talking Heads
Sian Newman, Camden & Islington NHS Foundation Trust; Rebecca Macey, Camden & Islington NHS Foundation Trust
With increasing evidence for the effectiveness of using CBT for long-term conditions, there is a need to adapt existing treatments available within the stepped-care model to accommodate the additional needs of these patients. Whilst the ability to adapt materials to individual patient’s needs is already an important part of the Psychological Wellbeing Practitioner role, this will become ever more important as IAPT continues to expand following recent Government directives (Talking Therapies: A Four Year Plan of Action, 2011). This case study outlines the treatment of a 51 year old woman presenting with depression resulting from Post-Concussion Syndrome, and offers an insight into the inherent challenges of doing so.

Following a mild brain injury incurred by shelving falling on her head, the patient experienced cognitive difficulties (particularly memory loss and impaired concentration) which impacted upon her ability to work and lead a normal life, triggering the depressive episode. Working collaboratively with Charlotte* to understand and accommodate the limitations her brain injury imposed on her daily life enabled us to adapt behavioural activation techniques to suit her needs and to successfully improve her mood. We had longer sessions in order to help her to pause and recap techniques where needed, and summary letters of our sessions were sent to her so that she could remember between-session tasks and keep track of the treatment plan.

*Pseudonym used to protect the patient’s identity.

Following eight treatment sessions of Guided Self-Help, her scores on the PHQ-9 and GAD-7 had reduced from 24 and 21 to 2 and 1 respectively. She also felt confident in her ability to maintain this recovery and continue to reduce the impact of her accident on her life.
The success of this case suggests that it is possible to use Guided Self-Help techniques to minimise the impact of a brain injury on a patient’s mood. As Long-Term Conditions become another part of the IAPT remit, it is encouraging to note that relatively small adaptations to a typical Behavioural Activation treatment plan can have a significant impact on wellbeing and recovery.
This case suggests it is possible to treat the mood symptoms relating to a brain injury in primary care settings, using a stepped-care model. Guided Self-Help techniques can be adapted for those with memory and concentration difficulties, and can still be very effective.

Developing a group therapy programme for depressed military personnel: Getting back to duty by getting active
Dean Whybrow, Royal Navy; Matthew Wesson, Royal Navy (Retired);
Clinical depression is one of the main causes of referral to Defence Mental Health Services (DMHS) (DASA, 2011). The aim of DMHS is to maximize the number of personnel fit for work (DMSD, 2007). Resource efficient, evidence based interventions with good occupational outcomes are desirable. The aim of this open paper is to summarize both published and unpublished data about the rationale, experience and occupational outcomes from a behavioural activation group therapy programme for helping depressed military personnel.
The literature was reviewed for CBT with an occupational agenda and behavioural activation for depressed military personnel (Wesson and Gould, 2010, Whybrow, 2013). A group therapy programme was trialed and audited against clinical and occupational outcomes.

Group based behavioural activation might be a relatively cheap, resource efficient but clinically effective intervention for helping military personnel to return to work. From a wider perspective, it supports the idea that CBT might be an effective therapy for helping people return to work.

Consideration should be given to the wider application of this discrete group therapy across DMHS in view of the gaps in delivering psychological therapy to service personnel (Iverson et al 2010). In addition, there may be some benefit to trialing its application in other occupational settings.

This is an example of the application of CBT to a workplace setting.

**Intellectual Disabilities**

**Keynote Addresses**

**The development of CBT-informed interventions for people with Asperger’s syndrome**

*Dougal Hare, University of Manchester*

As the recognition and diagnosis of Asperger’s syndrome and high-functioning autism has increased over the past twenty years, the issue of post-diagnostic treatment and support has been repeatedly raised but, to date, there is still a paucity of provision despite growing evidence of widespread emotional and psychological distress in this population.

Given the nature of the psychological differences and dysfunctions that have been identified in Asperger’s syndrome and high-functioning autism, some forms of cognitive-behavioural therapy would appear to be appropriate – a proposal that is reinforced by the nature of the mental health problems reported in this population, primarily anxiety, depression and delusional beliefs.

This paper takes as its starting point a programme of research undertaken by the author and his colleagues over the past decade. This has focussed on the phenomenology of the emotional and psychological problems within this population and the putative cognitive mechanisms that may underpin and maintain these difficulties. The presentation will cover both experimental work and studies of the lived experiences of people with Asperger’s syndrome and high-functioning autism and the implications for both research and, more importantly, for clinical practice and the provision of psychological therapy services.

**Psychotherapy with Persons with Intellectual Disabilities: Current Status and Future Directions**

*Tom Prout, University of Kentucky, USA*

Historically, psychotherapy with persons with intellectual disabilities has been variably received by health and mental health professionals. This keynote will address current status of this area with a specific focus on outcome research. Results from a meta-analysis of psychotherapy outcome research with persons with intellectual disabilities will be presented and implications discussed. Some comparisons between service delivery systems in the United States and the United Kingdom will be offered. Directions for future research and future directions in service delivery will be discussed.

**Symposia**

**Psychological Therapies for Adults with Intellectual Disabilities**

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

**mCBT for Adults with Mild and Borderline Intellectual Functioning**

*John Taylor, Northumbria University and Northumberland, Tyne & Wear NHS Foundation Trust*

People with intellectual disabilities are considered to have increased vulnerability to mental health problems. In spite of this psychological therapists and service providers have been reluctant to offer individual therapy to people with ID due to ‘therapeutic disdain’ for these clients and a lack of evidence to support these interventions. In recent years there have been numerous outcome studies and reviews and commentaries concerning CBT for people with intellectual disabilities. The evidence to support the effectiveness of modified CBT for people with mild and borderline intellectual functioning is reviewed in this presentation. Issues relating to the organisation, delivery, evaluation and active ingredients of these
approaches in routine service settings are considered, and priority clinical and research questions for future enquiry are highlighted. The evidence to support the use of psychological therapies with this client group, particularly mCBT, is limited but promising – suggesting that therapeutic disdain for this population is no longer justified. There are also some indications that people with ID can benefit from the cognitive content as well as the cognitive skills component of mCBT. Further research into the applicability of these therapies with this client group across clinical problems and service settings is indicated.

**Targeted Individual Progress System-ID**

**Tom Prout, University of Kentucky, USA**

Research in the last decade has pointed to the increased importance of using routine, regularly collected patient/client feedback in the delivery of mental health services. There is evidence that adding this component to routine service delivery enhances effectiveness. Notable measures in this area are the Outcome Rating Scale (ORS) and the Outcome Questionnaire series.

The TIPSTM is a new instrument for targeted monitoring of progress of mental health interventions and can be used by a range of professionals. The TIPS-ID is a version of the TIPSTM designed for use with persons with intellectual and developmental disabilities.

The TIP-ID consists of three components:

1. **Problem Checklist (Beginning of treatment; early or initial session or intake appointment).** This is a list of 66 items of different symptoms and problems in living. The client/patient is read the items and they circle any of the problems or concerns that they currently are experiencing. There is also space to list problems/concerns not on the list. Initial administrations in about 10 minutes. After going through the list, the clinician assists or facilitates indentifying the three the three “biggest” problems for the client/patient.

It is important to note that the TIPS-ID is a clinical tool and not a standardized test. As such, the clinician may deviate from administration or make other accommodations that suit the needs of the situation and/or client/patient. The goal of the initial list is identify a range of problems that present concerns and pinpoint the most problematic areas.

2. **Initial Problem Rating.** After the client/patient has identified the three primary problems, manually transfer the problem descriptions to the single page form entitled “My Problems.” On this form is a Likert type visual analogue scale where the client rates the degree of the problem from Not to Small or Medium to A Big problem. The scale also uses happy, neutral and sad faces of different sizes to anchor the scale. There is also an item that rates Well Being by rating I am doing Pretty Bad, OK/So-so, Pretty Bad, also with face anchors. Ongoing problem rating is similar to the initial rating.

3. **The Progress Graphing Form allows for charting progress across sessions/contacts.** The rating from the My Problems form entered on the Progress Graphing Form. This allows for tracking each problem, the Well-Being item, and a Level of Distress which is simply the sum of ratings for the problem/concerns rating and is intended to a more global rating of progress.

This presentation will describe the development of the TIPS-ID discuss uses in clinical practice and research.

**Treatment of Anger Dysregulation for People with Intellectual Disabilities**

**Raymond Novaco, University of California, Irvine, USA**

In numerous cross-national population studies of the prevalence of unmet treatment needs, neither anger, aggression, or violence have been so identified. However, in studies focused on persons with intellectual disabilities (ID), anger and aggression commonly have been found to be highly prevalent problems in both institutional and community settings and are the main reason for ID clients being administered anti-psychotic and behavioral control medications. Anger dysregulation and aggressive behaviour are salient clinical needs for adult and juvenile ID clients, both in custody and in the community.

Since the origination of “anger management”, nine meta-analyses on the effectiveness of psychotherapy for anger have been published, which overall have found medium to strong effect sizes, indicating that approximately 75% of those receiving anger treatment improved compared to controls. When various therapies have been examined, CBT approaches have greatest efficacy. In the ID field, there are now over 30 studies and 7 reviews on CBT anger treatment administered alternatively in group-based and individual-based formats and applied to forensic and non-forensic clients. The net findings offer substantial support for anger treatment efficacy.

For people having problems with aggression and serious clinical disorders across diagnostic categories, particularly among offender populations, there has been skepticism regarding the efficacy of CBT anger treatment, in that it may be irrelevant, be too weak, or not reach core clinical needs. Anger treatment interventions are successful in reducing anger levels in offender populations, but whether it has been successful in reducing aggressive behaviour, the evidence is less clear. The formats and protocols of CBT anger treatment with ID clients will be reviewed, exploring expansion of the scope of treatment targets. Various methodological issues will be discussed, such as impoverished anger assessment sets. Given the prevalence of anger dyscontrol problems, the capacity of anger treatment to be delivered by supervised trainee therapists will be examined. Treatment programme ingredients to promote generalization of treatment gains will be formulated.
Developments in CBT for People with Asperger’s Syndrome
Convenor and Chair: Dougal Hare, University of Manchester

Evaluating PEGASUS: a psychoeducation programme for children with autism spectrum disorder and their parents
Will Mandy, University College London, Kate Gordon, Great Ormond Street Hospital

BACKGROUND: Despite the increased focus on early recognition and diagnosis of ASDs, very little is known about how best to help children integrate their “label” in a positive way. There is anecdotal evidence that person-centred psychoeducation after diagnosis can enable people to develop helpful perceptions of their psychiatric condition, and can alleviate feelings of isolation and stigmatisation (Chowdhury, 2003; Proudfoot, et al, 2009). Currently, however, there are no evidence-based guidelines on how to communicate the diagnosis of ASD to children or their parents. Neither are there any psychoeducational packages available for this purpose.OBJECTIVES: To design, implement and evaluate a new psychoeducation group programme to teach children with ASD and their parents about the diagnosis. The PEGASUS programme comprises 6 weekly sessions, each lasting 1.5 hours with separate parallel sessions for children and for parents. The hypothesis was that PEGASUS would lead young people and parents to have greater knowledge about ASD, increased self-awareness and better coping strategies. Cognitive restructuring was a key element of the programme. For example, the materials have been designed to help prevent negative attributions associated with the diagnosis of ASD (e.g. ‘I will not be able to have friends because I have ASD’), enable positive reframing (e.g. ‘Having ASD means that I have a very good eye for detail’) and normalising (e.g. ‘Other kids have experienced this difficulty too’).METHODS: 48 children (9-14 years) with diagnoses of High Functioning Autism or Asperger’s Syndrome and their parents were recruited, half randomised to attend the PEGASUS groups and half to the control group ("treatment as usual"). In total, five PEGASUS groups each including 3-6 children were run. Primary outcomes were ASD knowledge and ASD-related self-awareness, measured using a questionnaire specially developed for this study (children and parent versions). Children also completed the Rosenberg Self-Esteem Scale, a self-concept scale and the Strengths and Difficulties Questionnaire (SDQ). Parents completed the SDQ, the Social Responsiveness Scale, the Parental Stress Index, a measure of parental self-efficacy and a measure of utility of ASD diagnosis. Data were collected blind to allocation at 3 time points: baseline, after 3 months (i.e. immediately post-treatment) and at 6-month follow-up. The Vineland Adaptive Behaviour Scale was administered at baseline and at 6-month follow-up.RESULTS: At this stage, preliminary analyses are based on a subset of data collected at baseline and 3-month follow-up (N=42). Parents’ ASD knowledge scores show a significant increase following PEGASUS (F(1, 40) = 8.23 p=0.007). A significant change in number of ASD-related behaviours reported by parents was also revealed (F(1, 40) = 5.39, p=0.025). Another promising trend is the medium sized effect of PEGASUS on children’s knowledge of their own ASD-related strengths, though this finding is not significant (partial eta squared=0.054, p=0.139). CONCLUSIONS: This is the first study to evaluate the efficacy of a psycho-educational programme for children with ASD. The programme appears to be effective in increasing children’s and parents’ knowledge of ASD as well as enhancing children’s positive perceptions of themselves and parents’ perceptions about the diagnostic label.

Effectiveness of CBT for anxiety disorders in children and adolescents with autism spectrum disorders:
Preliminary results of a controlled clinical trial
Bonny van Steensel, University of Amsterdam, Susan Bögels, University of Amsterdam

Anxiety disorders are highly common among children with autism spectrum disorder (ASD). Several studies have demonstrated the effectiveness of Cognitive Behavioral Therapy (CBT) for the treatment of anxiety disorders in children with ASD. However, very little is known about the effectiveness for children with ASD in comparison to typically developing children with anxiety disorders (without ASD), or about the effectiveness of CBT for children with ASD in the longer term. The aim of the current study was to evaluate the effectiveness of CBT for the treatment of anxiety disorders in children with and without ASD. All children, 7-18 years, were referred to mental health care centers in the Netherlands. Children diagnosed with ASD and comorbid anxiety disorders and children diagnosed with anxiety disorders (without ASD) were compared. Interviews assessing anxiety disorders (ADIS-C/P), and questionnaires assessing anxiety symptoms (SCARED-71), ASD-symptoms (CSBQ), quality of life (EQ-SD), child psychopathology (CBCL), parental anxiety (SCARED-A), and family functioning (FFS) were administered at pre- and post-treatment, three months after CBT and one year after CBT. At post-treatment and three months after CBT no differences between groups were found regarding the effectiveness of CBT. However, at one year follow-up, some differences between groups were found. At one year follow-up, CBT is less effective for the children with ASD compared to the children without ASD when considering dichotomous outcome measures (percentage free of primary anxiety disorder). However, considering the treatment effectiveness for the total anxiety severity score (ADIS), CBT is equally effective for children with and without ASD, also at one year follow-up. In addition, positive effects were found for quality of life, ASD-symptoms, child psychopathology, parental anxiety and family functioning, for both groups. It seems that CBT is not differently effective for children with ASD as compared to typically developing children in the short term (three month follow-up), however, possibly, differences in effectiveness become more prominent in the long term.
Older Adults

Keynote Address

The New Generation of Psychosocial Interventions in Dementia Care
Martin Orrell, University College London

The new generation of psychosocial interventions for dementia has been characterised by great improvements in methodology and high quality randomised controlled trials (RCTs) including cost-effectiveness analyses. Significant progress has been made with RCTs improving cognition (eg CST), activities of daily living, mood and behaviour. There is evidence on interventions that can help delay nursing home placement including counselling and support programmes for carers and people with dementia. The systematic reviews so far have concentrated on quantitative data derived from analyses of RCTs or other trials. This has enabled a considered assessment of the clinical effectiveness of interventions in relation to defined outcomes but has told us less about the general characteristics of successful interventions and the best context for them to operate within. Qualitative studies can provide an understanding of the various difficulties inherent in translating psychosocial interventions from RCTs into practice, and can also help identify the barriers to implementation and how to overcome them. Even for psychosocial interventions shown to be both clinically effective and cost effective, there are a considerable obstacles to getting them into widespread practice. Many interventions have either no practice manual or one that is so poorly specified that the intervention cannot be reliably replicated in practice. Training may be hard to access or not widely available. The lead researchers may lose interest and move on to other projects, particularly if no resources for an implementation study are forthcoming. In contrast, drug companies devote very considerable resources not only to drug development and clinical trials, but also to publicise the study results, and to promote the use of the drugs in practice. However, whereas drugs have a daily cost, the expertise derived from manuals and training can be used on a whole series of patients. The new generation of psychosocial interventions, a number of which have been shown to be effective in practice, can often provide excellent value. However, there is a pressing need for further research to promote implementation in practice.

Symposia

How is CBT different with Older People?
Convenor and Chair: Ken Laidlaw, University of East Anglia

How is CBT different with Older People: Augmenting CBT using gerontology to enhance outcome in late life depression and anxiety
Ken Laidlaw, University of East Anglia

CBT with older people is an empirically supported treatment for late life depression and anxiety, with recent RCTs in the UK attesting to the efficacy of this approach. CBT remains the most systematically evaluated psychotherapy with older people. CBT empowers people to find new ways of dealing with old problems and encourage self-agency in the face of challenges. Despite CBT being particularly appropriate for older adults because it is skills enhancing, present-oriented, problem-focused and straightforward to use, there are a number of challenges when applying this approach with older people. This paper reviews whether augmenting CBT with theories of ageing is necessary to improve treatment outcome. This idea is approached via the use of clinical case examples with some new ideas introduced into CBT with older people. A final consideration of this paper is the long-term outcome of CBT with older people and how CBT may be optimised to fit the needs of clients with chronic and complex histories and presentations.
Applying CBT with older people: lesson learned
Ian James, Northumberland Tyne and Wear NHS Trust, Katharina Reichelt, Northumberland Tyne and Wear NHS Trust
I worked in a CBT centre before specialising in Older People’s Care in a district hospital. Over the last 16 years I have been attempting to apply CBT in various ways within my clinics, wards and community practice. This paper tracks this rocky road, examining the successes and failures and lessons learned from my application of CBT principles for people with and without dementia, staff and trainees.

Learning from the values associated with successful aging and from people adjusting to a dementia diagnosis
Georgina Charlesworth, University College London / North East London NHS Foundation Trust
Third wave cognitive and behavioural psychotherapies such as Acceptance and Commitment Therapy and Brief Behavioural Activation emphasise the importance of client ‘values’ as beliefs that influence people’s behaviour and decision-making. In this paper I will: provide an overview of the attitudinal factors associated with successful aging based on longitudinal cohort studies of ageing and later life; review the items found in values-inventories developed for working-age adult populations and consider their applicability to older populations; outline the differences in values in different age-cohorts and the value changes associated with the need to adapt to illness or dependency; and, consider the implications of values for therapy with older populations. Especial consideration will be given to the values expressed by people with dementia as they move through the process of adjustment to illness, with examples drawn from a recent randomised controlled feasibility trial of cognitive therapy for anxiety in people with dementia (Spector et al., 2012)


The real power of CBT with older people: de-constructing ageism in the clinic roomSteve Davies, North Essex Partnership NHS Foundation Trust
Computerised therapies are recommended by NICE to improve access to psychological treatment for patients with depression and anxiety. However, despite demonstrated effectiveness in trials, large attrition and refusal rates suggest poor acceptability. Better understanding of the barriers to engagement is necessary to guide improvements to the design and delivery of computerised treatments.

We conducted semi-structured interviews with 36 depressed patients, recruited from Primary Care, who received computerised CBT as part of the REEACT Trial. We also reviewed the existing literature on patient experience of computerised therapies, and conducted a qualitative meta-ethnography across the studies.

Participant experience was on a continuum, with some patients unable or unwilling to accept psychological therapy without interpersonal contact, while others appreciated the comparative anonymity and flexibility of cCBT. The majority of patients were ambivalent, recognising the potential benefits offered by cCBT but struggling with challenges posed by the lack of support and limited personalisation of programme content. The meta-ethnography similarly revealed common barriers to engagement but also unique benefits, such as greater privacy and empowerment, suggesting ‘common factors’ of therapy delivered by technology which could be targeted to improve uptake.

Computerised therapies could be offered within a menu of options in stepped care if matched appropriately to individual patients, taking into account different preferences for computerised or face-to-face therapy. Alternatively, harnessing the ‘common factors’ of cCBT or enhancing it with greater support and personalisation could increase patient engagement amongst ambivalent patients.

Mind the gap: a consideration of the services available to Older Adults with severe Mental Health difficulties, and the impacts for clients, services and mental health practitioners.
Convenor and Chair: Stephanie Fitzgerald, Berkshire Healthcare NHS Foundation Trust

Examining the architecture of Older Adult services
Ian Scott, Berkshire Healthcare NHS Foundation Trust
The speaker identified the trend of increasing organic work in older adult mental health teams and the implications this entails for clients with functional disorders. Investigating this picture the speaker will share for the first time clinical data from both Primary and Secondary Care. The observed trend will be supported by the data presented. The speaker will unpack the detail of this; and highlight the gap that exists between services. Expected prevalence rates for depression are shared and recommendations for clinicians working with functional problems made. Opportunities for service developments unfold from this data, including the chance to begin to offer services that meet the broader mental health needs of an ageing population with recognised complexity. Consideration will be made to how services can meet the present hidden demand for under-represented functional disorders.
Clinician opinion - building or burning bridges?
Stephanie Fitzgerald, BHFT NHS Trust
This talk focuses on qualitative interviews conducted with staff to consider the impact that clinician opinion has on referral routes for functional older adults. There are some opinions which highlight a lack of interest, funds and beliefs around Older Adult care needs and these are emphasised by interviews with staff working within Older Adult services. Also this talk will hold a consideration of how these beliefs may be impacting on referral acceptance and the purpose that these referrals serve. Wider consideration is also given to the future of Older Adult services and it is hoped that this talk will provide a forum for discussion as to how we can overcome some of the barriers that are highlighted in the interviews conducted with staff.

Severe and Enduring Problems

Keynotes Addresses

Trauma and Psychosis: a Dangerous Duo
Mark van der Gaag, VU University, Amsterdam
Posttraumatic stress disorder is a quite prevalent comorbid disorder in psychotic disorders, but has been neglected for a long time. The disorder is still under diagnosed in clinical practice and if diagnosis is made, adequate treatment is very often not provided. One reason for under diagnose is similarity in symptoms, which makes it hard to disentangle. Hallucinations and reliving cannot be distinguished in some cases. Numbing and negative symptoms look alike. The hyper vigilance is characteristic for PTSD and paranoia. Also neurobiology shows reduction in hippocampal volume in both disorders.

The combination of PTSD and psychosis can be acquired in several ways. Schizophrenia patients decline in social rank and can be easily victimised once living homeless in the streets. Psychosis itself can be so traumatic that both disorders develop at the same time. And childhood traumas are associated to psychosis in adulthood and the dose-response relationship points to a potentially causal relationship, with the association being as strong as between smoking and lung cancer. Treatment and treatment research is developing and some clinical researchers are very cautious with complex trauma or even propagate to stabilise first for a long time withholding treatment. Other researchers have a more direct approach and do short intense treatments following the evidence-based protocols for PTSD. In the Netherlands a trial has just finished including patients comparing eight 90-minute sessions of either EMDR or Prolonged Exposure. Pilot data and the halfway RCT data concerning trauma symptoms and safety of treatment will be presented.

Reward Sensitivity in Bipolar Disorder: When, Where, and Why Might Mania Occur
Sheri Johnson, University of Berkeley, USA
For over two decades, theorists have suggested that mania relates to heightened reward sensitivity, and a growing literature provides cross-sectional and prospective support for this model. For researchers and clinicians, it is critical to understand how reward sensitivity might operate. That is, there is a need to examine more specific aspects of the reward system that might be disrupted in bipolar disorder. This talk will focus on which situations might trigger mania, which symptoms might shift most in the context of reward, and what types of cognitive and behavioural processes are most closely tethered to reward in bipolar disorder. Gaps in our understanding will also be noted.

Symposia

“Something for everyone?” A range of new ways to help people manage mood swings
Convenor and Chair: Fiona Lobban, Lancaster University

A novel approach to mania prevention: A pilot study of a parasympathetic intervention
Sheri Johnson, University of California, Berkeley, USA, Luma Muhtadie, University of California, Berkeley, USA
Previous research has shown that people with bipolar disorder engage in a number of strategies to reduce stimulation and arousal as a way of coping with manic prodromes, and that the use of these strategies predicts better outcomes over time. Drawing from these findings, we hypothesized that an intervention designed to increase parasympathetic nervous system activity through slowed breathing might help to reduce symptoms of mania and anxiety. We will present data from an open trial in which participants diagnosed with bipolar I disorder per the SCID used a portable device designed to improve
parasympathetic activation through biofeedback-guided breathing twice daily for 14 days. Symptom status and autonomic physiological parameters were gathered at baseline and immediately following the 2-week period of daily home practice. Ratings of helpfulness and satisfaction were gathered at follow-up. Early findings suggest the promise of this novel approach.

Ultra High Risk (UHR) and Bipolar Disorder
Paul French, Greater Manchester West Mental Health NHS Trust
Research has demonstrated the ability to identify (Yung et al., 2005) and treat (French & Morrison, 2004; Morrison et al., 2012) individuals with an Ultra High Risk (UHR) of developing psychosis and more recently that it may be possible to utilise a similar strategy to identify people who have emergent Bi Polar Disorder (BPD) (Bechdolf et al., 2010). We utilized the at risk criteria described by Bechdolf and colleagues (2010) to prospectively identify 11 individuals who were subsequently offered CBT to target emergent moods swings. At end of treatment we saw reduction in symptoms as measured on the BDI and YMRS and improvement in functioning as measured on the GAF. We will discuss the rational for the research and present results from the study at end of treatment and 6 month follow up.

Group Interventions for Bipolar Disorder
Fiona Lobban, Spectrum Centre, Lancaster University, UK, Lisa Riste, University of Manchester, UK; PARADES team, various
The PARADES Group Intervention trial is a large multisite pragmatic randomised controlled trial comparing Group Psychoeducation with Group Peer Support in the prevention of relapse for people with Bipolar Disorder. Clinical and cost effectiveness outcomes will be available at the end of a two year follow up period. Key factors in determining the effectiveness of group interventions are the ability to recruit and retain people to take part in the groups. This presentation will share what we have learnt about who wants to attend groups, how to facilitate attendance, service user preferences for and perceived effectiveness of different kinds of group intervention, predictors of attendance at group sessions, and reasons for drop out from groups. These findings have implications for recruitment and retention to group interventions in both research and clinical settings.

Recovery in Bipolar Disorder – results of new intervention trial
Steven Jones, Spectrum Centre, Lancaster University, Lee Mulligan, Lancaster University; Graham Dunn, Manchester University; Mary Welford, GMW Foundation Trust; Anthony Morrison, Manchester 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 report on the development and evaluation of a new therapy ‘Recovery informed CBT for bipolar disorder(RICBT)’ designed to enhance recovery outcomes. RICBT is informed by more traditional CBT but has been adapted based on our research into individual experiences of recovery in bipolar disorder and through consultation with service users about what they do and do not want in a psychological therapy for bipolar disorder. As such the therapy is an individualised, formulation-driven approach in which the traditional focus on relapse prevention alone is much reduced. 66 participants with a diagnosis of bipolar disorder within the last 5 years were randomised to receive RICBT or treatment as usual. This talk will report on feasibility and acceptability outcomes from the trial and on indicative clinical outcomes with respect to both relapse and recovery at post treatment and follow-up.

True Colours: an online self-management system for mental health
Jonathan Price, University of Oxford
The True Colours system is a simple ‘technology’ for capturing patient-reported outcomes (PROMs), including symptoms and functional status. It has been developed by the University of Oxford’s Department of Psychiatry, with support from the Oxford Health NHS Foundation Trust and the UK’s NIHR. Its key features are that it is efficient, requiring minimal interventions from clinical, nursing, and support staff; effective, providing weekly updates on patient status to patient, carers, and clinicians; easy for patients to use; highly flexible, and therefore personalisable to the individual patient’s needs; widely applicable, across a range of conditions, patient groups, and health providers; and interoperable, with existing technologies and data standards. The system is currently being used to monitor features of mood disorder in the following settings: a specialist mood disorder clinic, which manages patients with challenging unipolar and bipolar mood disorder, many of whom have high or fluctuating levels of suicidal ideation; several major research studies in mood disorder, including randomised controlled trials of pharmacological and psychological interventions; and generic community mental health teams, managing patients with recurrent mood disorders that are too challenging to manage in primary care alone. Recent developments of the True Colours system have further increased the system’s flexibility. In particular, more PROMs have been added to the standard list of monitoring options, and it is now possible for the patient or clinician to request specific, personalised questions which have a particular fit to that patient’s unique clinical situation. The extended True Colours system (for all diagnoses, not just mood disorders) is about to be rolled out across eight community mental health teams in the South of England, as part of a randomised controlled trial.
The treatment of traumatic symptoms in psychosis
Chair: Craig Steel, University of Reading

CBT for PTSD in schizophrenia
Craig Steel, University of Reading
There is increasing awareness of a high prevalence of traumatic life events, and symptoms of posttraumatic stress disorder, within individuals diagnosed with schizophrenia. However, a comorbid diagnosis of PTSD is rarely identified. Further, for those who do receive such a diagnosis, there are no current evidence-based psychological treatments to deliver. The opening presentation of this symposium will briefly review the early developments of evidence based developments within this area. A current randomised trial aimed at evaluating CBT for the treatment of PTSD within schizophrenia will then be introduced. This intervention adopted within this trial has previously been used within the United States for a wide variety of patients diagnosed with severe mental illness. Recruitment has taken place within Berkshire and East London. Baseline data and outcomes on the acceptability of the intervention will be presented.

Preliminary results of the treatment with Eye Movement Desensitisation Reprocessing versus Prolonged Exposure in people with a posttraumatic stress disorder and a psychotic disorder
Mark van der Gaag, VU University and EMGO Institute for Health and Care Research, Amsterdam
Background: Childhood traumatisation is strongly associated with the development of psychosis in adult life. But the diagnosis of posttraumatic stress disorder (PTSD) in psychotic people is very often missed and even when not, treatment is not always provided. Many professionals think treating PTSD in psychotic patients is dangerous to do. So, a vast proportion of psychotic people suffer from PTSD without any treatment for many years. Aims: To examine the efficacy and safety of treating PTSD with Eye Movement Desensitisation and Reprocessing (EMDR) and Prolonged Exposure (PE) compared to Waiting List (WL). Secondary examinations are the effects of trauma treatment on other symptoms such as psychosis, depression, anxiety and the moderators and mediators of therapy success. Also the associations between contents of symptoms and traumatic events will be addressed. Methods: Patients with lifetime psychosis and current PTSD were randomised to EMDR, PE and Waiting List. Therapy consisted of maximum 8 sessions of 90 minutes. Assessments were done at baseline, end of therapy (3 months), and follow-ups at 6 and 12 months. The trial had to report an interim analysis halfway the inclusion to report on the safety of the patients who are treated. Halfway three were 100 completers: 34, 33 and 33 in each condition. Results: Both interventions were found to be efficacious with large effect-sizes on the reduction of trauma symptoms at end of treatment. The interventions did not result in more adverse events than waiting list. Discussion: Preliminary results showed that the short and intense treatment of PTSD in schizophrenia spectrum patients is efficacious and safe.

Accuracy of the Trauma Screening Questionnaire and Prevalence of PTSD in a Population of Patients with Psychosis
Paul de Bont, Mental Health Care Organisation GGZ Oost-Brabant, the Netherlands. GGZ Land van Cuijk en Noord Limburg, Boxmeer, The Netherlands, Craig Steel, School of Psychology and Clinical Language Sciences University of Reading, UK; Mark van der Gaag, VU University and EMGO institute for Health and Care Research, Amsterdam, The Netherlands Head of Psychosis Research, Parnassia Psychiatric Institute, The Hague, The Netherlands; Berber van der Vleugel, Community Mental Health Service GGZ Noord-Holland Noord, Alkmaar, The Netherlands
Background: Trauma contributes to psychosis and in psychotic disorders PTSD is often a comorbid disorder. A problem is that PTSD is under diagnosed and undertreated in people with psychotic disorders. Screening can be an option to find cases in secondary mental health services. Aims: The Trauma Screening Questionnaire (TSQ) assesses the possible presence of PTSD. It is a 10-item scale with the five re-experiencing items and five hyper arousal items of the PSS-SR. The minimum score is zero and the maximum score is ten. The TSQ has a good sensitivity in assessing potential PTSD in crime victims (0.76) and rail crash victims (0.86), as well as a high specificity in both of these groups (0.93 and 0.97). Both studies indicate that the optimum cut-off score is 6 to predict PTSD best. This study aims to calculate the accuracy of the TSQ in the population of patients with psychosis; and to assess the prevalence of PTSD in this population. Methods: In thirteen secondary mental health institutions schizophrenia spectrum patients were screened with the TSQ and interviewed with the Clinician Administered PTSD Scale (CAPS) to determine PTSD status. Sensitivity, specificity and positive and negative predictive value will be examined. Results: The preliminary findings from the TSQ screen in more than 2500 patients with a current diagnosis of psychosis and about 400 CAPS interviews are that the prevalence of PTSD is about 19% in psychotic patients. The cut-off score of 6 has a sensitivity of 0.84 and the specificity of 0.78 to detect CAPS defined cases of PTSD with the TSQ. Discussion: Data are still coming in. Final results will be presented at the symposium. Interim clinical and researcher impressions are that the TSQ is a good screen in secondary mental health to detect cases of PTSD.
Are characteristics of posttraumatic memories affected by psychological treatment of PTSD in a population of patients with psychosis?

Berber van der Vleugel, Community Mental Health Service GGZ Noord-Holland Noord, Alkmaar, The Netherlands, Paul de Bont, Mental Health Care Organisation GGZ Oost-Brabant, The Netherlands; David van den Berg, Parnassia Psychiatric Institute, The Hague, The Netherlands; Agnes van Minnen, Radboud University, Nijmegen, The Netherlands; Mark van der Gaag, VU University and EMGO institute for Health and Care Research, Amsterdam, The Netherlands

Hypotheses about the working mechanism of EMDR have changed in recent years. Findings in a series of laboratory experiments with healthy subjects by Van den Hout and his research group1 were in line with the working memory (WM) account: the more a distracting task taxes WM, the greater the decline in vividness of the memory. But if the competing task is too taxing, not enough WM capacity remains available for reprocessing the memory. Since WM resources are more limited in psychotic patients, dual tasks that are suitable for non-psychotic patients may be too demanding for this population.

This study examines the association between WM capacity and the effects of EMDR treatment. Changes in the characteristics of the traumatic memories are examined in detail. The degree to which eye movements tax WM is assessed at baseline, using an auditory Random Interval Repetition (RIR) task. To detect changes in characteristics of posttraumatic memories, an adopted version of the Memory Characteristics Questionnaire2 is administered four times in the course of treatment.

Data of 50 patients in EMDR treatment are being collected at this moment. Interim impressions are that WM resources are strongly associated with diagnostic classification (i.e., most limited for schizophrenia) and may predict the extent of changes in memory characteristics.

Results on the relation between WM capacity and changes in memory characteristics (e.g., vividness, sensory details) will be presented at the symposium. Clinical implications will be addressed.


'Low Intensity' CBT for Psychosis

Convenor and Chair: Helen Waller, Institute of Psychiatry, King's College London

Training Frontline Mental Health Staff to Deliver Low Intensity CBT for Psychosis: Results to Date

Helen Waller, Institute of Psychiatry, Philippa Garety, Institute of Psychiatry; Tom Craig, Institute of Psychiatry; Suzanne Jolley, Institute of Psychiatry; Elizabeth Kuipers, Institute of Psychiatry

Background: The dissemination and delivery of psychological therapies for people with psychosis is typically limited by workforce and organisational factors. ‘Low Intensity’ delivery, whereby frontline mental health staff are trained to deliver brief, manualised and focused interventions, may be one way of improving access to psychological therapy. We have produced a treatment package, comprising a therapist manual and training package, specifically for people with psychosis. The intervention aims to support people to achieve a personal recovery goal, targeting either anxious avoidance or low mood completed the intervention. A range of assessments were administered to measure mood, functioning and psychotic symptoms at pre- and post-intervention and one-month follow up. Seven frontline mental health workers were trained over four half days to deliver the intervention, with weekly group supervision.

Results: Eleven out of the twelve participants achieved their personal goals. Statistical analysis revealed significant improvements in levels of depression, clinical distress, activity, negative symptoms and delusions across the three time points. No change was observed in hallucinations or anxious avoidance.

Conclusions: This pilot study provides preliminary evidence for the effectiveness of a brief intervention as a feasible model of therapy delivery for people with psychosis. The results suggest that frontline mental health workers can be trained relatively easily to deliver the intervention, under supervision. The study is small and the results should therefore be interpreted with caution. A randomised controlled trial of the intervention is currently under way.

Training Frontline Mental Health Staff to Deliver Low Intensity CBT for Psychosis: Therapist Views and Longer-Term Implementation

Catherine Tunnard, Institute of Psychiatry, KCL, Helen Waller, Institute of Psychiatry; Philippa Garety, Institute of Psychiatry; Tom Craig, Institute of Psychiatry; Elizabeth Kuipers, Institute of Psychiatry

Background: Increasing access to evidence-based talking therapies for people with psychosis is a national health priority. We developed a new, brief ‘low intensity’ (LI) CBT intervention specifically designed to be delivered by frontline mental health staff, following brief training, and with ongoing supervision and support. The therapy aims to support people with
Psychosis to work towards a personal recovery goal, using techniques based on either behavioural activation for depression or graded exposure for anxious avoidance. We have completed a pilot study of the intervention with clients in early intervention and recovery outpatient services. In this talk we will present the results of a qualitative analysis of participating staff therapists and service users, regarding the acceptability of the training protocol and the therapy. We will discuss the factors promoting and restraining implementation of the therapy, both in the shorter and longer-term.

Methods: All 7 therapists (n = 7) and service users (n = 17) completed a semi-structured interview to elicit feedback regarding positive and negative aspects of the intervention. All interviews were examined using thematic analysis (Braun and Clarke, 2006).

Results: Service users spoke positively about learning new skills (e.g. breaking down goals, sticking to a schedule) and feeling proud of themselves for achieving their goals. All service users gave positive reports of their work with the therapist. Service users had few negative comments, but one of the most common difficulties to arise was the complication of physical and mental health comorbidity.

Therapists spoke about being able to use a brief, structured intervention to achieve positive outcomes for their clients. All therapists viewed training positively and role plays were highlighted as particularly useful. The usefulness of group supervision for discussing difficulties encountered, and being able to celebrate successes was also highlighted. Therapists reported difficulties around time constraints, following a manualised intervention and managing endings. Both groups felt that longer, more sophisticated interventions were required to address more complex problems. Since completion of the study, a number of trained frontline mental health workers have continued to deliver the intervention. A number of barriers and facilitators to the continued implementation have been identified and will be presented briefly.

Conclusions: For both therapists and service users, completing the intervention was viewed as a positive experience. Therapists' perceived skill development and positive reaction to seeing their clients achieve personal goals may help to promote implementation. Work is needed to clarify whether and how more complex difficulties should be addressed by frontline staff.

A pilot investigation of providing low intensity carer interventions in an inner city community mental health team
Sarah Roddy, Institute of Psychiatry, KCL, Juliana Onwumere, Institute of Psychiatry; Elizabeth Kuipers, Institute of Psychiatry

Substantial research shows that carers of individuals with psychosis experience significant distress and psychological difficulties. It has been noted that carers need a separate service of their own to improve well-being and reduce distress. However, responding to carer needs is not readily identified as being the main responsibility of anyone in clinical teams and services (Kuipers, 2010). The small pilot study sought to evaluate the effect of providing low intensity carer interventions that are designed to meet the identified needs of carers of service users accessing a busy London community mental health team and to improve their general well-being. Carers completed a brief (2-3 individual sessions), needs led intervention that focused on goal setting, accessing information, problem solving, and sleep hygiene. Carers were assessed with self-report measures of impact of care, well-being and coping at baseline and post intervention. The results from the pilot are discussed in the context of recent models of caregiving (Kuipers et al., 2010; Mackay & Packenham, 2011).

Formulating Psychosis: How do the Clinical Cognitive Models work in Practice?
Convenor and Chair: Katherine Newman Taylor, University of Southampton and Southern Health NHS Foundation Trust

Formulating Psychosis based on a cognitive model: practice and data from several clinical trials
Presenter: Anthony Morrison, University of Manchester

Idiosyncratic case formulation based on a cognitive model is a cornerstone of good practice in cognitive therapy, but there is little research examining fidelity, service user experience and the impact on clinical outcomes. Examples of such case formulations based on a specific cognitive model of psychosis from clinical trials examining cognitive therapy for people with psychosis and people at high risk of developing psychosis will be presented. Strategies that were utilised to promote fidelity and adherence, as well as difficulties encountered, will be described, and research demonstrating the relationship between such formulations and good clinical outcomes will be presented. Implications for routine clinical practice and future research will also be discussed.

Developments in treating persecutory delusions
Daniel Freeman, University of Oxford

There is a clear challenge to improve markedly the efficacy of psychological treatments for delusional beliefs. In this talk an interventionist–causal model approach will be described: to focus on one putative causal factor at a time, show that an intervention can change it, and examine the subsequent effects on the delusional beliefs. New work will be described with patients with persecutory delusions that targets four key areas: difficulties sleeping, worry, negative thoughts about the self, and fears when outside.
Formulating psychosis: A model of paranoia for clinical practice
Katherine Newman Taylor, School of Psychology, University of Southampton

Cognitive theory and therapy for psychosis have developed dramatically over the last two decades. We now have psychological models to guide our understanding and interventions with people living with voices, paranoia and other psychotic experiences. The National Institute for Clinical Excellence (2009) recommends cognitive behavioural and family interventions for people with a diagnosis of schizophrenia, and the IAPT programme is being extended to improve access to evidence based psychological therapies for ‘Severe Mental Illness.’ These are exciting times. Psychosis is a broad concept. If we are to be successful in targeting the range of processes involved in the maintenance of distressing psychosis, case conceptualisation is likely to be a key component of therapy. In this symposium we focus on the practical application of some of the current cognitive behavioural models of psychosis. Katherine Newman Taylor presents a model of paranoia developed with Lusia Stopa (2012), and based on the model of social phobia. This approach recognises certain similarities between the two presentations, and emphasises the need to work with both content and process of cognition in therapy. The model and implications for treatment are illustrated using clinical examples.

Attachment Theory to Service Design in Early Psychosis: Developing service models to promote recovery
Andrew Gumley, University of Glasgow

Recovery from psychosis unfolds in the context of individuals’ engagement with services and it is in the relationships between individuals with psychosis and their service providers that the attachment system expresses itself. Life events involving threat, loss, separation and illness activate the attachment system and this is reflected in organised (and disorganised) patterns of affect regulation in the context of interpersonal relationships. Thus, the service providers’ capacities to provide an attuned response to the needs of individuals in context of their affective expression will determine the extent to which services can provide a safe haven and secure base for recovery. A key aspect of the attachment system is the individuals’ capacity for mentalization. Impoverished mentalisation arising from dismissing (avoidant) attachment creates a challenge for service providers to provide attuned support particularly where the avoidant attachment strategy is deployed in the service of individuals’ autonomy and independence at the cost of close interpersonal relationships (including help seeking) and a more nuanced understandings of thinking, affect and memory. Therefore attempts by service providers to engage these individuals in mental health services or discuss emotional experiences may be experienced as a threat to this group of individuals. This may trigger disengagement and further resistance. The paper will describe how Attachment Theory has informed the development of a Case Formulation approach to responding to the needs of service users with psychosis who are at risk of arrested recovery.

Using the psychological flexibility model to conceptualise the problems of people with persisting auditory hallucinations
Eric Morris, South London & Maudsley NHS Foundation Trust

This paper will present a case example of a person experiencing persisting auditory hallucinations and how their problems are understood using the Psychological Flexibility model, as described by Thomas, Morris, Shawyer and Farhall (2013). Psychological flexibility is the ability to connect with the present moment fully as a conscious human being (mindfulness and non-judgemental acceptance), and to change or persist with behaviour that is in line with identified values. For people distressed and/or disabled by auditory hallucinations, it is theorised that this experience is responded to in a psychologically inflexible manner: becoming a target for avoidance, control or focus, appraised as more powerful than the person experiencing the voices, and leading to actions that come at the cost of engaging in chosen life directions. Case formulation involves identifying the historical and situational contexts that support psychological inflexibility. In addition current client strengths in psychological flexibility are recognised, which may be harnessed to foster change in weaker skills. Contexts of voice hearing that select for narrow a

Attachment and Metacognition: establishing a developmental understanding of affect regulation and recovery from psychosis
Convenor and Chair: Andrew Gumley, University of Glasgow

Development and validation of the Narrative Compassion Scale: a new tool to explore emotional recovery.
Andrew Gumley, University of Glasgow, Angus Macbeth, University of Aberdeen

The ability to regulate affect in the face of stress has implications for recovery and chronicity in complex mental health problems such as schizophrenia and borderline personality disorder. In addition to adaptive integrating and maladaptive
negative symptoms would be worse in people displaying an I
in a first episode psychosis sample followed up over their first 1
use this information solve problems
symptoms are linked to the capacity for metacognition. This ability to represent the mental state of the self and others and
suggested that people with an insecure
theoreti
initially develop and then evolve over time will lead to more targeted and effective psychological interventions. Using
there is emerging evidence that psychological therapies can help. Gaining a better understanding of how these symptoms
recovery, greater carer burden, and reduced quality of life. The typical response to pharmacotherapy is only mo
reduced motivation, and social impairments. Higher levels of these symptoms are associated with poorer long
The negative symptoms of schizophrenia include problems with emotional withdrawal, d
Hamish
Metacognitive factors help explain the link between attachment style and negative symptoms
McLeod, University of Glasgow, Andrew Gumley, University of Glasgow; Matthias Schwannauer,
University of Edinburgh; Antonino Carcione, Third Centre of Cognitive Psychotherapy, Rome; Giancarlo
Dimaggio, Centre for Metacognitive Interpersonal Therapy, Rome
Metacognition can be understood in terms of how individuals’ make sense of their own and others’ behaviour in terms of mental states, impacting on individual’s ability to cope with distressing experiences and mental states. Evidence demonstrates significant metacognitive impairments in chronic psychosis samples (Lysaker et al, 2005), but the profile of metacognitive impairment is less well understood in first episode psychosis (FEP). Using a cross-sectional cohort design, individuals in the first 12 months of treatment for FEP were interviewed using the Adult Attachment Interview. Attachment classifications and metacognition (MAS-R) were derived from the interview. Psychotic symptomatology (PANSS), premorbid adjustment, and clinician rated engagement with services were also measured. The MAS-R was used to give scores for Understanding of one’ own mind (UM) and understanding of other’s minds (UOM). We hypothesized that UM and UoM would be associated with greater psychotic symptomatology, poorer premorbid adjustment, insecure attachment and poorer help-seeking. Data were available for 34 individuals (20 male; 14 female), the majority of whom were prescribed antipsychotic medication.
Contrary to our hypotheses UM was not significantly related to psychotic symptomatology (positive symptoms, negative symptoms, cognitive disorganization, emotional distress or excitement). Lower scores for UoM were significantly correlated with greater negative symptoms (r=-.44; p=.023), but not with any other symptom variables. Individuals coded as securely attached had significantly higher score for UoM than individuals coded as insecurely attached (M-W U = 55.5; p= .032). There was no difference between attachment categories for UM. Poorer Early Adolescent social adjustment was significantly associated with poorer UoM (r=-.40; p=.028). The association between poorer early adolescent premorbid adjustment and poorer UM approached significance (r=-.359; p=.051). Lower scores for UM and UoM were significantly associated with poorer clinician rated help-seeking (r=-.52; p=.013; r=-.61, p=.002 respectively).
Our findings demonstrate a specific pattern of associations in FEP between metacognitive understanding of other’s minds, negative symptoms, and ability to seek help from services. This suggests that individuals with difficulties in understanding other’s minds have more social deficits and may be less able to make effective use of treatment. Significant associations with early adolescent premorbid social adjustment and insecure attachment suggest that these metacognitive difficulties may be a reflection of psychodevelopmental factors. Although limited by small sample size and the cross sectional design of the study, these data generate useful hypotheses for further exploration of mediating and moderating factors between premorbid function, metacognition and the development or forestallment of recovery trajectories in FEP. These findings also highlight the potential benefit of metacognitive approaches in psychological therapies for individuals with a FEP.
Metacognitive factors help explain the link between attachment style and negative symptoms
Hamish McLeod, University of Glasgow, Andrew Gumley, University of Glasgow
The negative symptoms of schizophrenia include problems with emotional withdrawal, diminished emotional expression, reduced motivation, and social impairments. Higher levels of these symptoms are associated with poorer long-term recovery, greater carer burden, and reduced quality of life. The typical response to pharmacotherapy is only modest but there is emerging evidence that psychological therapies can help. Gaining a better understanding of how these symptoms initially develop and then evolve over time will lead to more targeted and effective psychological interventions. Using theoretical ideas and evidence from adjacent fields will stimulate new ideas and hypotheses. For example, it has been suggested that people with an insecure-dismissing (I-D) attachment style are more likely to display greater negative symptoms because of their tendency to deal with stress through avoidance. It is also increasingly recognized that psychotic symptoms are linked to the capacity for metacognition. This ability to represent the mental state of the self and others and use this information solve problems has yielded numerous new insights into the factors that may impact on the development and persistence of negative symptoms. We examined the links between metacognition and attachment style in a first episode psychosis sample followed up over their first 12 months of contact with services. We expected that negative symptoms would be worse in people displaying an I-D attachment style and those with poorer metacognitive
ability. Fifty participants were assessed with the Adult Attachment Interview (AAI) and allocated to Secure (n=17), Insecure-Dissmissing (n=23), or Insecure-Preoccupied (n=10) categories according to standard procedures. The narratives about attachment relationships were then independently coded with the Metacognition-Assessment Scale—Abbreviated (MAS-A). Symptoms were assessed longitudinally with the Positive and Negative Symptom Scale (PANSS). Comparison of negative symptom scores for Secure versus I-D patients over twelve months showed that symptoms were worse at baseline for I-D participants (Total PANSS Negative Symptom Scale Score = 24.48 vs. 19.41; U = 139, Z=-2.12, p<.05). This difference was no longer statistically significant at six and 12 months, possibly due to the relatively small sample. The I-D patients scored lower than Secure patients on three of the MAS-A subscales: Self-reflectivity (U = 128, Z=-2.41, p<.05), Understanding others minds (U = 133.5, Z=-2.31, p<.05), and Decentration (U = 119.5, Z = -2.68, p<.005). Non-parametric correlations between MAS-A scores and negative symptoms across the 12 months revealed several significant negative correlations indicating that lower metacognitive functioning was associated with higher negative symptom ratings. Taken together, these data indicate that an I-D attachment style is associated with worse initial negative symptoms and poorer metacognitive functioning in the early stages of psychosis. However, the most direct link is seen between metacognition and negative symptoms. It is possible that the connection between early attachment relationships and negative symptoms will be explained by taking account of metacognitive factors.

**Attachment and mechanisms of therapeutic change – Cognitive Interpersonal Therapy in two adolescent onset psychosis samples**

**Matthias Schwannauer, University of Edinburgh, Helen Griffiths, NHS Lothian; Laura Dickson, University of Edinburgh**

To date clinical intervention studies in the efficacy and effectiveness of cognitive behavioural treatments in adolescent onset psychosis show mixed results in terms of essential indicators of clinical outcomes and differential effects for different subgroups within this disorder group. These developments clearly emphasise the need for robust and convincing psychological models for psychosis and their underlying mechanisms in order to further the enhancement of effective clinical management. In particular the apparent differential response rates to psychological intervention in early onset and recurrent psychosis merits attention. Attachment and mentalisation are key themes in the clinical management, therapeutic engagement and psychological treatment of adolescent onset psychosis and readmissions and relapse are often driven by an amplification of these factors. There is a need to develop a better understanding of the early phase of psychosis in late adolescence, and to develop and evaluate effective psychosocial treatments and interventions that assist people in this early phase. In this paper we want to present some current work on affect regulation and mentalisation in a group of adolescents following their first and second episode of psychosis. Early results of two clinical pilot trials of CBT treatment of adolescent onset psychosis and bipolar disorder are presented in the context of possible adolescent specific risk factors. The trialed treatment approach shows promising results in terms of reduced mood episodes and perceived quality of life for these groups of adolescent onset psychosis and bipolar disorders. Changes in mentalisation and interpersonal functioning are clearly related to therapeutic gains and are positive indicators of specific models of psychological intervention for this population.

**Exploring psychological processes & co-morbidity in bipolar disorder: New advances**

**Convenor and Chair: Alyson Dodd, University of Lancaster**

---

**Impulsivity in Bipolar Disorder: Towards more Specific Models**

**Sheri Johnson, University of California Berkeley**

Previous research has established that bipolar disorder is characterized by impulsivity, and that impulsivity can predict the onset of bipolar spectrum disorders. Nonetheless, less is known about the nature of impulsivity within bipolar disorder, and several researchers have shown that impulsivity is a multi-faceted phenomenon. Recent evidence indicates that people with bipolar disorder may experience particular difficulties with impulsivity during periods of heightened emotion. More specifically, across three studies, risk for mania, as measured using the Hypomanic Personality Scale, was shown to correlate with emotion-relevant impulsivity more than with other forms of impulsivity. In a fourth study, 91 persons diagnosed with bipolar I disorder (per the SCID) endorsed high elevations of impulsivity during positive mood states compared to 80 persons with no mood disorders, and those elevations were substantially higher than those observed for other forms of impulsivity. Among those with bipolar I disorder, the degree of impulsivity during positive mood states predicted worse social functioning and quality of life. Findings were not explained by comorbid diagnostic conditions. Findings suggest that impulsivity may be a state-dependent phenomenon for those with bipolar disorder, and interventions designed to target impulsivity during periods of high emotion may be helpful.

**Understanding mood management: A computer-based questionnaire study**

**Heather Robinson, Lancaster University**

Demonstrating differences between euthymic bipolar participants and healthy controls regarding the psychological processes that underlie the self-regulation of mood may inform psychological interventions. Based on the Self Regulation Model (Leventhal et al. 1984), stages of mood management were identified and examined. Fifty bipolar and fifty control participants were randomly allocated to either a positive or negative mood induction condition. Visual analogue scales
assessing current mood were completed before and after mood induction. Following successful mood induction, participants completed a number of computer-based questionnaires about current mood, mood interpretation and potential strategies for mood management. For both groups, mood induction was successful 60% of the time and negative mood was easier to induce than positive mood. Significant differences between groups were found in how current mood was interpreted following an induced mood change and in the types of strategies participants chose to self-regulate mood. The differences found at these stages may indicate why symptom escalation occurs for people with bipolar disorder. These results have potential implications for treatment by specifying where interventions may be best focused. Such interventions should allow individuals with bipolar disorder to make informed choices about managing their mood to maximise the positive elements and control their mood fluctuations in a way that will minimise the negative aspects of extreme mood changes. Details of results and implications for treatment will be presented.

The interaction of mood and anxiety in bipolar disorder: An experience sampling study
Kay Hampshire, Lancaster University
Current research highlights the potentially important link between anxiety and mood in bipolar disorder, with anxious individuals experiencing a more severe illness course including higher rates of relapse and earlier age of onset of bipolar disorder. However, research to date has focused heavily on outcome rather than process, and as such the exact nature of the relationship between mood and anxiety symptoms in bipolar disorder is as yet relatively unexplored. We report an experience sampling study which compares mood and anxiety symptoms in 50 healthy control participants and 50 participants with a diagnosis of bipolar I or II disorder. Participants were asked to record thoughts, mood and activities up to 10 times per day for seven days in response to a pre-determined, but essentially random, signal from a watch or mobile phone device. Analysis was completed using multi-level modelling to account for the hierarchical structure of the data. The primary analysis focused on the relationship between ratings of anxiety and ratings of positive and negative mood. It was found that bipolar participants were significantly more anxious, had higher levels of negative mood and lower levels of positive mood overall. Bipolar participants also had greater variability in ratings of all mood states compared to controls. For both groups, negative mood was associated with concurrent anxiety ratings and increased ratings of anxiety at subsequent time points. Positive mood was negatively associated with anxiety and increases in positive mood lead to decreased anxious mood for bipolar and control participants. The context of mood changes was also explored using thought and activity data at each response. The results are discussed in terms of the potential underlying mechanisms of mood and anxiety and implications for the treatment of anxiety in bipolar disorder are considered.

The inter-relationship between mood, self-esteem and response styles in adolescent offspring of bipolar parents: longitudinal analyses
Hana Pavlickova, Bangor University
Background: Response styles theory to depression (Nolen-Hoeksema, 1991) proposes three main strategies individuals employ in response to low mood. Although recent literature has suggested the usefulness of this theory in understanding the behavioural sensitivity in bipolar disorder, no study has so far investigated these processes in individuals at genetic risk of bipolar disorder.

Methods: Twenty-three adolescents of bipolar offspring and 25 offspring of well parents completed the Experience Sampling Method (ESM, Csikszentmihalyi & Larson, 1987) diary for six days. Longitudinal analyses were carried out to examine the inter-relationship between mood, self-esteem and response styles.

Results: Increased negative as well as positive mood resulted in greater ruminations in both groups. In addition, low self-esteem triggered greater risk-taking at the subsequent time point in the bipolar group, while negative affect instigated increased active coping in the control group. In both groups, engagement in risk-taking improved mood at the subsequent time point, whilst rumination dampened self-esteem.

Conclusions: Differential longitudinal associations between mood, self-esteem and response styles between bipolar and control offspring suggest early psychological vulnerability in the bipolar offspring, with important indications for early intervention therapies.

The role of positive and negative appraisals of mood states in adolescent mood symptoms
Rebecca Kelly, King’s College London
Recent research has studied the role of cognitive factors in bipolar disorder, with a view to developing effective psychological therapies. Research has demonstrated the importance of appraisals of mood states, over and above factors such as impulsivity, in predicting mood symptoms and bipolar disorder in adults. The present research aims to investigate these relationships in adolescents. A sample of 100 14-15 year olds completed measures of appraisals of mood states, mood symptoms, hypomanic personality, impulsivity, and responses to positive affect at baseline. Three months later, the sample completed measures of mood symptoms and appraisals of mood states a second time, along with a measure of life events in the intervening period. It was hypothesised that appraisals of mood states will be associated with mood symptoms and hypomanic personality, an index of mania risk. It was further hypothesised that appraisals of mood states will predict changes in mood symptoms over 3 months. The findings will be discussed and clinical implications for adolescents with bipolar disorder will be considered.
Recognition and psychological interventions of early onset bipolar disorder
Convenor and Chair: Matthias Schwannauer, University of Edinburgh

A pilot randomised controlled trial of Cognitive Interpersonal Therapy for early bipolar disorder
Jamie Kirk, NHS Greater Glasgow & Clyde / University of Glasgow, Andrew Gumley, Matthias Schwannauer, Ian Mark Kevan, Nicola Cogan, Kelly Chung, Jacqueline McTaggart, Michel Syrett, Craig MacNeil, Andrew McIntosh, Seonaid Cleare, Ross White & John Norrie
Objective: The study aimed to assess the feasibility of recruiting a sample of participants early in the course of Bipolar Affective Disorder (BP) to a randomised control trial of Cognitive Interpersonal Therapy (CIT). We aimed to randomise participants within 12 months of a first or second treated episode of mania and/or hypomania.
Design: The study was a 12 month prospective, single-blinded randomised control trial exploring the feasibility of using CIT to facilitate recovery and adaptation in early BP. The study compared CIT plus treatment as usual (TAU) with TAU alone.
Methods:
We aimed to establish recruitment, randomisation and assessment of outcome amongst individuals who had experienced their first or second treated episode of mania and/or hypomania in the previous 12-months prior to study entry. We assessed symptoms of depressed mood, mania or hypomania over a variable monthly follow-up of between 3 to 8 months dependent on the date of entry to the study. In addition, global assessment of functioning and perceived social support was assessed on a monthly basis.
Results: A total of 20 participants were randomised to the study. CIT was acceptable amongst those randomised to the experimental treatment. We noted suggestive trends to indicate CIT may be associated with improved wellbeing and depression.
Conclusions: Further research is required to establish further research parameters including effect size, sample size, competence to deliver treatment, evaluation of health economic outcomes, and proposed mechanisms of change.

Adults’ experiences of engaging in a cognitive interpersonal therapeutic approach to treating the early phase of bipolar disorder
Nicola Cogan, NHS Lanarkshire/University of Glasgow, Jamie Kirk, University of Glasgow
Introduction: An episode of mania or hypomania can be a powerful life event characterised by severe, unusual and distressing changes in a person’s thoughts, feelings and behaviours. It can also create a sense of interpersonal threat.
Objective: A central aim of the Bipolar Intervention Study was to adapt and develop a new psychological intervention for treating the early phase of bipolar disorder. Cognitive Interpersonal Therapy (CIT) is a structured, focused and collaborative approach to psychotherapy. It was originally outlined in the manual Staying Well After Psychosis and targets emotional recovery and relapse prevention.
Design: A randomised controlled feasibility trial was used to determine what adaptations to CIT were needed to address the specific issues facing adults following an episode of mania or hypomania. The lived experiences and reflections of participants who engaged in CIT were also explored in order to identify the therapeutic elements of the intervention that felt most important for their realisation of change.
Method: Participants were randomised to either the CIT or treatment as usual (TAU) component of the trial. Given it was a time-limited feasibility trial, the duration of therapy was determined by the point of randomisation to the study. Therapy sessions were adapted to ensure CIT was completed. Qualitative semi-structured interviews were conducted with participants that engaged with CIT in order to explore their understandings and experiences of the therapeutic intervention.
Findings: Important areas of therapeutic change were identified, including the development of cognitive and interpersonal skills and understanding and managing traumatic reactions to mania or hypomania. The development of a strong therapeutic alliance with the therapist was seen to hold a key role in the process of change. Generalization of these skills to everyday life was seen as important, and several ways in which this happened, including the use of relapse prevention work were discussed.
Conclusions: Working with the early phase of bipolar involves encouraging the development of insight and understanding and treating traumatic reactions to mania or hypomania. Encouraging the development of coping within an interpersonal context and emphasising functional recovery is central to the CIT approach. In order for CIT to be accessible and effective in the early phase of bipolar disorder numerous adjustments need to be made. Factors related to service structure and delivery, adults’ knowledge and beliefs about bipolar disorder and the therapy itself require further consideration.

Interpersonal Cognitive Therapy (CIT) treatment for young people with bipolar affective disorder: A pragmatic randomised control trial
Matthias Schwannauer, University of Edinburgh, Helen Griffiths, University of Edinburgh; Abbie Green, NHS Lothian
In this paper we are going to present the development and efficacy of IPT for adolescents with bipolar disorders. Community studies have shown a point prevalence of 1 to 2% for bipolar disorders and recent studies are showing suicide to be one of the chief cause of death in young people. Clinical and epidemiological data have documented that bipolar
disorder and recurrent mood difficulties in adolescents are a largely underrecognised underserved population. The undertreatment of adolescents with bipolar disorders, including limited access to appropriate psychological therapies, can be explained by a combination of their limited access to and underutilisation of mental health care. The implementation and evaluation of CIT as treatment that is regarded by adolescents as "more immediately relevant" must be an objective for anyone aiming to better meet the needs of this vulnerable group. In this presentation we will highlight the development of a bespoke practice model of Cognitive Interpersonal Therapy for adolescents with bipolar disorder, considering key features of adolescent development in the treatment manual. The paper will present results of a pragmatic RCT of CIT for adolescents with bipolar disorders. The session will focus on the application of the CIT model to bipolar disorder and present the outcome of a randomised trial in the Child and Adolescent Mental Health Services in Lothian, Scotland, examining the effects of treatment on core symptoms, coping styles and interpersonal problems. The results showed clear improvement in core symptomatology and quality of life for following intervention. The treatment trial further demonstrated the dominance of interpersonal psychological variables in predicting treatment outcomes and relapse rate in this population.

Early Identification of Bipolar Disorder – two population studies

Sonia Madrid, University of Edinburgh

Bipolar disorder and associated mood instability is a highly compromising condition characterized by high relapse rates associated with significant social and economic costs. Early identification of vulnerabilities to mood instability is crucial, yet bipolar disorders remain notoriously hard to diagnose and treat and long delays between onset and appropriate recognition and treatment are common. Concerted research is therefore being undertaken to identify sensitive and specific risk factors for bipolar disorder, as well as understanding short-term predictors of acute mood states. Preliminary findings arising from two PhD projects on developmental and cognitive factors linked to bipolar disorder are presented.

Study 1 was conducted with 2500 participants of whom 400 were considered to be at high risk of developing bipolar disorder. Risk level was determined by means of the Hypomanic Personality Scale. The sample was recruited and assessed online using questionnaires to measure the variables of hypomanic personality, mood, depression, emotion regulation, attachment, reflective functioning and metacognition. Preliminary findings based on correlations, suggest that the group at high risk of developing bipolar presents lower interpersonal functioning when compared to the low risk group. Higher insecure attachment, lower reflective functioning, higher metacognition scores, higher depression scores and higher dysfunctional emotion regulation scores significantly correlate with higher HPS scores. The results suggest that interpersonal functioning is fundamentally different in high and low risk groups and its quality is strongly associated with hypomanic tendencies. In addition they support the notion that developmental factors play a pivotal role in the manifestation of psychopathology, including bipolar disorder. They provide insight into what constitutes higher vulnerability to develop bipolar disorder, highlighting the importance of developmental aspects such as attachment, reflective functioning and emotion regulation as key components of early identification criteria.

Study 2 aimed to investigate time perspective (TP) as a predictor of acute episodes in bipolar disorder. TP is a cognitive variable that measures the dominance of our past, present and future in our current thinking. It was conceptualized by Zimbardo & Boyd (1990) in the aftermath of the Stanford Prison Experiment in an attempt to explain the dramatic and rapid changes in participants' moods that led to the termination of the study. Based on his observations, Zimbardo speculated that the quick development of severe depressive symptoms in the 'prisoners' was underpinned by dramatic changes in their time perspectives. The present PhD study puts this hypothesis to the test by examining whether TP is in fact a predictor of extreme mood states. 140 participants suffering from bipolar disorder completed a battery of questionnaires online that included measures on time perspective (ZPPI, 1999) and current mood state (ISS, 1991), as well as impulsiveness (BIS-11, 1983) and BIS/BAS functioning (BIS/BAS, 1994). The findings of a multinominal logistic regression suggest that future- time perspective is a predictor of depressive mood states, while past-negative time perspective predicts mixed mood states. These results suggest that individuals whose thinking is strongly influenced by an aversive recollection of their past were more likely to be experiencing a mixed mood episode, whilst future-oriented thinking appeared to protect from depressive moods. Overall, time perspective predicted acute bipolar episodes over and above impulsiveness and BIS/BAS functioning.

Early Identification of Bipolar Disorder – two population studies

Melanie Suettmann, University of Edinburgh, Sonia Madrid, University of Edinburgh, Matthias Schwannauer, University of Edinburgh

Bipolar disorder and associated mood instability is a highly compromising condition characterized by high relapse rates associated with significant social and economic costs. Early identification of vulnerabilities to mood instability is crucial, yet bipolar disorders remain notoriously hard to diagnose and treat and long delays between onset and appropriate recognition and treatment are common. Concerted research is therefore being undertaken to identify sensitive and specific risk factors for bipolar disorder, as well as understanding short-term predictors of acute mood states. Preliminary findings arising from two PhD projects on developmental and cognitive factors linked to bipolar disorder are presented.

Study 1 was conducted with 2500 participants of whom 400 were considered to be at high risk of developing bipolar disorder. Risk level was determined by means of the Hypomanic Personality Scale. The sample was recruited and assessed online using questionnaires to measure the variables of hypomanic personality, mood, depression, emotion regulation, attachment, reflective functioning and metacognition. Preliminary findings based on correlations, suggest that the group at
high risk of developing bipolar presents lower interpersonal functioning when compared to the low risk group. Higher insecure attachment, lower reflective functioning, higher metacognition scores, higher depression scores and higher dysfunctional emotion regulation scores significantly correlate with higher HPS scores. The results suggest that interpersonal functioning is fundamentally different in high and low risk groups and its quality is strongly associated with hypomanic tendencies. In addition they support the notion that developmental factors play a pivotal role in the manifestation of psychopathology, including bipolar disorder. They provide insight into what constitutes higher vulnerability to develop bipolar disorder, highlighting the importance of developmental aspects such as attachment, reflective functioning and emotion regulation as key components of early identification criteria.

Study 2 aimed to investigate time perspective (TP) as a predictor of acute episodes in bipolar disorder. TP is a cognitive variable that measures the dominance of our past, present and future in our current thinking. It was conceptualized by Zimbardo & Boyd (1990) in the aftermath of the Stanford Prison Experiment in an attempt to explain the dramatic and rapid changes in participants’ moods that led to the termination of the study. Based on his observations, Zimbardo speculated that the quick development of severe depressive symptoms in the ‘prisoners’ was underpinned by dramatic changes in their time perspectives. The present PhD study puts this hypothesis to the test by examining whether TP is in fact a predictor of extreme mood states. 140 participants suffering from bipolar disorder completed a battery of questionnaires online that included measures on time perspective (ZPI, 1999) and current mood state (ISS, 1991), as well as impulsiveness (BIS-11, 1983) and BIS/BAS functioning (BIS/BAS, 1994). The findings of a multinominal logistic regression suggest that future-time perspective is a predictor of depressive mood states, while past-negative time perspective predicts mixed mood states. These results suggest that individuals whose thinking is strongly influenced by an aversive recollection of their past were more likely to be experiencing a mixed mood episode, whilst future-oriented thinking appeared to protect from depressive moods. Overall, time perspective predicted acute bipolar episodes over and above impulsiveness and BIS/BAS functioning.

Prodromal signs and risk factors for bipolar disorders – Useful for early identification?

Thomas Meyer, Newcastle University

Bipolar disorder (BD) is a serious condition having a major impact on quality life of individuals and their families. A major concern is the delay, on average about 8-10 years, between first symptom onset and first manic episode (and therefore recognition that the individual has BD). Delay of recognition and treatment of BD is however associated with increased risk for suicide, emotional and economic burden. Early intervention seems therefore important hoping to be able to avoid some of the negative short-term and long-term consequences of being diagnosed with BD. Intervening in time however requires the reliable identification of people at ultra high risk for BD.

The presentation will review what risk factors have been identified predicting BD and whether these factors could help us targeting interventions at early stages of BD to potentially prevent some of the negative consequences of untreated BD. It will also be discussed what ethical issues arise when risk factors such as a family history of BD might be chosen to select people for screening and intervention. The topic of using screening measures will be touched upon as well.

Acceptance and Commitment Therapy, Psychological Flexibilty and Psychosis: New Research and Developments

Convenor and Chair: Eric Morris, South London & Maudsley NHS Foundation Trust & Institute of Psychiatry, King’s College London

ACT for Life Study: An Evaluation of Acceptance and Commitment Therapy (ACT) Groups for Psychosis in Community Settings

Louise Johns, South London and Maudsley NHS Foundation Trust

We evaluated ACT in a group format for clients with psychosis. We predicted that clients would find the intervention acceptable and show improvements in daily functioning, mood, and relationship with symptoms.

We ran 12 ACT groups across three clinical services, one for people with chronic psychosis, one for young people with first episode psychosis and one for individuals at high risk of developing psychosis. 61 clients completed a 4-week group intervention, which aimed to encourage more flexible responding to symptoms of psychosis and associated emotions / thoughts in order to increase values based behaviour. The main components were values clarification, mindfulness exercises, willingness, defusion and committed action.

The clients found the intervention acceptable, as shown by very high ratings (average 3.5 out of 4) on a satisfaction measure given independently by a psychology assistant.

We included a range of measures to assess hypothesised changes in daily functioning, mood, and relationship with symptoms. These were given by a psychology assistant at referral (week 0); pre-intervention (week 4); post-intervention (week 8); subsequent 6- and 12-week follow-up. Clients did not show a significant improvement in mood (anxiety and depression) at the end of the group, but their mood was significantly improved at follow-up. Similarly, significant gains in daily functioning were not evident immediately after the group, but were reported at follow-up. In terms of relationship with their symptoms, clients were responding more mindfully to distressing experiences following the group, and they were less caught up with these experiences.
We conclude that ACT delivered in a group format is acceptable to clients across the spectrum of psychosis. The clients in the current study showed improvements, as predicted, but these were mainly evident a few weeks after the group. Mediation analyses will determine whether the changes found in participants’ relationship with their symptoms led to the positive changes in their mood and functioning.

**ACT for Life: A grounded theory analysis of acceptance and commitment therapy groups for psychosis**

Sally Bloy, Canterbury Christ Church University

Little is known about the mechanisms of change in acceptance and commitment therapy (ACT) for psychosis. A qualitative analysis grounded in participants’ accounts of the therapy offers a model of how participants’ experienced change through an ACT for psychosis group intervention. A grounded theory analysis based on in-depth interviews of participants with psychosis is outlined. Participants’ perspectives on the therapeutic process of the intervention are discussed with respect to acceptability, understanding, group process, positive and negative changes and their relation to distress following the group intervention. Their accounts of therapeutic change are discussed in the context of the theoretically proposed mechanisms of change underpinning ACT for psychosis groups. This paper outlines an emerging theory that accounts for common experiences of the therapeutic process, as well as highlighting discrepancies. It discusses how participant perspectives might contribute to the further development of acceptance and mindfulness group therapies for individuals with psychosis. Clinical implications and further research questions are also illuminated.

**Delusional ideation in early psychosis: the role of schemas, mood, psychological flexibility, and mindfulness.**

Blaithin O' Dea, King’s College London, Blaithin O’ Dea, Institute of Psychiatry, King’s College London

Delusions are phenomena now thought to exist on a normative curve across the general population as well as being a key feature of psychosis. Environmental and biological explanations for the development of delusional symptoms have been put forward, however; psychological models, seek to specify triggering and maintenance mechanisms. This research examines whether predictive associations found in non clinical populations between negative schemas, mood, mindfulness and psychological flexibility and delusional ideation(Oliver, McLachlan, Jose, & Peters, 2011; Oliver, O’Connor, Jose, McLachlan, & Peters, 2011) exist in those who have experienced one or two psychotic episodes.

40 individuals were recruited form early intervention for psychosis services (age range 18 to 35) to complete a one hour assessment. Validated questionnaires measuring delusional ideation the predictor variables of interest were administered in conjunction with a clinical interview to assess positive symptoms. Preliminary results from this study suggest significant main effects on delusional variables for negative self schemas, mood and a facet of mindfulness called “acceptance without judgement”. Results will be discussed with reference to findings in non clinical populations.

Potential clinical implications have been suggested by previous authors whereby the identification of specific measurable psychological variables which are predictive of the development and or maintenance of delusional thinking may be helpful in the development of effective clinical interventions. Acceptance and Commitment Therapy is one such treatment which targets processes such as willingness to accept internal experiences without judgement which has been shown here to be implicated in delusional ideation.

**ACT for people distressed by hearing voices: A case series**

Abigail Clark, Barnet, Enfield & Haringey NHS Trust, Joseph Oliver, South London & Maudsley NHS Trust; Clara Strauss, University of Surrey; Eric Morris, South London & Maudsley NHS Trust

Objective: This study aimed to provide a preliminary investigation of the mediators of change in an Acceptance and Commitment Therapy (ACT) intervention for people distressed by hearing voices. ACT proposes that it is the context within which people experience voices that impacts upon distress and valued living. The cognitive mediation model proposes that it is beliefs about the voice/s and the fact that is causally related to distress and diminished life circumstances. Consequently, Cognitive Therapy (CT) aims to alter such beliefs. This study investigates the shared and distinct mediators of change in these two models.

Design: Following a four-week baseline four participants who were distressed by hearing voices engaged in a 12-week ACT intervention. ACT and CT process measures were completed at every session. Outcome measures were completed at the end of each phase. A qualitative Change Interview was conducted at the end of the intervention.

Results: Two of the four participants responded to the intervention. They demonstrated meaningful changes on measures of general psychological flexibility, psychological flexibility in relation to hearing voices, and in beliefs about voice omnipotence. No meaningful changes were demonstrated on a measure of positive and negative self-beliefs. It was tentatively hypothesised that changes may have occurred during the Acceptance phase of the therapy.

Conclusions: This study provided further support for ACT as a promising intervention for people distressed by hearing voices. ACT appears to impact upon psychological flexibility, as hypothesized, as well as the content of beliefs about voices, possibly through the development of meta-cognitive awareness. Tentative findings suggest that changes may occur following the introduction of acceptance and mindfulness based techniques, but this finding needs to be replicated. However, one hypothesis is that clients presenting with significant interpersonal difficulties may not benefit from ACT or require a longer-intervention. Clinical implications and suggestions for future research are discussed.
Compassion and psychosis: developing an understanding of mechanisms underpinning recovery
Convenor and Chair: Andrew Gumley, University of Glasgow

A Compassion Focused Model of Recovery after Psychosis
Andrew Gumley, University of Glasgow, Christine Braehler, University of Glasgow, Paul Gilbert, University of Derby
People recovering from psychosis can show a range of problems in their ability to experience certain kinds of emotion and drive. There can also be a lot of shame and stigma around the experience of having suffered a psychosis. CFT is based on a model of affect regulation derived from neuroscience and evolutionary psychology and is particularly suited to exploring the difficulties in recovering from psychosis and offering compassion-focused interventions. In addition it was designed for people with high levels of shame and self-criticism, a common feature in some people recovering from psychosis. This paper will explore the application of CFT as a way of conceptualizing some of the difficulties of psychosis and outline some potentially useful interventions.

Compassion and metacognition: Associations from a new scale in a complex psychopathology sample
Angus MacBeth, University of Aberdeen, Andrew Gumley, University of Glasgow; Laura Mitchell, NHS Greater Glasgow and Clyde; Elizabeth Reilly, NHS Greater Glasgow and Clyde; Giancarlo Dimaggio, Centre for Metacognitive Interpersonal Therapy
Introduction:
The ability to regulate affect in the face of stress has implications for recovery and chronicity in complex mental health problems such as schizophrenia and borderline personality disorder. The capacity to compassionately relate to self and others may be linked to recovery trajectories. Metacognitive understanding of one’s own and others’ thoughts and feelings also has implications for recovery. Using an interview-based measure of compassion (Narrative Compassion Scale, NCS) we present associations with metacognition, symptoms and interpersonal problems in a mixed clinical sample of individuals with diagnoses of psychotic disorder (with or without interpersonal violence) and Borderline Personality Disorder.
Method:
A cross-sectional mixed methods design was used with a within subjects condition and three between subjects groups. Forty-Three individuals were interviewed and transcripts coded with the Narrative Compassion Scale (NCS) and metacognitive assessment scale (MAS). The NCS permits coding of compassion-related narratives. Self-report measures of compassion, attachment anxiety/avoidance, interpersonal problems and psychiatric symptoms were also completed.
Results: We will report associations between compassion, metacognition, symptoms, attachment style and interpersonal problems. The paper will also explore the interaction between compassion and metacognition in relation to symptom and psychological functioning variables.
Discussion:
Results will be discussed with reference to processes of affect regulation in response to stressors. Implications are discussed in terms of a transdiagnostic understanding of recovery in complex psychopathology.

Exploring change processes in Compassion Focused Therapy in Psychosis: the role of mentalization
Christine Braehler, University of Glasgow, Sonia Wallace, NHS Ayrshire & Arran, UK; Rebecca Fisher, University of East London, UK; Tobias Nolte, Anna Freud Centre, UK; Andrew Gumley, University of Glasgow, UK
Increasing research is pointing to the role of impaired affect regulation and mentalization in the maintenance of psychosis. Recovery after psychosis is hindered by internal and external threats including feelings of shame, stigma, entrapment and social isolation, which have been associated with increased rates of emotional dysfunction. Compassion focused therapy (CFT) aims to stimulate capacities for soothing and affiliation to self and others and for mentalizing as a way to regulate threats and associated emotional dysfunction. Recent research found CFT for psychosis to be associated with increased compassion. Increases in compassion were related with a reduction in depression and perceived social marginalisation. To date no study has explored the role of mentalization as a potential mechanism of change in CFT. This study explored associations of mentalization with compassion, avoidance, depression and indicators of internal and external threat in the context of a feasibility trial of CFT. Forty adult outpatients with psychosis were recruited on the basis that they were experiencing emotional difficulties following psychosis and assessed at baseline and post-treatment/wait. Participants’ narratives of recovery were coded for the level of mentalization (operationalized as reflective functioning), compassion and avoidance. The Beck Depression Inventory (BDI-II) and Personal Beliefs about Illness Questionnaire (PBIQ-R) were administered. Baseline correlations between mentalization, compassion, avoidance, depression and indicators of threat will be reported. Tests of differences between mentalization before and after CFT for psychosis will be reported. Findings will be discussed in relation to mechanisms of change in CFT for psychosis.

A Compassionate Mind Training (CMT) group for acute inpatients: Feasibility, initial pilot outcome data and recommendations
Cognitive and Affective Approaches to Understanding Psychotic Experiences

Chair: TBC

Taking account of depression in a study of ‘jumping to conclusions’ by people with persecutory delusions.

Natasha Vorontsova, Royal Holloway, University of London; Natasha Vorontsova, Royal Holloway, University of London; Philippa Garvey, Institute of Psychiatry, King's College London; Daniel Freeman, University of Oxford

Psychological therapies for psychosis are undergoing refinement, guided by research clarifying the mechanisms that drive symptom persistence. People with delusions, particularly those with persecutory delusions, have demonstrated a hasty data gathering bias, referred to as ‘jumping to conclusions’ (JTC). A multifactorial model of delusion maintenance includes JTC and depression, as relatively independent contributors. However, affective and cognitive predictors of delusion persistence have rarely been examined together in a prospective study. This study systematically examined JTC, depression and associated cognitive factors over six months among 60 participants with persecutory delusions, 30 participants with non-psychotic depression and 30 non-clinical controls. Participants with persecutory delusions demonstrated significantly more JTC than the groups without psychosis, as predicted. Among participants with delusions, however, those who were concurrently depressed were less likely to JTC than those who were not depressed, with no corresponding difference in delusional conviction. Depression, and not JTC, predicted the persistence of persecutory delusions over time. JTC was, however, associated with poor problem solving performance, which in turn predicted the persistence of delusions. JTC may be more prevalent in the subset of people with persecutory delusions who are not concurrently depressed. Trials are underway of stand-alone interventions for JTC and for affective disturbance in people with delusions, and these may be optimally applied to groups with different symptom profiles. Our findings highlight the heterogeneity of cognition and affect in people with psychosis, supporting the relevance of specific psychological therapy techniques for subgroups of people with different combinations of symptoms.

How do people with persecutory delusions evaluate threat in a controlled social environment? A qualitative study using virtual reality

Miriam Fornells-Ambrojo, University College London; Daniel Freeman, King's College London; Mel Slater, University of Barcelona/University College London; David Swapp, University College London; Angus Antley, University College London; Chris Barker, University College London

Environmental factors have been associated with psychosis but there is little qualitative research looking at how the ongoing interaction between individual and environment maintains psychotic symptoms. The current study investigates how people with persecutory delusions interpret events in a virtual neutral social environment using qualitative methodology. Twenty participants with persecutory delusions and twenty controls entered a virtual underground train containing neutral characters (Fornells-Ambrojo et al. 2008). Under these circumstances, people with persecutory delusions reported similar levels of paranoia than non-clinical participants. The transcripts of a post-virtual reality interview of the first 10 participants in each group were analysed. Thematic analyses on interviews focusing on the decision making process associated with attributing intentions of computer-generated characters revealed 10 themes grouped in 3 main categories (evidence in favour of paranoid appraisals, evidence against paranoid appraisals, other behaviour).

People with current persecutory delusions are able to use a range of similar strategies to healthy volunteers when making judgements about potential threat in a neutral environment that does not elicit anxiety, but they are less likely than controls to engage in active hypothesis-testing and instead favour experiencing ‘affect’ as evidence of persecutory intention. Virtual reality has the potential to be incorporated into cognitive behavioural interventions for psychosis as it has occurred with anxiety disorders. A series of virtual scenarios that are increasing anxiety-provoking could be used while the client is
encouraged to use a range of strategies to evaluate evidence in favour and against a possible threat (e.g. active hypothesis testing, use of social scripts). This rehearsal process could provide clients with experiential evidence and increase their confidence when evaluating stressful environments in everyday life.

**Appraisals and responses to experimental symptom analogues in clinical and non-clinical individuals with psychotic experiences**

**Thomas Ward, King's College London, Institute of Psychiatry;** Keith Gaynor, King's College London, Institute of Psychiatry; Mike Hunter, University of Sheffield, School of Medicine and Biomedical; Peter Woodruff, University of Sheffield, School of Medicine and Biomedical; Philippa Garety, King's College London, Institute of Psychiatry; Emmanuelle Peters, King's College London, Institute of Psychiatry

Cognitive models of psychosis suggest that anomalous experiences alone do not always lead to clinical psychosis, with appraisals and responses to experiences being central to understanding the transition to ‘need-for-care’. Cognitive models of psychosis suggest that the ways in which experiences are appraised and responded to are central to understanding the transition to ‘need for care’.

**Method:** The appraisals and response styles of Clinical (n=28) and Non-Clinical (n=34) individuals with psychotic experiences were compared following two experimental tasks inducing anomalous experiences. The Cards Task was used as an analogue of thought interference, and the Virtual Acoustic Space Paradigm as an analogue of auditory hallucinations. **Results:** The groups were matched in terms of their psychotic experiences. As predicted, the Clinical group scored higher than the Non-Clinical group on maladaptive appraisals following both tasks, rated the experience as more personally significant, and were more likely to incorporate the experimental set-up into their ongoing experiences. They also appraised the Cards task as more salient, distressing, and threatening. The Clinical group scored higher on maladaptive, and lower on adaptive, response styles, than the Non-Clinical group on both tasks. **Conclusion:** The findings are consistent with cognitive models of psychosis, with maladaptive appraisals and response styles characterising the clinical group only. Clinical applications of both tasks are suggested to facilitate the identification and modification of maladaptive appraisals.

The study provides support for psychological interventions that target maladaptive appraisals (for example self-denigrating and conspiratorial appraisals) and unhelpful modes of responding (such as rumination). Despite the interest in enhancement of natural coping (see for example Tarrier et al., 1990) there is increasing recognition that no single strategy is likely to be successful across different people and situations (Phillips, Franey, Edwards & McMurray, 2009). However, comparison of the different ways in which clinical and non-clinical groups respond to unusual thoughts and experiences has important implications for treatment development. The current study has presented a framework for response styles grounded in previous research (including factor analytic studies) - this framework achieved face validity for clinicians and appeared meaningful to Clinical and Non-Clinical participants. This framework goes some way towards addressing Farhall et al.’s (2007) suggestion that adoption of a more explicit model of coping may be useful with respect to integrating research findings and clarifying clinical implications.

The findings with respect to rumination are consistent with a growing acknowledgment of the relevance of anxiety and worry processes to clinical psychosis (Startup, Freeman and Garety, 2007). The fact that the Clinical Group was more likely to endorse both the ‘Active Resistance/ Distraction’ style and the ‘Passive/ Giving up’ style, following the VASP, is consistent with the finding that voices perceived as powerful and malevolent are at first resisted, but ultimately submitted to or appeased (Birchwood & Chadwick, 1997). In contrast the Non-Clinical group was more likely to endorse a ‘Decentring’ response style characterised by either mindfulness or reappraisal, thus supporting the normalising and decentring rational of Cognitive Behavioural Therapy (see e.g. Peters et al., 2010) and third-wave therapies for psychosis (e.g. Chadwick et al., 2009).

**Living with the aftermath of psychosis: A qualitative research study looking at the experience of emotion in the development and maintenance of psychosis**

**Jonathan Hutchins, South Essex Partnership University NHS Foundation Trust;** John Rhodes, Central and North West London NHS Foundation Trust; Dr Saskia Keville, University of Hertfordshire

**Background:** Traditionally studies have neglected emotion in psychosis; possibly as a consequence of the psychiatric model’s emphasis on psychotic symptoms rather than individuals’ lived experience of emotions during psychotic episodes. **Aims:** This study sought to investigate how individuals experienced their emotions in the context of psychosis. **Methodology:** A Qualitative Interpretative Phenomenological Analysis (IPA) research methodology was used to interview eight purposely sampled participants from a local Early Intervention in Psychosis NHS service. **Results:** Three super ordinate themes were found through the IPA. The first super ordinate theme focused on participants’ intense emotional experiences in the context of psychosis. The second super ordinate theme focused on how participants cope with both their non-psychotic and psychotic emotional experiences. The third super ordinate theme highlighted participants emotional consequences of their psychotic experiences. **Clinical Implications and Conclusion:** There were numerous clinical implications highlighted in the study including the importance of trying to normalise participants’ experiences in order to promote engagement in services, the importance of
Bulimia nervosa and the positive values of illness: an investigation of the differential motivation towards illness-specific cues

Caitlin O’Hara, Institute of Psychiatry, King’s College London; Ulrike Schmidt, Institute of Psychiatry, King’s College London
Bulimia nervosa (BN) can be a chronic condition in young women with long-term negative effects on the individual, their family, and society. Several behaviours associated with BN are hypothesised to be highly salient and rewarding for these people, thus challenging full recovery. This study aimed to improve understanding of the motivational processes involved in the valued nature of BN symptomatology.

Twenty participants with BN and 20 healthy controls (HC) were tested using behavioural experiments to investigate the salience attributed to BN-specific cues and behaviours. Specifically, conscious and unconscious motivation towards these stimuli were measured using a progressive ratio (PR) exercise breakpoint task, a startle eyeblink modulation (SEM) task, and a food challenge task. Compared to HC, individuals with BN were expected to attribute greater salience to BN-related stimuli as measured primarily by increased PR exercise breakpoints (i.e., an increased willingness to sustain effort for exercise reward) and increased startle inhibition (i.e., an appetitive response) to BN-related stimuli.

Preliminary analysis suggests that, relative to HC, women with BN rate images of underweight women as significantly more attractive (M=2.38,SD=1.49; M=4.73,SD=2.38, respectively) and desirable (M=2.43,SD=1.74; M=5.67,SD=2.49, respectively) than images of healthy thin women (p<0.0001). The exercise breakpoint scores for women with BN and HC were M=238.33(SD=386.26) and M=91.00(SD=59.81), respectively. The magnitude of the differences in the breakpoint means is of medium effect (Cohen’s d=0.56; p=0.10). Findings contribute to the understanding of the role of reward processes in the pathology of BN and extend current concepts related to the mechanisms that maintain its symptoms.

Skills Class

Metacognition-Oriented Social Skills Training for social recovery of individuals with schizophrenia

Manuela Pasinetti, Centre for Metacognitive Interpersonal Therapy in Rome, Italy
Patients with schizophrenia show impaired emotional and social behaviours, such as lack of theory of mind (ToM), and communication and interpersonal limitations in social situations. Although research on social competence in schizophrenia has continued to evolve over the years, there is scarcity of interventions focusing on deficits in social abilities of these patients. Recent theories of schizophrenia assign a central role for recovery in schizophrenia to the improvement in social cognition; social cognition has been linked to metacognition (i.e. ToM, empathy, mentalization); and deficits in metacognitive functions have been shown in both early psychosis and chronic schizophrenia as well as in ultra high-risk state for psychosis. In the recent past, a variety of psychosocial interventions (e.g. Social Skills Training [SST], Metacognitive Training [MCT], Social Cognition and Interaction Training) have been proposed. Although their efficacy has been demonstrated, their feasibility, generalisability and effect-size seem to be limited (Kurtz & Richardson, 2012; Tungpunkom et al., 2012). For these reasons we consider fundamental to enhance current psychosocial rehabilitation approaches by integrating components that target metacognitive capacity. We proposed a Metacognition-Oriented Social Skills Training (MOST), which maintains some elements of standard behavioural SST with the addition of specific exercises aimed at building and improving the skill of thinking about mental states of oneself and others in specific social situations. The following will be presented in details: a) MOSST programme; b) target social skills; c) metacognitive and behavioural instructions; d) criteria for conducting a metacognitive group; and e) role-playing technique using a metacognitive approach.

Objectives: By the end of the class, participants will be able to: 1) Assess metacognitive functioning in patients affected by schizophrenia; 2) Master a variety of useful interpersonal techniques to improve patients’ metacognitive capacities during sessions; 3) Conduct role-plays providing metacognitive instructions; 4) Use several tasks to elicit mentalistic narrations in patients; 5) Create assignments for facial and situational emotion recognition.

Manuela Pasinetti is a Clinical Psychologist and a CBT therapist at the Center for Metacognitive Interpersonal Therapy in Rome, Italy. She has been working with inpatient and outpatient services for people with schizophrenia for years. She is currently leading the MOSST training programme with Dr Ottavi.

References
Mindfulness-based Cognitive Therapy in Treatment Resistant Depression: a Randomized Controlled Trial in a Psychiatric Outpatient Setting

Anna Ehnvall, Institute of Clinical Neuroscience, Gothenburg University and Psychiatric Out-patient Clinic, Varberg; Tadeusz Jarawka, Psychiatric Out-patient Clinic, Halmstad, Sweden; Peter Jacobsson, Out-patient Clinic, varberg, Sweden; Henrik Kok, Brännö, Gothenburg, Sweden

Fifteen to 20 per cent of depressed patients develop treatment resistant depression (TRD). Our aim was to evaluate the effect of Treatment As Usual (TAU) as compared to add-on treatment of Mindfulness-Based Cognitive Therapy (MBCT) to TAU in patients with TRD in an out-patient psychiatric setting.

Eighty-nine patients (67 women and 22 men) with a mean age of 45 ± 11 years were randomized to treatment as usual (TAU) or to MBCT as add-on treatment to TAU. MBCT as add-on treatment included 8 weekly sessions as well as 2 follow-up meetings at 4 and 6 months after baseline. Depression severity was measured using the Beck Depression Inventory II (BDI-II) and the Montgomery-Åsberg Depression Rating Scale (MADRS); anxiety levels were assessed using the Beck Anxiety Inventory (BAI); and level of mindfulness was evaluated using the Mindfulness Attention Awareness Scale (MAAS). Self-ratings in both groups were administered at baseline, 4 weeks, 8 weeks, 16 weeks, 24 weeks and at 52 weeks. At baseline both groups showed moderate to severe depression. Depression severity, as measured by MADRS, was significantly reduced at 24 weeks in the MBCT as add-on treatment sample as compared to the TAU sample (p=0.018) and showed trend significance as measured by BDI (p=0.117). After 52 weeks from baseline there were no significant differences between groups on any of the depressive severity measures. There were no significant differences in anxiety or mindfulness measures between groups at any time.

We found a significant decline in depression severity in the MBCT as add-on treatment at 24 weeks indicating promising treatment for this group of difficult to treat patients. However, our results indicate that this group of patients might need longer follow-up treatment than six months to maintain effect over time. Patients with difficult-to-treat depression might need longer follow-up treatment than 6 months in order to benefit from MBCT.

Outcome on Discharge and Follow-up of Inpatient Therapy for Severe-Treatment Refractory Obsessive Compulsive Disorder associated or not with OCPD/Perfectionism

Ruxandra Ion, National and Trustwide Services for OCD and BDD; Lynne Drummond, National and Trustwide Services for OCD and BDD

Obsessive-Compulsive Disorder (OCD) symptom severity can be measured using a variety of methods. The Yale-Brown Obsessive Compulsive Scale (YBOCS) has been widely used in psychopharmacological and psychological research to assess severity and change. However, it is unreliable in the most severely ill patients who often score lower than expected. Secondly it is not responsive to change. A reduction of 4 hours daily in obsessive or compulsive activity may mean a reduction of 1 point on the YBOCS scale. We therefore decided to investigate the YBOCS alongside other methods of severity and change in a group of patients with profound OCD. Successive patients admitted to an inpatient unit for profound OCD that had been previously treatment-refractory were examined using:

- YBOCS
- Sheehan Disability Scale (SDS) measuring functioning self-care; private leisure; work and relationships
- Clinical Global Improvement (CGI) measuring improvement by experienced clinicians
- Percentage Global improvement (PGI) rated by the patients.

All ratings were positively correlated with the YBOCS (stats). However, it was notable that the percentage improvement obtained on the SDS, CGI and PGI were all substantially greater than the improvement obtained in the YBOCS score. Obsessive-Compulsive Personality or perfectionistic traits had no effect on overall improvement although they had a higher rate of post-discharge relapse 67.6% v 12.5%)

This study shows that YBOCS is a relatively insensitive measure of change in patients with profoundly severe OCD. Obsessive-Compulsive Personality or perfectionism did not effect treatment outcome but did predict a higher rate of relapse.
Further research is necessary to specifically define the difference in outcome in the two groups. It might be useful that relapse prevention work in clients with perfectionism takes into account these findings.

A Cost-Effectiveness Evaluation of CBT for Psychosis in a Specialist Outpatient Clinic (PICuP)
Bryony Sheaves, Institute of Psychiatry, King’s College London; Emmanuelle Peters, Institute of Psychiatry, King’s College London; Louise Johns, Institute of Psychiatry, King’s College London

The Psychological Intervention Clinic for out-patients with Psychosis (PICuP) is a specialist tertiary service that offers Cognitive Behavioural Therapy (CBT) for individuals with distressing positive symptoms of psychosis or individuals with emotional difficulties in the context of a history of psychosis.

Clinical benefits of CBT for Psychosis
A meta-analysis has indicated that CBTp has a modest effect on positive symptoms of psychosis (.37), negative symptoms (.44), functioning (.38) and mood (.36) (Wykes et al., 2008). In comparison with standard care alone, the full NICE guideline report that CBT reduces rehospitalisation rates up to 18 months following the end of treatment and reduces the duration of stay by an average of 8.26 days (NCCMH, 2010). As such, it is recommended by the NICE Schizophrenia Guideline (2009) as an adjunct to medication.

Economic impact of CBTp

Despite the clear health benefits of CBTp, there is a relative scarcity of research evaluating the economic impact of such gains. Three studies have indicated that despite the cost of providing therapy, CBTp is associated with no increased health costs (Kuipers et al., 1998, Startup et al., 2005 & Peters et al., 2010). However, one multi-site randomised controlled trial (van der Gaag et al., 2011) has found that the clinical gains of CBTp were accompanied by higher overall costs. These costs were mostly attributable to a small number of participants who were long stay inpatients before entering the study. The full NICE schizophrenia guideline (NCCMH, 2010) used results from a meta-analysis to offset the cost of CBTp with reduced hospitalisation rates. This resulted in a net cost between £-2,277 (ie. a net saving) and £751 per person.

The current evaluation sought to provide further data on the effect of CBTp on the cost of care in a specialist outpatient clinic through measurement of high cost care; inpatient stays and home treatment / crisis resolution teams.

Measuring high cost care

Cost of care was measured through inpatient admissions and home treatment / crisis resolution team contact. The full Nice Guideline (NCCMH, 2010) states inpatient treatment to be by far the most costly healthcare component in the treatment of schizophrenia. Home treatment and crisis resolution teams were introduced in order to provide high intensity community based support at the point of crisis. This level of supports is accompanied by a high average cost per case of £30,592 (Curtis, 2011). Participants:

Seventy participants were included in the evaluation. Inclusion criteria were: 1. The participant must have completed at least five therapy sessions. 2. Complete medical records available from South London and Maudsley NHS Foundation Trusts electronic patient journey system. 3. Must have completed either a follow up assessment or, a full year since ending therapy. 4. Must have given prior consent to participate in research.

Procedure:

Participants were ordered by date of initial assessment for therapy. All participants who were assessed prior to 01 December 2009 were assessed in reverse order for the inclusion criteria, until a sample size of 70 was met (n=183 assessed). For those who met the inclusion criteria, their initial assessment date, the date they were allocated a therapist and their end of therapy date were noted from medical records. The number of inpatient days and home treatment / crisis resolution days for each of the reference periods was totalled. In order to account for variance in the time periods, the total days of each care type was divided by the number of months making up that time period. This provided a measure of inpatient and home treatment / crisis resolution days per month, which was then multiplied by unit cost per day.

Dependent Variable:

Unit costs per day of inpatient care (£312) and home treatment / crisis resolution (£103) were used to calculate the cost of care per month for each participant at each of the three time points.

Independent Variable:

Time period in relation to therapy: 1. one year prior to accepted referral 2. During therapy and before discharge 3. One year following discharge, or until the follow up assessment was complete.

Cost of care for 70 participants:

There was a decrease in the total cost of care from the period before therapy (£31,602), to during therapy (£15,159), and a further decrease following cessation of therapy (£12,057) (figure 2). However, there was no statistical difference in cost over time [Friedman statistic: X^2 (2, n=70) = 4.48, p = n.s.]. This was likely due to positive skew in the data; at least 75% of participants exhibited no care costs across all three time periods.

Sub-group analysis; participants who utilised high cost services:

Thirteen participants utilised high cost services prior to entering therapy. This group decreased their care costs during therapy (wilcoxon signed rank: Z = -1.99, n=13, p <.05) and this was maintained to the 12-month follow-up period after cessation of therapy, (Z = 2.62, n=13, p <.01). The median cost of care fell from £1870 prior to therapy, to £0 during therapy and after therapy. Analysis of costs over time indicate that 10/13 participants decreased their care costs from the period prior to therapy, to follow up assessment after therapy (figure 3).
When the cost of therapy was offset against service costs for the thirteen high cost service users, the cost saving was lost. Instead, a mean investment of £1022.33 was required. Those who utilised high cost services prior to therapy were equally distributed between those who completed therapy and those who completed less than 5 sessions ($X^2 (1, n=88) = .12, p = n.s.$).

The majority (at least 75%) of patients entering this specialist outpatient clinic did not incur costs from inpatient and home treatment / crisis resolution care in the periods prior to, during, and after therapy. However, CBTp, delivered in routine clinical practice by a specialist outpatient service (PICuP), can reduce the cost of care in those who did utilise high cost services prior to entering therapy. Furthermore, these cost gains extend beyond the cessation of therapy into a twelve month follow up period. This result is not accounted for by drop-out; those who used high cost care services were equally distributed between those who did and did not engage in at least five sessions of CBTp.

The decreased care costs were no longer significant when the cost of therapy was offset against costs savings. A mean investment of £1022.33 was required, however this did not raise costs beyond what they were prior to therapy.

There were limitations to the study:

- Current service use costs were used which may not have reflected actual costs at the time they were incurred.
- The method of estimating service costs for each patient was not exact; inpatient stays did not account for days of leave and home treatment team for example are billed on a ‘per contact’, rather than ‘per day’ basis.
- Cost estimation was based on high cost health services only, the cost of care co-ordination by GP or CMHT, lost employment of the participant or a family carer for example, were not accounted for.
- However, the evaluation was retrospective; the results are therefore a reflection of standard therapy at PICuP and were not biased by the fact the evaluation was taking place.

A longer follow up period (beyond one year) is necessary in order to ascertain whether therapy costs a recouped through continued reduction of high cost care use, or rather, whether cost savings are lost through future relapses. This evaluation suggests that the clinical gains of CBTp, delivered in routine practice by a specialist outpatient service translate into economic gains through decreased high cost service use in a sub-sample of participants.

More specifically, patients who have recently relapsed, but who receive CBT, decrease in their use of high cost care services following CBtp from a specialist outpatient clinic. This is a helpful result to feedback to Primary Care Trusts, individual referrers and tertiary referral panels. When deciding on whom to refer for CBTp, they could consider those who have recently relapsed, but who feel able to engage in regular therapy sessions.

Furthermore, given that 75% of participants incurred no costs across each time period, the study highlights the importance of recognising alternative economic outcome measures. These might include measures such as discharge from secondary care to GP care co-ordination or return to employment of both the participant themself, or their carer/relative.

Improving Access to Psychological Therapies for People with Psychosis and their Carers: the South London and Maudsley (SLaM) IAPT-SMI Demonstration Site for Psychosis

Louise Johns, South London and Maudsley NHS Foundation Trust; Suzanne Jolley, King’s College London; Juliana Onwumere, King’s College London; Miriam Fornells-Ambrojo, South London and Maudsley NHS Foundation Trust; Craig Milosh, South London and Maudsley NHS Foundation Trust, Devon Elliott, South London and Maudsley NHS Foundation Trust; Philippa Garety, King’s College London

Cognitive-behavioural therapy and Family Interventions for psychosis (CBTp & FIp) are clinically and cost effective (NICE, 2009), and receive high satisfaction ratings from service users and carers. NICE recommend that CBtp is offered to everybody with psychosis and that FIp is offered to all psychosis clients with a caregiver. Current NHS provision is unable to meet demand (All Party Parliamentary Group on Mental Health, 2010; Schizophrenia Commission, 2012). The Improving Access to Psychological Therapies (IAPT) for Severe Mental Illness (SMI) project aims to increase access to NICE approved psychological therapies for psychosis, bipolar disorder and personality disorders.

The SLaM NHS Foundation Trust is one of two IAPT-SMI Psychosis demonstration sites, offering a strategic approach to improving access to high quality evidence-based therapy. This involves seeing more clients for therapy, reducing waiting times, taking direct referrals, conducting regular assessments of progress, and providing training and close supervision opportunities. Our IAPT-SMI service spans three psychosis teams: an Early Intervention team, a specialist recovery service, and a psychological therapy team.

To date, we are exceeding our referral targets and have reduced waiting times by 60%. We are collecting the minimum data set for psychosis, including 3-monthly outcome measures and a session-by-session measure. Completion rates are very high, and client feedback on completing measures is routinely collected. We will be able to present 6-month outcome data.

The findings of the pilot will contribute to a national guideline/toolkit for the effective implementation of psychological therapies for psychosis.

The national toolkit will provide guidelines for:

- Therapist caseloads for CBTp and FIp
- Frequency and format of supervision
- Use of outcome measures in this client group
- A therapy pack for practising CBTp and FIp
Social Perception in People with Eating Disorders  
Beth Renwick, King’s College London; Daniella Waterman-Collins, King’s College London; Anna Lose, King’s College London; Celia Heneage, King’s College London; Sammanany Tauschek, King’s College London; Rachel Long, Oxford Health NHS Foundation Trust; Ulrike Schmidt, King’s College London

Social perception (SP) is a key aspect of social cognition (SC) which has not yet been investigated in eating disorders (ED). Poor social cognitive abilities have a negative impact on treatment outcome and prognosis in these severe and often long-term conditions. Interventions that enhance social cognition may therefore improve quality of life in chronic illness. This study therefore aimed to investigate SP in individuals with anorexia nervosa (AN) and bulimia nervosa (BN) treated for AN [restricting subtype (AN-R): n=51; binge-purge subtype (AN-BP): n=26] and BN (n=57) and healthy control (HC) (n=50) participants completed the Interpersonal Perception Task (IPT-15). This is an ecologically valid task consisting of 15 video-clips depicting complex social situations relating to intimacy, status, kinship, competition and deception. Participants assess relationships between protagonists’ based on non-verbal cues.

Overall, there was no difference between groups on IPT total and subscale scores. Group differences on the Intimacy subscale approached significance so post hoc comparisons were carried out. AN-R participants performed significantly worse than HCs in determining the degree of intimacy between others. SP is largely preserved in ED patients. Film scenarios allow individuals to be a social observer and tap into cognitive rather than emotional SC, making the task less difficult for patients. However, individuals with AN-R do show impairments in identifying intimacy in social situations, this may be due to lack of relationship experience.

Social Cognition can be an important factor when using CBT in the treatment of Eating Disorders.

Therapist Experiences of Delivering Two Psychological Therapies to Patients with Anorexia Nervosa: A Qualitative Study  
Beth Renwick, King’s College London; Daniella Waterman-Collins, King’s College London; Anna Lose, King’s College London; Martha Kenyon, King’s College London, Charlotte Davies, King’s College London; Ulrike Schmidt, King’s College London

Adult Anorexia Nervosa (AN) is a serious, long-term mental disorder with a great need to develop and evaluate novel and effective treatment. The Medical Research Council recommends including clinicians, patients and other stakeholders perspectives in the design, development and dissemination of any novel treatments. Within eating disorders research exploration of therapists’ experiences of treatment delivery has been largely neglected. The Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC) is an ongoing Randomised Controlled Trial (RCT) which aims to determine the efficacy of two treatments, the Maudsley Model for Treatment of Adults with Anorexia Nervosa (MANTRA) and Specialist Supportive Clinical Management (SSCM). The current study, embedded in the MOSAIC RCT, utilised a qualitative approach to gain an understanding of therapists’ experiences of treatment delivery.

20 MOSAIC therapists took part in individual semi-structured interviews. These were recorded, transcribed, coded and analysed thematically.

Treatment specific subthemes emerged under themes of positive and helpful aspects of treatment, challenges and therapeutic fit. Positives to MANTRA were the structure, flexibility and use of the manual as a tool, challenges included the time consuming and demanding delivery. The space to talk and ability to set own goals in SSCM were positives; challenges included the lack of therapeutic tools and a strong focus on food and eating.

Findings are discussed in terms of their implications for clinical practice, therapist training and further treatment development.

Conclusion: This study provides valuable insights into treatment characteristics deemed most useful by expert ED therapists. This study offers insight into how therapists experience working within specific treatment modalities and provides information on the important factors to take into account when treating individuals with Anorexia Nervosa. Many of these factors are applicable to all Anorexia Nervosa treatment, including CBT, and therefore may be useful for clinicians to consider.

"Groups – more than the sum of the parts? Engagement and empowerment; illustrations and reflections from groups with people with learning disabilities”  
Rowena Rossiter, Sussex Partnership FT/Tizard Centre; Celia Heneage, Salomonos, Christ Church

This poster will describe groups for people with learning disabilities and demonstrate how groups may offer therapeutic opportunities which may be more accessible for “hard-to-reach” people.

This is illustrated through presentation of:
- a summary of existing evidence-based practice from literature and reviews
- results of a recent small survey on groups and people with learning disabilities
- descriptions of some of our recent practice-based groups and resources used
- reflections on process issues, evaluation, mechanisms of change and implications for increasing effectiveness of, and access to, future groups.
The descriptions of groups and associated resources will illustrate simplified and visual approaches to formulation, psycho-education and CBT. These are tailored to enable “socialisation to the model” and therapeutic change for people with learning disabilities across a range of problem or “diagnostic” presentations across the lifespan, in a range of service settings and delivered by a range of professionals.

In addition, we draw attention to themes identified as key in effective groups with people with learning disabilities, how they relate to group process, and applicability across other client groups. The poster demonstrates how CBT can be made more accessible and effective for service users who may otherwise be disempowered/disenfranchised from psychological interventions.

**Pole to Pole – The Collaborative Development of a Resource for Exploration in Bipolar**

Laura Walton, NHS Fife; Duncan Isobel, Fife Bipolar Group; Gledhill Edie, Fife Bipolar Group; Sorley Lorraine, Fife Bipolar Group; Mitchel Gordon, NHS Fife, Walton Laura, NHS Fife; Babbs Graeme, NHS Fife

The SIGN guidelines for Bipolar Disorder identified that patients want to be more involved with diagnosis and treatment and that carers wanted help communicating with their loved ones when they were unwell. More locally, an informal needs assessment with Fife Bipolar Group (FBG) identified these same needs and also the need for greater collaboration between voluntary and statutory organisations in Fife. The Pole to Pole project was set up in order to develop a resource to help individuals with a lived experience of Bipolar Disorder to conceptualise and communicate this experience in a person-centred way by collaborating with FBG.

Acceptance and Commitment Therapy (ACT) is a third wave cognitive behavioural therapy which considers that psychological suffering is a natural part of life and avoiding this distress increases suffering. This is especially relevant for severe and enduring psychiatric disorders which are not only associated with high levels of emotional distress, but are themselves a continuing source of distress. Therefore, within the collaboration, ACT was used as the basis for developing a new approach for people with Bipolar and their families.

A thematic analysis of data from focus groups with people with a lived experience of bipolar disorder in Fife was carried out to inform the development of the approach. Group sessions were developed to support people to use the group, and the format was then piloted with members of the original resource development forum and further adapted following feedback discussions.

Major themes extracted from the focus group discussions were: communication, interaction, collaboration, individuality, universality, experience and involvement. These themes were applied in order to develop the Pole to Pole approach.

Pole to Pole is helps individuals with bipolar disorder, their carers, friends and family to reflect on their own experiences of living with bipolar disorder and to facilitate communication of this experience between the relevant parties.

Pole to Pole is a person-centred approach which enables people to reflect together on their experience of Bipolar and, it facilitates self-management strategies. People with Bipolar and carers have been central to the design of the approach and will be involved in future delivery and evaluation. As clinicians we have found this a rewarding way of working as we can see people responding to being listened to, and having their ideas incorporated. We have had considerable positive feedback from carers about how the approach involves them, and encourages recognition within services of the role they already play in supporting their relative. They have also told us that they appreciate the additional insights the approach gives them into the nature of the disorder and how they can respond to the person experiencing it. Pole to Pole delivers ACT, as an intervention for bipolar, in a collaborative and community driven manor that makes cognitive behavioural therapy an accessible intervention for the target population.

**Exploring the past experiences of intimate relationships of lesbian, gay and bisexual users whilst being treated on adult acute inpatient wards: the role(s) of intimate relationships in recovery.**

Jennie Robertson, Royal Holloway, University of London; Angela Byrne, Royal Holloway, University of London

The LGB population is more likely to experience mental health difficulties than heterosexual populations and has traditionally been discriminated against by mental health services (Cochran & Mays, 2009; King et al., 2011; McFarlane, 1997). Recovery models have historically discussed the importance of personal relationships but little attention has been paid to the importance of sexual orientation and/or intimate relationships. Indeed, intimate relationships and severe mental health difficulties remains a relatively unexplored area in research and clinical practice (Fairbank, 2011); intimate relationship needs remain largely ignored in inpatient services (McCann, 2010), and where they are addressed, it is often in a risk-management and pathologising manner (Davison & Huntington, 2010; Quinn, Happell & Browne, 2011). Engaging in intimate relationships can have long-term benefits for psychological well-being (Pierce, Sarason, & Sarason, 1996).

Conversely, factors associated with the absence of or difficulties within intimate relationships may contribute to poor mental health; for example, limited social access and social skill: low self-image and confidence: poor self-care: abuse: sexual dis-inhibition and risk to self and others: and the side effects of psychotropic medications (McCulloch, Coverdale & Bayer, 1992; Miller & Finnerty, 1995; Attenborough & Watson, 1997; Coverdale, Turbott & Roberts, 1997; Walkup, Crystal, & Sambamoorthi, 1999). Thus, it would appear important to consider the role of intimate relationships in recovery. The current study sought to explore intimate relationship needs and recovery based on the experiences of LGB people in adult mental health inpatient settings and to develop Repper and Perkin’s (2003) recovery model by considering these experiences.
A qualitative and exploratory design which adopts a phenomenological position was employed. Six adults who self-identified as lesbian or gay and who had been inpatients on adult acute mental health wards within the last five years were recruited. Semi-structured interviews were conducted with participants and were explored using Interpretive Phenomenological Analysis (IPA). It is hoped the results will add further clarity to understandings of intimate relationships for LGB service users and, in particular, the role of intimate relationships in their recovery. The clinical implications of this extended understanding include possible changes in the assessment of relational needs for this population, the development of clinical interventions such as inpatient programmes to address the relationship needs of LGB people with mental health difficulties, changes to the ward environment to accommodate partners and training of staff members in issues related to sexual orientation, sex and intimate relationships.

Five master themes were identified during the analysis: the meaning of intimacy, the reciprocal relationship between intimacy and mental health; the ward as a barrier to intimate relationships; invisible barriers to intimate relationships within services; and the staff-service user relationship as non-intimate. Participants described the importance of numerous relationship types within their social network including relationships with friends, family and ex-partners; thus, intimacy was not restricted to relationships with partners. Sexual and emotional intimacy were seen as separate by the majority of participants and all male participants commented on the importance of multiple sex partners for themselves or their regular partner. The social value of having a partner was commented on by all participants and the ability to be in a relationship was highly-prized; this ability was seen to be impacted by past experiences of trauma, negative childhood events and the experience of mental health difficulties. Participants talked about the positive and negative implications of being in a relationship and experiencing mental health difficulties. For example, relationships could be seen as tools for promoting mental health and offered participants support and motivation to recover. However, relationships were often experienced as pressurising and stressful, because of the impact of mental health difficulties, sexual dysfunction and expectations around involvement with care. Barriers to forming and maintaining relationships on the ward included the ward being a physically unpleasant, hostile and threatening environment in which to be and the disruption to normal, routine activities usually performed by partners. In addition, prejudice and discrimination based on sexual orientation, issues of power and control between services and service users and failure to talk about sex, relationships and sexual orientation made it difficult if not impossible for participants to talk about or be with their partners on the ward. Finally, the relationship between staff and service-users was felt to be important; participants described this as lacking the qualities of successful intimate relationships. That is, communication was felt to be poor with staff and staff was felt to have negative attitudes towards those with mental health difficulties. Consequently, there was a break down in the trust and honesty between staff members and service users. CBT could be employed to address both staff and service users’ understandings of intimate relationships and to develop programmes on wards which address the difficulties experiences in intimate relationships as a result of mental health difficulties and the experience of being on the ward. CBT offers an important contribution in understanding the impact of past childhood experiences on current relationship functioning, which could be used with service users on or off the ward.

Training and Professional Issues

Keynote Addresses

The Dissemination of Psychological Treatments
Christopher Fairburn, University of Oxford

Treatment researchers focus their efforts on identifying effective treatments, and for whom and how they work, but there are matters over and above these that are of concern when it comes to treatment dissemination and implementation. These include the clinical range of the treatments concerned, the ease with which they can be learned, and their mode of delivery. It is these topics that will form the basis of this presentation, together with the place of modern technology in both treatment and training.

“Learning is not a spectator sport” (anon). Is it true that Experience is Essential for the Effective Acquisition of Knowledge and Skill?
Melanie Fennell, University of Oxford

Cognitive behaviour therapy can be counted a major success story. It is a live, evolving organism, still expanding its range and its evidence base. It has attracted major government funding in the UK, to a degree previously undreamt of in relation to psychotherapy. It is used and valued by therapists and patients worldwide. But with success comes also challenge, not least in how most effectively to ensure its dissemination. The keynote will address this issue, considering three key areas: what we should disseminate; how we should evaluate the success of our efforts, and how best to ensure that those whom we train achieve lasting gains in knowledge and skill.
Symposia

What can qualitative research tell us about CBT? A showcase of the contribution of qualitative methodologies to advance our understanding of the development and application of CBT interventions.

Convenor and Chair: Yvonne Awenat, University of Manchester

Experiences of Cognitive Behavioural Suicide Prevention (CBSP) therapy: A qualitative study exploring the acceptability and feasibility for high risk individuals with psychosis.

Yvonne Awenat, The University of Manchester

This paper will describe the contribution of qualitative methodologies to the exploration and evaluation of client experiences of a novel CBT intervention specifically designed to target suicidality. Participants were drawn from a larger RCT sample of individuals with psychosis and a history of suicidal behaviour. Client acceptability is a crucial component necessary for the successful implementation of CBT interventions with the primacy of the “user experience” now being firmly enshrined in Department of Health policy. When used by skilled researchers, qualitative approaches hold particular value in their ability to investigate challenging ‘taboo’ topics such suicide with so called ‘heard to reach’ groups.

Results of the study will be presented along with a description of the processes used to develop a bespoke data collection instrument. Qualitative analytical procedures applied will be outlined along with a discussion of lessons learned concerning the training and support needs of novice qualitative researchers involved in highly sensitive mental health research.

How clinicians and service users can enhance the development of assessment and treatment in recovery from psychosis

Gillian Haddock, The University of Manchester

This paper will describe a programme of work carried out collaboratively with clinicians, academics and service users with lived experience of psychosis with the aim to improve outcomes and recovery from psychosis. Unresolved research and clinical questions will be highlighted, particularly in relation to how implementation of available psychological treatments is poor. Results from a recent audit of delivery of psychological treatments will be presented which highlights how individual CBT and family interventions are poorly implemented within routine care for people with psychosis. Reasons for this poor implementation will be highlighted and a series of qualitative studies exploring service user views of key outcomes and choice in relation to psychological therapies will be presented. Data from recent work on the development of a new service user outcome for psychosis, and novel ways of delivering recovery oriented psychological treatments for psychosis will be discussed.

Use of qualitative approaches in the development and evaluation of targeted CBT for suicide prevention therapy delivered within a high security male prison

Fiona Ulph, The University of Manchester

Suicide is the leading cause of preventable death in prisons with a suicide rate up to five times greater than for the community. However, there are no evidence-based suicide prevention interventions for this group. Consideration of contextual factors are of prime importance in carrying out research within the closed society of the prison where a different set of social norms, rules and language mitigate against and impose major challenges to standard research practices.

This paper will describe the application of qualitative approaches to investigate the acceptability and feasibility of a new cognitive behavioural suicide prevention intervention for male prisoners. The contribution of a forensic Service User Reference Group of ex-offenders in the development of the bespoke data collection instrument to elicit prisoner views of the new targeted suicide prevention CBT intervention will be discussed. The particular benefits and challenges of utilization of focus group interviews rather than individual interviews will be presented along with the early findings of prisoner participant’s qualitative feedback of their experiences of therapy.

Can qualitative research tell us anything about negative aspects of CBT for Psychosis?

Rory Byrne, The University of Manchester

Cognitive Behavioural Therapy for Psychosis (CBTp) is now a well-established treatment for psychosis and schizophrenia recommended in the UK by NICE. While evidence from clinical trials of CBTp have established efficacy and acceptability, there have been few examinations of potential harmful side-effects or negative outcomes (including inefficacy) for recipients. In general, where these aspects have been discussed, it is within the growing body of qualitative research into CBTp.
This paper will therefore present a review of qualitative research evaluating CBT, with the aim of identifying negative or harmful aspects of CBT as highlighted by those with personal experience of the therapy. Relevant thematic areas and findings will be discussed, along with limitations within this research area, clinical implications, and suggestions for future research efforts.

**The Art and Science of CBT - Becoming Metacompetent**

Convener and Chair: Adrian Whittington, Sussex Partnership NHS Foundation Trust

---

**How to flex and adapt CBT whilst remaining true to its principles**

Adrian Whittington, Sussex Partnership NHS Foundation Trust

Cognitive Behavioural Therapy is an empirically based intervention, based on theory, experimental and treatment-trial evidence. However, many therapists perceive a tension between the need to adhere to evidence-based protocol and the need to be appropriately flexible and adaptive to individual needs. This tension may in part reflect myths about the nature of differences between conditions in research trials and routine clinical practice. Metacompetence allows therapists to move beyond this tension, representing a set of higher order competences that “focus on the ability to implement models in a manner that is tailored to the needs of the individual client” (p.9) (Roth and Pilling, 2007). Metacompetences may be thought of as multiple procedural rules by which therapists can apply the methods of therapy in a theoretically coherent, but appropriately adapted and individually tailored way, as a good cook may use but adapt a recipe. This paper distinguishes between the principles, tactics and techniques of CBT, and proposes how these can be applied in order to achieve competent practice and move beyond this to metacompetent practice. It highlights the twin pitfalls of therapist drift (Waller, 2009), and rigid application of technique, and proposes how these can be avoided. Roth, A. and Pilling, S. (2007). The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders. Department of Health.Waller, G. (2009). Evidence-based treatment and therapist drift. Behaviour Research and Therapy, 47, 119-127.

**Developing your own style in CBT**

Nick Grey, Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Foundation Trust

Simon Darnley, Anxiety Disorders Residential Unit, South London and Maudsley NHS Foundation Trust

This talk focuses on how to be a more effective cognitive behaviour therapist by reflecting on your own personal style, and how this can be developed and adapted in therapy, supervision and teaching. To some degree this is the “performance of CBT”. It is recognized in music that “it is possible to perform a piece of music with absolute technical mastery yet with no expressive skill whatsoever” (Sloboda, 2000). By analogy we suggest that for the best performance by a CBT therapist there needs to a melding of conceptual knowledge, technical skill, emotional attunement, self-reflection and being oneself. We will provide examples of various facets of style and performance including: the performance of metaphor, the use of humour, and guided discovery leading to ‘penny-drop’ moments. We highlight the implications for therapy, supervision and training.

**Is it them or is it me? Transference and countertransference in CBT**

Stirling Moorey, South London and Maudsley NHS Trust

The concept of transference is central to the psychodynamic understanding of psychotherapy and has been accepted with varying degrees of questioning by most other schools of therapy. CBT has tended to avoid this term because of its association with psychoanalysis, yet many of the patients we work with have strong emotional reactions to us that seem to arise from beliefs, emotions and behavioural patterns that were learned in childhood. These patients can evoke responses in us that are equally strong and different from our usual professional style and behaviour. This presentation will translate transference and countertransference into the language of interpersonal beliefs and schemas and show how they can be useful concepts in CBT despite their origins in an alien tradition. CBT has a number of structural features that tend to damp down some forms of transference fostered in more interpersonally based therapies, and when alliance ruptures do occur they can often be worked with without carrying out intensive work on interpersonal schemas. A model of conceptualisation will be presented that allows the therapist to follow a protocol based model yet takes account of how beliefs and interpersonal compensatory strategies may affect the therapy process. Some common transference reactions and the schemas that give rise to them will be described.

**What to do when CBT isn’t working**

Michael Worrell, Central & North West London Foundation Trust

Any honest reading of the available research literature will lead you to conclude that even if you were practicing all of your CBT interventions at an appropriate level of competence, you will have many experiences where the intervention does not work. There are two related questions that I would like to address in this paper. Firstly, what should you do when CBT isn’t working? How can you develop metacompetencies for responding flexibly when you encounter stuck points in the process of an on-going therapy? In the wider therapeutic literature this topic can be thought about as falling within the notion of ‘working with resistance in therapy.’ Secondly, what should you do when both you and quite possibly your client have done
the best possible and yet CBT hasn’t worked? How do you draw such unsuccessful interventions to some form of acceptable closure? This topic falls more broadly within the area of ‘managing endings’. In this paper I will address a range of issues including: how do we define ‘treatment failure’?, How can we respond flexibly rather than rigidly to various forms of ‘resistance’?, How to we balance ‘adherence’ with ‘flexibility and adaptation or innovation’? and how can unsuccessful treatments be drawn to a successful close?

A Tough Nut to Crack: Adaptations to CBT Training in Primary Care
Convenor and Chair: Harry O’Hayon, University of Reading

Psychological Perspectives in Primary Care (PPiPCare): Development and evaluation of an IAPT-driven and GP-led primary care training programme.
Michelle Lee, Charlie Waller Institute, School of Psychology and CLS, University of Reading; Costas Lambropoulos, Healthy Minds Bucks, Oxford Health Ineke Powell, South Central Strategic Health Authority; John Pimm, Health Minds Bucks, Oxford Health
Evidence suggests that low-intensity psychological treatments may be successfully delivered in primary care, as part of a stepped-care approach to disorders such as depression and anxiety. In recognition of this, a training programme (Psychological Perspectives in Primary Care or ‘PPiPCare’) has been developed as part of the South Central SHA Education Strategy (2010-2012), aimed at all primary care professionals, including GPs and specialist nurses. This paper aims to provide an overview of the aims and objectives of this IAPT-driven and GP-led training, and to further describe the nature of the training itself. Additionally, we outline a preliminary pilot evaluation carried out for training delivered by a specific IAPT service (Healthy Minds, Bucks). Initial findings indicate that this training is favourably received by primary healthcare professionals, and has a positive impact in terms of resulting clinical knowledge and skill. Longer term follow up also indicates that clinicians in the main are making use of training materials, and are able to utilise basic CBT taught techniques in primary care consultations, although they may face significant barriers in the application of new skills. We review some of these barriers in further detail, and consider how they might best be overcome.

Adapting CBT Skills for General Practice: Linking Theory, Values and Compassion
Alison Sedgwick-Taylor, Independent Consultant Clinical Psychologist, Sundee Soa-Nuang, Charlie Waller Memorial Trust/ Oxford Deanery
1 in 4 of us will suffer from a mental health problem within a given year, with anxiety and depression being the most common combination of mental health disorders in the UK (DoH, 2012). Most people with mental ill health will get their support from the primary care services that deal with 90% of diagnosed mental health problems. (Goldberg and Huxley, 1992). The Royal College of GPs has acknowledged the need to strengthen GP training in mental health (RCGP Curriculum 3.1 May 2012 Revision) and the need to build emotional resilience in GPs has been further highlighted (Howe, 2012). Cognitive Behavioural Therapy (CBT) has the most robust evidence base of all the psychological therapies in the treatment of depression and anxiety. The National Improving Access to Psychological Therapies (IAPT) Programme has made a significant dent in assisting people with common mental health problems to access evidence based treatment but many people will (for a variety of reasons) never be referred or will prefer to be treated by the GP. There are mixed results regarding the effectiveness of training GPs in CBT (Hoifodt et al, 2011; King, 2002). The brief training course described here aimed to offer GP trainees the following; a CBT/Compassionate Mind toolkit for use in their own lives; a model for understanding common mental health; a set of psychological skills to help them better work collaboratively with the patient to self help and an opportunity to explore their values regarding their own mental health and that of the patients they serve. The early qualitative and quantitative results are very encouraging and suggest that an emphasis on compassion and the emotional resilience of the GP may facilitate learning and improve training outcomes.

Adaptations to CBT for GP trainers
Harry O’Hayon, The Charlie Waller Institute, University of Reading
Transferrable CBT skills and interventions have been adapted and applied to teach GP trainers to apply them within their role as teachers and trainers of GP trainees. The training consists of an introduction to CBT skills followed by a series of master classes. The learning objectives include; understanding core CBT skills that can be adapted to use in the GP trainer role; how to apply these skills as an intervention to resolve specific issues that arise between GP trainer and trainee; practice through experiential master classes to rehearse how to use those skills and interventions. Early qualitative and quantitative results indicate that GP trainers are being provided with helpful CBT tools to use in their role as trainers and mentors of GP trainees. Using those CBT tools in their training and mentoring role is showing some reported signs of enhancing both learning and training outcome.

Current Issues in CBT Implementation across Services
Chair: TBC
Decision-making in stepped care: How do therapists decide whether to prolong treatment or not?  
Judith Gellatly, The University of Manchester; Jaime Delgadillo, Leeds Community Healthcare NHS Trust;  
Simone Stephenson, Touchstone, Leeds

The fundamental role of decision-making within stepped care is clear, however, there is a paucity of research in this area. Recent research has identified a discrepancy between the theory and implementation of the model and the tensions between the ‘caring’ values of clinicians and the ‘economic/public health’ perspective. The difficulties experienced when faced with making such decisions were also found to be associated with ‘holding’ (Gellatly 2011).

To advance our understanding of decision-making associated with prolonging or concluding treatment where little evidence of therapeutic gain is evident, psychological therapists completed two questionnaires – the likelihood of ‘holding’ scale and the factors associated with referrals and holding (FARAH-Q). A cross-sectional sample of eighty-two therapists participated.

The factor structure, internal consistency and test-retest reliability of the measures was examined prior to assessing correlations between FARAH-Q items and likelihood of ‘holding’. A four-factor solution indicated that therapists’ decision-making is influenced by a complex interplay between beliefs, attitudes, subjective norms and self-efficacy.

Ajzen’s theory of planned behaviour (Ajzen 1991) provides a conceptual framework to examine why some clinicians may retain non-improving patients in treatment, which is likely to have efficiency and cost drawbacks for stepped care systems. The analysis suggests that the decision to retain a patient is more likely to happen if there are perceived barriers to refer the patient for further treatment, if the therapist likes the patient and has a good therapeutic alliance, and if the therapist feels confident that they have the experience to achieve a positive outcome by prolonging treatment.

Evidence is presented in this paper which affirms that some professionals’ decisions are directly influenced by a combination of evidence and patient preferences. However, other influencing factors have been identified, which may be of particular interest to clinical supervision within these services. While therapists may feel confident (self-efficacy factor described above) that they have the ability to treat patients affectively and thus ‘hold’ them in therapy, clinicians should also be confident enough to know when the decision to ‘hold’ may be inappropriate. Raising awareness of such factors among professionals delivering treatment may helpfully draw attention to their own subjective norms, attitudes and beliefs which may –in some cases– be at odds with best evidence, efficiency and effective care.

Stepped Care Exposure and Response Prevention for Obsessive Compulsive Disorder: A Pilot Study  
Fredrik Folke, Department of Neuroscience, Psychiatry, Uppsala University Hospital, Uppsala, Sweden;  
Jesper Bedinger, Private Practice, Stockholm, Sweden; Mårten Skogman, Uppsala University Hospital, Uppsala, Sweden; Sergej Andréewitch, Karolinska University Hospital at Huddinge, Outpatient Service for OCD and Internet Psychiatry, Sweden

Exposure and Response Prevention (EX/RP) is the psychosocial treatment of choice for Obsessive Compulsive Disorder (OCD; Koran, Hanna, Hollander, Nestadt, & Simpson, 2007). Despite the empirical support, EX/RP is not available to most individuals with OCD (Mancebo et al., 2006; Torres et al., 2007). EX/RP accessibility may improve if services are delivered in a stepped care fashion, starting with low intensity formats (e.g. Guided Self-Help) and only stepping up intensity (e.g. individual therapy) for those who do not respond. Preliminary research show that stepped care is a efficacious, acceptable and cost-effective service delivery format for OCD (Giilliam, Diefenbach, Whiting, & Tolin, 2010; Tolin, Diefenbach, & Gilliam, 2011; Tolin, Diefenbach, Maltby, & Hannan, 2005).

The current open pilot study evaluated stepped care EX/RP for nineteen individuals with OCD at a Swedish Anxiety Treatment Centre. Treatment was arranged in three consecutive steps; 1) guided self-help, 2) group EX/RP, and 3) Individual EX/RP. Participants started in the first treatment step and progressed to the next step only if they did not meet responder criteria.

Results indicated that eight patients (42.1%) in step one, five patients (26.3%) in step two, and two patients (10.5%) in step three were considered responders. A total of four (21.1%) dropped out of treatment. Overall, the clinical gains were retained at 12 weeks follow-up. The number of therapy hours were reduced to approximately 50% of what would have been the case if all participants would have received individual EX/RP.

Overall, results confirm previous research on stepped care for OCD. Further more study provide preliminary support for group EX/RP as one treatment step. Group EX/RP has not been included previous stepped care trials for OCD. Making OCD-treatment widely accessible is a great challenge. This preliminary study can provide clinicians and program leaders with ideas for how to organise treatment resources efficiently.

The uptake of an online intervention for depression in a primary mental health care setting  
Graham Walker, NHS, CPFT; Cecily Morrison, CLARHC

Existing online interventions for depression and anxiety have shown good clinical effectiveness (Christensen, Griffiths, & Jorm, 2004), but uptake in primary mental health care settings is minimal. This paper considers issues that arose in the uptake of a therapist-assisted online intervention for depression during a pilot service-based clinical trial in a primary mental health care setting.

MindBalance, built on the SilverCloud platform (http://www.silvercloudhealth.com/) was used as part of an Increasing Access to Psychological Therapies (IAPT) program. People with mild or moderate depression who were appropriate to
receive manualised treatment either face-to-face or over the phone were offered a choice between MindBalance or treatment as usual. Routine IAPT clinical measures were used to measure outcome and effectiveness of treatment. Of the 4,500 number of referrals in that period for low-intensity care, only 29 people were approached; 17 of which agreed to take part; 5 of these participants withdrew. Neither age, gender, severity of depression, or ethnicity seemed to affect intention to use MindBalance. We identified issues with both therapist and patient projected benefit (as opposed to actual benefit). We also noted that it is unrealistic to use a package only for depression as most patients seen have co-morbid anxiety. Our study, although small in numbers, illustrates that it is important to consider service-use of online interventions and not just their clinical effectiveness. Although NICE Guidelines advocate cCBT interventions, they do not go as far as to advocate any specific programs. The outcomes of this experiment help to move us towards an understanding of the shift that needs to take place in order for a single cCBT package to be seen as a legitimate intervention.

**Integrating therapist delivered text based internet CBT into step 3 NHS IAPT services**

**Sarah Batteup, PsychologyOnline.co.uk; Sue Wright, PsychologyOnline.co.uk**

Research has shown live text based therapy provided via the internet to be an effective method of delivery (Therapist-delivered internet psychotherapy for depression in primary care: a randomised controlled trial, Lancet 2009; 374: 628-34). The conclusion of this study was that this method of delivery could broaden access to CBT. PsychologyOnline ran pilots in NHS IAPT services to consider whether online therapy could be integrated into the IAPT environment. Step 3 IAPT waitinglist patients were contacted by phone to offer the choice of online therapy. Those who chose to do this were sent an activation link to register for online therapy and were matched to therapists according to times preferred by patients. Therapists met with patients weekly mirroring the session durations and therapy length of traditional IAPT step 3 therapy. IAPT Minimum Data Set (MDS) questionnaires were completed online before every session. Online therapy was successfully integrated into IAPT including compliance with information and clinical governance. Supervision guidelines followed those of IAPT. PsychologyOnline supervisors were meta-supervised by service supervisors. Communication between supervisors to ensure consistency was identified as critical. NHS IAPT therapists were trained to provide therapy alongside PsychologyOnline therapists. Information about user requirements was gathered including patients' preferences for weekday evening appointments (6pm-10pm) and the need to develop an online facility for completing MDS questionnaires and reviewing scores. Recovery rates appeared similar to those achieved in standard IAPT delivery. Live therapist delivered text based internet CBT can be integrated into a Step 3 NHS IAPT service. Patient choice may be extended as it was found that most patients preferred weekday evening appointments between 6pm and 10pm which may not be available in the existing IAPT services. The potential implications are that, using an online facility to deliver CBT can extend patient choice, not only as patients can choose from extended hours, but as they can do it from their computers they do not have to travel or take costly time off work. Those that suffer mobility problems may find online therapy more accessible as well as mothers with small babies and children who can fit therapy around childcare issues. It has also been suggested that people reluctant to seek help because of issues of stigma may also find this an easier route to therapy. Therapy can be provided online in a number of different languages allowing greater access to ethnic minorities. Thus, online therapy can open access for many people who otherwise may not be able to receive therapy.

**New Developments in the Training and Assessment of Health Professionals Delivering CBT**

**Chair: Helen Matthews, Centre for Workforce Intelligence**

---

**Description of the Psychological Well-being Practitioner Role in the NHS**

**Gemma Nash, University of Surrey; Nimmi Hutnik, University of Surrey; Gemma Nash, University of Surrey; Olivia Adams, University of Surrey; Serenia Yip**

Little research has been reported on the Psychological Well-being Practitioner (PWP) role, which was established within the Improving Access to Psychological Therapies (IAPT) initiative to provide Low Intensity CBT interventions to people experiencing mild to moderate depression and anxiety. PWPs treat a high volume of people in a short space of time via face to face (F2F) or telephone interaction. Providing CBT interventions to a high volume of people in this manner was developed to save the nation huge sums of money in terms of work days lost due to depression and anxiety. 18 PWP trainees completed a Patient Data Analysis Log (PDA) which collected demographic information, presenting problems, intervention/s used, modality of contact and outcome for the patients that they worked with. T2599 records of patient data were analysed using SPSS 19. Multiple demographic variables are described. The most common treatment outcome for patients was discharge which we infer successful conclusion of treatment ($p<0.000$). Telephone work was significantly more effective than F2F work. ($p=0.03$). PWPs are effective in treating patients with mild to moderate depression and anxiety and they positively impact the mental health of large numbers of people.
Research indicates that medication is most effective when taken along with cognitive behaviour therapy (van Apeldoorn et al., 2008). It is therefore crucial that GPs fully understand the nature of the PWP role in order to maximize outcomes for patients and minimize inappropriate referrals to IAPT services.

A Review of Methods for Assessing Therapist Competence in Cognitive Behavioural Therapy
Kate Muse, University of Oxford; Freda McManus, University of Oxford
Effective assessment of CBT competence is crucial to the success of the UK’s current drive to expand CBT training and service provision, and to the widespread dissemination of CBT into routine clinical practice settings. However, a lack of consensus about how CBT competence should be assessed has resulted in the use of numerous different methods, many of which have been widely criticized. This talk will describe and evaluate the various methods of assessing CBT competence. A systematic literature search identified 64 articles pertaining to a method of assessing competence in the provision of standard CBT interventions to adults experiencing mental health problems. Ten methods for assessing CBT therapist competence were identified from these articles.

Priorities for future research will be highlighted and tentative recommendations for assessing therapist competence will be made within the context of the limited evidence base and need for feasibility in clinical practice settings. The central aim of this talk is to provide an overview and evaluation of the CBT competence assessment methods which are currently available, thus enabling those involved in assessing CBT competence to make informed decisions about which assessment tools are most appropriate.

An evaluation of the impact on the learning environment of using Video Conferencing as a medium for post graduate CBT training
Sean Harper, NHS Lothian; Anne Joice, NHS Education Scotland; David Peck, University of Stirling; Alicia Picken, NHS Lanarkshire
The South of Scotland CBT training programme in collaboration with NHS Education Scotland initiated a pilot project for intake 2011/12, offering the option of training via Video Conferencing. This paper presents the results of an evaluation of this pilot project.

Phase 1-Quantitative analysis of past cohorts of students to establish academic performance ‘norms’ for comparison
Phase 2-Qualitative analysis of the experiences of the learners, course lecturers and clinical supervisors

Quantitative Results: Detailed performance norms were established from the analysis of 150 previous trainees with a number of interesting findings including a clear negative bias for access to training for those from remote and rural service locations. The consequent pilot project using VC as a training medium indicates that trainees have performed comparatively well.

Qualitative Results: Key emerging themes included positivity regarding the training opportunity; challenges included VC equipment reliability; limited peer support and compromised supervisory relationships

Government targets for delivering psychological therapies will continue to require innovative practice in the delivery of quality therapist training. Video Conferencing, enhanced by the learning gained through this evaluation, provides a cost effective and efficient method of training in CBT which may offer a useful model that can be adopted elsewhere in CBT training programmes.

Looking After You Looking After Me: Using Positive Cognitive Behavioural Techniques to improve emotional well-being
Gita Bhutani, Lancashire Care NHS FT;
Stress is one of the most common reasons for sickness absence. Stress is costly in time, money and its negative impact on other employees. The need for well-being interventions and better support for stressed employees has been documented (Boorman, 2009; DH, 2011). With current NHS changes and uncertainty, this is particularly important.

Strengths based cognitive-behaviour therapy (CBT) approaches have been used successfully therapeutically. Positive psychology principles build strengths and positive experiences to enable individuals to enhance well-being. Guided imagery approaches have enabled individuals utilise previous positive experiences and/or construct positive future templates increasing the likelihood of better outcomes.

The 117 participants were from NHS clinical or corporate settings. The Looking After You Looking After Me (LAMLAY) programme comprised three 3-hour or four 2-hour sessions weekly. Positive imagery and strengths based cognitive behaviour approaches were delivered via participant exercises and didactically.

The completion rate was 77.8% (missing one session at most). Seventy-five participants (83% of completers) completed the WEMWBS pre-course (mean 46.4) and post-course (mean 52.4). Significant improvements in well-being were obtained (t=9.32, df=74, p<0.0001). Satisfaction ratings indicated high approval levels; qualitative feedback also identified participant-identified positive benefits.

Follow-up data will be presented demonstrating the impact of the course at 3 and 6 months post-course. These results demonstrate the initial benefits of the LAMLAY programme for NHS staff. Further development will include increasing sustainability and longer-term evaluation. The importance of improving staff well-being is discussed in the context of the Francis report and new nursing strategy.
Improving staff well-being and widespread dissemination and implementation of CBT techniques from a well-being approach.

**Training multidisciplinary long-term condition staff in psychological skills – what works in the ‘real world’?**

Leeanne Nicklas, NHS Lothian

The value of psychological care in helping to maintain and improve quality of life, reduce distress and increase motivation and ability to engage in self-management in LTCs is increasingly recognised in political drivers, and policy documents (e.g. Department of Health, 2011). Staff competence in empathic listening and appropriate detection and management of co-morbid problems can greatly aid adjustment to and management of LTCs (NICE, 2009). With limited psychology practitioners working in LTCs, the increasing flexibility and skill of multidisciplinary staff in this sphere is important, as is the adoption of a holistic, biopsychosocial approach. (Naylor et al, 2012).

Two training packages for staff working in LTCs will be discussed. Both packages had the same content – introduction to the CBT model, screening for mood issues and health behaviour change techniques. The structure in which the training was conducted differed with Prochaska and Di Cemente’s stages of change model being built in to the package in one trust (i.e. staff could opt-in to training depending on their level of readiness) and training being applied in on a mandatory basis in another trust.

The differences in the outcomes of staff training in terms of satisfaction with training, changes in knowledge and changes in skills attained will be discussed. Poorer training outcomes were apparent when training in psychological skills was mandatory.

The implications of these findings for future training of multidisciplinary staff in psychological skills will be discussed. Some structures of training lead to better outcomes than others.

Tips and ideas for engaging MDT staff in training in less than ideal scenarios for example mandatory settings and brief consultations will be shared.

**Skills Class**

**Improving your Chances of Getting your Submissions accepted for presentation at BABCP Conferences**

Glenn Waller, University of Sheffield and Roz Shafran, Institute of Child Health, University College London

It is important that BABCP conferences should represent clinical practice that is firmly rooted in good science. It is equally important that new presenters should enter the arena over time - clinicians and researchers who can help the field of CBT to develop by presenting their innovative ideas on pathology, treatment and services. However, entering that arena can seem daunting, and those potential new entrants need to know what is necessary to get in. In order for all BABCP members to consider the possibility of presenting papers, symposia, workshops and skills classes, it is helpful for them to understand how to translate their work into a submission that has the best chance of being accepted for the conference.

This Skills Scientific Committee is fully transparent. It will outline the criteria that are applied in assessing such submissions, including the quality of the work, the links to the wider evidence and theory bases, and previous feedback. It will also outline the process of peer review. The aim will be to help attendees shape Class is aimed at helping people to submit work successfully and to help ensure the work of the their preparation of submissions in the future in order to give them the best possible chance of being accepted, and to encourage attendees to make such applications in the future.

The workshop will include basics (working to deadlines, formatting, picking a title that grabs the reader) and more core issues (working to conference themes where possible, demonstrating breadth of interest and timeliness, drawing on a range of theoretical and practical support). It will involve practical exercises.

The session will be presented by the co-Chair and future co-Chair of the scientific committee of the BABCP, who are familiar with the processes and the reasons for accepting and rejecting submissions.

**Posters**

**Developing Clinical Leadership in CBT Practitioners**

Rebecca Minton, NHS Leadership Academy;

Clinical leadership is at the heart of recent healthcare reforms and key to improving the quality of care patients receive. CBT therapists, directly exposed to the problems affecting patient care, are well equipped to identify and make improvements to healthcare services. CBT therapists have valuable skills and qualities which can be applied to leadership.

With the emergence of IAPT and changes to mental health services, they have the opportunity to lead innovative and novel ideas.
A national multi-profession initiative designed to develop leadership potential amongst clinicians awarded a place to one CBT therapist. The NHS Clinical Leadership Fellowship was a one-year part-time programme run by the NHS Leadership Academy involving a combination of academia (Postgraduate certificate in Leadership and Service Improvement) experiential learning, and application of leadership skills through a service improvement project. The Fellowship showed how skills required to be an effective CBT therapist overlap with those required to be an effective leader (e.g. engagement and collaboration). Yet exposure to a number of leadership tools (e.g. Myers Briggs) offered deeper insight into one’s own leadership style and those of others, benefiting both leadership development and CBT clinical practice. An appreciation and understanding of the wider context of healthcare was also invaluable. There has been much focus on doctors and nurses taking on positions of leadership in healthcare but CBT therapists also have an important role. Medical training is putting a greater emphasis on leadership and management, could this be incorporated into CBT training too? Training and developing CBT therapists who aspire to become clinical leaders can lead to improvements in healthcare and CBT services, in addition to personal and professional growth.

**Training Health Practitioners To Use The Pain Management Plan**

**Frances Cole, Bradford Teaching Hospitals NHS Foundation Trust; Polly Ashworth, Gloucester Royal Infirmary; Patrick Hill, Birmingham Community NHS Service; Eve Jenner, Birmingham Community NHS Service; Bob Lewin, University of York, Robb Hunt, Gloucester Royal Infirmary**

The Pain Management Plan (PP) is a facilitated cognitive behavioural, self-management support programme for people with long term pain, in an interactive, accessible, pictorial workbook. 94 multi-disciplinary facilitators, both mental and physical health and IAPT have been trained through 4 x one day national workshops This is a summary of the participants’ evaluation.

Knowledge and Skills Assessment: Participants self-rated knowledge and skills before and after the workshop on the 15 domains that encompassing self management for living with pain
Confidence: 1 week after training participants self-rated their confidence online in using the PP and gave the trainers feedback.

Results show change in ratings in pre and post-workshop knowledge and skills, completed by 62% of trainees (N=58) which showed improvement in all domains. Results from 72% (N=68) who completed the online feedback and confidence survey indicate satisfaction with all aspects of training and high levels of confidence to implement skills gained.

The training evaluation was carried out immediately before and within two weeks after training with high response rate. Using knowledge and skills preassessment and post assessment allows individuals to discover their own skills level and focus on the skill areas they needed to gain. The confidence levels rated in the online survey within the two weeks of completing training would seem to indicate valued training both content, practice and presentation. The knowledge and skills domains were drawn from combination of research and practical frontline experience working with individuals with pain Training programmes that allow individuals to self assess their knowledge and skills of self management of long term conditions like pain, before and after training may enhance implementation in the use of CBT based programmes like the Pain Plan.

**CUDAS: Coventry University Depression and Anxiety Support. Improving access to psychological care for people with long term conditions**

**Patrick Kennedy-Williams, Coventry University; Puja Joshi, Coventry University; Catherine Bailey, George Eliot Hospital NHS Trust; Raymond Bell, Coventry University; Tania Gulko, Coventry University, Julie Highfield, UHCW NHS Trust; Gill Furze, Coventry University**

People with long term conditions (LTCs) are two to three times more likely to develop common mental health problems than the general population (Naylor et al., 2012); however, specialist nurses are often unsure of the options for psychological care. Improving Access to Psychological Therapies (IAPT) services can deliver support for people with LTCs and co-morbid anxiety and/or depression but these services are often underutilised. We developed, with feedback and input from clinical psychology and physical health specialist staff, a decision support tool web application, which supports physical health clinicians through the assessment of anxiety or depression in people with LTCs. The tool includes clinical measures that facilitate referral to IAPT (PHQ-7 & GAD-7) and gives guidance on appropriate onward referral where needed. The tool also includes a video tutorial, which guides the clinician through a role-play assessment (including how to assess for risk). Interviews with specialist nursing staff (N=15) regarding the content, usability and clinical utility of the tool were audio-recorded, transcribed and analysed using Thematic Content Analysis (TCA). Results from TCA were positive regarding the design and content of the tool. Several other major themes emerged, including the necessity of screening for anxiety/depression, why assessment may not currently occur, and how the tool better facilitates the assessment and referral process.

Feedback from specialist nursing staff was instrumental to the design of the tool. It is now in the public domain and is free to access. In addition to its availability as a paper-based version and a web-based app for personal computers, the tool has
been further developed as a downloadable app for both Apple and Android mobile devices, and will be available via NHS Local for download by any health professional. It is hoped that wider dissemination of the tool will improve the assessment and evidence-based psychological care for people with LTCs and co-morbid anxiety and/or depression, particularly by improving the referral of people with LTCs to IAPT services. Many IAPT services are expanding to work with these patients, and it is hoped that the tool will help these services to meet this unmet psychological need.

Training and Supervision Developments in Evidence Based Psychological Therapies for Psychosis

Louise Johns, South London and Maudsley NHS Foundation Trust; Elaine Hunter, South London and Maudsley NHS Foundation Trust; Suzanne Jolley, King’s College London; Juliana Onwumere, King’s College London; Emmanuelle Peters, King’s College London, Philippa Garety, King’s College London

Cognitive-behavioural therapy and Family Interventions for psychosis (CBTp and FIp) are clinically and cost effective (NICE, 2009), but are not routinely delivered (Schizophrenia Commission, 2012). One of the barriers to implementation is insufficient skilled staff (Tansella and Thornicroft, 2009; All Party Parliamentary Group on Mental Health, 2010). In collaboration with the South London and Maudsley NHS Foundation Trust, we have developed a portfolio of training opportunities in King’s College London for training mental health professionals in CBTp to develop workforce skills and improve access to psychological therapies for clients with psychosis.

Training provision includes specialist and dedicated academically accredited and in-service programmes for CBTp and FIp. Flexible completion on a modular basis is possible. Programmes span the workforce, from introductory awareness training through brief interventions and ‘top-up’ training to supervisory level. Closely supervised practice is strongly emphasised, and we measure competence and adherence using general cognitive therapy rating scales and Cognitive Therapy for Psychosis Adherence Scale (CTPAS).

We will present pilot training outcome data in relation to therapy quality and clinical outcomes. We will highlight how our training and supervision initiatives will be linked to the new national competence framework for psychological therapies for people with severe mental illness.

It is possible to develop a flexible high-quality training and supervision structure for CBTp and FIp. This will be tailored to the IAPT-SMI training framework as it emerges. There is capacity to offer distance learning, to help roll out training and supervision nationally and overseas.

Specific CBTp competences are required for good clinical outcomes, with delivery of the full range of therapy techniques. Competent delivery of NICE compliant CBTp in routine practice requires specific training and close supervision.

Improving wellbeing for staff working in a Medium Secure Setting using Mindfulness

Talent Chinyemba, Norfolk and Suffolk NHS FT, Graduate of University of East Anglia (UEA)

Forensic Medium Secure Units are particularly challenging places for service users to be but equally there challenging places for members of staff to work in. The stress associated with the therapeutic milieu often results in staff sickness and inconsistencies in care. The national picture reported by Boorman’s report indicates that sickness costs the NHS £555 million yearly. Nice guidelines, the Whitepaper and elements of the QIPP (Quality, Innovation, Productivity and Prevention) focusing on improving the wellbeing of staff, as a healthier workforce deliver better, safer and quality care for patients.

Mindfulness is often described as paying attention in a particular way, on purpose, in the present moment non-judgementally (Kabat- Zin 1996). Brown and Ryan 2003 state that mindfulness is an attribute of consciousness believed to promote well-being. The 8 week MBSR course was run using the principal outlined in Jon Kabat-Zinn’s work. To measure outcome the Mindfulness Awareness Attention Scale (MAAS) which is a 15 item self reporting scale (Brown and Ryan 2006) and Kentucky Inventory of Mindfulness Skills (KIMS) which is a 39 item self reporting scale (Baer et al 2004) were utilised in pre and post intervention testing. The pre and post testing has the ability to be affected by other confounding vulnerability factors. In this study we used two assessment tools to increase the credibility and validity of the data collected. The group was picked at random from the self selecting applicants, a balance was achieved of participants from each clinical department to allow for equity across the board in the service and variety in the group.

The first measure MAAS, showed a 11% improvement, which suggests that the staff who engaged in this training experienced in improvement openness/ receptive awareness and attention to what is taking place in the present moment. The other measure KIMS showed a 2% increase in mindful disposition specific to observing, describing, acting with awareness and accepting without judgement (Baer et al 2004).

Pre and post data was collect using self-assessment tools in order to measure the effectiveness of the intervention. When interpreted the results indicated an improvement in the mindfulness disposing of the group post intervention. These are result of a quasi study and provision of proof of concept. There is an increasing evidence base of using mindfulness to improve wellbeing in the work place, but little research has been done specific to this clinical area. There is scope for this area to be studied with more measures implemented to provide more credibility to results there could also be benefit in using a mixure of outcome measure not only self reporting tools.

Mindfulness in the workplace has been associated with boosting attention, concentration, raising levels of emotional intelligence, increases resilience and improves relationships. (Chashkals 2011) Improving the wellbeing of staff using psychological intervention has the potential impact of improving productivity and quality of care. The results of this quasi
study suggest an improvement in the mindful disposition of staff which can be associated with an ability to provide better health care.

The Psychological Treatment of Comorbid Anxiety Disorders in Clinical Practice: A Clinical Vignette Study

Gavin Clark, University of New England, Australia; Tanya Hanstock, University of New England, Australia

This presentation will report on the results of an online clinical vignette study, which investigated how single and co-morbid anxiety disorders are conceptualised and treated in routine clinical practice in a sample of Australian clinicians.

Background: A number of diagnosis-specific psychological interventions have been demonstrated to be effective in the treatment of individual anxiety disorders with Cognitive-behavioural therapy (CBT) in particular having been demonstrated to be a highly effective treatment for the major anxiety disorders. However, at present little data exists which demonstrates whether clinicians delivering psychological therapy in routine practice have knowledge of these evidence-based interventions or utilise them in their work with patients with anxiety disorders. The implications for training, monitoring and reporting for clinical practice is considerable. Additionally many patients with anxiety disorder presentations (40%-80%) meet criteria for multiple (two or more) anxiety disorders. This is a problem as it highlights two very significant gaps in the current research literature; (i) there is very little empirical research concerning the most effective way to treat the 40-80% of patients with anxiety presentations who meet criteria for multiple (comorbid) anxiety disorders. (ii) there is little knowledge about how clinicians usually understand and treat patients with multiple anxiety disorders in routine clinical practice (and particularly how they would do this using a CBT approach). It is therefore important to find out how clinicians in their routine practice currently conceptualise and treat comorbid anxiety disorder presentations.

The study utilised an online survey design to conduct a clinical vignette study. The study aimed to recruit a sample of Psychologists delivering psychological therapy across Australia to participate in the study. The online survey aimed to assess how clinicians reported they would treat each of the major anxiety disorder diagnoses and comorbid anxiety disorder presentations and to evaluate how those clinicians would respond to clinical vignettes reflecting single and multiple anxiety disorder diagnoses.

The talk will report the findings of the study in order to address the following questions:

(i) What psychological treatments are used by clinicians in the treatment of anxiety disorder presentations in routine clinical practice?
(ii) Do these interventions reflect evidence-based practice and clinician knowledge of the evidence-based protocols?
(iii) How do clinicians delivering psychological therapy conceptualise and treat co-morbid anxiety disorders when utilizing a CBT approach?

The implications for clinical practice, supervision and the dissemination of evidence-based psychological treatments will be discussed.

The talk will describe clinician knowledge and use of evidence-based protocols and discuss implications for supervision and dissemination of current diagnosis-specific CBT treatments.

Secondly, and more significantly, this talk will report on how clinicians conceptualise and treat multiple comorbid anxiety disorders utilizing a CBT approach. This will be discussed in relation to current research on the treatment of comorbidity in anxiety disorders and suggestions for future research and clinical practice.

Secondary Care Mental Health Practitioners’ Perceptions of the Effect of Intermediate Cognitive Behavioural Therapy Training on their Clinical Practice

Romina Scaramagli, Community Mental Health Nurse, Cornwall Partnership NHS Foundation Trust.

Cognitive behavioural therapy (CBT) is recommended by the National Institute for Health and Clinical Excellence for the treatment of a number of mental health problems. This study explored secondary care mental health practitioners’ perceptions of the effect intermediate cognitive behavioural therapy training had on their clinical practice. A generic qualitative approach was adopted using thematic analysis. Secondary care mental health practitioners who had completed an intermediate CBT course were recruited from two NHS mental health trusts. Convenience sampling was used to recruit participants.

Eight participants were interviewed using one to one semi-structured interviews. Three main themes were identified from the analysis. In Becoming a CBT Practitioner, participants talked about the benefits they experienced from undertaking the intermediate CBT training and how it helped them build on existing skills and develop new clinical skills and techniques. Being a CBT Practitioner described how participants were able to incorporate CBT into their clinical practice to varying degrees. Participants found they were able to use CBT successfully with clients with a range of mental health problems. Providing CBT enabled participants to experience both personal and clinical benefits. In Maintaining CBT Practice, participants discussed barriers they encountered to implementing CBT and made suggestions of things that would help facilitate improved implementation of CBT. These changes have been incorporated into recommendations for future practice.
Therapeutic Techniques

Symposia

Adaptations of CBT for Specific Populations
Chair: Ken Laidlaw, University of East Anglia

Behavioural Activation - clarifying the implementation of behavioural techniques
Fredrik Folke, Department of Neuroscience, Psychiatry, Uppsala University, Sweden; Jonathan W. Kanter, Department of Psychology, University of Wisconsin-Milwaukee; Stefan Thungström, Center for Clinical Research Dalarna; Per Söderberg, Center for Clinical Research Dalarna; Timo Hursti, Department of Psychology, Uppsala University, Sweden; Klara R. Jakobsson, Center for Clinical Research Dalarna; Lisa Ekselius, Department of Neuroscience, Psychiatry, Uppsala University, Sweden

Behavioural Activation (BA; Martell, Addis, & Jacobson, 2001) contains a variety of behavioural techniques. However, therapists are not provided with guidelines for when and how to implement these strategies (Kanter et al., 2010). Kanter, Busch, & Rusch (2009) described a logical sequence for BA, moving from simple assessment and activation techniques to more complex behavioural strategies if needed. Specifically, when clients fail to carry out scheduled activities therapists go through a functional assessment procedure that leads to the specification of appropriate interventions. This procedure has only been evaluated in one preliminary study (Baruch, Kanter, Bowe, & Pfennig, 2011).

In the current paper we provide clinical descriptions of the above mentioned BA procedure. We also compile data related to the procedure from approximately 250 BA sessions conducted in mental health care settings. Data include session by session therapist rated activation adherence, functional assessments of non-adherence and inter-rater reliability of such assessments.

Overall, results indicate that adherence is more common than non-adherence. The function of not carrying out scheduled activation assignments is most commonly avoidance of private events. Clinicians can make functional assessments with good agreement.

BA is a simple and efficacious therapy. Therapists agree on when to implement different techniques used in BA when using a procedure that clarifies functional assessment.

This preliminary paper may provide therapists with clarification of when and how to implement the different techniques of BA.

Individual Manualised Cognitive Behavioural Therapy for common mental disorders in people with mild to moderate intellectual disability
Marc Serfaty, Mental Health Unit, UCL, London and Lorna Vincent, Camden and Islington NHS Foundation Trust; Andre Strydom, Mental Health Unit, UCL, London.; Sue Martin, Camden and Islington NHS Foundation Trust; Kiran Azam, Camden and Islington NHS Foundation Trust; Michael King, Mental Health Unit, UCL, London.; Angela Hassiotis, Mental Health Unit, UCL, London

There are increased mental health problems in people with Intellectual Difficulties (ID). CBT has been shown to be effective in anxiety and depression in a non-ID population. Although people with mild to moderate ID are able to link thoughts and emotions, CBT approaches tend to focus on behavioural interventions. The description of the feasibility of this approach is provided along with findings from a preliminary RCT of Treatment as Usual (TAU) compared to TAU plus CBT using a combined cognitive and behavioural approach.

People with mild to moderate ID and attending two adult outpatient ID services were screened using the PASSAD for significant anxiety and/or depressive symptoms. Significant cases (n=32) who consented were equally randomised, with those allocated to CBT receiving up to up to 16 weekly hourly sessions of manualised CBT delivered by a BABCP accredited therapist and facilitated by a keyworker. The Beck Depression and Anxiety Inventories-Youth were the main outcomes, collected at baseline and post intervention (4 months). Quality of therapy was assessed by an independent rater using the CTS-R.

Mean change (95% CI) in the Beck Depression Inventory-Youth (BDI-Y) score from baseline to the 16 week endpoint (primary variable) was 0.10 (-8.56, 8.76) and in the Beck Anxiety Inventory-Youth (BAI-Y) 2.42 (-5.27, 10.12). Preliminary findings suggest that from a random sample of 19 recordings gave a median CTS-R score of 48.5 (QR 44.5-51.7) and identified a number of cognitive interventions in therapy.

Uncertainties about the clinical and cost effectiveness can be fully answered by a large scale clinical trial. Findings from the CTS-R suggests that it is possible to deliver a good level of CBT.

The feasibility study demonstrates that it is possible to set up and carry out a randomised controlled trial of a psychological intervention in ID and that the intervention can be integrated clinically.
The effectiveness of Cognitive Behavioural Therapy as a treatment for Generalised Anxiety Disorder in later life compared to adults of working age: A Meta-Analysis and Systematic Review

Albert Aspinall, University of Edinburgh; Ken Laidlaw, University of Edinburgh

Cognitive Behavioural Therapy has already been demonstrated to effectively treat anxiety disorders in adults of all ages. However, no research has conclusively examined the extent to which CBT is effective for treating Generalised Anxiety Disorder in later life compared to those of working age. The contemporary opinion is that a deficit in cognition, in particular executive control, reduces the effectiveness and longevity of CBT for treatment in later life. The aim of this research project is to determine, at least partially, the difference in outcomes of cognitive behavioural therapy, and it’s constituent therapies, in treating GAD between these two age groups.

In order to identify all the relevant studies, we conducted a search of the databases MEDLINE, PsychInfo and EmBase between 1974 and 2013. We used the text key terms “Generalised Anxiety Disorder” and “Generalized Anxiety Disorder” in combination with each of “Rational-Emotive Therapy”, “Cognitive Therapy”, “Cognitive Behavioural Therapy”, “Cognitive Behavioural Therapy”, “Problem Solving”, “Acceptance and Commitment Therapy”, “Coordinated Learning Anxiety and Management”. The resulting publications were then limited to adults over 18 years old. A subsequent manual search of the reference lists of these, and other, publications including reviews and prior meta-analysis assessing psychological treatments for late-life generalised anxiety disorder was conducted, in addition to searching “first look” sections of online journals concerned with Gerontology, Anxiety and Psychotherapy. Studies were included only if they were (a) Randomized controlled trials (b) with patients that were diagnosed clinically with Generalised Anxiety Disorder (in accordance with the DSM-III-R, DSM-IV or DSM-IV-TR) and verified using a structured or semi-structured clinical interview by a trained professional. Additionally these studies needed to include (c) a therapeutic arm of pure CBT or one of its derivatives based on principles of CBT, this includes psycho-education, a form of relaxation training, cognitive restructuring and exposure to anxiety-inducing stimuli. Studies also needed to include a between groups comparative control condition, such as a waiting-list (WL), Treatment as usual (TAU) or enhanced usual care (EUC) group, with effect sizes and effectiveness of therapy measured using (d) an appropriate and valid outcome measure, employed by researchers who are blind to the allocation group. These studies were then ranked by the two authors, A.A and K.L, in terms of methodological quality based upon a number of factors such as participant number, which included drop outs and completers, type of treatment, average age and duration of symptoms.

This publication has highlighted the need for a large sample randomized controlled trial to evaluate whether Generalised Anxiety Disorder in older adults is as effectively treated by CBT when compared to adults of working age. The primary limitations within this study, such as combining different therapies, the potentially ambiguous use of age classifications and the impact of small sample sizes could all be reduced. It is still debatable whether any differences found between these groups are the result of deficits of cognition within older adults that causes CBT to be less effective, or alternatively the way in which GAD is expressed. Whereas previous research has determined an important role for executive control in developing the effectiveness of CBT, Generalised Anxiety Disorder has not been developed or explored as extensively. There is the possibility that GAD could be reclassified or repositioned diagnostically further from other anxiety disorders, as opposed to left as a residual category for when other criteria for other disorders are not met. Should a difference between groups be present the next step within research should be to discover why this deficit exists and how best to overcome it. This publication will help develop our understanding of CBT in late life and expand current contentions about Generalised Anxiety Disorder. By constantly developing an awareness of how CBT for GAD may differ in later life, clinicians will be made aware of the variations that need to be taken into account when treating older adults. Future research and application of CBT should be concerned with investigating the most effective amalgamation of CBT with other methods of cognitive enhancement and increasing the number of therapeutic and booster sessions for each patient, with the aim of improving success rates and reducing a relapse of symptoms.

Mindfulness and Distress Tolerance skills for inpatients in later life?

Kirsty James, University of Bath

Clinical observation and empirical research suggests that older adults in inpatient settings may have heterogeneous and complex needs hypothesised to be a result of emotion regulation difficulties. Cognitive-behavioural interventions, particularly Dialectical Behaviour Therapy (DBT; Linehan, 1993), have been found to be beneficial across disorders characterised by emotion dysregulation. This paper describes a weekly group intervention developed to begin to adapt and explore mindfulness and distress tolerance skills for an older adult inpatient population.

On the basis of a consultation process with both inpatient staff and clients, alongside literature on DBT, a group titled ‘Coping with Emotions’ was developed. A preliminary evaluation was conducted comparing the rate of incidents on the ward before and after the group, and looking at client feedback with the use of a weekly questionnaire.

A total of twenty-seven participants attended across six sessions (mean of 5 clients per session). Following six sessions, the number of ward incidents involving impulsive behaviours reduced from three to zero. Client feedback suggested the group was perceived as helpful, and that clients felt listened to and more able to cope with and discuss their emotions.

 Whilst considering its limitations, this preliminary study may support the use of a group intervention focusing on DBT mindfulness and distress tolerance skills with clients in later life in an inpatient setting. This study begins adapting mindfulness and distress tolerance skills for an older adult inpatient population within routine clinical practice and demonstrates the feasibility of running a weekly group intervention on this basis. The feedback
Helping Aged Victims of Crime (HAVoC) Study: The impact of common crime on older people and the feasibility of a cognitive behavioural therapy (CBT) based intervention.

Marc Serfaty, University College London; Anna Ridgwell, University College London, UK.; Vari Drennan, University of London & Kingston University, UK; Anthony Kessel, London School of Hygiene and Tropical Medicine.; Gloria Laycock, University College London, UK.; Martin Blanchard, University College London, UK.

Older people have an increased fear of crime and they may also be more vulnerable to its impact. There are however limited data whether interventions are beneficial.

Older victims, identified through the police, were screened for psychological distress using the K6, PHQ-2, GAD-D and PTSDS within one (n=605) and at three months (n=487) of a crime. A further assessment for a DSM-IV diagnosis of MDD, Anxiety or PTSD was undertaken for those significant at 3 months’ screening, and if agreeable victims were randomised into a pilot RCT of treatment as usual (TAU) or TAU plus 8 sessions of a manualised, CBT informed, Victim Improvement Package (VIP), delivered within 3 months. Qualitative interviews were also undertaken at randomisation and post intervention. The primary outcome was the WHODAS-II; the BDI-II, BAI and PTSDS were secondary outcomes; all were collected at baseline and post intervention (3 and 6 months post crime respectively).

Recruitment is best done through Safer Neighbourhood Teams. At three months post crime 134/487 (36%) reported significant distress; 33 had a DSM-IV diagnosis; 25 agreed to be randomised. The WHODAS-II was poor at measuring change, but a trend towards improvement was observed for depressive and anxiety related symptoms.

Psychiatric symptoms tend not to resolve spontaneously. Older people can engage in the VIP with preliminary findings suggesting an improvement with the VIP.

The impact of crime in older people is significant. This is the first study in which the delivery of a specially developed CBT informed VIP appears realistic and promising, although further research is necessary to evaluate its clinical and cost-effectiveness.

Innovations in Treatment and Delivery

Convenor and Chair: Chris Williams, Institute of Health and Wellbeing, University of Glasgow

Gratitude diaries as part of the CBT toolkit: Do they ameliorate depression, negative thinking and hopelessness, and increase gratitude?

Moray Leyland, Coventry University; Authors: Moray Leyland, Coventry University; Emma Swan, Nottingham Trent University; Alex Sumich, Nottingham Trent University

Interventions aimed at increasing gratitude have recently gained attention as a useful method for improving psychological well-being: specifically depression. Aims: This study evaluated (a) whether a two-week gratitude diary would reduce clinical scores of depression, hopelessness, negative automatic thoughts, and increase gratitude measures; (b) whether a two-week positive diary would reduce clinical scores of depression, hopelessness, negative automatic thoughts, and increase gratitude measures; (c) whether there were any differences between the gratitude diaries and positive diaries.

Participants (N=44) aged 20-71 years that scored 10 or more on BDI-II measures were recruited from depression self-help groups and randomly allocated to one of three experimental conditions: ‘gratitude journal’ (N=16), or ‘positive journal,’ (N=14) or ‘no intervention’ control (N=14) for two weeks.

Both gratitude and positive diaries were similarly effective in significantly reducing clinical scores of depression and negative thinking, but gratitude diaries were more effective in increasing measures of gratitude and decreasing hopelessness.

Conclusions: Gratitude diaries are effective in reducing self-report measures of depression, negative thinking, and hopelessness, and increasing self-report measures of gratitude. Gratitude diaries and positive diaries are similarly effective in reducing depression and negative thinking, but gratitude diaries are more effective in reducing hopelessness and increasing gratitude.

Gratitude diaries offer promise as an effective CBT technique for treating depression, hopelessness and negative thinking. The user friendly simplicity of this technique could make them an effective step 2 approach in th IAPT service.

Homework adherence, Patient Perception of the Therapist & Clinical Improvement in Cognitive Behaviour Therapy (CBT): The Introduction of the Session Bridging Worksheet

Caroline Williams, South West Yorkshire Mental Health NHS Trust; Caroline Williams, South West Yorkshire Mental Health NHS Trust

Judith Beck introduced the SBW in her book ‘Cognitive Therapy: Basics & Beyond’ (Beck, 1995) as a tool to review positive and negative aspects of the homework assigned and to assess patient learning, assimilated from the previous session, and...
to be the structure of the next (a bridge between sessions). It was considered that the SBW could provide a structure to therapy sessions and had the potential for improving homework adherence but also may have the potential to improve the alliance between the therapist and the patient. The 'bridge' between sessions could potentially introduce repetition thus encouraging learning and self efficacy. It was also considered that this in turn may have an effect on symptom improvement. The aim of the study was to evaluate the use of a session bridging worksheet (SBW) (Beck, 1995) within cognitive behaviour therapy (CBT) and its effect on homework adherence, treatment outcome and participants perceptions of therapist homework setting behaviours. A systematic literature review was undertaken on the use of homework in CBT and the main themes within the literature were identified, this was followed by a pilot study (n=7), which found a very large effect size (Cohen's d > 0.8) supporting the use of the SBW intervention. Power calculations a priori identified a sample size of up to 22 participants for a larger study. Following consultation with the author of the SBW, the SBW was modified following the pilot patient study and a revised version was created. (SBW-R) A study was undertaken of 22 participants attending a routine private outpatient clinic who met the criteria for mild to moderate mental health problems as defined by the national IAPT criteria. The study was part of a thesis for the M.Ed Psychology of Education at the University of Manchester. The therapist was the investigator and was an accredited BABCP CBT therapist with 10 years experience.

The study employed a quasi-experimental quantitative methodology and was an open trial with randomisation. A convenience sample of 22 participants targeted from a private outpatient clinic and randomly allocated to an experimental condition (SBW-R + CBT) (n=11) or a comparison control group (CBT TAU) (n=11) were recruited. Following rates of attrition, a final sample size of 16 was included into the final analysis (SBW-R + CBT n= 9; CBT TAU group n=7). An intention to treat analysis was not conducted. All participants were assessed using the online version of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (First, Spitzer, Gibbon, & Williams, 1997) to ensure appropriate inclusion to the study. Clinical symptom change, was evaluated by the use of the revised version of the Beck Depression Inventory – Revised (BDI-II) (Beck, et al., 1996), the Beck Anxiety Inventory (BAI) (Beck & Steer, 1987) and the Beck Hopelessness Scale (BHS) (Beck & Steer, 1993). A ‘Homework Questionnaire’ (HQ) was identified from the literature review (Startup & Edmonds, 1994), that was considered to have face validity and a good fit for the study and was used to measure participants perception of the therapist on the homework setting qualities. All HQ ratings were blind to the therapist and were not opened until the main study had been completed.

The level of significance was set at alpha (?) 0.05 and the level of power at 0.95. Data was analysed using Statistical Package for the Social Sciences (SPSS) and Microsoft Excel. Effect size was calculated by the use of SPSS and an online effect size calculator. Ethical approval was received via the Ethics Committee at the School of Education, University of Manchester.

Both groups (CBT+SBW-R and CBT TAU) had large within group treatment effect sizes across all clinical symptom improvements, however between-group mean differences were small. The results also suggested that there was an appreciable effect for session attendance in favour of the SBW-R + CBT intervention and homework adherence. The effect size between groups, evaluating therapist qualities was very small and both groups rated the therapist high in their adherence to the CBT model, however a small appreciable effect was observed in favour of the SBW-R+ CBT group, for the therapists’ description of homework and discussion of the problems expected. The use of the SBW-R did not have a considerable effect on hopelessness between the groups or how the participants perceived the therapist when providing a rationale for the homework assignment or level of involvement in the setting of the task.

There was a significant difference in the dependent variable for change in anxiety symptoms between the SBW-R+CBT group and the TAU group (t (13.78) = -1.77; p=0.04 one tailed).

The results suggested that treatment using the CBT model, whether enhanced by a structured in session protocol or without still had a large effect on treatment outcomes. However the inclusion of an in session protocol such as the SBW-R has a small but appreciable effect on perceptions of therapist qualities, clinical improvement in anxiety and session attendance. However the effect sizes are small following treatment in respect to clinical outcomes and it is not certain whether the SBW-R has wider benefits. The improvement in anxiety raises presents interesting conclusions which require further investigation, particularly investigating the structure of sessions and whether therapist qualities can be manualised. Further research is required on the use of the SBW-R to refine its use and evaluate its implementation across an increased number of therapists and increased population sizes. Further studies also need to control for outliers and real world interfering variables.

The research has potential resonance within a clinical environment, which assumes adherence to clinical competencies (e.g. Roth & Pilling, 2007) and timely delivered manualised cognitive therapy. The research, although small, has implications for real world application within IAPT services where a critical mass of therapists need to prove to commissioners the effectiveness of their therapies. Using a manualised structure to inform the mechanics of the therapy session can be seen in therapies such as CBASP and EMDR and therefore the question is whether adherience to the process can and should be manualised. However this question should be rooted in empirical evaluation and further research and evaluation is required.

**Developing and Testing a Computerised Cognitive–Behavioural Intervention for Dysfunctional Impulsive Behaviour**

Sirous Mobini, University of Newcastle

Impulsivity is a multifaceted construct that defines a range of prominent features of many psychological disorders in adults and young populations. A major shortcoming in our understanding of the nature of impulsivity is the scarcity of information on the cognitive attributes contributing to impulse control related disorders characterised by ‘an inability to resist the impulse to perform an action that is harmful to one’s self or others’. Consequently, there seems to be a lack of
specific psychological interventions in the treatment of pathological impulsive behaviour. In two studies (Mobini et al., 2006; Mobini et al., 2007), we examined the cognitive processes underlying impulsive behaviour. In the first study, we developed a measure of dysfunctional cognitions (Cognitive Distortion Scale, CDS). The results of these studies suggested that negative dysfunctional beliefs may operate as underlying cognitive processing associated with some subtypes of impulsivity, i.e., dysfunctional impulsivity, non-planning and cognitive impulsiveness. Taken together, consistent with Beck’s cognitive theory (Beck, 1976) our findings suggest that high-impulsive individuals have dysfunctional interpretations of events around them that may contribute to their tendency to act rapidly with disregard to the consequences of behaviour. These dysfunctional beliefs may impair the impulsive individuals’ ability to think carefully and to take into account the long-term consequences of their reckless actions. These findings have clinical implications suggesting that cognitive-behavioural interventions targeting information processing characterised by specific cognitive distortions may help people with high levels of impulsivity regulate their behaviour and emotions more effectively, thereby increasing self-control. Building on our previous findings, we developed a computerised CBT-based treatment for dysfunctional impulsive behaviour. We will discuss 1) the underlying cognitive processes involved in impulsiveness and 2) the preliminary findings from a computerised CBT-based program for the treatment of dysfunctional impulsivity.

Implications: The preliminary outcome of this project is the development of a computerised cognitive-behavioural intervention to be used in the treatment of impulsive control disorders. Furthermore, the results of this study will further develop our understanding of cognitive processes involved in various features of impulsive behaviour. The ultimate benefit of this research is to improve public mental health by making this intervention available for impulse control disorders via e-Health.

Think Positive: An investigation of an exercise of the MoodGYM online CBT programme
Conall Tunney, University College Dublin; Gary O’Reilly, University College Dublin

Online CBT has been shown to have a positive impact on symptoms of depression and anxiety. Differences in the effectiveness between programs that are therapist assisted versus open access have led to further investigation of open access programs to determine whether certain sections have a greater impact on people. Christensen, Griffiths, Mackinnon & Brittiffe (2006) divided the MoodGYM program into 6 versions to assess them individually. The present study will break the program down further by isolating a single exercise and assessing it. The primary independent variable will be the frequency of positive automatic thoughts. Secondary independent variables will be depression anxiety and stress scores. Participants will be randomly assigned to one of two groups. Group 1 will receive the intervention and Group 2 will be the control. There will be 30 participants in each group. Measures will be the Automatic Thoughts Questionnaire – Positive (Ingram & Wisnici, 1988) and the Depression, Anxiety and Stress Scales (Lovibond & Lovibond, 1995).

Results will be participants’ scores measured at time 1 and time 2 testing. Results will be discussed in relation to efficacy of the isolated exercise compared to previous studies of larger sections of the program as well as the impact that this research methodology has on future trials of open access CBT programs. The present study will provide new information on the efficacy of open access online CBT programs. Results will also indicate whether programs broken down to individual exercise can be assessed as stand-alone interventions.

Skills Classes

Cultivating Openness and Acceptance: Working with Difficult Emotions in Mindfulness-Based Cognitive Therapy
Thorsten Barnhofer, Oxford Mindfulness Centre

One of the main intentions of Mindfulness-Based Cognitive Therapy (MBCT) for prevention of relapse in depression is to help patients become better at recognizing and disengaging from maladaptive repetitive patterns of thinking. Yet, the approach of mindfulness does not aim to achieve this objective by teaching participants to “step away” from negative thoughts and feelings, but instead is one of welcoming and allowing. At the core of the program are practices that invite participants to meet even the most difficult experiences with openness and acceptance. Teaching these practices holds many challenges, particularly when working with previously depressed patients who have suffered from suicidality or early adversity, and requires a firm experiential and theoretical understanding of the way in which mindfulness practices can, paradoxically, transform difficult emotions and the cognitive and bodily contexts they arise from.

Objectives: This class will offer an opportunity for personally exploring and investigating qualities of openness and acceptance in a mutual process of learning and discovery. It will provide participants with a detailed structure of the key practices of MBCT for approaching the difficult, and information on their delivery, and will aim to clarify the rationale of these practices from a cognitive and embodied cognition perspective.

Thorsten Barnhofer is an associate teacher at the Oxford Mindfulness Centre and leads MBCT workshops and retreats for mental health professionals internationally and in the UK. He has been involved in research programs on the effects of Mindfulness-Based Cognitive Therapy (MBCT) in suicidal and chronic depression as a researcher, clinician, and meditation teacher in Prof. Mark Williams’ team at the University of Oxford, including a recent trial of MBCT for suicidal depression. He
is currently funded by the German Research Foundation to conduct research into the cognitive and neurobiological effects of mindfulness meditation as a Heisenberg-Fellow at the Freie Universitaet Berlin.


Accessing and Incorporating Clients’ Strengths in Case Conceptualisation
Rob Dudley, Newcastle University

Our task as a therapist is to marry the unique experience of the client with the theory and research of Cognitive therapy to help explain the onset and maintenance of emotional disorders. This is the process of case conceptualisation. This shared understanding helps promote client engagement, helps normalise and make sense of presenting issues and guides effective treatment choices. When done well this is an important part of effective treatment. However, there are a number of potential issues with this exclusive focus on client’s problems. First, client’s reactions to the process of case formulation can be mixed with people sometimes reporting that they feel overwhelmed with their difficulties or that the formulation has focussed on all that is wrong with that person. Second, this focus is very much on alleviating distress whereas client’s not only want to feel less distressed, they also want to remain well and lead fulfilling and satisfying lives. In short, they want to be resilient. CBT has traditionally focussed on alleviating distress and has not necessarily worked towards these other more personally defined goals.

In our work on case conceptualisation myself and colleagues have identified three key principles that enhance the process of case conceptualisation. One of these principles is incorporating client’s strengths in the formulation. This workshop will address briefly the research on case formulation and the value of eliciting and incorporating client’s strengths. Second, it will consider ways to help recognise and elicit client’s strengths and attributes. To do this we will draw on theories and models of resilience, and wellbeing. This helps provide a framework for identifying client’s strengths and for identifying ways to remain well in the future. Third, it will demonstrate how these can be incorporated into a formulation that enables a client to draw on their natural resources to overcome their difficulties but also acts as a blue print for them to remain resilient and well into the future.

Objectives: By the end of the skills class participants will
a) be aware of theories and models of resilience, wellbeing and strengths
b) be able to use this knowledge to help identify previously hidden or overlooked client’s strengths
c) be able to incorporate strengths into a formulation of a presenting issue
d) be able to develop with a client a formulation of resilience and wellbeing

Robert Dudley is a Consultant Clinical Psychologist and Degree Programme Director for the Clinical Psychology Doctorate at Newcastle University. He is a clinician and researcher mainly working with people with psychosis. He has worked closely with colleagues Willem Kuyken and Christine Padesky on the subject of case conceptualisation and has published on the subject area and led workshops nationally and internationally.


Helping Those Who Binge Eat
Christopher Fairburn, University of Oxford

There is an extensive body of research on the treatment of binge eating problems. The leading treatment is a specific form of CBT. However, a significant subgroup of people respond to cognitive behavioural guided self-help.

In this class an evidence-based approach to the management of binge eating problems will be described and illustrated.

Objectives
- Specify the nature and range of binge eating problems encountered, and their distribution
- Evaluate the treatment options
- Implement guided cognitive behavioural self-help
Professor Christopher Fairburn directs two research centres at Oxford, the Centre for Research on Eating Disorders and the Centre for Research on Dissemination (CREDO; credo-oxford.com). He has two main research interests: the nature and treatment of the eating disorders, and the development, evaluation and dissemination of psychological treatments. He has an international reputation in both fields.

References
Posters

Individual Manualised Cognitive Behavioural Therapy for common mental disorders in people with mild to moderate intellectual disability
Marc Serfaty, Mental Health Unit, UCL, London and Lorna Vincent, Camden and Islington NHS Foundation Trust; Andre Strydom, Mental Health Unit, UCL, London.; Sue Martin, Camden and Islington NHS Foundation Trust; Kiran Azam, Camden and Islington NHS Foundation Trust; Michael King, Mental Health Unit, UCL, London.; Angela Hassiotis, Mental Health Unit, UCL, London.

There are increased mental health problems in people with Intellectual Difficulties (ID). CBT has been shown to be effective in anxiety and depression in a non-ID population. Although people with mild to moderate ID are able to link thoughts and emotions, CBT approaches tend to focus on behavioural interventions. The description of the feasibility of this approach is provided along with findings from a preliminary RCT of Treatment as Usual (TAU) compared to TAU plus CBT using a combined cognitive and behavioural approach. People with mild to moderate ID and attending two adult outpatient ID services were screened using the PASSAD for significant anxiety and/or depressive symptoms. Significant cases (n=32) who consented were equally randomised, with those allocated to CBT receiving up to 10 weekly hourly sessions of manualised CBT delivered by a BABCP accredited therapist and facilitated by a keyworker. The Beck Depression and Anxiety Inventories-Youth were the main outcomes, collected at baseline and post intervention (4 months). Quality of therapy was assessed by an independent rater using the CTS-R.

Mean change (95% CI) in the Beck Depression Inventory-Youth (BDI-Y) score from baseline to the 16 week endpoint (primary variable) was −0.10 (−8.56, 8.76) and in the Beck Anxiety Inventory-Y (BAI-Y) 2.42 (−5.27, 10.12). Preliminary findings suggest that from a random sample of 19 recordings gave a median CTS-R score of 48.5 (QR 44.5-51.7) and identified a number of cognitive interventions in therapy. Uncertainties about the clinical and cost effectiveness can be fully answered by a large scale clinical trial. Findings from the CTS-R suggests that it is possible to deliver a good level of CBT. The feasibility study demonstrates that it is possible to set up and carry out a randomised controlled trial of a psychological intervention in ID and that the intervention can be integrated clinically.

The effectiveness of Cognitive Behavioural Therapy as a treatment for Generalised Anxiety Disorder in later life compared to adults of working age: A Meta-Analysis and Systematic Review
Albert Aspinall, University of Edinburgh; Ken Laidlaw, University of Edinburgh

Cognitive Behavioural Therapy has already been demonstrated to effectively treat anxiety disorders in adults of all ages. However, no research has conclusively examined the extent to which CBT is effective for treating Generalised Anxiety Disorder in later life compared to those of working age. The contemporary opinion is that a deficit in cognition, in particular executive control, reduces the effectiveness and longevity of CBT for treatment in later life. The aim of this research project is to determine, at least partially, the difference in outcomes of cognitive behavioural therapy, and it’s constituent therapies, in treating GAD between these two age groups.

In order to identify all the relevant studies, we conducted a search of the databases MEDLINE, PsychInfo and EmBase between 1974 and 2013. We used the text key terms “Generalised Anxiety Disorder” and “Generalized Anxiety Disorder” in combination with each of “Rational-Emotive Therapy”, “Cognitive Therapy”, “Cognitive Behavioral Therapy”, “Cognitive Behavioural Therapy”, “Problem Solving”, “Acceptance and Commitment Therapy”, “Coordinated Learning Anxiety and Management”. The resulting publications were then limited to adults over 18 years old. A subsequent manual search of the reference lists of these, and other, publications including reviews and prior meta-analysis assessing psychological treatments for late-life generalised anxiety disorder was conducted, in addition to searching “first look” sections of online journals concerned with Gerontology, Anxiety and Psychotherapy. Studies were included only if they were (a) Randomized controlled trials (b) with patients that were diagnosed clinically with Generalised Anxiety Disorder (in accordance with the DSM-III-R, DSM-IV or DSM-IV-TR) and verified using a structured or semi-structured clinical interview by a trained professional. Additionally these studies needed to include (c) a therapeutic arm of pure CBT or one of its derivatives based on principles of CBT, this includes psycho-education, a form of relaxation training, cognitive restructuring and exposure to anxiety-inducing stimuli. Studies also needed to include a between groups comparative control condition, such as a waiting-list (WL), Treatment as usual (TAU) or enhanced usual care (EUC) group, with effect sizes and effectiveness of therapy measured using (d) an appropriate and valid outcome measure, employed by researchers who are blind to the allocation group. These studies were then ranked by the two authors, A.A and K.L, in terms of methodological quality based upon a number of factors such as participant number, which included drop outs and completers, type of treatment, average age and duration of symptoms.

This publication has highlighted the need for a large sample randomized controlled trial to evaluate whether Generalised Anxiety Disorder in older adults is as effectively treated by CBT when compared to adults of working age. The primary limitations within this study, such as combining different therapies, the potentially ambiguous use of age classifications and the impact of small sample sizes could all be reduced. It is still debatable whether any differences found between these groups are the result of deficits of cognition within older adults that causes CBT to be less effective, or alternatively the
way in which GAD is expressed. Whereas previous research has determined an important role for executive control in developing the effectiveness of CBT, Generalised Anxiety Disorder has not been developed or explored as extensively. There is the possibility that GAD could be reclassified or repositioned diagnostically further from other anxiety disorders, as opposed to left as a residual category for when other criteria for other disorders are not met. Should a difference between groups be present the next step within research should be to discover why this deficit exists and how best to overcome it. This publication will help develop our understanding of CBT in late life and expand current contentions about Generalised Anxiety Disorder. By constantly developing an awareness of how CBT for GAD may differ in later life, clinicians will be made aware of the variations that need to be taken into account when treating older adults. Future research and application of CBT should be concerned with investigating the most effective amalgamation of CBT with other methods of cognitive enhancement and increasing the number of therapeutic and booster sessions for each patient, with the aim of improving success rates and reducing a relapse of symptoms.

**Mindfulness and Distress Tolerance skills for inpatients in later life?**

*Kirsty James, University of Bath*

Clinical observation and empirical research suggests that older adults in inpatient settings may have heterogeneous and complex needs hypothesised to be a result of emotion regulation difficulties. Cognitive-behavioural interventions, particularly Dialectical Behaviour Therapy (DBT; Linehan, 1993), have been found to be beneficial across disorders characterised by emotion dysregulation. This paper describes a weekly group intervention developed to begin to adapt and explore mindfulness and distress tolerance skills for an older adult inpatient population.

On the basis of a consultation process with both inpatient staff and clients, alongside literature on DBT, a group titled ‘Coping with Emotions’ was developed. A preliminary evaluation was conducted comparing the rate of incidents on the ward before and after the group, and looking at client feedback with the use of a weekly questionnaire. A total of twenty-seven participants attended across six sessions (mean of 5 clients per session). Following six sessions, the number of ward incidents involving impulsive behaviours reduced from three to zero. Client feedback suggested the group was perceived as helpful, and that clients felt listened to and more able to cope with and discuss their emotions. Whilst considering its limitations, this preliminary study may support the use of a group intervention focusing on DBT mindfulness and distress tolerance skills with clients in later life in an inpatient setting.

This study begins adapting mindfulness and distress tolerance skills for an older adult inpatient population within routine clinical practice and demonstrates the feasibility of running a weekly group intervention on this basis. The feedback received from those attending the group suggest that it was helpful, with further initial support from a comparison of incident rates on the ward. This has implications for the use of aspects of an evidence based approach both within this population and setting. Increasing this population’s accessibility to CBT is particularly important, following findings by the Sainsbury Centre for Mental Health (2004) that CBT is available on fewer than 20% of inpatient wards in England. This study is an initial step towards exploring and evaluating these adaptations, with further research still needed.

**The impact of an attentional bias modification (ABM) intervention on reducing attentional bias and symptom reporting in women experiencing troublesome menopausal symptoms: an exploratory study**

*Evgenia Stefanopoulou, Institute of Psychiatry, King’s College London; Oana Cobeanu, Babes-Bolyai University, Cluj-Napoca, Romania; Myra S Hunter, Institute of Psychiatry, King’s College London*

In the presence of a health condition, difficulties in disengaging attention away from somatic symptoms have been associated with poorer levels of general functionality and health-associated behaviours. To our knowledge, this is the first study to examine the impact of an attentional bias modification (ABM) intervention on reducing attentional biases in women experiencing troublesome menopausal symptoms, particularly hot flushes and night sweats (HF/NS). Its impact on subjective reports of flush frequency and problem-rating were also examined.

11 women experiencing 10 or more problematic HF/NS per week and for at least a month attended 4 weekly attention-training sessions using a modified version of the visual dot-probe task. 9 asymptomatic women of similar age were also included for baseline comparison.

At baseline, symptomatic women reported 45.36 (SD=26.76) HF/NS per week and a problem-rating of 5.7 (SD=2.2) out of 10. They also showed a negative bias score (mean=-3.95 SD=13.4) whereas asymptomatic women showed a positive bias (mean=2.24 SD=9.4). After ABM, women reported 34.12 (SD=25.79) HF/NS per week and a problem-rating of 4.54 (SD=1.96) suggesting less frequent and problematic HF/NS; there was also a reduction in the bias score (mean=-2.41 SD=10.7) although differences were non-significant (p>0.05).

Preliminary findings from this study suggest that clinically relevant, multisession ABM intervention might reduce symptom reporting in women experiencing troublesome menopausal symptoms. Moreover, compared to the asymptomatic group, symptomatic women showed slower response latencies suggesting higher levels of difficulty disengaging their attention from competing tasks. Further research is however warranted to delineate these findings further.

The possible impact of attention training sessions within cognitive behavioural interventions on symptom reporting warrants further investigation.
Case Report: Narrative Exposure Therapy in a medical setting

Gillian Colville, Paediatric Psychology Service, St George’s Hospital, London

The father of a child who had been hospitalised for two years, was referred for psychological support by a paediatric community nurse, six months after hospital discharge. He was expressing continuing anxiety about the child’s health and was having difficulty relaxing and sleeping.

The case formulation was that the degree of life threat to the child, and the chronic stress on the patient related to his child’s protracted treatment, had led to the development of symptoms of PTSD sufficient to meet DSM-IV criteria, which were not resolving naturally. The patient was offered Narrative Exposure Therapy (NET) – a manualised intervention.

The patient completed the treatment over six bi-weekly sessions and, in the process produced a lifeline diagram illustrating particularly memorable events using symbolic flowers and stones. He was also presented with a detailed narrative chronology, typed up by the therapist. Follow up outcome data at 3 and 8 months post-treatment, showed a significant improvement in symptomatology.

The NET approach proved acceptable to the patient and effective in terms of its impact on his most troubling presenting symptoms. Access to the child’s medical notes was particularly useful for cross checking the chronology. The patient found this particularly therapeutic, as it enabled him to create a meaningful and accurate narrative of a period during which he had regularly felt overwhelmed.

Brief evidence based approaches, such as NET, may offer a timely solution for the reduction of PTSD symptoms in patients and relatives who are repeatedly traumatised in medical settings.

References


Difficulty in executive control and alertness in trait anxious individuals

Vincent Leleu, Univ Lille Nord de France, Lille, France and UDL3, PSITEC; Céline Doulliez, Univ Lille Nord de France, Lille, France and UDL3, PSITEC; Stéphane Rusinek, Univ Lille Nord de France, Lille, France and UDL3, PSITEC

Attentional bias towards threat in anxiety is a relatively robust phenomenon (Bar- Haim, Lamy, Pergamin, Bakermans-Kranenburg, & van Ijzendoorn, 2007). However, it is important to disentangle general attention deficits and specific attentional biases towards threat. In this study we wanted to determine whether trait anxiety is related to specific or generalized impairments in the attentional networks.

Participants were 72 undergraduate students from Lille University. The participants were selected on the basis of their response to the French version of the Spielberger Trait Anxiety Inventory (Bruchon-Schweitzer & Paulhan, 1993). Following the French norms, 23 participants (T note ? 55, 70th percentile) were classified in the high trait anxiety group (HTA), and 22 participants (T note ? 49, 50th percentile) in the low trait anxiety group (LTA). Each participant carried out the Attention Network Task (Fan, McCandliss, Sommer, Raz, & Posner, 2002). This task assesses efficiency of three attentional networks: orienting, alerting, and executive control.

To test the effect of Trait Anxiety group (2: HTA, LTA) on attention, separate analyses were conducted for each attention index (3: alertness, orientation, executive control). The groups did not differ on the orientation network index, F(1,43) = .06, ns, but differed on alerting, F(1,43) = 4.01, p = .05, and executive control indices, F(1,43) = 4.01, p = .05. Results showed that, compared to LTA individuals, HTA individuals had greater difficulties in controlling interference and lower alerting efficiency.

In anxious people, the difficulty in controlling interference might explain why they had impairments in ignoring voluntarily distracters throughout a task. Moreover anxious people might show a greater attentional capture only when threatening information is present in the environment.

It seems important not only to focus on reducing the attentional bias for threat (i.e., attention modification bias treatment) but also on improving executive control and alerting efficiencies.

CBT for OCD: habituation or cognitive shift?

Lottie Morris, University of Bath;; Ilm Nightingale, Avon and Wiltshire Partnership NHS

It is established in the literature that Cognitive Behavioural Therapy (CBT) is an effective treatment for Obsessive Compulsive Disorder (OCD) (NICE, 2005). However, gaps in empirical knowledge remain in the understanding of how the process of therapy drives change (Polman et al., 2010). Cognitive Behavioural Therapy (CBT) including Exposure and Response Prevention (ERP) is recommended by NICE (2005) as the psychological treatment of choice for OCD. However, a recent meta-analysis suggested there is insufficient evidence to suggest ERP is improved by cognitive methods (Jonsson and Hougaard, 2008). 25% of OCD patients refuse ERP (Franklin and Foa, 1998), and many psychologists advocate formulation-driven cognitive therapy, including ERP, as opposed to ERP alone (e.g. Rachman, 2003; Radomsky et al., 2010; Wilhelm, 2001). This paper proposes to contribute to this debate by describing the successful treatment of a patient with OCD, exploring which aspects of CBT were particularly meaningful in this case.
X was referred to an IAPT service as she had been experiencing distressing intrusive thoughts and urges for over five years. X experienced urges to look at other people’s chests and groins, and believed others noticed this and were upset by it. X had spent thousands of pounds on private “alternative” treatments, all of which had been ineffective. X and her therapist developed a cognitive behavioural formulation of the problem, which corresponded well with Salkovskis’s (1985) model of OCD. They hypothesised that unwanted sexual attention as a child had made chests and groins threatening to X, and that she either looked at chests and groins no more than others, but was more likely to notice it; or she did look at chests and groins more than others, as a Darwinian threat-detection behaviour. X then thought that others would notice this and would interpret her glances as a sexual, predatory behaviour. X’s safety-seeking behaviours (including avoidance, hypervigilance, thought-suppression, and self-monitoring) prevented her from finding out that her interpretations were inaccurate, and worsened the problem. Based on this formulation, X and her therapist collaboratively agreed some testable hypotheses and devised a series of experiments to interrogate them.

The cumulative results of these tasks led X to discover that: her interpretations about her urges and other people's reactions were inaccurate; and that her safety seeking behaviours were worsening the problem. By the end of therapy (13 weeks), X reported that she had been able to begin to re-build her social life, and make changes to her personal and work life that she was not happy with. OCI scores reduced from clinical to non-clinical and continued to show improvement at follow-up, as did PHQ-9, GAD-7, WSAS and IAPT Phobia Scales. In the Helpful Aspects of Therapy Questionnaire, X outlined that the tasks aimed at challenging her cognitions were the most helpful aspects of therapy, particularly a video feedback exercise which highlighted the discrepancy between her perceptions and reality.

The primary focus of the present paper is to add evidence to the debate around treatment of OCD: is it truly the case, as Abramowitz and colleagues (2002) argue, that supplementing ERP with cognitive methods is unnecessary? Or, is a formulation-driven approach, incorporating a person-centred range of cognitive change methods preferable, as advocated by several prominent authors (Rachman, 2003; Radomsky et al., 2010; Wilhelm, 2001)? The results of this study suggest that, from the patient’s viewpoint, change was due to a range of behavioural experiments designed to test specific cognitive hypotheses identified by X with the therapist’s assistance. The mechanism of change in this case appears to have been X’s discovery that her perceptions and interpretations were inaccurate. There is no indication from X’s self-report, or the content of therapy, that the mechanism for change was ERP and subsequent habituation to stressful situations.

The findings of this case report present an interesting avenue for further larger scale research projects exploring the effectiveness of individualised, formulation-driven, CBT, as well as a case example for clinicians who are concerned about high drop-out rates in ERP.

Helping Aged Victims of Crime (HAVoC) Study: The impact of common crime on older people and the feasibility of a cognitive behavioural therapy (CBT) based intervention.

Marc Serfaty, University College London; Anna Ridgewell, University College London, UK.; Vari Drennan, University of London & Kingston University, UK; Anthony Kessel, London School of Hygiene and Tropical Medicine.; Gloria Laycock, University College London, UK.; Martin Blanchard, University College London, UK.

Older people have an increased fear of crime and they may also be more vulnerable to its impact. There are however limited data whether interventions are beneficial.

Older victims, identified through the police, were screened for psychological distress using the K6, PHQ-2, GAD-D and PTSDS within one (n=605) and at three months (n=487) of a crime. A further assessment for a DSM-IV diagnosis of MDD, Anxiety or PTSD was undertaken for those significant at 3 months’ screening, and if agreeable victims were randomised into a pilot RCT of treatment as usual (TAU) or TAU plus 8 sessions of a manualised, CBT informed, Victim Improvement Package (VIP), delivered within 3 months. Qualitative interviews were also undertaken at randomisation and post intervention. The primary outcome was the WHODAS-II; the BDI-II, BAI and PTSDS were secondary outcomes; all were collected at baseline and post intervention (3 and 6 months post crime respectively).

Recruitment is best done through Safer Neighbourhood Teams. At three months post crime 134/487 (36%) reported significant distress; 33 had a DSM-IV diagnosis; 25 agreed to be randomised. The WHODAS-II was poor at measuring change, but a trend towards improvement was observed for depressive and anxiety related symptoms.

Psychiatric symptoms tend not to resolve spontaneously. Older people can engage in the VIP with preliminary findings suggesting an improvement with the VIP.

The impact of crime in older people is significant. This is the first study in which the delivery of a specially developed CBT informed VIP appears realistic and promising, although further research is necessary to evaluate its clinical and cost-effectiveness.